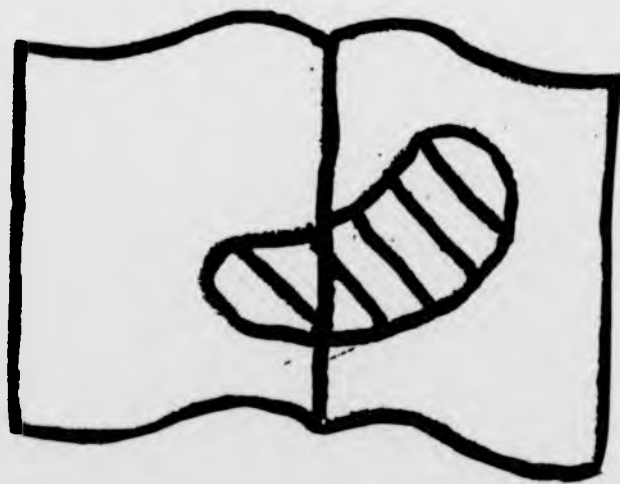# AN ETHIC FOR FLOURISHING IN MENTAL HEALTH PRACTICE:
A PHILOSOPHICAL AND SOCIOLOGICAL STUDY

A thesis submitted to the Faculty of Sociology of the University of Warwick in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Sociology

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April, 2004

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Declaration

I confirm that this thesis is entirely my own work and has not been submitted for a degree at any other University. The thesis has been prepared in accordance with the University of Warwick's guidelines on the presentation of a research thesis.

ABSTRACT

The relevant literature suggests that ethical codes regulating mental health care are 'more honoured in the breach than in the observation' (Pritchard, 2001) and that current codes of good practice may, paradoxically, be bad for this. Patient-centred medicine with its emphasis on user autonomy and participation in care plans has provoked harsher questioning of traditional deontological codes and renewed interest in those based on neo-Aristotelian virtue ethics and the ethic of care. However, much recent work has claimed the latter as "essentially feminine", whilst mental health practice itself is considered by feminists to be paternalistic in ideology and attitude. This dissertation asks, therefore, which type of ethic is best suited to flourishing mental health practice and what are the gender considerations relevant to answering this question?

Ethical practice can be understood only in the context of its interpretation by the relevant players. This, in turn, requires an investigative approach true to the precepts of the relatively new discipline of empirical ethics, which combines sociological grounded theory and fieldwork, informed by philosophical ethics. This is, therefore, the theoretical and methodological framework of this thesis.

Analysis of the data collected suggests that claims of gender differences in approaches to caring cannot be substantiated. Mental health professionals of both sexes practice either caring or emotional labour, or both, or neither. Ethical codes are widely disregarded by both male and female carers, who claim to act upon intuition and 'common sense' in addressing ethical dilemmas. Most users believe codes of good practice to be generally respected by healthcare professionals, but describe poor communication, disempowerment, a lack of "genuine" caring and, above all, adverse discrimination. Whereas practitioners echo their views, they blame poor care on a lack of resources. Both consider adverse discrimination in both clinical and social settings to reduce all chance of flourishing in mental health care today.

Values are inherent to the recurring theme of stigmatisation, and to ethics and codes of good practice. Their influence is all-pervading, yet until recently they have not been considered central to ethics education curricula. Although all codes of ethics, regardless of their orientation, are regularly reviewed, revised and extended, until practitioners and policy-makers become fully aware of the essential role of values in practice and make education in these an *a priori* condition to training in ethics, such codes, lacking a solid base of understanding, will continue to be bad for good practice and the flourishing which should result from this.

ACKNOWLEDGEMENTS

AN ETHIC FOR FLOURISHING IN MENTAL HEALTH PRACTICE:
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PART ONE:

DEFINING THE TASK

'In philosophy, where one begins generally   makes
a difference to   the outcome of one's enquiries'.
(Alistair MacIntyre).

Chapter One: Introduction

1.1.Introduction

Recent discussion on empirical ethics in healthcare focuses predominantly on controversial issues, such as cloning and euthanasia, which provoke media interest. Less attention is given to topics providing a "human context" in which to evaluate new pharmacological or technological approaches to healthcare. Mental health practice is not immune to this process. With the advance of evidence-based psychiatry, the medical model of mental disorder and the increase in managed and community-based care, the traditional and dominant form of mental health practice[1] has, in some respects, become divorced from its beneficence-based ethical traditions and is increasingly perceived as a form of pharmacologically-based technology, its practitioners not so much carers as technicians.

In spite of this, debates on the ethics of the practitioner-user relationship remain highly topical. The continuing advance of "science" in mental health practice has created a paradox, for although new technologies can be applied in a relatively impersonal manner, as a result of pressure from survivor and human rights groups more is now demanded of practitioners in terms of meeting users' needs and the effects of interpersonal relationships and the professional ambience upon the user's well-being (Lawler, 1991, p35).

Mental health practice is a more divided discipline than any other branch of medicine.

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[1] That based upon pharmacological or physical, rather than "talk" therapies.

There are various schools of thought in psychiatry, but the most obvious division is between the biological (medical) model, currently favoured by both the American Psychiatric Association (A.P.A) and some sectors of the Royal College of Psychiatrists (R.C.Psych.)[2], and the psychological and social models favoured by critical psychiatrists[3] and psychoanalysts, amongst others. Those favouring the former identify closely with medicine, believing that mental health practice treats physical disorders of (generally) unknown aetiology. Those who support the latter embrace a variety of opinions as to its causes, ranging from the learned determinants of behaviour to the developmental intra-psychic nature of emotional conflict. At best, mental health practice includes several approaches and combines the expertise of many disciplines. At worst, it is disconcertingly fragmented.

The integration of these different approaches is arguably essential to successful mental health practice. In order to avoid categorising the user into the practitioner's preferred model of treatment it is necessary to evaluate his/her needs in the light of all possible treatments. Good mental health practice is not characterised by unthinking allegiance to one particular school of thought, but by the empathic and *holistic* evaluation of the user's needs, aspirations and perspectives, coupled with professional technical expertise. Given the present lack of real knowledge of the aetiologies which it treats, mental health practice must be considered "peculiar". It cannot, therefore,

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[2] According to a letter sent on the 30th October, 1997 to Dr. R. Kendall, President of the Royal College of Psychiatrists, from Dr. Charles Medawar, Social Audit, Ltd., London: 'The independence of the college might be called into question since it has done much to promote the use of, in particular, SSRI antidepressants, while receiving major financial contributions from the manufacturers of all such products. Some of these companies have also financed the work of leading figures of the Defeat Depression Campaign. See Social Audit's *The Antidepressant Web*, sent to the R.C.Psych., on 2nd December, 1997.

look to other forms of medicine but, as a result of developing deep understanding of various facts and theories, could become a "role model" for medical practice generally. In no other area of medicine is the user-practitioner relationship so vital to successful outcomes (Dyer, 1988; Fulford et al., 2002). It is, therefore, this thesis argues, the ethics of the professional relationship, as much as scientific knowledge, which defines and distinguishes the role of mental health workers.

Amongst other approaches, an ethic based on neo-Aristotelian virtue ethics and care ethics, such as that described here, would promote the client–practitioner relationship and the personal and professional flourishing (*eudemonia*[4]) of both parties. *Eudemonia* literally means 'having a good guardian spirit', and achieving an objectively desirable life, something universally agreed by ancient philosophical theory, and popular opinion, to be the supreme human good. This objective character distinguishes it from the modern subjective concept of happiness. In the context of mental health care ethics, the 'good guardian spirit' would be the practitioner who, whilst discreetly "watching over" the user, intervenes only in critical situations. The end of mental health practice itself would be such an 'objectively desirable life' for both user and practitioner.

1.2. The Rationale and Research Questions

Recent criticism of the predominant deontological and consequentialist theories[5] in

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[3] For example, Pat Bracken, whose work is described in later chapters.
[4] Usually translated as "flourishing" or "well-being". (See Honderich, 1995, p252)
[5] Defined at length in Chapter Two

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healthcare ethics includes references to their relative inflexibility and consequent inability to meet either the contingencies of today's professional practice (Beauchamp and Childress, 1984; Hursthouse, 1999; Campbell, 1998), or the concurrent growth of patient-centred medicine and demand for increased user participation in care plans (Fulford, 2002). As Hursthouse (1999) says, deontological and consequentialist codes tend to ignore several topics which any moral philosophy is required to address today. These are motives and moral character; moral education; moral wisdom or discernment (*phronesis*); friendship and family relationships; flourishing (*eudemonia*) in the sense of achieving the objectively desirable life previously described; the role of the emotions in moral life, and the questions of what kind of person we should be and how we should live. All these topics are discussed in Aristotle's *Ethics*[6], which therefore seems a particularly relevant starting point from which to engage with good practice in patient-centred mental health care.

1.2.1. 'Aristotelian' Flourishing and 'Feminine' Caring in Mental Health Practice.

In *Poetics* (1448a) Aristotle claims that art perfects nature[7]. For human nature the art which would achieve this perfection was ethics, the task of which was to restore people to what Aristotle (and Plato) considered their natural flourishing condition. Ethics was a kind of healing, an emotional therapy, the end of which was happiness, moderation and inner harmony. This "therapeutic" version of ethics appears ideally

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[6] For many centuries, the Nichomachean Ethics have been regarded as the Ethics of Aristotle. Twenty manuscripts on these survive from the Byzantine, whilst only two of the Eudemian Ethic do so. 20th century scholars have regarded the Eudemian Ethics as the product 'of a comparatively young Aristotle under the stiflingly metaphysical influence of Plato' (Kenny, 1978)

suited to health care and is quite unlike the justification of the rules for behaviour which currently constitutes much moral philosophy.

This thesis will argue that the Aristotelian emphasis on "flourishing" provides a direct link with the ethic of care and that in mental health care 'flourishing' can only occur in the presence of the practitioner's caring both for and about the user. This notion is central to the ethic of care, whilst central to virtue ethics are those of flourishing (*eudemonia*), the 'virtuous agent', moral intelligence (*phronesis*), and the concept of community. Aristotle connects flourishing to proper function in a way which reflects some of those values by which psycho-pathological concepts are partly defined, yet remains consistent in principle with neuroscientific understanding of brain functioning (Fulford, 1998). Given the rapidity of technological advances in psychiatry and psychology, this is a vital factor in considering an ethic adequate to today's increasingly 'scientific' (and potentially dehumanised) mental health practice.

The "Aristotelian" view of mental disorder may be preferable in terms of good practice to one posited on a value-free account of human function. This is because a central tenet of Aristotelian theory is that practices are associated with certain goods

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[7] 'As tragedy is an imitation of personages better than the ordinary man (1448a) we should follow the example of the good portrait painters who reproduce the distinctive features of a man, and ... make him handsomer than he is. The poet in like manner, in portraying men ... must know how to represent them as such and at the same time as good men" (ibid,1454b). The quotations are from Hursthouse, R. (1992) *Truth and Representation*.

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(*agatha*)[8], which exist within a hierarchy of other goods. The relationship between goods, which are part of a hierarchy of goods and practices is an internal one. Whilst the hierarchy of goods could be the ideal of practice as such, particular goods are specific to one user, making this hierarchy notional. This does not imply that a specific good relates to an individual's needs - the sub-set of goods from which we might remove a particular hierarchy for an individual user - for example that the risk of suicide is more important than hunger. For whilst Aristotle argues (N.E.I.I., 1094a 8-17;I.2,1094a25ff) that activities (such as psychiatry and nursing) are generally believed to have functions, or goals, these are not in themselves goods. Prescribing medicines, nursing care and so on are the means to a further good. Their functions are, therefore, dependent upon there being at least one further goal that is a good in itself. That goal and good in itself is flourishing.

What are the goods internal to mental health practice and how do they relate to ethical notions of flourishing and care? Three different senses of "flourishing" must be distinguished in this context. In the case of the practitioner "flourishing" is the role realisation of ideals of practice applied to particular patients. The "flourishing" of the user, on the other hand, implies returning to the community as an accepted member of this, without necessarily fully conforming to its ideology and social mores. The mental disorder could come to be seen as a catalyst to living an 'examined' life. "Flourishing" in practice, unlike both the former, is a more abstract ideal, the good which is its end being the best possible professional support for those with mental

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[8] Goods are the objects of directed activity and so of desire, the satisfaction of which completes the activity. They also contribute to and are partially constitutive of flourishing.

health problems. What is important is that the functionings which together create a picture of each of these kinds of flourishing within the context of mental health practice can be listed. It is also necessary to ask whether 'flourishing' in the Aristotelian sense can occur in mental health practice in the absence of 'caring' both for and about the user? Or are these inseparable, complimentary, or quite distinct entities, which may or may not be related to the considerations of gender raised by feminist such as Gilligan, Noddings et al? (see 1.3.1.).

Whilst respect for user autonomy is a central tenet of patient-centred healthcare ethics today, mental health care is a special case insofar as the duty of care often requires limiting this (Fulford et al. 2002). Balancing conflicting moral values in particular cases is something that requires more study, both empirical and philosophical, than has so far taken place (Gillon, 1996). Such balancing would be acceptable to both an ethic of care and virtue ethics, in that flourishing does not necessarily entail complete freedom of action and allowing this would not necessarily be virtuous or caring. The prime virtue is moral intelligence or practical rationality (*phronesis*) and virtue ethics does not suppose that moral dilemmas can be resolved other than by the exercise of this. It can therefore accept that two virtuous agents, exercising moral intelligence or practical rationality, could reach distinct resolutions to a moral dilemma yet both be "right" and "virtuous" (Hursthouse, 1999).

Considering a combination of agent rather than act centred neo-Aristotelian virtue ethics, and an ethic of care in mental health practice requires evaluating individual

practitioners' actions and characters, selves and lives. Such ethics are therefore particularly relevant to the psychotherapeutic setting, in which the agent's character and ethical self play a unique part. As Campbell (1998) says, we might trust a dentist, even knowing him to be an immature or immoral person, insofar as he is essentially a 'mechanic of the mouth'. Of the mental health practitioner, whose character is inherent to the effectiveness of the therapy, we expect more. In this discipline, successful treatment may depend upon the user's trust and belief in the practitioner's character. The requirements of this unique role and the particular features of mental disorder would ostensibly be met by character-based ethics. The ethic of care, too, is particularly appropriate given the cultural associations described in Chapter Three, which link women to caring and mental disorder, and men to patriarchal attitudes and the dominant psychiatric ideology. These ethics can also counteract the 'dehumanising' of treatment which has been claimed to accompany scientific advances in medicine and can leave the user stripped of dignity, disempowered and 'labelled' as a diagnosis or clinical artefact, rather than a person.

The notion of flourishing as the empowerment of and respect for the user itself raises challenges. Neo-Aristotelianism, as will be seen in Chapter Two, implies a certain antagonism towards modern liberal rationalist individualism, invoking instead a concept of community. How this concept of community can be reconciled to the notion of individual 'flourishing', given that an ethic of flourishing - in the context of mental health practice - would consider empowerment of the user central to treatment and essential to both user's and health worker's flourishing is also debatable. However, there is no conflict between individual and community, since individuals

are such by virtue of pertaining to a community. Even should they opt out, they are already formed, (or perhaps in the case of mental disorder 'deformed'[9]) by this community. Human inter-dependence is, as MacIntyre (1999) indicates, just a fact. That we can only be self-conscious through consciousness of others is what it means to be human.

Growing dissatisfaction with current ethical codes has several aspects but this study examines in particular the *prima facie* growing gap between the ethics or codes of good practice developed by professional bodies for their members and the latter's own views of what constitutes "good" practice in the context of clinical work. The principal aim of existing codes[10] is regulation. They also specify rules of etiquette and responsibilities towards users and practitioners. Considered 'beneficial' if they effectively incorporate defensible moral norms, some codes oversimplify moral requirements or claim more competence than they reasonably should. As a result, health professionals may erroneously believe that they satisfy all moral requirements in merely adhering to such codes, just as many people consider themselves to discharge their moral obligations when they meet all the relevant legal requirements (Beauchamp and Childress, 1994, p7).

However, good practice is not promoted by essentially unrealistic standards which can result in (albeit well-motivated) rule-breaking. This can 'let in just those abuses of power that healthcare ethics has properly sought to prevent' (Fulford et al. 2002,

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[9] See Noguera (2000), *'Mad, Sad or Bad, Moral Luck and Michael Stone'*.
[10] Discussed in detail in Chapters 2.2.4 9. and 6

p3). Some ethical dilemmas, for example those related to confidentiality, are arguably the undesirable result of ever-increasing regulation, both legal and in the form of professional ethics and codes of conduct. Indeed, the previously cited work describes them as 'inimical to good' practice' (Op.cit. p13).

1.2.2. Ethics and Gender

Further criticism of the dominant deontological and consequentialist theories stems from gender-related issues. According to Sayers (2000), Giddens (1976, 1984), Habermas (1984, 1987) and others who defend abstract theory, theory itself is only contingently gendered (cited in Holmwood, 2001). Like many philosophers, they also conceive theoretical discourse as meta-theoretical and therefore independent of empirical research. This type of argument led some feminists to refer to a 'missing feminist revolution in sociology' (Stacey and Thorne, 1985). They complain of a 'gender-neutral conception of discourse in sociology, like philosophy, largely the preserve of male theorists, which finds 'no necessary reason to engage in a dialogue with ... feminist theory or research'. (Holmwood, 2001, p948). Nonetheless, in debating ethical theory and practice today, following the works of feminists such as Noddings (1984), Gilligan (1982), Ruddick, (1989) and Tong (1993), it is essential to consider, as Chapters Two and Three do, to what extent these are conditioned by gender.

In order to test the question of whether neo-Aristotelian virtue, and care ethics could prove more appropriate to mental health practice than the dominant quasi-legal "principles" approach considered 'malestream' by feminist critics, a prior analysis of

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the efficacy and appropriateness of the codes of good practice currently adhered to (or not) in mental health settings is required. The growth in the quantity and exigencies of such codes, is the embodiment of the response of professional colleges to increasing ethical challenges in healthcare. Yet the rising number of disciplinary hearings involving practitioners of both sexes appears to reveal that the possibility of fruitful dialogue between practitioners and users may be forestalled, rather than facilitated, by existing codes. Both these and current education in ethics are apparently not only inadequate, but may even push healthcare workers into malpractice. Paradoxically, current ethics may be bad for good practice.

This is the catalyst to the research question: what type of ethic is best suited to good mental health practice? The quasi-legal (deontological and consequentialist) ethics at present prevalent are clearly not sufficient. This study attempts to answer this question and test this claim - and those of possible alternatives in the form of neo-Aristotelian virtue and care ethics - in the specific context of mental health practice.

1.3. Links between the Philosophical and Sociological Literature

Although interpretations of Aristotle vary greatly (Barnes, 1976), Rosalind Hursthouse's (1999) *On Virtue Ethics*, one of the first authoritative accounts of neo-Aristotelian virtue ethics, gives what has been described as 'the defining exposition' of 'how the life of the virtuous agent is both possible and desirable' (Blackburn, S., 1999). Her version of a neo-Aristotelian virtue ethic is a revival of classical

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Aristotelian virtue ethics without the 'lamentable parochial details'[11] (Hursthouse, 1999,p2) of certain aspects of Aristotle's original ethic. Neo-Aristotelians of this school neither restrict themselves to those virtues listed by Aristotle, nor consider him right with regard to the treatment of women, slaves and animals. However, Hursthouse does follow his ethics closely in other respects. This particular neo-Aristotelian virtue ethic promotes the notion of flourishing as the ultimate human good and aim of human life and considers *phronesis* (translated by Hursthouse as 'moral intelligence' and by MacIntyre (1985) as 'practical rationality') a pre-requisite for the practice of all other virtues.

Full appreciation of Hursthouse's work requires reading several versions of Aristotle's *Nichomachean* and *Eudemian* Ethics and philosophical commentaries on these such as Hutchinson's (1986), *The Virtues of Aristotle*. Elizabeth Anscombe's (1958) *Modern Moral Philosophy* represented the views of an influential group of post-war philosophers who, suspicious of the is/ought distinction and the naturalistic fallacy, turned instead to traditional concepts of virtue. However, MacIntyre's (1985) *After Virtue*, in which he describes a Nietzsche-Aristotle dichotomy between the will to power on one hand and communally defined virtues on the other, presents the most impassioned and synoptic case for the revival of virtue theory. MacIntyre argues for the 'construction of local forms of community within which civility and the intellectual and moral life can be sustained' (1985, p236). These lines of thought are

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[11] In making this comment, Hursthouse is referring to what would today be considered Aristotle's misogynistic references to women and his claim that neither they, nor slaves and animals had souls, a belief common to the Athenian community of 500B.C.

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developed in Chapter Two.

1.3.1. The Feminist Critique

Work by several female philosophers has developed a distinctively "feminine"
standpoint on healthcare ethics. The first, and arguably most influential, of these was
Gilligan's (1982) *In a Different Voice*, followed by Noddings' (1984) *Caring: A
Feminine Approach to Ethics and Moral Education* and Ruddick's (1989) *Maternal
Thinking*. These writers consider impartial observation inappropriate to ethical
dilemmas, in which an attitude of caring involvement, such as that reputedly practised
by women, is the ideal model. Gilligan (1982) set up a categorical distinction
between the ethic of care, responsibility and relationships and the ethics of justice,
rights and autonomy. Noddings' work, which describes her "feminine ethic of care"
as 'a woman's morality', is essentially a philosophical elaboration of Gilligan's
views. 'Characteristically and essentially feminine', Noddings claims that it arises
from the very experience of being a woman.

Noddings also promotes the notion of 'engrossment', a type of exaggerated empathy,
and this perception of empathy as essential to moral behaviour is echoed in Marta
Nussbaum's claim, in *Finely Aware and Richly Responsible* (1985), that acting
morally requires: 'thinking oneself into the other's best possibility' (p521). Baier's
(1991) *Who Can Women Trust?*; Fox's (1992) *Seeing Through Women's Eyes: The
Role of Vision in Women's Moral Theory*; and Calhoun's (1992) *Emotional Work*,
also imply this women-care connection. Noddings is particularly critical of the
'principled' ethic approach which has dominated Anglo-American analytical

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philosophy. This is, on the other hand, considered by Hursthouse (not a feminist) to be compatible with virtue ethics, a view elaborated in Chapter Two.

Ruddick (1989) discusses the values and virtues inherent to mothering, using this approach to develop a feminist standpoint in moral philosophy. She disagrees with Noddings, considering that although traditionally the domain of women, mothering (analogous to Noddings' 'caring') can be practised by men and women in what, although not specifically described as such, is a form of emotional labour (see Chapter Three). Development of the argument in favour of caring as a form of emotional labour would have been impossible without prior study of Hochschild's seminal work: *The Managed Heart: Commercialization of Human Feeling* (1983).

The writings of second-wave feminists: Virginia Held's (1993) *Feminist Morality*; Joan Tronto's (1993) *Moral Boundaries, a Political Argument for an Ethic of Care* and Peta Bowden's (1997) *Caring: Gender Sensitive Ethics* also posit versions of an ethic of care as valid feminine approaches. According to Webb's (1996) *Caring, curing and coping: towards an integrated model* many female healthcare workers have found the care perspective highly productive.

However, other feminist philosophers: Claudia Card (1991a) *Feminist Ethics* and E.V. Spelman (1991), *The Virtue of Feeling and the Feeling of Virtue*, criticise care ethics, considering it to reinforce 'conservative gynocentrism'. They also reject its complacency regarding women's failure to care for other women. In Bubeck (1995) *Care, Gender and Justice* and Baier (1987a) *Hume, The Woman's Moral Theorist?*

both Aristotle and Hume are (not uncritically) posited as possible theoretical models for an alternative care perspective.

In focussing on formal contrasts, the care-justice division converges with those critiques of impartial and universalistic deontological approaches predominant in contemporary moral philosophy. Consequently, in their quest for ethical theories more appropriate to a "Godless" age, those seeking alternative theoretical models turned their attention to the newly revived virtue theory (Anscombe, 1958; Murdoch, 1985; McDowell, 1979; MacIntyre, 1985, et al.) which focuses on the agent's moral character. Rosemary Tong's *Feminine and Feminist Ethics* (1993) described caring as a virtue, and care ethics as a form of virtue ethic, a sentiment echoed in Card's (1991) *The Feistiness of Feminism* and (1995) *Gender and Moral Luck*, and Baier's (1987) *The Need for More Than Justice* and (1994) *Moral Prejudices: Essays on Ethics*. Tong's (1998) *A Feminist Virtue Ethics of Care for Healthcare Practitioners* provides a specific link between gender, care ethics and health.

Denise Russell's (1995) *Women, Madness and Medicine* supports both Gilligan's notion of women's voices as "different", and the view that gender discrimination in contemporary, reputedly patriarchal, mental health care may exacerbate rather than resolve women's psychiatric problems. Elaine Showalter's (1987) *The Female Malady* argues that the construction of madness is the most recent method of controlling women by means of misogynistic practices – citing the 19th century growth of "asylums" as the commencement of male medical dominance over women's mental health (see also Perkins Gilman, 1892). Phyllis Chesler (1972),

influenced by Szasz (1972), argues that the use of labels of mental disorder conditions male and female behaviour, ensuring that this conforms to social expectations. Two key issues emerge from feminist literature on women and mental illness. The first is that of psychiatry as a method of socially controlling women. The second is the medicalisation of women's unhappiness. However, current debates tend to focus on gender relations, rather than exclusively on women's issues.

Views such as these, together with the gender issues inherent to the ethic of care, demand investigation of the relationship between gender, caring and ethics, as well as gender and mental health. Arber and Gilbert's (1989) *Men, the Forgotten Carers*; Sabo and Gordon's (1998) Men's Health and Illness; Annandale and Hunt's (2000) *Gender Inequalities in Health* and Bendelow et al's (2002) *Gender, Health and Healing: the Public Private Divide* offer a range of views. Most imply that current stereotypes of women as carers and men as law-givers are excessively essentialist[12].

Works specific to healthcare[13] whilst providing useful information and insights into the ethical issues pertinent to mental health practice, also sometimes tend to perpetuate stereotypical 'gendered', allegedly "masculine" approaches to ethics. More importantly, perhaps, many of these also recognise that current codes of

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[12] Many other recent publications, journals, Internet sites and the press, ensured the topicality of the material studied, providing information on recent developments in mental health policy and practice. A full list of sources consulted, but not directly cited, is given in the References.

[13] Beauchamp's and Childress's (1994) classic: *Principles of Healthcare Ethics*; Gillon's (1994) *Principles of Health Care Ethics* and Fulford et al's recent *Healthcare Ethics and Human Values* (2002); Barker and Baldwin's (1991) *Ethical Issues in Mental Health*; Allen Dyer's (1988) *Ethics and Psychiatry, towards Professional Definition*, and Bloch, Chodoff and Green's (1999) *Mental Health Practice Ethics* also provided information and insights into the ethical issues most pertinent to mental health practice.

practice are ill equipped to meet the particular requirements of patient-centred mental health care.

1.4. The Research Process

The research develops and is described in three stages. First, the problem is identified in theoretical and practical terms and the rationale behind combining the disciplines of philosophy and applied sociology explained. Specific philosophical (ethical) and sociological theories on gender related issues which inform the research are also discussed[14].

The second stage is empirical, focussing upon exploring ethical attitudes by means of sociological fieldwork and qualitative and philosophical analysis of this. It explores the extent to which mental health care themes in the ethics literature are identifiable in practice, examining the putative gap between present codes and practice and evidence of possible reasons for this. At this stage possible gender differences in practice and treatment are also sought, and the specifics of various ethical theories related to principles, flourishing, practical wisdom and emotional labour in practice are identified.

The third stage engages with the research findings and their implications for practice. The study concludes by summarising the research process as a whole, before

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[14] Due to the limitations inherent to working within a word count, neither all the possible ethical theories which might have informed ethical decision-making, nor all the possible ethical problems and dilemmas which might emerge in mental health practice are described in the research data. Since this is not of direct relevance to the flow of the argument there has been no attempt to bring these into the work – they have simply been left out.

subsequently discussing its implications in terms of a unified and practical ethical agenda for care and training in mental health practice.

1.4.1. The Reasons for Combining Philosophical Theory and Applied Sociological Methodology in Researching Empirical Ethics

Conventionally, philosophy is normative. Its definitive tools are those of theories of morality, practical rationality, analyses of moral concepts and so on. Much sociological research, on the other hand, is empirical, providing the 'facts that healthcare ethics grinds in its normative mill' (Nelson, 2000, p12). However, the distinction is not that clear. To be sure philosophical approaches to ethics are inclined to be normative, whilst those of social science are more empirical. However, some sociologists working in areas relevant to medical ethics have 'disavowed any interest in the application of their researches to procedures and policy-making. They prefer to stress their implications for such abstruse matters as the sociology of the professions, "theories" of organisations, or the social organisation of cognition' (Zussman, 2000, p7).

A necessary condition for any research on *empirical* ethics is that it employs the 'combined philosophical and sociological approach' of the title of this dissertation. In such an approach these disciplines have a two-way relationship not unlike that between theory and experiment in the natural sciences. Empirical ethics draws primarily upon applied sociological research methods to test a number of questions raised by the ethics literature and brings in specific sociological theorising in discussing the implications of the findings for practice. Philosophy can, in turn,

enrich the form and content of the empirical study and research findings by providing a set of theories and skills which help frame the questions to be asked, especially where, as in this case, these involve high-level concepts such as beliefs or values. Philosophy also guides analysis of the results, the findings of the empirical study informing and contributing to the development of the philosophical theory.

Working simultaneously in both philosophy and applied sociology reveals that the difference between these disciplines is more subtle than it might initially seem. Perhaps because they believe that it is enough to know that a phenomenon exists, regardless of those characteristics such as distribution and social trends which interest sociologists, philosophers tend to be less systematic in dealing with empirical matters. The former, on the other hand, can says Zussman (2000) sometimes appear incapable of making more than a limited range of normative claims. Deontological arguments about moral judgements are, this author suggests, remarkable for their absence in sociological thought.

Whilst significant, such differences do not imply a deep and totally insuperable 'incomprehensibility' between philosophical and applied sociological approaches to healthcare ethics. Rather, they imply that degree of complementarity described by Fulford et al. (2002, p12) and which this study, in which applied sociological research informs substantive philosophical discussion of the ethical issues involved in the care of the mentally disordered, aims to demonstrate.

It could, therefore, be considered surprising, even disappointing, that applied sociology has not so far made a valuable contribution to medical ethics. This is incongruous given that the questions being examined in this, such as informed consent, managed care, and so on, hinge to a very large extent on *empirical* considerations, whilst tending to be based on *consequentialist* arguments.

The fact is that at present a good deal of healthcare ethics - the QALYS[15] system would be a good example - is based upon consequentialist claims which sociologists, with tools such as quantitative and qualitative analysis at their disposal, are particularly well-equipped to assess. If an ethical claim is based on the belief that a practice or arrangement is ethically either desirable or questionable because it results in a particular outcome, then that claim - as this research will show - is empirically testable. It is, though, most unusual for philosophers specialising in healthcare ethics to perform such tests themselves. They often prefer the more conventional philosophical tool of the "thought experiment" (see footnote 16 for an example). However, sociologists can very effectively carry them out, for regardless of whether the issue in question is informed consent, violence, managed care or the withdrawal of rights, ethical arguments depend to a great extent on empirical propositions. There are many kinds of ethical issue about which an empirical study of mental health care practice might ask questions. In this study these questions are raised, and the findings which emerge from fieldwork are analysed and discussed.

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[15] QALYS are quality-adjusted life years and are used to evaluate the number of "quality" years, which a user would be likely to live, compared to another, in prioritising treatments. Implicit in their use is 'the idea that the only objective of health services is health maximisation' (Beauchamp and Childress, p311)

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According to Beauchamp and Childress (1994), good moral reasoning involves the following:

1. Accurate empirical beliefs
2. Defensible moral values
3. Clarity about relevant concepts
4. Formally valid argumentation.

The first of these is an area in which applied sociology would naturally operate. As far as Beauchamp's and Childress's second point is concerned moral philosophy, theology and other disciplines all serve to inform the articulating and defence of moral values. Finally, philosophy, as the 'guardian of conceptual analysis' (Nelson, 2000, p13) and logic informs both point three, conceptual clarity, and point four, the formal validity of the arguments.

However, Beauchamp's and Childress's four-step approach to moral reasoning might, not unreasonably, be considered by the sociologist to be a gross oversimplification of the moral, conceptual and empirical relationship. Sceptics of this so-called 'linear' view might, for example, ask how the normative effect upon fact-finding is to be recognised without undermining the moral arguments that draw upon the facts. Nonetheless, it could equally be argued that the values inherent in applied sociological research do not necessarily distort the healthcare ethicist's access to the factual world at all, but to the contrary, deepen and enrich the normative understandings on which those moral concepts and beliefs employed in analysis are based.

Clarifying the workings of values in empirical disciplines seems, in itself, to be an empirical task. As such this process is potentially subject to undermining by distortions caused by the personal scale of values which the researcher inevitably brings to enterprises such as that under consideration. Whilst this kind of scepticism may be common, it is not necessarily plausible and might even be considered paradoxical in that: 'It makes ambitious knowledge claims itself, concerning what knowledge is and what's wrong with all efforts to establish any' (Nelson, 2000, p14). The fact that empirical enquiry incorporates values does not necessarily imply that it is self-defeating. In reaching a better understanding of the norms inherent to factual accounts, as Nelson points out, healthcare ethicists can also deepen their understanding of values. In addition to providing the latter with facts, sociologists may act as "catalysts", causing ethicists to investigate and challenge their particular notions of what is worth studying and, more importantly, whose interests are worth serving. This appears to be the result of the research process described here.

Can sociology really embody normative traditions? Sociologists, as human beings with all the defects and weaknesses inherent in this condition are, as Nelson says: 'hardly likely to be distinguished from philosophers with regard to political and ethical affiliations consistently enough to see their fields as sources of distinct moral views on features of medicine or any other aspect of society' (p14). They do not present a 'morally united front' (ibid.). However, given their particular interest in group dynamics, sociologists may be able to indicate normatively significant features of human life which are virtually overlooked by disciplines such as applied ethics,

which is explicitly concerned and inextricably linked with moral values. Epistemic and ethical values can perhaps inform one another in the sense that what sociologists consider effective ways in which to study people *scientifically* can influence what ethicists consider to be good ways to think about people *morally*. Healthcare ethics can benefit from using the investigative procedures and engaging with the heuristic interests characteristic of applied sociology. This would provide a new and different "gaze" and consequent understanding of the ethical inferences to be made from the study of individuals, communities, relationships and responsibilities.

Something which originally interested philosophers working in healthcare ethics was the notion, held by some, although not all, that 'reflecting on developments in health care provided ... a very good way of doing philosophy' (Op. cit. p17). However, the success of healthcare ethics in informing clinical practice has been relatively minor and in some areas, including mental health practice, has arguably proved frustrating. Ethics cannot merely give advice. It must improve understanding of morally relevant ideas and promote deeper understanding of those aspects of these which can be, as the research findings reveal, at best confusing and at worst counterproductive, in both clinical and research contexts.

If this is so, philosophical and sociological collaboration is essential insofar as the normative understandings which attend sociological practice must come to be regarded as significant to ethics generally. This is beginning to happen and healthcare ethicists are seeking and creating approaches to ethics which rely quite heavily upon empirically demonstrated understandings of social life. Indeed, a recent editorial in the *Journal of Medical Ethics* (Gillon, 1996) described the publication of empirical

studies as a healthy development in what it termed the 'maturing' subject of medical ethics.

Theoretical tenets of various kinds - ideological, metaphysical and value-based - underlie the prescriptions of present mental health ethics, but the resolution of many ethical dilemmas within practice demands appeal to sociological theory. Theoretical assumptions which raise and affect concerns about mental health practice can also be identified. Is it, for example, true that most female health workers care instinctively, whilst the majority of their male colleagues tend to exercise paternalistic power? Or is this a socially constructed 'myth' which research, informed by sociological theorising on emotional labour, may prove to have little foundation in fact? This is important, for if men are revealed as 'carers' in the feminist sense, or if caring proves to be a form of emotional labour, then an 'ethic of care' cannot be described as uniquely 'feminine', in spite of Noddings' title and the credence given to her views by many feminists. (Although it could be argued that this might be the case if this was construed as a gender orientation in biologically sexed men/males[16]).

The conventional contrast between normative philosophical approaches and empirical sociological perspectives draws upon excessively clear-cut distinctions. If, as has been claimed, different theoretical tenets underlie the prescriptions of mental health ethics, any empirical study of these must consequently be informed by philosophical *and* sociological theory and analysis. Theories may be the roots of the tree upon which informed knowledge and understanding of social reality grow, but they cannot

be based upon simple observation of society. Whilst social and medical research are essentially about 'humans investigating humans' (Shipman, 1997, p3), this involves philosophical and empirical issues. Empirical research aims to ascertain and clarify facts, making arguments based on these more substantive. However, although facts may thus discipline reason this is: 'the advance guard in any field of learning'. 'Empirical projects must have implications for theoretical constructions', (Wright Mills, 1959, p205).

From a philosophical point of view, the epistemic strategy described by Deutsch (1966) allows for a reflexive dimension, which understands itself as the theory's social and historical embeddedness, to be incorporated into this. The Deutschian notion of science as the process whereby our world knowledge is acquired is represented in the following reflexive cycle (Fig.1). This shows how early theoretical consensus on basic assumptions and methods is followed by a period of empirical research, producing data which in turn lead to further philosophical questions.

Figure 1.

| PHILOSOPHY | ⟶ | OBSERVATION |
| NEW PHILOSOPHICAL PROBLEMS | ⟵ | DATA COLLECTION AND ANALYSIS |
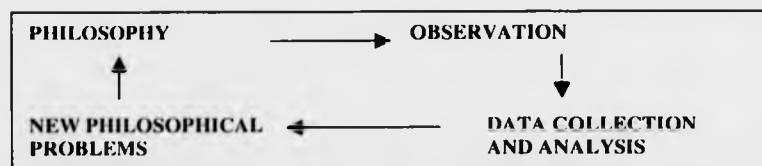
As Deutsch says:

> 'Philosophic stages in the development of a particular science
> are concerned with strategy; they select the targets and the main
> lines of attack. Empirical stages are concerned with tactics; they

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[10] Thanks are due to Dr. Simon Williams for pointing this out to me.

> attain the targets, or they accumulate experience indicating that
> the targets cannot be taken in this manner.
>
> (Deutsch, 1966, pp 3-4)

For sociologists who study healthcare ethics, the normative implications of their task
are unavoidable, although it might be the philosopher who clarifies these. Applied
sociological research can, on the other hand, effectively inform any philosophical
discussion of the ethical issues involved in patient-centred practice. Analytic ethics is
ethically neutral and therefore arguably "needs" the input which only applied
sociological research methods can provide '... content must be added to form, data to
concept, if conclusions bearing on a concrete issue are to be drawn' (Fulford, 2002,
p162). Combining philosophical ethics and social scientific empirical fieldwork in
researching mental health ethics would, therefore, seem to make good sense.

The relevance of applied sociology to empirical ethics also lies in the fact that: 'moral
theory begins in practice' (Hoffmaster, 1992, p1421). This author points out that
moral decision making is essentially the search for an adequate response to a
particular situation and more a question of finding creative solutions than applying
philosophical formulae[17]. First, how moral dilemmas are perceived and constructed
is investigated. Second, how each individual confronts such problems is recorded.
Third, these attempted resolutions are analysed. Research such as that undertaken for
this dissertation will reveal the forms of moral rationality in mental health practice,
provisionally indicating and defining the strengths and limitations of each form of
resolving ethical dilemmas.

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[17] This has a certain resonance with Jonsen and Toulmin (1988). See section 2.2.1.

What Hoffmaster suggests is a style of ethical theory that, like grounded theory, works from the (research) ground up and is based on a real and detailed knowledge of the situation in question. His argument constitutes what has been described as a 'virtual manifesto' (Zussman, 2000, p10) of healthcare ethics for sociology and must consequently merit close consideration. If Hoffmaster's views were taken seriously, a radical change could occur in these, the present boundaries between sociology and philosophy, between normative and empirical, eventually disappearing. Applied sociology's most important contribution to healthcare ethics could be bringing into the practice setting a set of ethical standards which are 'not native to the occupational and organisational cultures' (Zussman, p10), such as those pertaining to the professional organisations of mental health practitioners of all disciplines.

Hoffmaster also asks how ethical issues are generated. In one form, he claims, the medical ethicist merely reacts to issues raised by practitioners. In another (which this study seeks to emulate) the former is a Socratic "gadfly", reading, thinking and then researching the potentially awkward questions and situations which serve to make users, practitioners and policy-makers question what may be the previously unquestioned *status quo*.

It might be claimed that healthcare ethics has adequately survived without the "help" of applied sociology, but the empirical ethicist would claim that being informed by this discipline brings a more pragmatic and "practical" dimension to the occasionally

ludicrous flights of imagination which characterise some works in healthcare ethics[18].
Whilst few sociologists are trained in moral reasoning and analysis, disavowing
normative concerns will not help sociology, either. Social sciences, sometimes
thought to provide 'just the facts' (Nelson, 2000), may leave attending to moral
values, clarifying concepts and constructing formally valid arguments to philosophy.
However, all disciplines are informed by epistemic values, and healthcare ethicists
are increasingly aware that sociological practices and normative understandings of
what is relevant to human flourishing are important to ethics generally.

1.4.2. Gender, Ethics and Mental Health Practice

Sociology, rather than philosophy, can also better inform the gender considerations
inherent to the research questions. The development of a feminist sociology (Bell and
Roberts, 1984) has had a profound effect upon all areas of healthcare research. It is
concerned not only with raising gender issues in formulating research questions,
methods and analysis but also considers 'differences in the way that research is
organised, carried out and written up as being based on the gender of the researcher'
(Op.cit.,p3). Gender is inscribed on the body and we never interact as genderless
beings. A nurse, for example, 'never just interacts with a doctor – it is a female doctor
or a male doctor and this makes a difference. Doing gender is accomplished in these
practices' (Davies, K. 2002, p65).   This notion is explored further in Chapter Three.

In mental health practice, gender also affects women as users. Various authors

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16 J. Jarvis Thompson's thought experiment, in which someone wakes in the morning to find a brilliant
violinist, dependent upon them for life-support, grafted their body, is an example of these.

suggest that 'gender affects prevalence rates, diagnostic profiles and service utilisation' (Teplin et al. 1997) and official statistics reflect this. Although some studies have found no gender difference in the incidence of depression and the gender gap is undoubtedly narrowing, women's greater risk of suffering non-psychotic disorders has until recently been a consistent finding in mental health epidemiology (see Table 1).

Table 1 - The Prevalence of Neurotic[19] Disorders by Gender.

CONDITION	WOMEN	MEN
Mixed Anxiety	108	68
Generalised	46	43
Depressive	28	24
Obsessive-compulsive	13	9
Panic Disorders	7	7
All Phobias	22	13

**(Great Britain, 2000, rates per 1000 population –
Sourcewww.national-statistics.gov.uk/CCI/nscl.asp?ID=6436)**

Numerous explanations have been offered to account for women's experiences of mental disorder. 'Reductionist or biological explanations have considered women's hormonal changes (Ussher, 1991), whereas Freud (1935) emphasised women's sexuality as being 'all important.' (Wright and Owen, 2001, p143). Such differences cannot feasibly be attributed to purely biological factors, particularly since amongst women themselves rates of depression do not vary by parity. It must be concluded that females' greater risk is a consequence of gender differences in roles leading to differences in the experience of life events[20]. The fact that in modern society, in which such roles are less clearly defined, men are "catching up" with women in statistics of this kind may support this view. However, with few exceptions, research

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[19] Although the term "Neurotic" and "Neurosis" are no longer used in psychiatry, broadly 'neurosis', as used here, covers non-psychotic conditions.

and official data confirm that gender influences how and if mental disorder is defined and, within gender groups, factors such as age, employment, ethnicity and social class affect the perception and treatment of this.

Mental health ethics must therefore acknowledge and address gender differences by developing a theory of ethics which includes these considerations. It is not merely the radically feminist who consider psychiatry to uphold patriarchal power arrangements and support a masculine individualism unfitted to women's socialisation and gender identity. Such assertions should be taken particularly seriously since psychiatry and psychology work directly with the self and self-identity. If they are correct, mental health practice must recognise and act upon the kind of value and metaphysical assumptions about the nature of "self" and "other" which feminist theorising has revealed. It must adopt ethical practices which incorporate and make allowance for these. Only an ethic in which possible paternalism on the part of the practitioner is counter-balanced by increased user autonomy and participation, thus diminishing the "self"-"other" dichotomy, would meet these requisites.

Various authors previously cited (Davies, C. 1995; Russell, 1995, Chesler, 1972 and 1990) also claim that female and male healthcare workers' roles reflect different ethical positions: an ethic of care and a principles-based ethic, respectively. In many areas of health care, the latter appears to dominate ethical thinking, regardless of the fact that female philosophers such as Baier (cited in Fulford et al.1996, p162) would agree that '...regulation is the enemy of trust'. However, recent works (Arber and

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Some studies have found no gender differences in the incidence of depression, however.

Gilbert, 1989; Sabo and Gordon, 1998) claim that these different positions are artificial and that men, far from wishing to control, can and often do 'care' in ways similar to women.

Given much feminist literature's claim that men, with few exceptions, are concerned with explicit rational principles, right and wrong acts and legal regulations protecting society, whilst women emphasise emotions, responsibilities and the social processes which protect relationships, the question of whether or not ethical practice is gendered is addressed in depth in Chapter Three.

1.5. Context – Ethics in Mental Health Practice

In the United Kingdom today, although one in four people will experience mental health problems of varying severity during the life course, the mental health services are 'widely perceived as the Cinderella of the National Health Service' (Mental Health Today, January 2002, p12). The proposed new Mental Health Act has provoked anxiety amongst users and anger amongst many practitioners and defenders of human rights[21], as has the possible incarceration of potentially dangerous people believed to suffer personality disorders. Copious press coverage with headlines (in these examples all from The Guardian) such as: *Civil Liberty Row on Mental Health Law* (9.12.99, p14); *Psychopaths to be Denied Liberty* (16.2.99, p9); *Mentally Ill Face Enforced Treatment* (17.11.99, p11) and, ironically, *M.P.s Back Detention of Dangerous Psychopaths*, (15.3.00.) and *M.P.s Criticise Lock-Up Plan for the*

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[21] See 'Mentally ill need help, not locking up', "The Independent", 7.7.02.p9.

Mentally Ill (25.7.00, p8) has been given to this theme. Discussion on the side-effects of medication versus quality of life abounds, whilst cases in which those suffering chronic psychotic illness have abandoned prescribed treatments and thrived, or been misdiagnosed and wrongly treated for many years, feature regularly in the media[22].

Recent statutory inquiries into abuse in psychiatric hospitals for chronic and "special" users produced vignettes of grossly corrupted professional standards. The 9th biennial report of the Mental Health Act Commission (MHAC), based on visits to 2193 units in England and Wales, describes dingy, overcrowded wards in which, due to lack of other activities and acute staff shortages, users – including a disproportionate number of people from ethnic minorities – pass their days smoking, sleeping and watching television. In many units only psychopharmacological treatments are offered and there is increasing use of the temporary holding Section 5.2. to prevent "voluntary" patients leaving wards often locked due to staff shortages (Mental Health Commission 9th Biennial Report). The number of people forcibly admitted to psychiatric hospitals rose from 18,000 in 1990-91 to 26,700 in 2000-01. Other users may enter hospital for voluntary treatment and later be refused permission to leave. The result is that almost 50,000 people were detained in mental hospitals in 2001, 20,000 more than in 1991.[23]

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[22] A well-documented recent case is that of Renee McAllister, diagnosed twenty-three years ago, as suffering from schizophrenia after experiencing hallucinations related to the head of a woman whose decapitation by a train she had witnessed. In 1999, following attempted suicide, she was re-diagnosed as suffering post-traumatic stress disorder. Having abandoned medication in favour of eye-movement desensitisation and processing (EMDR) she now wants to "move on and develop my poetry as a way of expressing ... this incredible spiritual journey towards recovery" (Guardian Society, 25.10.00.p12).
[23] Laurance (2002) 'Pure Madness', London: Routledge.

It is, therefore, not surprising that 'survivor' movements express growing dissatisfaction with many areas of present practice. To give the example of nursing: more users complain of misconduct by nursing staff; more disciplinary cases are processed by their governing bodies and more nurses are being removed from the register than ever before. In 2000, allegations of misconduct to the UKCC[24] increased by 16%, from 1084 to 1255. The Professional Conduct Committee sat on 205 days, compared to 151 in 1999 and 113 practitioners were removed from the register, as against 74 the previous year, a rise of 53%. (UKCC Register, Spring 2001, No.35, p12).

This tendency is reflected in studies as far apart as Goffman, 1968, Laing, 1985, Bissonette et al, 1995, Ellis, 2000, Pitarka-Carcani, 2000, and Read, J. 2001, to name but a few. Possibly the richest source of such information is the World Wide Web (WWW) which contains myriad sites in which users and practitioners express dissatisfaction with current psychiatric practice (see References). All these sources support an ethical erosion hypothesis[25] which, together with the emphasis on "patient centred medicine", has made ethics an important and topical subject in mental health practice.

Within the health profession, too, reflection upon problems of ethics has evolved through formal codes of good practice, of research ethics and reports by government

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[24] United Kingdom Care Council, now the Nurses and Midwives' Council.
[25] A study by Wolf et al. (1989) is, however, ambiguous and that of Price et al. (1988) refutes this claim.

sponsored commissions. Professional organisations currently specify and putatively enforce role obligations correlative to the rights of users and practitioners[26] by means of codes of ethics or good practice. The difference between these is that an ethic sets the highest possible standard or principles, whilst a code of practice is essentially rule based. As such, it does not allow departures from these on matters of principle, demanding total conformity and obedience. An ethic can set standards without being a code of conduct, a point relevant to virtue and care ethics. Both ethics and codes are intended to ensure that those who enter into professional relationships with their members find them competent and trustworthy.

In mental health care today, the relevance of traditional ethical positions depends upon whether they resolve the moral dilemmas facing practitioners. It has been claimed that an 'enormous disparity' exists between ethical decisions made by participants in recent studies and the ethics and codes of practice prescribed by the National Association of Social Workers (N.A.S.W.); the United Kingdom Care Council (U.K.C.C.), now the Nursing and Midwifery Council (N&MC); the Royal College of Psychiatrists (R.C.Psych.); the General Medical Council (G.M.C.); the Royal College of Nurses (R.C.N.) and the British Psychological Society (B.P.S.), amongst others. Whereas 'these codes of ethics suggest that, for example, confidentiality is maintained more than it is breached ... research would suggest quite the opposite.' (Watson, F. 1999 p21).

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[26] Although the research findings show that some practitioners feel that they do little to defend their own interests

In fairness to practitioners, they are themselves grossly understaffed and overworked[27]. This, together with the increased number of mental health workers accused of malpractice each year (UKCC register, No.35, 2001, Pitarka-Carcani, 2000) brings into question the whole issue of the practicability of "enforcing" ethical practice by means of professional codes.

1.5.1.The Institutional Policy/Ethical Practice Dilemma

The National Service Framework for Mental Health states that '...the essence of effective care and co-ordination is sound professional judgement and practice' (p3). However, even the most mundane judgements in practice ultimately involve making ethical choices. Mental healthcare professionals must be aware of both this and, as is manifest in the transcripts of disciplinary hearings[28] and reports of the Ombudsman for Health[29], of a natural human tendency when faced with criticism or "uncomfortable" situations, to try to limit their concerns to technical matters which can be defended and require little or no emotional involvement.

Ethical dilemmas resulting from the 'conflict between institutional policy and the ethical standards of mental health care professionals' (Barker and Baldwin, 1991, pxiv) are apparently a harsh reality in mental health practice today. Matt Muijen, of the Sainsbury Centre for Mental Health describes psychiatric hospitals as the "dustbins" of the mental health service, whilst also commenting on the difficulty of remedying this when 'national policy is so preoccupied with community care'

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[27] See the Mental Health Act Commission's 9th Annual Report
[28] Those studied were from UKCC Professional Conduct Case Summaries, August 1999.

(*Mental Health Today*, January 2002, p9).

Scheid (2000) claims that in mental health practice, overt conflict exists between managed care and patient-centred practice. This arises because the former is designed to alter the latter. 'Providers must negotiate between contradictory institutional demands for cost containment and quality care in their everyday work practices, and consequently experience a series of ethical dilemmas' (p700). The way in which mental health care is managed could, this author believes, potentially undermine the professional autonomy, prerogative and good practice of all practitioners.

The claim is that ethics no longer pervades professional healthcare, (if it ever did), but is usually now employed as a form of analysis in complicated (and potentially litigious) ethical dilemmas. Following the displacement of ethical reflection from the clinical setting to that of professional/public policy, and attempts to establish ethics as an area in which the healthcare professional is no longer considered an expert, even considering ethics in today's so-called "patient-centred" medicine might, claims Scheid, be seen as complicating decision-making in practice.

1.5.2. The Dynamics of Power in Practice – Users' and Practitioners' Views

Whilst, due to research findings, such definitions are constantly in flux, it is not surprising that in an ostensibly democratic society the power to treat people with what is frequently 'no known physical pathology' provokes serious ethical reflection, particularly as "madness" is frequently associated with "badness":

See the list of WWW sites in the references for this site

'One major purpose of these services is not to "care" for people, but rather to control them ... Psychiatry functions ... as a wing of a strategy of transcribing problems of collective order ... into problems of morality; that section of the population that cannot be assimilated to society by methods of improvement must be neutralised as a social danger'.

(Gordon, 1986 cited in Barker and Baldwin, 1991).

Whether 'controlling' or 'neutralising' mentally disordered people, which would imply that mental disorder is as much a moral as medical condition, is commonplace deserves further elucidation.

Although control and "neutralisation" cannot be condoned as 'therapy', since suffering physical violence is an increasing hazard in the professional life of mental health care workers their use is not, perhaps, surprising. Sixty-five thousand violent incidents took place against National Health Service staff during 1998-1999 and the average number of such incidents is three times higher in mental health and learning disability settings. (UKCC, Register, No.34, 2001, p9). However, the "dangerousness" of the mentally-disordered population has been grossly exaggerated by the popular media and the result of this is reflected in both the National Service Framework, which describes risk assessment and management as '*at the heart of* effective mental health practice[30] and needs to be *central* to any training developed around the care plan approach' (p22, my italics) and the proposed new Mental Health Act. This is widely rejected by user movements such as the National Schizophrenia Fellowship[31] and MIND, practitioners and human rights lawyers:

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[30] Although on page 3 of this same document, sound professional judgement and practice are considered to be the 'essence' of this.
[31] Now renamed "Rethink".

'I am very concerned with some of the proposals and wonder whether some are compliant with European Law. The government seems to have gone ahead and ignored the advice it has been given. The system will collapse unless they drastically increase funding – they won't be able to afford all the extra tribunals they have promised, for instance.'
(Rebecca Fitzpatrick, Human Rights Lawyer, cited in *The Independent on Sunday*, 7.7.02.p9).

The National Service Framework, on the other hand, claims that: 'Changes in the legislative framework to support the effective delivery of modern mental health services will arise from the current review of the Mental Health Act' (p15).

1.5.3. The "Perils" of Technology

Part of the tension between objectivity and subjectivity which has caused facts and values to develop as separate areas of knowledge in practice, originates, according to Dyer (1988), in the previously described biological versus psychosocial dichotomy evidenced by "scientific rationalists", who emphasise objectivity, fact, abstraction and certainty, and "humanitarian idealists" who stress subjectivity, values, emotions and experience. Medical practice should, he continues, be well situated to resolve this tension, but most healthcare workers and many users apparently misconceive new technologies, overestimating their power. An area as sensitive as mental health practice involves far more than technology, yet the science and humanitarian empiricism divide in this may have provoked an imbalance in professional healthcare ethics between valuing and knowing, between facts and values (see also Fulford et al, 2002).

There are currently two prevailing (and competing) views on professional healthcare

ethics. The first considers the expertise of the practitioner to define the profession. The second claims it is based upon a trusting relationship between practitioner and user and defined by the ethics, or codes of good practice of the individual healthcare discipline. This ethics-knowledge divide was once unthinkable, insofar as these factors were inseparable from the personal values of the "knower" in question. However, today scientific medical practice sometimes appears to have reduced the user to little more than a physically or pharmacologically manipulated artefact (Hopkins, 1972 and 1979, Shorter, 1986 and 1996; Dyer, 1988; Jonsen 1998, et al.). This process of reducing the user to "clinical material" has facilitated the expertise-ethics divide.

Since in a conception of morality based on rules, the sensibilities important to moral judgement and action are frequently underestimated, this is arguably of greater relevance to mental health practice, which prioritises behaviour, than to surgical treatments which prioritise the body. An article from the New York Times Sunday Magazine describes the dilemma of a young intern in psychiatry which illustrates this dichotomy between practical technology and personal sensibility:

> '... (she) told me she was thinking of abandoning the field. She had studied psychiatry to find out how the human mind works ... but all she learned was which drug would control socially incorrect behaviour. And who's to say what's incorrect? "If he showed up here tonight", she said, "I would drug Vincent van Gogh so that he would never paint again".' (Alcabete, 2000)

Not that "scientific" treatment is inevitably undesirable to the user. Many people suffering mental disorder actively seek professional help, request medication and

consider compulsory admission necessary in situations of crisis. There is no conflict

in this. The conflict arises in deciding how this help is best given.

Chapter Two: The Philosophical Concepts

2.1. Introduction

The problem central to this thesis is that of evaluating which of several moral theoretical frameworks best undergirds the ethical prescriptions of mental health practice. The contrast between deontological, duty-based systems and consequentialist[1] systems, such as utilitarianism, is familiar to those working in medical ethics. However, as was said in Chapter One, in considering mental health practice other contenders for preferred ethical framework and their relevance to patient-centred practice merit close attention.

Discussion of the theories behind and structure of ethics in mental health practice should be informed by the historical context and content of the theories in question and the moral dilemmas they are to address. This chapter explores the philosophical origins of the relevant theories, identifying the principal characteristics and values inherent to each. It compares and contrasts them with virtue ethics and the ethic of care, discussing their potential advantages and disadvantages for mental health practice. Distinctions are made between clearly different major ethical theories, Aristotelian and neo-Aristotelian ethics and the ethic of care. An ethic based on both the latter, the end of which is 'flourishing', was described (in Chapter 1.2.1) as potentially particularly appropriate to the specific needs of mental health practice.

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[1] Both explained further in 2.2.2.

2.2. The inadequacy of principles-based ethics and codes of practice

Promoting a case-based approach to virtue ethics, Jonsen and Toulmin (1988) reject the 'tyranny of principles'. This approach, known as casuistry, contends that although philosophers believe that moral judgements start with principles, upon examining the means by which consensus is reached in moral dilemmas, it becomes clear that agreement on principles is not inevitable. These authors describe how several people analysing the resolution to a particular moral problem could reach agreement on this readily, but disagree upon the principles by which the resolution was attained. Casuistry argues that the *locus of certitude* in moral discussions does not lie in an agreed set of intrinsically convincing *general* rules or principles, but a common perception of the issue *specifically* at stake in particular kinds of human situation (p18, their italics). In this case, the focus of ethics should not be on normative rules designed, as in professional ethical codes, to apply to a range of particular situations, but on the Aristotelian virtue of *phronesis,* the capacity for practical, intelligent reasoning which starts with perceptions about cases and moves upwards towards only limited general rules or guidelines.

Principles are also rejected by most care ethicists because they are employed inflexibly, without regard to context, in moral decision-making. However, only the very strong particularists amongst these totally reject the possibility of generalisation and of principles. Other feminists are prepared to endorse principles as part of an ethic of care, as 'Aristotelian rules of thumb'. The issue is not whether virtues such as justice may be included, but how. It will

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here be argued that this can result from simply recognising the ethic of care as a virtue ethic, as do several of those female philosophers cited in Chapter 1.3.1. (Tong, 1998; Card, 1995; Baier, 1994). To be practicable, which at present it is arguably not, the ethic of care must include those considerations of value which allow carers to seek a balance between caring for others (promoting their flourishing) and for themselves (in the context of this thesis, flourishing *qua* health professional), flourishing being the ultimate aim of Aristotelian virtue ethics. The crux of the argument *pro* virtue and care ethics is that real events neither require, nor conform to rigid principles, much less norms, for in mental health practice as in no other area of medicine, dealing as it does with disorders of emotion, character and behaviour rather than specific physical manifestations, each ethical dilemma is unique and necessarily resolved as such.

2.3. Historical Background

The recent history of ethics could be described as one of disillusion and uncertainty. This results from the post-war shift in emphasis from the problem of knowledge to that of meaning, which has separated ethics and epistemology. Disinclined to accept the notion of ethical "knowledge", analytic and linguistic philosophers have argued that moral language is, epistemologically speaking, empty (Audi, 1995 pp.508-510). Many still believe this, in spite of the excellent work currently taking place in this field.

It may be difficult to verify ethical statements such as "abusing the mentally disordered is wrong", much less philosophically validate them by the exercise of

logic. Consequently, they appear to be purely subjective, emotional utterances and if all moral philosophy has done is produce essentially empty "pseudo-propositions", then all ethical foundations disappear. Only unverifiable human beliefs, lacking a solid base and offering no guarantees remain. However, Enlightenment thinkers, such as Hume, suspicious of reason as a source of moral wisdom. Hume believed our practical moral distinctions to derive from the sentiments, or feelings, provided by our moral sense. 'Passions direct the will, and reason serves the passions'. (Hume, D., 1969 [1739/40] *A Treatise on Human Nature*) is a sentiment which female philosophers (see Chapter 1.3.1.) claim finds resonance in both virtue ethics and the ethic of care.

Continental philosophers, such as Lyotard and Derrida, developed similar arguments, claiming that reason itself - as a human linguistic construct, rather than a transcendent entity - is a fiction. They suggested that adulating reason *per se* had caused much self-inflicted human suffering and questioned many philosophers' faith in rational man's ability to produce the true, universal and eternal. In addition - and importantly to this thesis - they believed that blindness to the fact that beliefs are simply selective and contingent linguistic constructs could result in social and political creeds which involved excluding the "other", the dissenter, the political opponent, indeed all powerless and non-conforming minorities – including the mentally disordered. This notion of 'otherness' must inform any discussion on mental health practice given that social exclusion is frequently a consequence of mental disorder.

Roland Barthes suggested that those who control the dominant discourse (in mental health practice, policy makers, managers and practitioners) determine what is 'real' or 'rational' and therefore *not* symptomatic of madness. Barthes considered much of the essentially cultural or political to have been naturalised and re-presented as "common sense". He employed the word 'myths' to describe ostensibly 'natural' ideological constructs which, upon examination, frequently prove to be subjective and unfounded value judgements - for example those about the poor being "work shy", women more "hysterical" than men, and the mentally disordered "dangerous".

Michel Foucault echoed these views, developing the view of knowledge as an ideological construct used by the powerful to oppress the weak. In *Madness and Civilisation* (1989), he offers an archaeology of how the exchange between madness and reason was silenced. He suggests that the powerful, in claiming to know what is 'reasonable', claim the right to decide what is permissible and rational in thought and behaviour[2] (and the proposed new Mental Health Act might be said to justify this suggestion). They have convinced everyone that local and regional ideologies are, in fact, universal and unquestionable, categorising those who dissent from them as mad, even dangerous, and treating them accordingly. This could explain, for example, the totally disproportionate number of Afro-Caribbean men currently interned in psychiatric hospitals in the U.K. and the U.S.A.[3] The notion of knowledge of the 'rational' as a weapon of social control is revisited in Chapters 3 and 5.

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[2] See Perkins Gilman *The Yellow Wallpaper* for an example of this.

Great changes also occurred in post-war Anglo-American analytical moral philosophy. Prior to the fifties, discussion of normative ethics centred on those two opposing rational traditions: the deontological position favoured, for example, by Kant, and the Utilitarian or consequentialist position, favoured, for example, by J.S. Mill. Obligation-based deontological (from the Greek *dei* = one must) codes are based on moral theories according to which acts must, or must not, be performed regardless of the consequences. They are intrinsically right or wrong and do not specify good independently of right, or right as maximising the good. Deontology is, therefore, perceived as generally opposing consequentialist ethics based upon the claim that the rightness or wrongness of an act depends wholly upon its consequences. On this view, one should act only in terms of achieving the best general state of affairs. There are two classes of utilitarian, or consequentialist. The *act* utilitarian considers what good and bad consequences will result from this action, in this circumstance. The *rule* utilitarian, closer to deontology, considers an act's conformity to a rule justified by the principle of utility to be what makes it right. The rule is not expendable in a particular context, even when following it does not maximise utility. Both theories base moral worth exclusively on rationality, claiming that our development as moral beings depends solely upon an ability to rationally perceive universal and impartial rules of "rightness" and "wrongness".

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[1] According to Nazroo, J. (1997) Ethnicity and Mental Health, the 4th National Survey of Ethnic Minorities, the rate of psychosis among Caribbean men is no greater than among white men, but they are far more likely than the latter to be receiving hospital treatment for psychosis, compulsorily treated, and treated in secure wards. This work provides support for both Foucault's and MacIntyre's views on the local being considered to be universal.

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G.E.M. Anscombe (1958), attacked deontology and consequentialist theories, suggesting that when no law-giver is assumed, a foundation for morality based upon legal notions of rules and obligations is nonsense. She believed that secular moral philosophy could no longer employ concepts of rightness and wrongness linked to moral obligation. Instead ethics should be based on the Aristotelian notion of virtue (*arete*) understood, independently of obligation or good consequences, as part of human flourishing. The notions of virtue are, she suggested, essentially more "basic" than the concepts central to Kantian and Consequentialist theory, and may replace some of these, particularly that of "obligation". Modern virtue ethics focuses on moral agents, their characters and lives, specifically emphasising moral education since virtuous character traits are developed in one's youth.

Central to virtue ethics is the notion that sound moral choices depend upon a virtuous character, rather than principles and rules. It emphasises the agent who performs the act and makes the choices. Aristotle distinguished between right action and proper motive by suggesting that an action can be right without being virtuous, but can be virtuous only if performed in the right state of mind (*Ethics* 1103a10). An intellectual virtue is a trait of character that is socially valued, such as intelligence or charm, and a moral virtue is a trait that is morally valued, such as courage, temperance or justice (Ethics II -1103a14-b1). Virtuous agents must consciously decide to perform virtuous actions for themselves and must do so from a firm and unchanging state of mind.

Because of this, McDowell (1979) claimed that virtue has only a secondary role in ethical codes primarily concerned with 'right conduct' and the principles governing this. This a gross oversight: 'Right conduct' should come 'from the inside out' (*Virtue and Reason, 1979*, pp331-50), beginning with the notion of the virtuous agent. Virtue is knowledge and in some sense 'getting it right' from a sensitivity to the demands inherent to the particular situation.

McDowell's 'sensitivity' is arguably closely related to Aristotle's *phronesis*, the deliberative excellence necessary to realise the true conception of the good life in practice via choice (Honderich, 1995, p679). *Phronesis* is, in Aristotle, natural to the virtuous agent, who sees things as they are and acts accordingly. That awareness of how to live cannot be captured in a set of universal principles (or deontological codes) is implied in Ethics, Book V-1137a35-b24, in which Aristotle insists that laws cannot (or should not) be applied indiscriminately, even when framed universally. The virtue of equity is needed to balance a law's universality against the canons of justice. Morality cannot be coded, nor the virtuous agent's awareness of how to live captured in a set of *universal* principles or codes. Virtue is a question of character, not act.

Iris Murdoch (1985) relates virtue and care ethics, claiming that morality cannot be understood as a set of contractual arrangements, but involves our whole way of life, hence the Socratic question: "How should one live...?" For her, respect is found in the ethical sphere, particularly in the exercise of altruistic love and justice. In Murdoch's account, virtue consists in a movement beyond the self which includes a capacity for love itself and, ultimately, for love of "the Good".

This altruistic love has points in common with Noddings' (1984) and Ruddick's (1989) description of the feminine "ethic of caring". However, Murdoch believes not only that the self is a source of falsity and deception, but also – and here her thinking is opposed to that of both Aristotle and Noddings - that human beings are naturally selfish. Noddings would totally reject this notion, at least in so far as women are concerned. Only in moving beyond the self, says Murdoch, can one contact with the world as it is, a view which links philosophical moral theory to the need for sociological empirical observation.

These arguments contain scepticism about objective accounts of the good and aspects of virtue ethics, representative of much contemporary work on this. In *After Virtue*, MacIntyre (1985) adopted elements of all these themes, moving towards the creation of a neo-Aristotelian variant of virtue-centred ethics. He claims that much contemporary moral decision making, based on fallacious notions of timeless truths about the nature of moral discourse or foundations of moral judgement, is nonsense. Developing Aristotle's view that there should be no conflict between the individual and communitarianism, MacIntyre suggested that ethics concentrate less on individuals and private moral decisions and more on the moral health and welfare of the community.

Communal life is, MacIntyre believes, maintained by tradition and the dispositions of virtue which groups encourage in individual members. All morality results from tradition and believing one can exist as a 'pure individual', or formulate a tradition-free and timeless moral system based upon reason alone, is futile. Greek morals have, says MacIntyre, been undermined by sceptics such as Hume. Kant,

like other deontologists, reduces morality to a cold exercise in reason, whilst consequentialists produce a set of unworkable pseudo-scientific calculations.

In addition, these doctrines claim to be universal when, like Foucault, MacIntyre considers them essentially 'local'. For him, modern ethical philosophy either covers the internal warfare between deontology and consequentialistism described earlier, or is unfeelingly analytic and theoretical. Consequently, in *After Virtue* (1985), MacIntyre recommends a neo-Aristotelian virtue ethic based on one of Aristotle's central tenets – that people should be habituated into having a good disposition towards others. Morality consists in three parts: the raw nature of human beings, the laws of morality, and a conception of human nature as it would be if it realised its goal (*telos*). Ethics, MacIntyre argues, is the means to this, the fulfilled (*eudemon*) existence or flourishing (1985, p53). Aristotle describes this goal as our biological nature *qua* human beings, but MacIntyre argues that it is acquired within a communal practice, shaped by an historical tradition. Interestingly, given the nature of this thesis, MacIntyre claims that 'a moral philosophy ... presupposes a sociology' (1985, p23). His example is the virtue ethics of the heroic societies of military aristocracies. This was first raised by Plato (*Republic*) and Aristotle as a result of the shift to the *polis* and subsequently further displaced by the transformations of Christianity and modern Western individualism. MacIntyre overlooks Goffman's (1961) suggestion that the "mechanical solidarity" of loyalty to the group never entirely disappears, but continues to be generated wherever social interaction has the characteristics of interaction rituals.

For neo-Aristotelians, moral behaviour cannot be reduced to a set of principles or rules since these are frequently inapplicable in 'unusual' situations. Any principle is liable to exception and 'any universal moral judgement (strictly construed) is false' (Barnes, 1976, p21). At best one can aspire to a set of general principles which will cover the exigencies of most commonplace situations, but always risk coming 'unstuck' (ibid). In such a situation, Aristotle himself would recommend abandoning these in favour of a more satisfactory set, or resorting to moral intuition.

Although somewhat uninformative about the nature of the dispositions or virtues (aretes) that he believes would produce excellent moral behaviour, MacIntyre describes them as qualities which enable us to achieve "eternal goods" which are grounded in human practices and 'the wisdom of ages'. What he may have in mind is that the practice of the virtues is constitutive of excellent practice, a notion central to the study of ethics in mental health settings.

2.4. An Empirical Ethic for Mental Health Practice

Descriptive theory explains how things are. Normative theory tells us what morally ought to be the case. In focusing on ethics, we are normally understood to be concerned with the latter and in assessing actions and behaviour all ethical theories use some kind of normative ethical principles. To be workable and beneficial an ethical discourse must employ understandings, procedures and judgement criteria which all those concerned with morality and ethics can affirm.

This thesis argues that as the fact that codes would appear to be more honoured 'in the breach than in the observance' (Pritchard, 2001) reveals, current principles-based ethics are insufficiently adaptable to the subtleties of ethical dilemmas in patient-centred mental health practice, in which the user's values, priorities and psychological and social circumstances (Barker and Baldwin, 1991) are emphasised. Necessary to this is an awareness of the importance of good user-practitioner communication and the ability to integrate this with the demands of today's highly technical bio-medicine.

From the perspective of empirical ethics what is interesting about Aristotle's virtue ethics is the seriousness of his attempt to ground ethical life in a realistic understanding of human psychology, in which both character and virtues are type-specific[4]. Aristotle amassed empirical observations on an enormous scale and believed that 'it is the business of experience to give the basic principles which belong to each subject' (*Prior Analytics*, 1.30). Aristotle's insistence that the ethical life is primarily concerned with the agent's character and experience of life, rather than with abstract moral rules and their logical justification, appears to make virtue ethics particularly relevant to the irrational and unclear situations frequently encountered in mental health practice.

Deontological codes of good practice appear, to judge by the disproportionately large proportion of disciplinary hearings related to mental health practice, ill-fitted to deal with the ethical dilemmas inherent to mental health practice. A courageous

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[4] In philosophy, type is contrasted with, or compared to token. Types are abstract things and tokens are particulars. It could be said, for example, that 'the event which is now your reading is a token of the type reading' (Honderich, p877).

person faced with violence would, for example, be sensitive and responsive to what in any particular circumstance was the courageous thing to do without needing to refer to "the rules". There is no authority independent of this courageous person, such as a fixed moral code, which could explain or justify that judgement. According to Aristotle (*Metaphysics* 1078b27-32), Socrates himself showed that any attempt to define courage by prescribing particular rules will admit obvious counterexamples. As McDowell (1979) said, virtue is 'getting it right' due to a sensitivity to the demands of the situation. This has nothing to do with rules, but relates to moral "intuition", experience and *phronesis*.

The Aristotelian virtue ethical theory employed here is 'neo' insofar as whilst generally embracing his ethical writings, its proponents regard some of Aristotle's views, particularly those on women, slaves and animals as 'just plain wrong' (Hursthouse, 1999, p8). It also includes virtues such as charity and concern for *all* sentient beings, something Aristotle, due to the cultural context of Athenian society of the 5th century B.C., did not consider. Neo-Aristotelian virtues ethics, in various "formats", is widely recognised as a rival to what many modern philosophers now consider outdated and insensitive deontological and consequentialist ethics. Virtue ethics seems particularly relevant to healthcare practice insofar as Aristotle prescribes as a realisable universal in what good practice should consist - the exercise of the virtues, particularly *phronesis,* in the professional task. Mental health practitioners must aspire to achieve in terms of that definition in order to 'flourish' *qua* practitioner in the clinical context. This contrasts with the flourishing of the user, which is essentially being able to resume a full and satisfying life. The main problems here lie in considering how to

educate those who lack them in the necessary virtues and in redefining these in the context of mental health practice.

In addition, there is a distinction between Aristotle's abstract universal and the real. In the *Politics*, Aristotle claims that those lacking the abilities necessary to a life of excellence or virtue are natural slaves and therefore rightfully deprived of the freedoms enjoyed by those with higher capacities. By this very harsh criterion[5], the mentally disordered would apparently fall short - would be, as it were, Aristotelian *untermensch*. Chapter 1.5. showed that even today they are frequently perceived and treated as such.

Neo-Aristotelian ethics totally rejects the notion of *untermensch* and the possibility of socially excluding the mentally ill for the reasons that Aristotle might have done. Respect and care for all sentient beings is a central tenet of neo-Aristotelianism. Such an ethic, requiring as it does the practice of the virtue of *phronesis*, is highly relevant in the context of mental health care, since this would permit guidelines, rather than rules, to be employed in both encouraging good practice and in ethics education. A greater emphasis would be placed upon on values, reflexivity, role models and mentors, than on apparently unrealistic and unhelpful codes.

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[5] It should be remembered that Aristotle's views on only free Greek male citizens as fully worthy human beings were typical of his age and culture, although Plato held a more magnanimous view of (some) women.

2.4.1 Flourishing (*eudemonia*) and the good (*agathos*) in the context of mental health practice

Having defined flourishing for mental health practice in general terms in Chapter 1.2.1, it is necessary to consider and define it in the context of mental disorder, for it might appear that the concept of *universal* flourishing is questionably realisable in this. Flourishing was earlier described as a function, that is, as a purpose or goal. We define some things, such as man, in terms of function. Some men are considered more 'manly' than others, and so on. Structures make this realisable, indeed it is only realisable as a structure. Insofar as the universal of nursing cannot, for example, be separated from the nurse, good mental health practice can arguably only be as good as its health care workers, regardless of the codes of practice stipulated by professional bodies.

Whether this 'good practice' is a real or an ideal thing is unproblematic in that it is workable either way, but the flourishing of users must always be conceived in real terms. The good practitioner's principle aim is to discern and develop the user's potential for flourishing which, for Aristotle, is the greatest good. As was indicated in Chapter 1, (p9) a central tenet of neo-Aristotelian theory is that 'practices' are associated with certain goods *(agatha)*, which exist within a hierarchy of other goods. Aristotle held that flourishing consisted in the exercise of the virtues and this in itself instantiates all the human goods. In *Nichomachean Ethics*, he develops the idea of a good-in-itself or intrinsic good, distinguishing between things pursued for their own sake, for example health, and things pursued for the sake of their consequences, such as fame. He considered many things to be goods in themselves, including intelligence, wit and so on. Neo-Aristotelians

would add to this modern values such as the conservation of the bio-system. (Honderich, pp322-323).

At this juncture it is necessary to consider the nature of the goods internal to mental health practice and their relationship to notions of function, flourishing and care. Flourishing in practice could be described as an abstract ideal, yet meeting this would serve for little if the practitioner did not at the same time meet the ideal for flourishing and make his/her professional objective the simultaneous flourishing of the user. In speaking of functions, as for example in the case of the nurse, these are universals, based on commonly shared notions of what a good nurse is. But what is a 'good' mentally disordered person? Does it mean that in diagnostic terms, for example, a 'good' psychopath has to lie, rob or murder? This is obviously not the case.

The conflict lies in the fact that one individual's flourishing is not necessarily another's. Common ground is needed in order to be able to say that one person's flourishing is effectively not *exactly* the same as another's, but that it does fit a universal description. This enables us to claim, for instance, that it is definitive of psychopathy to cause harm to others, but this is obviously not what is meant by the psychopath's "flourishing". Can 'flourishing', in the Aristotelian sense of *eudemonia*, occur in mental health practice in the absence of 'caring' both for and about the user, or are the two inseparable, complimentary, or quite distinct entities which may or may not be related to considerations of gender?

How, too, is the user's 'good' or best interest discerned? It initially seems that mental health practitioners would almost inevitably fall short in this function in the case of the highly irrational or sedated user, incapable of clearly expressing him or herself. In a sense, this aim appears unrealisable for lack of resources and therefore, like rules, more likely to be honoured in the breach than in the observance. But this is not an excuse for not at least trying. If mental health professionals are to be educated in what to strive for, the objective must be clear. It may fall short of an ideal, but if only a minimum, such as containment, is attempted, practitioners could fail in other important ways.

To return to the example, how can the flourishing of the nurse, versus that of the psychopath, best be described? The aim of each is quite different and almost certainly mutually incompatible, but in any Aristotelian ethic a sense of community is essential and this implies a sense of responsibility towards the psychopath. This is something fully and increasingly, should proposed changes in the Mental Health Act become law, coherent with the role of professional mental health practitioners. However, abuse must be guarded against. From this point of view, the nature of flourishing for the psychopath might be described, but the description will refer solely to this *particular* psychopath, not to psychopaths in general. "This-ness" must be considered for there can be no prescriptions or rules of good conduct in dealing with this, or that, particular sufferer from schizophrenia or bi-polar disorder. In order to promote user flourishing it is essential that the good practitioner discerns the individual interest and values of each user.

It could be objected that we talk of **this,** but that in talking of psychiatric practice, we are generalising. However, when talking at all we universalise. Assuming this is not an excuse for failing to address the problem, there is another way. Although this commonly occurs, we should not, for example, reduce the person who suffers from schizophrenia to the label "schizophrenic" simply because we know nothing more of him or her. Ignorance cannot absolve us of the need to go beyond the label. Phrases such as "only five minutes to visit", "no nurses" and so on, are all variables to be considered, but we cannot talk in general terms, for example, of "the psychiatric service we deserve". However, a universal concept of flourishing for practice is still necessary, even if we need its anti-thesis for individuals. Guidelines, which are realistic, without being so low-level or inflexible as to actually hinder good practice are necessary. Having an ideal of practice, a *eudemonia* for practice, is another matter. A dialectical process comes of good practice, but given the nature of some dilemmas inherent to treating mental disorder it is essential to remember that this must be enshrined in law.

The concept of *eudemonia* could be said to cause problems in Aristotelian ethics itself, in relation to both user and practitioner, due to Aristotle's tendency to "pigeonhole", someone either making the universal grade, or failing to do so. However, although what is good for A is not necessarily equally good for B, A may still be useful as a model because the flourishing of both A and B depends on knowing and *analysing* their desires and potential. We cannot make rules about A or B, but neither can we generalise about flourishing. Both for mental health care workers and users this is different, but not antithetical. To some degree it is also different to Aristotle's universals, because whilst universals are necessary to

diagnosis, they must not be confused with the individual user for whom flourishing begins in not being dehumanised, either chemically or psychologically, and lost in a sea of diagnostic labels. This is not to condemn diagnosis or treatment, but given the variety and nature of mental disorders and our relative ignorance of the aetiology of some of these it is vital to take a whole view and to question both, if necessary.

Perhaps practice cannot be perfect, but we should, nonetheless, strive for perfection. What is proposed here is to take Aristotle's notion of virtue as a model and adapt it, saying that it is not a universal, except in the abstract sense of flourishing practice and in relation to flourishing mental health care workers (and users). A realistic core of flourishing is thus achieved in practice, which does not condemn both practitioners and users to being incapable of meeting the ideal, nor reduce them to the lowest common denominator. This relates to the realism of a universalism of *eudemonia* in practice. How this is best achieved will be discussed in part three.

2.4.2. Virtue and Care Ethics as Normative Ethics

Another argument against neo-Aristotelian virtue ethics is that it does not produce *specific* rules of the kind necessary to professional colleges' deontological codes. However, virtues can generate prescriptions (and vices prohibitions). It cannot therefore justifiably be claimed that virtue ethics does not involve "rules", although these are couched in evaluative, rather than dogmatic terms. Developing and defining a normative ethic is a complex task and while it is legitimate to believe in a normative virtue ethic, safeguards are necessary to ensure that this is

part of a dialectical process. Normative ethics always run the risk of being excessively rigid or too fluid and both extremes must be avoided. Given that a large body of evidence indicates that deontological codes are frequently ignored by mental health practitioners, something new, less rule-bound and more sensitive to individual circumstances is required. As MacIntyre (1985) indicates, each community creates its own set of norms and allows for only relatively subtle variations from these. But individuals, mental health professionals or users, should be urged to be as autonomous as possible. 'Properly motivated people often do not merely follow the rules. They also have a morally appropriate desire to act as they do' (Beauchamp and Childress, p64). Given this requirement, how a virtue-care ethic can, in fact, be a normative ethic will now be discussed.

As Barnes (1976) says:

> "The Ethics is a work of practical science ... the aim of studying ethics is not the acquisition of knowledge about action, but action itself – we read the Ethics ... not in order to know what good men are like, but in order to act as good men do (1095a5; 1103b25)' (p17).

Virtue theory, then, is not only concerned with character, at the expense of act, but answers the questions: "What kind of person should I be?" (Answer: Flourishing) and "What should I do? (Answer: Practice the virtues, for in the absence of virtue there is no real flourishing). In the case of an ethic of care, these answers would be "caring" and "empathically care for and about" respectively. Both describe particular "rules" and principles, although they differ from deontological codes in that, according to Hursthouse (1996), virtues generate positive instructions, for example: "Act kindly", whereas vices generate prohibitions such as: "Do not be cruel".

Deciding on how to act within the framework of virtue theory does not necessarily involve asking what an "ideal" virtuous or caring person would do in similar circumstances. Exercising *phronesis*, the agent simply considers whether in behaving in a specific fashion s/he will be acting justly or unjustly, for or against the patient's, the family's or society's flourishing, and so on. Where this question elicits a clear answer, the agent employs his/her own concepts of virtue or vice directly. Whilst Aristotle's original ethic did not allow for open-ended virtues, nor for all individuals to be accorded equal rights, neo-Aristotelianism accords greater attention to the particular than to the universal. This makes this ethic 'adaptive to novelty' and capable of meeting problems with 'creative and practical solutions', both criteria of acceptability that promote 'reflective equilibrium' (Beauchamp and Childress, p26) in a principle or theory.

Neither is virtue theory committed to a reductionism which defines *all* moral concepts in terms of the virtuous agent. As Hursthouse (1996) points out, the virtue of charity, for example, is concerned with the good of others. Good, as Aristotle explains (*Ethics* 1096a19-b29[6]), is related to evil or harm, in turn related to the concepts of the worthwhile, advantageous, or pleasant. If the agent's conception of the latter is erroneous, so will his/her conception of what is good for or harmful to him/herself and others and it will consequently lack, for instance, the virtue of charity. Neo-Aristotelian virtue theory cannot, therefore, contemplate reductionism.

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[6] '... things are called good in as many senses as they are said to exist; for they are so-called in the category of Substance (e.g. God or mind) and in Quality (the virtues) and in Quantity (what is moderate) and in Relation (what is useful) and in Time (opportunity) and in Place (habitat) and so on' (Ethics, trans. Thomson, p70)

Virtue ethics also shares some problems with deontology. Defining the virtues is difficult and 'subject to the threats of moral scepticism or pluralism[7] or cultural relativism' (Hursthouse, 1996, p222), a thought which echoes the danger, pointed out by Foucault and MacIntyre, of local and regional ethics being passed off as 'universal'. Every rule specified in deontological codes could be disputed on philosophical or cultural grounds and this applies equally to the virtues, since the character traits necessary for flourishing may be contested, or not even considered virtues by others.

Critics could also claim that unreasonable conflict is inherent in virtue theory, for the exigencies of virtue frequently clash in much the same way as values might. Charity, for example, can demand one line of action, whilst justice requires another. This is a problem for virtue theory, but deontology can confront the same dilemma. Rules may clash because acts can be at the same time *prima facie* right and prima *facie* wrong. For example, the rule "save lives", can, under certain circumstances, yield conflicting instructions[8]. The act of killing may involve the relief of suffering and respect for the person's autonomy, if it is at his request, but this does not necessarily make it right. Aristotle emphasises that the sciences cannot attain equal precision because: 'different subject matters make different demands ... ethics in particular allows only a modest amount of precision' (Barnes, 1970, p20). Ethical judgements inevitably lack precision because they

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[7] Hursthouse claims that virtue theory is not compatible with all forms of pluralism since it allows for competing conceptions of *eudaimonia*, for example, in that it allows for a plurality of *eudaimon* lives. It does not by any means follow Aristotle in perceiving the life of contemplation as uniquely constituting *eudaimonia*.

[8] See William's Jim and Pedro case in Smart, J.C. and Williams, B. (1973) Consequentialism: For and Against.

only hold 'for the most part' (*ibid*) and moralists are restricted to generalisations, examples of which are found in *Ethics* IX.2.1165a.

Critics also claim that virtue theory is not based on argument. But requires simplistically asserting that certain actions are, for example, just or unjust. Deciding upon and applying such criteria is difficult, but this is a criticism of the theory as such if, and only if, we assume 'as a condition of adequacy' (Hursthouse, 1996, p223) that an action-guiding theory must stipulate what constitutes acting well and what should not be done. This condition is implausible, says Hursthouse, because the relevant condition of adequacy - and virtue theory does meet this - is that it should incorporate a truth expressed by Aristotle in the *Nichomachean Ethics* (1142a.12-29): that moral knowledge requires phronesis and is therefore unlikely to be found in those lacking wisdom and experience of life. Neither can it be acquired by attending lectures (although it will later be claimed that ethics and good practice *can be* taught to mental health practitioners).

To conclude, a virtue theorist would say that meeting obligations is a means to an end, which is flourishing. However, a deontologist would say that meeting one's obligations is itself an obligation and that if this results in happiness, all well and good, but this is not the specific end of doing so. For Aristotle, in order to achieve flourishing, man must engage in activities which elicit those feelings of happiness inseparable from this. There is a very real difference in these concepts of what constitutes happiness, or flourishing, for whilst Aristotle would contemplate different types of flourishing for different people and this dissertation posits different flourishing for users and mental health practitioners, a deontologist

would probably claim that there is a blanket, humanoid flourishing in doing one's duty.

2.5. Identifying Virtuous Act and Virtuous Agent

In Book One of the *Nichomachean Ethics*, Aristotle says: '... the Good has been rightly defined as that at which all things aim' (1094a). Our task is to become good men and achieve the highest human good, which is flourishing, an activity of the soul in accordance with virtue. How can virtue ethics define good and right in terms of the virtuous agent? If the question is how can virtue ethics specify right action, the answer is apparently straightforward: "An action is right *iff* it is what a virtuous agent ... acting in character would do in the circumstances" (Hursthouse, 1991, p22). In this case, she adds, it is also necessary for virtue ethics to identify virtuous agents, giving a non-deontological specification of their characteristics by means of a specification of their virtues:

- A virtuous agent is one who acts virtuously, both possessing and exercising the virtues
- A virtue is a character trait that...

The standard neo-Aristotelian completion describes a virtue as a character trait necessary to flourishing. This structurally resembles the specifications of act-consequentialistism and various forms of deontology. If virtue ethics can generate such a specification, it is reasonable to claim that it, like these, can tell us how to act. Virtuous agents are not merely caring, truthful and so on, their actions are also based on excellent practical reasoning (*phronesis*) referred to by Barnes as 'fine excogitations' (1977, p37). Conditions for virtuous action are stipulated in

Ethics Books I – III, and Aristotle later goes on, in Books IV – IX, to clarify the characteristics of certain 'moral' and 'intellectual' virtues. Most people have clear ideas as to what the virtuous agent would do in a given situation. In the philosophical analysis of the research data in Chapter Six, the character traits and values exhibited by practitioners and users are enumerated and analysed in terms of virtue and care ethics theory and deontological codes.

In the *Eudemian Ethics* (EE 1220b7-10).*)*, Aristotle describes character traits, dispositions and capacities (*Hexei*[10]). Virtues (*aretai*)[11] are those traits by which a man's character is capable of obeying reason (EE 1220b5-6) and are therefore *Hexei* of character. According to Hutchinson, a *hexis* is a disposition of character in virtue of which:

- the object disposed is both stably and well (or badly) disposed,
- the object is in a natural and perfect (or unnatural or imperfect) condition,
- the object has a dispositional property to perform its characteristic task (*ergon*) well (or badly).

In the context of healthcare, all these can be linked to the notion of emotional labour, to be discussed in Chapter Three.

In order to decide whether a virtue and care ethic would be appropriate to flourishing mental health practice it is necessary to answer the following questions:

- What is a practitioner's/user's characteristic task?

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[9] *Iff* = If and only if

[10] A *hexis* is a "having", a disposition, capacity, ability or faculty (1098b30 – 1097a7)

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- What are character traits exhibited by and necessary to mental health practitioners? Are these those of emotional labour according to the criteria described by Hochschild (1983)?

- What are the specific virtues necessary to practitioner and user?

- Are there different, yet equally legitimate concepts of human flourishing for mental health care workers and users?

- Is it true that, with regard to ethical practice, there are gender differences in the type of virtue exercised in mental health practice?

Aristotle says that virtues of character are special traits of this, and qualities of the non-rational part of the soul. Although non-rational, they can be trained, by the repeated disciplines of prescriptive reason, to be capable of obeying reason. In acquiring the virtues the spontaneous capacity to act and feel reasonably (as opposed to the capacity which most[12] people have to allow the voice of reason to overcome that of the emotions) develops. To paraphrase Beauchamp and Childress: character is more important than conformity to rules and virtue should be inculcated and cultivated over time through educational interactions, role models and so on (1994, p65). How this may best be done in the case of mental health professionals is discussed in Chapter Seven.

2.6. A Proposal for an Ethic for Flourishing in Mental Health Practice

As it cannot be commanded, Kant claimed that love has no part in moral agency. Duty requires total obedience to the moral law and adding other emotions to this basic requirement can only result in contingency in the moral life and the

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[11] Arete, virtue, is commonly used as the abstract noun for *agathos* or good. Goodness' or 'excellence' is, therefore, sometimes a better translation than "virtue".

subsequent loss of its universal application to all rational beings. Kant's rules are rules for their own sake, to be generated purely rationally, independently of their impact on people. They should be obeyed from a sense of duty, rather than any kind of human sympathy since acting out of sympathy for others is to act on a mere inclination and consequently entirely lacking in moral worth.

Such principles are said to be paralleled in the quest for an over-riding framework of principles for healthcare ethics (Beauchamp and Childress, 1994). Most medical codes develop general principles such as "do not harm" and rules such as those concerning medical confidentiality and informed consent. However, few engage with their implications in terms of virtues such as veracity and justice, although some have recently been incorporated into statements of patients' rights which invoke, for example, the principle of respect for autonomy. These professional codes also differ from others by focussing on the rights of users, as much as the obligations of practitioners. At times, they apparently conflict with more general moral norms and the pursuit of professional norms may appear to do more to promote the professions' corporate interests than an impartial and comprehensive moral viewpoint. Both an ethic of care and virtue ethics on the other hand: 'share a willingness to return to the uncertainties and contingencies of emotion and character in describing the moral life' (Campbell, 1998, p353). What could be better than ethics based on both the former, in dealing with what are also the uncertainties and contingencies of emotion and character inherent to mental disorder?

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[12] (Although this capacity is often claimed to be absent in the case of those suffering psychotic disorders)

2.6.1. An Ethic of (Health) Care

The ethic of care is a group of moral reflections emphasising those traits most valued in intimate personal relationships - sympathy, compassion, fidelity, discernment and love. Care refers to caring both for and about – an emotional commitment to other people and, if necessary, a willingness to act on their behalf. It downplays deontological rules, impartial consequentialist calculations and, perhaps paradoxically, individual rights.

In healthcare, it grew from two roots: the first, the traditional Hippocratic emphasis in medical ethics on the beneficence of the doctor (Campbell, 1998). An ethic of care appears to offer more benevolent resolution to dilemmas than the mere completion of rule-base obligations and is widely considered to result in better care than duty–based ethics. As a form of virtue ethic it does not guarantee any particular resolution to ethical dilemmas, but considers the interests of all involved parties in terms of fairness and beneficial outcomes. Emphasising the practitioner's role in including the user as the primary agent in care plans, it is not *inevitably* "maternalistic" since the user's good is often equated with his/her own choices. Overt "maternalism" only occurs when the health professional, considering his/her 'scientific' knowledge more relevant to treatment than the users' own desires and rights, decides independently what is "in his/her best interest" and tries to impose this view.

Where science or technology is "God", the most scientific or technologically minded tend to be perceived as the purest and the highest, but scientific explanation need not necessarily imply a lack of communication with the user.

Professional beneficence must adopt 'a consistently supportive role' (Campbell, 1998, p356), whilst the latter, as well-informed as possible as to the nature of his/her disorder, decides what is in his/her own best interest. The involvement of the professional as an empathic individual, attentive to the user's own values is central to the ethic of care. The aim of the doctor-patient interaction has probably always been the same: to empathise, to 'think oneself into the other's possibility' (Nussbaum, 1985, p521) by asking: 'If I was this person and had been given all the appropriate medical information about this condition, how would I want to be related to, and what management decisions would be important to me?' (Law, D. 1998). The paternalistic 'doctor as God', not unknown in practice, in spite of the fact that: 'this (*paternalism*) has turned out to be a limited and generally unreliable basis for medical ethics' (*Beauchamp and Childress,* p25), is far removed from the ideal of professional beneficence, or even genuine caring.

Not that mental health professionals are necessarily to blame for what is sometimes an abuse of power. As Laing (1985) explains, it is ensured that they perform their tasks by giving them such power. If they wished to practice as psychiatric specialists they could not refuse this and many do not find such power ethically problematic. This arguably regresses to traditional associations between mental disorder and dangerousness which persist today. These place the former between 'badness' and 'illness', pertaining to deviant *acts* as well as deviant states, and therefore needing treatment *and* control (Szasz, 1972). Campaigning against such discrimination and disempowerment is a major activity of user groups such as "Mind". With the increasing influence of these and a growing tendency to litigation, the time has come for mental health practitioners to

'renounce control that traditionally has been in the hands of the professional. This is the moral imperative of patient-centred practice.' (Stewart and Weston, 1995 p16).

This comment leads to the second root of the ethic of care. Critiques of patriarchy and over-rationalist, "masculine" medical ethics (described in Chapter 1.2.), have been important in recent work on healthcare ethics, particularly in nursing, as distinct from male, medically dominated traditional healthcare ethics. Some versions of the ethic of care have a highly emotional content – something which could be construed as relating to Aristotle's own claim that the virtues of character are linked to pleasure and pain because they are related to feelings which provoke these sensations. This is what legitimates the description by Tong (1998) of care ethics as 'a virtue ethics of a certain kind' (p161) and a 'contemporary feminist virtue ethic' (Conly, 2001, p12).

A key factor in care ethics is user empowerment. Decision-making, although not entirely one-sided, is *primarily* under the user's control. Therapeutic decisions normally depend upon his/her own evaluation of the relative importance of different life factors, informed by that of his/her carers. This relates to Aristotle:

> 'On important issues, we do not trust our own ability to decide and call in others to help us deliberate' (N E III, 1112b.p43).

Providing care would thus become an 'exercise in power-shifting' (Campbell, p357), something important given the views of users such as the late Marion Beeforth, who claimed that the user becomes totally "disempowered" and helpless

in traditional mental health settings[13]. Creating a care plan for flourishing, in which all those involved can participate in a spirit of Aristotelian-type friendship, in which the user benefits from friendship as an "instrumental good" becomes the central concern. To paraphrase MacIntyre (1999, p67): In order to flourish we need to learn to understand ourselves as practical reasoners about goods, about what on particular occasions is best for us to do and about how it is best for us to live out our lives. Without learning this, no-one, health care professional or user, can flourish

The development of an ethic of care is informed by: A 'progressively more adequate understanding of the psychology of human relationship – an increasing differentiation of self and other and a growing comprehension of the dynamics of social interaction' (Gilligan, p74). It '… evolves around a central insight, that self and other are interdependent' (*ibid*). In practising this ethic, the practitioner becomes, *qua* Noddings, 'engrossed' with the client's own reality. There is something vaguely alarming in the notion that care consists in mutual dependence to the point of "engrossment". The sympathy and empathy implied in this term, whilst enabling recognition of another's suffering, fail to raise awareness of how most constructively to respond to this. Such "engrossment" could cause practitioners to act not merely in an irrational and excessively subjective fashion, but might, in some situations, cause more harm than good to the object of this.

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[13] As a result of her own experiences as a mental hospital in-patient, Marion Beeforth, a physicist, mathematician, pioneer researcher into colour television, and committed Christian, developed an acute awareness of the powerlessness of psychiatric patients and spent most of her life campaigning for patients' rights and user involvement.

In mental health settings, allowing the user total autonomy in decision making could raise difficult questions with regard to professional responsibility and the duty of care[14]. In acute mental disorder, the user is not necessarily *always* authoritative in judgements about what is good or best in terms of eventual flourishing. In the temporary absence of the ability to reason rationally on his/her part, virtue and care ethics could conceivably concede that the care team and those closest to the user should make a decision, albeit contrary to the latter's own wishes. However, this process must be clearly understood as one of caring for and about, rather than power over the user.

Nussbaum's (1988) *Non-relative Virtues* discusses situations such as that described above, suggesting that an objective account of human good, according to which non-relative virtues can be specified should be possible. We may also recognise certain areas in which, due to our own limitations as human-beings, the decisions we make are 'non-optional and somewhat problematic' (Op.cit.p37). In mental health practice, legal factors may inhibit choice and in such a situation, it could become necessary to distinguish between "thick" and "thin" accounts of virtue. A "thin" account identifies 'whatever it is to be stably disposed to act appropriately in that sphere' (*ibid*) whilst a "thick" account requires more detailed specifications and is therefore more vulnerable to the cultural values and influences described by Foucault and MacIntyre. Debate on virtue ethics in mental health practice may concentrate on the correct identification of the relevant spheres of human experience, or on the adequate "thick" description of the virtues necessary to good practice, but sometimes the more we try to "thicken" these

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[14] See Fulford, 1996.

virtues, the less we are able to find a common view of what they involve. "Sectioning", in a particular case might, for example, be considered justified by one practitioner and an abuse of power by another, yet both could be acting as virtuous agents. This echoes the Aristotelian view that there is more than one virtuous stance in some dilemmas. This is a *key* difference from the prescriptive right answer of quasi-legal codes.

Such situations show why Nodding's person-centred approach cannot stand alone in the context of mental health care, but must be combined with a neo-Aristotelian virtue ethic. Her notion of individuality and respect for user autonomy, whilst recognising the mutual dependence of human beings, overlooks something central to virtue ethics, the fact of belonging to a community. The ethic of care alone is inadequate, for virtues other than caring must be exercised in the quest for individual *and* community flourishing.

In the sexual division of labour, too, care performed by women, associated with women and traditionally expressing and symbolising femininity (Harding, 1987) is inseparable from oppressive gender divisions. If only women embrace a care perspective whilst they care (emotionally, morally and physically), men, more concerned with liberty and rights, remain free to pursue more profitable activities. Such reinforcement of the sexual division of labour should make feminists highly suspicious of the ethic of care. As Harding says, the problem of exploitation, located as it is at the social level, points to the need for an examination of this ethic beyond the boundaries of moral philosophy and towards sociological critiques of the kind to be made in the chapter which follows.

2.6.2. Virtue + care ethics = flourishing?

In comparing and contrasting care and virtue ethics, the focus shifts from issues of choice to those of character and attitudes towards self and others. Most modern moral philosophy has asked: "How should I act?" Virtue ethics attempts to answer the question: "How should I live?" the shift being from act to agent. This makes it particularly relevant to chronic mental disorder. Every user must, as an ethic of care demands, make specific treatment-related decisions, but these form part of the ongoing question: 'How can I best achieve flourishing?'. There are well-documented cases of people suffering severe mental disorder who have been highly successful in answering this question for themselves[15] - contrary to the advice of mental health professionals. Such cases make an eloquent case for virtue and care ethics.

The genuine act of caring is love (Campbell and Solomon, 1988). In this sense it is similar to goodwill since it wills that its object should flourish, achieving whatever is good for him/her. Referring to Scheler's work, *The Nature of Sympathy*, Campbell describes love as 'an active valuing of the other, one which both discloses and enhances' their self-esteem and worth and is thus, in itself, therapeutic. It is:

> '... that movement wherein every concrete individual
> object that possesses value achieves the highest
> value   compatible with its nature and ideal vocation'
> (Scheler, 1954, p161)

This is also the nature of flourishing.

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[15] David Crepaz'Keay, for example, has suffered from schizophrenia for over twenty years. He claims that he has only led a "normal" life as the happily-married, successful director of a mental health media organisation since defying clinical advice and abandoning the medication which he felt was destroying his quality of life.

It has been said that caring has two dimensions, caring for and caring about. To care for someone involves developing their potential, understanding their struggle and supporting them in this. The ethic of care as a form of virtue ethics unites user's and practitioners' quests for what is 'good' in provoking personal and professional flourishing. Acknowledging and promoting value in the other in the awareness that humans fully flourish only upon achieving that state of being able to perform 'with some success the most perfect of typically human tasks' (Barnes, 1976, p36). It encourages both to look to the future in terms of the capacities (*hexei*) which might be cultivated in order to transcend the difficulties of the present and flourish. Good practice in mental health should therefore involve the virtuous/caring agent embracing a 'Biophysical Philosophy of Care' Scheid (2000) which 'emphasises community integration, continual personal growth and awareness, rather than simply the relief of symptoms' (p703).

Whilst accepting that there is an intrinsic value in actions performed for moral reasons, Aristotle insists in Books VI and VII of the *Nichomachean Ethics,* that the principles of the virtues themselves are arrived at by *phronesis*. The virtuous agent necessarily exercises this, all choices made by him/her for moral reasons following a process of deliberation. Paradoxically, Aristotle also says that it is a surer sign of courage when an agent acts virtuously in a crisis than where there is time to deliberate upon the *pros* and *cons* of action (NE1117a, p53). This is because he considers an "impetuous" act of virtue to be a clear manifestation of a firm character. However, earlier, (NE 1105a, p27), he describes choosing an act after deliberation, for its own sake, as a necessary condition of its being

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'virtuously' performed. It is possible to interpret these remarks not as meaning that "impulsive" acts of virtue are not chosen, but that as expressions of a virtuous character they are not "calculated" in the pejorative sense of this word. (Cooper, J. 1986).

This is important insofar as Aristotle, *contra* Noddings, states (NE 2.2.4) that the disposition to choose to act in certain ways, in full knowledge of our acts, is the result of habituation and training (NE 1104a-b, p24-25) rather than instinct. It requires educating the mind by making oneself act repeatedly in a caring and virtuous fashion. As those undertaking moral "education" become accustomed to acting virtuously, they achieve understanding of the nature and the motives behind the acts in which they are being educated. Thus the adoption of virtuous policies is founded upon *phronesis*, upon explicitly deliberated decisions. This does not imply that virtuous agents spend hours deliberating, but that they could, if necessary, defend their acceptance of virtuous policies and justify their acts, since virtue always entails *phronesis*.

2.7. Conclusion

'We don't much hold with talking to patients in this ward. Our main objective is to break the cycle of madness and get them out', a charge nurse once said to the psychiatrist Ronald Laing[16]. How much has changed in this respect in the face of patient-centred medicine and user movements' demands for more "talking therapies"?

In spite of the brave words and good intentions of the National Service Framework, public mental health care, as Chapter One indicated, is notoriously under-funded. There is also constant managerial pressure to treat and discharge users as fast as possible, thus avoiding "bed-blocking"[17]. Social factors, too, play a part. In today's "wellness" obsessed society, good health is regarded as a symbol of success and the chronically mentally or physically ill person becomes an 'embarrassing anomaly'. Mulvany (2000) reveals that those who suffer mental disorder are excluded from 'generic disability programmes in areas such as employment and training, housing and accommodation support, generic social support, recreation and disability services' (p586). The final indignity, therefore, is to be more or less cared for, but not to be cared about, receiving the concern of others, but not being considered by them to be a potential source of value or insight. We may eventually return to the kind of society and culture described by MacIntyre (1985) in which our essential vulnerability and dependency upon one another are the dominant theme in ethics. If this is to occur, a process of transformation is required. Those who formulate and teach ethics in mental health practice must not avoid the question of how to persevere in the quest for human flourishing in the miserable circumstances in which many of those using and working in mental health services find themselves.

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[16] The conversation is described in Laing, R. Op.cit. p18.
[17] According to the "Today" programme on BBC 4, 30th August, 2002, mental hospitals are currently running at 120% of their capacity, users being sent home "on leave" simply so that another user can occupy their bed.

Providers, too, should be concerned not only with the quality of the care 'but also adhere to a professional rationality which is shaped by ethical standards' (Scheid, p704). What is needed is an ethic which, like that described by Campbell (1998), is 'communal in scope ... forward looking in its delineation of values' (p364) and which directs the attention of both mental health practitioners and users to those 'fundamental human experiences in which virtue gains its richest and most complex expression' (ibid).

Chapter Three: Sex, Gender, Power, Caring and Emotional Labour

3.1. Introduction

Whilst "sex" refers to the biological dimorphic division of male and female, gender refers to the culturally constructed meanings attributed to these. Women have come to be defined not only in relation to men, but also as dependent upon and subordinate to them. 'Men's specific gender is ignored, they represent the universal and human to which women are the "Other") McDowell and Pringle, 1992, p3). First discussed by Simone de Beauvoir (1972) in *The Second Sex*, this perception has been taken for granted at all levels of socio-political functioning and the status of men and women is consequently constructed around a series of dichotomous categories.

Gender is now considered to be one of the principle axes around which social life is organised, 'both at macro-structural level of the allocation and distribution of rewards in a hierarchical society, and at the macro-psychological level of individual identity formation and interpersonal interaction' (Sabo and Gordon, 1998). Conell (1987) argued that, at any given time, in any society, a hegemonic gender ideology that prescribes socially acceptable norms and behaviour will exist (pp98-99). In healthcare, this ideology has traditionally been that of the male middle-class and is considered to have empowered men at the expense of women and the socially underprivileged.

However, the term "sex" has been critically questioned not simply as 'dimorphic' but

as discursively constructed and, indeed, variations are apparent in patterns of female "nurturing" and male "aggression" at all levels. Women do not inevitably assume the responsibilities associated with child care. Men are increasingly assuming the role of primary child carer and appear to have no less nurturing capacity than that traditionally attributed to mothers. Rather than addressing these situations, however, many sociobiologists ignore them. This may be due to their lack of knowledge of feminist critiques which 'rest on a vast array of scientific research that casts doubt on physiological explanations for gender hierarchies' (Rhode, 1997, p26). Some of these are examined in this chapter, which discusses issues of sex and gender in relation to mental health practice and to the culturally constructed meanings attributed to these terms.

3.2. Theories of Sex and Gender

Explanations as to the origins of the difference between males and females have existed since antiquity, but substantiated evidence for these is highly contested and controversial. Aristotle suggested that their source lay in the fact that women were biologically 'defective', amongst other reasons because they lacked bodily heat, something, which rendered them less perfect than men. In other ways, male and female bodies were considered structurally similar and 'what could be seen of men's bodies was assumed as the pattern for what could not be seen of women's' (Martin, p30).

Many gender scholars are currently modifying feminist theory to accommodate analyses of differences in power and privilege amongst the inter-male dominance

hierarchies described by Dominelli and Gollins (1997), which constitute the larger

gender order. Busfield (1996) claims that an adequate theory of gender must be based

on feminist foundations. However, if feminist theory itself is to develop, it needs to

evolve and be 'mature' enough to recognise, as did Enlightenment intellectuals such

as Hume (Essays, 560) and Choderlos de Laclos, that women should not be assumed

by either other women or men to never themselves jockey for places in dominance

hierarchies and achieve power simply because they have frequently been "victims".

Baier (1991), says that having been subject to deceit, exploitation and betrayal

'cannot be expected to make (women) less ready themselves to lie, cheat and betray'

(p234). This view severely undermines Wolf's, (1996) and Noddings' description of

almost all typical women as self-abnegating, altruistic carers.

Gender relations are also subject to on-going negotiation within the workplace.

Whilst everyone is now aware of them, there has been little research into their

implications for gender inequalities in mental health practice, in spite of the fact that

male health care workers, whilst greatly outnumbered by their female colleagues,

occupy a disproportionate number of senior positions in professional hierarchies[1] and,

somewhat ironically, are also far more likely to be subject to disciplinary hearings for

professional misconduct[2]

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[1] The incidence of men amongst policy makers in nursing, for example, is quite disproportionate to their numbers in the profession as a whole. Two new professional officers were appointed to the UKCC (now N&MC) in 2001, both were male.

[2] 'The UKCC (now N&MC) id currently commissioning research into this area of concern. Whereas male members of the nursing professions comprise only 9% of the Register, almost 50% of the respondents on PCC (Professional Conduct Committee) hearings are men. More information needs to be gathered as to the types of allegations of misconduct that are made against male practitioners and

In view of this, Annandale and Hunt's (2000) assertion that: 'The closer we move towards embracing complexity, inevitably the closer we simultaneously move towards undermining the primacy of gender as difference, that is male/female as a binary division of power' (p25) is intriguing. Recently, it has been suggested that gender should not be perceived as a set of fixed attributes and behaviour, but more as a process – 'doing gender' – in which gender is continually 're-established, sustained or modified', depending on the extent to which actions, and the rationales for these, conform to particular gender ideologies (Dunscombe & Marsden, 1998, Berk, 1985; West and Zimmerman, 1987). Others claim that it is necessary to retain gender and sex as dichotomies in order to facilitate recognition of the means by which women are oppressed as 'others' and the implications of this for health care (Doyal, 1998, Scambler, 1998).

On this theme of 'selves' and 'others', Anthony Giddens (1991), referring to men and women, suggests that self-identity can be continuously reflexively rewritten. This is the result of a continuous dialogue with the self, in the face of new social experiences and dilemmas. This view is endorsed by Butler (1990) and Hood-Williams (1996) who stress the relative fluidity of gender as it is currently enacted in everyday life. Dunscombe and Marsden (1998), on the other hand, suggest that the processes involved in becoming an 'emotionally warm and sensitive new man' or a 'ruthless career woman' are not simply those of re-inventing self-identity to make it

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further scrutiny of the available data is necessary' (UKCC, 1996, Issues arising from professional conduct complaints, p6)

correspond to a chosen gender ideal. 'Doing gender' involves 'the more complex task of displaying the emotional skills, capacities and propensities to do emotional labour[3] in a manner appropriate to the chosen gender ideology' (p218). They believe that in this process individuals may experience a tension between the strain of the emotion work involved in reconciling the feeling 'rules' of the gender ideology to which they aspire and how they 'really' feel as a consequence of the 'core self' or 'core identity' developed in childhood (ibid).

From the analysis of how male practitioners in mental health perceive themselves as carers and are perceived by users, it should be possible to ascertain whether this tension exists in the therapeutic use of the self in caring and emotional labour. Gender structures appear to be changing in a manner likely to affect different social groups in diverse ways. Inevitably some similarities may emerge between men and women but the overall picture remains generally obscure. Hence the need to re-examine the gender inequalities inherent to health care from user and carer perspectives.

3.3. The Effect of Gender Upon Moral Reasoning in Healthcare.

Many feminist care theorists (Gilligan, 1982; Ungerson, 1983; Harding, 1987 and Card, 1991) argue that traditional female virtues such as co-operation and caring, should be accorded greater value in the masculine sphere of public health. They suggest that we are mistaken in accepting the domination of what they consider

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[3] By emotion "work" Hochschild refers to the emotional management which is carried out in private. By emotional "labour", she means the emotion management done for a wage.

patriarchal and inflexible codes of professional practice based upon duties, rights and obligations. In their view, women, unlike men, look not only at the 'specifics' of a moral dilemma but also at the emotions involved in this and will always try to negotiate, rather than impose.

Prioritising agent over act and negotiating rather than imposing would initially seem a more humane and less disempowering form of engaging with someone as vulnerable as the mentally disordered person. But whether only women are equipped to practice an ethic of care in this way - or even genuinely desirous of doing so - is a controversial matter. Ungerson (1983) argues that the skills involved in caring are imbued with sex-role stereotypes and the view that women's unique "expertise" in caring is the result of their sex can trap men and women into socialised gender roles. Hursthouse (1999) joins those who rebut gender essentialism, arguing that it is far from "essential" to women to care and that they do so because society has traditionally cast them in the role of carers. She suggests that in some cases 'caring' women are demonstrating virtue and in others, practising emotional labour. Although some feminists have condemned virtue ethics as 'misogynistic' due to Aristotle's views on women, neo-Aristotelianism of the kind espoused by Hursthouse cannot be accused of this. It is, therefore, necessary to examine gendered attitudes to care closely in considering ethics and codes of good practice.

It has long been claimed that that the moral judgements of women and men differ (Freud, 1925, Hahn, 1975, Holstein, 1976, Gilligan, 1982) insofar as those of women are based upon feelings of empathy and compassion, whilst men seek the rational

resolution of real, rather than hypothetical dilemmas. Gilligan (1982) believes that women's deference is 'rooted not only in their social subordination but also in the substance of their moral concern, which is a sensitivity to the needs of others and the assumption of responsibility for taking care of others' (pp 16-17). This, in her opinion, makes them better inclined to listen to other points of view and include these in moral judgements.

Consequently, women's so called moral "weakness" (diffusion and confusion in judgement) is inseparable from their moral "strength" (concern for relationships and responsibilities). Gilligan believes that women's reluctance to make moral judgements may indicate the concern for others that infuses the psychology of women's development generally and is responsible for what is seen as 'problematic in its nature' (ibid).

Those qualities and capacities considered characteristic of the mature adult – 'autonomous thinking, clear decision making and responsible action' (Gilligan, p17) – are normally associated with masculinity. Men are reputed to reach moral and ethical decisions through the application of rational, logical thinking and law, whilst women are popularly seen as relying on 'communication, assuming connection and believing that (their) voices will be heard' (p27). This implies that only women's moral and ethical judgements contain those insights and understandings of the nature of choice essential to an ethic of care. Men's, reflecting the 'logic of the justification approach' (ibid), might be better suited to what Meerabeau and Page (1998) considers the alien rules of feeling related to managed, technical care, rather than to any real

vocation to care for people.

That women are widely considered to be less rational then men and more intuitive and emotional in their decision-making processes could be perceived as a weakness, rather than a strength, in their ability to resolve ethical dilemmas. This would clearly be the case for philosophers such as Kant, who favour deontological approaches and consider the central feature of ethics to be its universality. They would reject the notion of agent-based negotiation of the kind implicit to virtue ethics and the feminine ethic of care. However, this same negotiation might prove essential in meeting the growing demands of user groups and human rights movements and the increasing tendency to litigation characteristic of modern medicine.

In reality little is known of how gender and other axes of inequality mediate exposure to the influences of underlying inequalities and differences in health care and in the moral judgements made by health practitioners (Graham, H., 1983,1993; Dominelli and Gollins, 1997, Arber, S. and Cooper, H. 2000). Until the mid-nineties many theorists considered gender inequalities in healthcare settings to be socially constructed (Chesler, 1972, Davies and Rosser, 1986, Miles, 1988, Russell, 1995). Later, doubts about the theoretical and conceptual foundations of this belief set in and Graham, (2000) highlights the 'systematic way in which men's and women's health is shaped by socio-economic circumstances' such as class and ethnicity, rather than by gender *per se* and how these are 'polarising due to broader social trends' (p92). In the social context, factors such as status, power and so on also combine with reproductive biology to shape experiences and relations between the sexes. Because

of this, Gilligan (1982) says:

> '...the discrepant data on women's experience provide a basis upon which to generate a new theory, potentially yielding a more encompassing view of the lives of both sexes' (p4).

Her opinion is reflected by Arber and Cooper (2000) who say that it is necessary to take a 'life course perspective' insofar as only this: '...takes social change seriously and sees lives as dynamic and responsive to changed circumstances and opportunities' As a result of views such as these: 'a new vibrancy is being injected into debates on gender inequalities in health as an emerging "new agenda" challenges received wisdom' (Annandale and Hunt, 2000, p2).

3.4. Gender and Mental Health Practice

What distinguishes a feminist from a non-feminist history of psychiatry is that gender is seen as a social construct and masculine and feminine as cultural comparisons, not objective factors. Feminism critiques the assumption central to medicine and psychiatry, that the differences between the genders are biologically or psycho-dynamically determined. It re-evaluates psychiatric concepts and the treatment of women. In particular feminism examines the social construction of disease, psychiatry as a means of social control, and deconstructs scientific claims to objectivity.

'In the life-cycle, as in the Garden of Eden, the woman has been seen as the deviant' (Gilligan, 1982, p6). Consequently, when women have not conformed to the expectations of psychological theories based upon the white, middle-class male as

norm, the conclusion has been that something is wrong with them, that they are mentally "ill". (Russell, 1995, Chesler, 1972, 1990) and need to be "cured". This claim is supported by statistics such as those which reveal not only that more women than men suffer non-psychotic mental disorders[4], but also that two-thirds of those treated with electro-convulsive therapy are women (Breeding, 2000). These statistics are currently in a process of rapid change, but with few exceptions, research literature agrees that gender affects psychiatric prevalence, diagnosis and treatment. According to the Psychiatric Morbidity Survey of Adults, 2001, although more males than females commit suicide, men's mental health is generally better. In 2000, 135 men per 1000 were assessed as having 'some kind of neurotic disorder', whilst for women the rate was 194 per 1000. Men also had 'significantly lower rates of phobias and mixed anxiety and depressive disorders', 68 men per 1000, as compared to 108 per 1000 in the case of women. Against this, according to GPRD[5] data, the number of males aged between 16 and 24 treated for depression in 1998 (16 per 1000) was almost double that of 1994. (Dataset SFM 509, The Prevalence of Neurotic Disorders, by Gender, 2000. Social Focus on Men).

A large body of research indicates that such differences cannot be attributed to biological variations between the sexes. They appear to be the result of gender differences in roles which, in turn, lead to differences in the experience and expression of life events. Changing gender roles in society would also explain why men increasingly suffer traditionally 'female' mental disorders. It has, over recent

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[4] See Table 1. However, psychotic disorders do not reveal such clear cut differences.
[5] The General Practice Research Database

years, become acceptable in western society for men to 'get in touch with their feminine side' and express, rather than repress emotion. If this phenomenon has extended to the psychiatric consultation, this may account for the increase in diagnoses of male 'neurotic disorder'. Changing roles may also explain why more women are now imprisoned for violent crime. "P.M.T." is possibly no longer a valid excuse for aggression.

Given growing interest in and awareness of such issues, mental health practice must address the adoption of an ethic informed by a theory of gender. This must not only be based upon a clear comprehension of what gender actually means but should recognise and act upon the values and metaphysical assumptions about the nature of the self which sociology and recent feminist thinking, have revealed.

It has been suggested (Miller, 1976, Wolf, 1996) that women judge themselves by their ability to care, whilst men tend to assume or devalue that care because maturity is equated with personal autonomy and concern with relationships seen as a weakness, not a strength. Herein lies the paradox described earlier which implies that the traits that traditionally define the 'goodness' of women, such as care for and sensitivity to others, are also those that 'mark them as deficient in moral development' (Gilligan, p19). However, in spite of the predomination in both society, and many works on the ethic of care, of descriptions of women as 'helpful, loving, without expectation of return, emotionally dependable, supportive and generally nurturing' (Strickling, 1988) and of men as ill-disposed towards and incapable of caring, the current increase in the number of men engaged in this, and a re-evaluation

of their attitudes to this work, could lead to a re-thinking of the image of men as carers and the social meanings attached to the words "gender" and "caring" per se.

3.5. Women's Health

Echoing women's image of themselves as inseparable from the role of altruistic carer, Susan Wolf (1996) claims that those suffering terminal illnesses are more likely to request euthanasia than men, in an attempt to avoid burdening their families. She considers this a perversion of the feminist ethic of care that appears to take women's caring for and about others to the extreme. Wolf also suggests that doctors are more disposed to fulfil women's petitions for euthanasia, basing their decisions on 'the same historical valorisation of women's self-sacrifice and the same background sexism' (pp. 282-317).

Jennifer Parks (2000), on the other hand, suggests that women's requests for euthanasia may be ignored for exactly the same reasons that Wolf believes them likely to be fulfilled. 'By virtue of the fact that women will be altruistic, self-abnegating carers, women's own voices and their claims to autonomy in requesting death are easily dismissed' (p31).

These statements, whilst disagreeing as to the results, consolidate feminine and feminist thinking on the negative effects in terms of choice, perceived capacity to reason, and their ability to defend their own interests, of the stereotypical image of women as altruistic carers. Certainly they seem to have been historically victimised in mental health practice which has a long tradition of male practitioners imposing their

own ideologies of 'normal' femininity on helpless female patients (Perkins Gilman, 1892, Showalter, 1985, Ussher, 1991, Russell, 1995). Nurses' understandings of and contribution to health care are also, claims Davies (1995), systematically undervalued as a result of the perspectives of those in power and the patriarchal criteria by which nurses' views are judged.

A study by N. Charles and V. Walters, *Age and Gender in Women's Accounts of their Health* (1998) reveals the extent to which women's caring roles are implicated in their health concerns and self-image. That women are no more naturally disposed to caring than men is very strongly implied in this study, in which almost all younger women expressed ambivalence about the relative merits of employment and caring. The exigencies of caring for a terminally ill relative often precipitated feelings of anxiety and depression in older women, one of whom described herself as holding the family together and keeping the anxiety which this responsibility provoked hidden from them by 'crying in the bath'.

That women's lives are demanding and that women, old and young, attribute this to material circumstances structured by class and gender is undoubtedly frequently the case. According to Whitehead (1992), due to social isolation and lack of support networks, working class women in urban areas run three times more risk of suffering depression than professional women (p247). This claim is supported by many works on the psycho-social causes of disease and the role of life events, difficulties and social support in the onset of physical and mental illness (Brown and Harris, 1989, Thoits, 1995, Williams, S. 1996) There is also a marked generational difference, new

patterns emerging in gender relationships between younger, educated and employed females and males and older, educationally disadvantaged women and men 'who built their life trajectories around patterns of private patriarchy' (ibid). Bendelow (1993) reports physical pain as considered 'normal' for women as a result of their experiences of childbirth and differential socialisation. If they need to hide in the bathroom to cry, it would certainly appear that some women consider it 'normal' to suffer emotional pain, too. Their disadvantaged position may explain women's higher morbidity in mental disorder, particularly anxiety states and depression.

In view of this, it seems reasonable to conclude that women amongst themselves employ different discourses in discussing health and related issues. Whether this extends to the discourse between female mental health practitioners and users is something, which is explored here. Since feminists claim that men and women also employ different discourses, one empowered and the other disempowered or diffident, communication, particularly with a practitioner of the opposite sex, or of a different generation would seem problematic for both sexes.

Atkinson and Coffey (1995) describe a major centrifugal tendency in contemporary sociology, which has given rise to a variety of standpoints. Throughout these runs a 'discursive turn' which treats as central the relationship between language, knowledge and power. Women are usually regarded as highly verbal yet paradoxically language is one of the means by which they have been disempowered in psychiatry as in many other areas of life. The lack of words to refer to experiences unique to women has been discussed by many feminist writers, and social and

institutional factors often impede women's access to certain forms of knowledge and to certain ways of speaking (Ussher, 1991, Crowley and Himmelweit (eds.) 1994). It also affects how women are perceived when they do speak. These restrictions on women's speech need to be seen as part of more general social restrictions imposed upon women. One claim frequently made about their speech is that it is more hesitant and uncertain than men's is, that it is "powerless". This is often apparent in psychiatric interviews, in which hesitation could be misconstrued as a manifestation of anxiety or depression. On the other hand it has also been claimed that women's speech is more supportive than men's, in which case females could prove to have an advantage in all forms of caring. Whether the "supportive" nature of this speech is "natural" in the sense of being innate to women, or socially constructed remains to be seen.

Miller (1976) calls for a new language in psychology to separate the description of care and connection from the vocabulary of inequality and oppression. She envisages this new language as originating from women's experience of relationships. As long as it does not exist, Miller feels that problems of interpretation will continue to impede psychological understanding of women's experience. The 'different voice' to which Gilligan (1982) refers is not characterised by gender in this way, but by theme. The central assumptions of Gilligan's work are that it is the way in which people talk about their lives that is significant and that the language which they employ in doing this and connections which they make reveal the world in which they act as they see it, a view apparently echoed in Charles and Walters (1998).

Fishman (1983) goes so far as to speak of 'male interactional shitwork', in describing how men support a male conversational partner's topic, but do not enable women to put across their own points of view. Various studies also show that in talk between men and women, the interruptions are almost invariably from the man. These different interactional styles tend to operate to the man's advantage since they dominate, whilst women cede power in the face of this type of interaction, characterised as 'small insults' (West and Zimmerman (1983). Can insults, however small, ever be considered therapeutic, much less ethical? Do women, both health care workers and users, feel that men listen to them and, more importantly, take what they say at face value, resisting the temptation to 'interpret' it according to male criteria of rationality? Do male users, in turn, feel that female health care workers can fully understand men's 'rational' use of language and, what, in any case, is the nature of this rationality in the context of the mental health disorder? This issue of communication is absolutely vital in considering ethics for:

> 'The outputs from analytic ethical reasoning, combined with empirical methods, are not ethical rules, conventionally understood, but improved clinical skills, notably of communication ... Communication skills have a substantive rather than a merely executive role in healthcare ethics'.
> (Fulford et al., 2002,p163).

These considerations are relevant to examining the ethics of psychiatric interviews for how the practitioner's speech is perceived by the user must also affect his/her assessment of their attitude.

Related to this is Scheff's labelling theory, which claims that it is not falsity, but power, which is central to the diagnosis of delusions, and that in situations of conflict

'the most powerful party's views are counted as real and the less powerful's are discounted as delusions' (Palmer, 2000, p666). If this is so, women should be more frequently diagnosed as suffering from delusions than male users, yet this does not appear to be the case. Unlike "neurotic" disorders, those conditions most commonly associated with delusions such as schizophrenia, paranoid states and mania (i.e. those considered the paradigm of real madness), do not manifest clear-cut gender differences. 'It is less madness that is identified as the female malady than the broader territory of more minor psychiatric conditions' (Busfield, 1996, p19). She talks of the 'gendered landscape' which prevails in Western communities, where in disorders of thought, such as schizophrenia and dementia the male/female balance is approximately the same, whilst in other disorders such as depression, anxiety and so on, there tends to be a female predominance. In behaviour and personality disorder, as in drug and alcohol abuse, males outnumber females. 'There tends to be a roughly even gender balance in disorders structured around thought, a female predominance in disorders structured around emotion and a male predominance in disorders structured around behaviour' (Op.cit, 1996, pp3-4).

3.6 Men's Health

Annandale and Hunt (2000) reveal that: '... at the beginning of the twenty-first century, *being male or female remains a key organisational feature of all aspects of our lives, systematically structuring opportunities and experience*' (p20, my italics). Until fairly recently, men have been comparatively neglected in sociological studies on health, but the emergence of special interest groups such as "The Men's Health

Forum"[6] and works such as that of Sabo and Gordon (1995), which question feminist orthodoxy to the effect that men in their approach to health, as to all other social institution, deem only their own manner of 'rational' thinking and acting to be 'normal' and valuable is changing this.

Busfield (1996), for example, argues that there is 'no single rationality, but rather a set of traditions of rationality that are normatively governed and whose influence varies across time and place' (p73, cited in Williams, S., 2000). These traditions may not, as Williams points out, themselves be particularly 'reasonable' and feminists and post-modernists have sought to redress the balance by championing 'more emotionally founded ways of being and knowing as a challenge to dominant Cartesian traditions' (Op.cit, p565). These challenge the disdain for and pathologising of, not just in psychiatric settings but also in quotidian life, female 'emotion-driven thought' and practice in favour of male 'disembodied reason'.

It has been long argued by feminists that claiming masculine values as the "norm" and female ones as "odd" (belonging to the "other") and therefore needing explanation, is one way in which men's power is sustained. As a result of feminist research, men may have become 'decentred' and their angle of vision changed. No longer those who "gaze" and define, men are just one possible identity which can itself be examined. This research will ask if patriarchy has, in fact, been superseded in health care? Or has it simply assumed new forms which are not dependent upon the binary division of gender which Annandale and Hunt (2000) describe as a 'key

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[6] See menshealthforum.org.uk

organisational feature of all aspects of our lives' (p20)? Does it continue to exist and could it be the case that as Annandale (1998) suggests, far from being advantageous to men, patriarchy undermines their health as much, or perhaps more than women's?

Walby (1990) makes a distinction between degrees of patriarchy, referring to the 'intensity of oppression within a specified dimension' of social life and to forms of patriarchy as referring to the 'overall type' of patriarchy within a society (p174). Stanton (1981) suggests that men's vices (publicly represented as virtues) have set the wrong standards for behaviour in the public world. She warns that women's self-abnegating benevolence may effectively perpetuate their second-class status, and asks if they can afford to be benevolent in an essentially patriarchal society. Male doctors, including psychiatrists, are frequently accused of adopting patriarchal attitudes towards users, something which would seem to conflict with the notion of patient-centred medicine. However, with the rise of the men's health movement, the very notion of patriarchy is now in question.

As far as relationships amongst practitioners are concerned, ninety percent of nurses are female but the way in which conduct is evaluated as moral and rational ergo professional, has been masculinised[7]. Davies (1995) insists that the ways in which men and women conduct themselves in professional and social spheres are affected not only by culturally coded notions of masculinity and femininity, but also by a historically hierarchical relationship between the two. She discusses a Weberian model of bureaucracy, traditional models of professionalism and managerialism in

health care, describing them as masculinised versions of reality which, whilst relying upon the work of females, simultaneously devaluates and displaces it. Critical feminists (Chodorow, 1978) have long pointed out that men's institutional domination of women has caused men to learn to function psychologically in ways which maintain their authority and psychosocial priorities rather than women's in male-dominated institutions and cultures. On this view, men's psychology and gender identity derives from and revolves around status and power differences between the sexes and also among men.

3.7 Gender and Power

Gender and class relationships in medical practice, including mental health, have been described as based on power and it is often claimed that social power and status inequalities fundamentally influence the content of user/practitioner and practitioner/practitioner relations. Armstrong's Political Anatomy of the Body (1983), referring to decision-making in health care, tells us that it is not the members of given communities themselves who decide their own needs and how these can best be met. Such decisions are taken by 'experts' such as mental health professionals and managers. Resources and services are distributed by the latter on the strength of their ability to define what the object of health care is and how best to meet its requirements. This ability, Armstrong claims, rests as much on the power of the professional groups to retain control over this task as on a 'correct analysis' of what makes us ill or healthy. Is this still the case, twenty years on?

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[7] See footnote 1 of this Chapter.

Oakley (1998) maintains that authoritarian power patterns can not only engender feelings of hostility and anger, but also a consequent refusal to collaborate with the therapist[8]. Differences in status sometimes appear to produce what is experienced, rightly or wrongly, as contempt from those above and insecurity in those below (Dominelli and Gollins, 1997). It is therefore necessary to explore the gender factors inherent to empowerment and the exercise of power in caring, on the part of user and carer.

'Disempowerment' is a term which regularly occurs in users' descriptions of their experience of mental health care regardless of their sex. Power is often perceived as related to notions of class and gender, male practitioners exercising power over female colleagues and users[9] and also over more vulnerable males, whether users or amongst lower professional 'ranks':

> '... although my intentions were only to serve what I conceived as her welfare, I was guilty of the worst sort of paternalism. I had withheld information because I was afraid the patient might use it to make what I thought of as a wrong decision'.
>
> (Nuland, 1993, cited in Webb, 1996).

Battersby (1988) defines patriarchy as 'that form of social organisation which takes male bodies and life-patternings as both norm and ideal in the exercise of power' (p15). But power of this kind is, in fact, a complex phenomenon, undergoing continuous re-negotiation in all areas of life, including mental health practice. 'No

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[8] See graph in Chapter 5 on fieldwork research findings

[9] For feminist critiques of psychotherapy and associated forms of psychological and psychiatric treatment see Showalter (1987), Russell (1995), Chesler (1972, 1990) and Ussher (1991). All these examine women's past and present experiences in a patriarchal society and culture.

one party to any interaction is either all-powerful or all powerless' (Dominelli and Gollins, 1997). Although social contract theorists such as Hobbes and sociological and political thinkers such as Marx and Weber have described power as a game, with a clear winner and a loser, their views may be excessively simplistic, even misleading. On the other hand, as Lawler (1991) says a good working relationship in healthcare requires the user's compliance and that s/he does not 'resist or obstruct' the practitioner, who '…assumes and at times demands control. *"Good"* patients relinquish that control and *unpopular* patients do not … all the literature suggests this to be so' (p147. My italics).

It would be ingenuous to suggest that only male workers demand compliance and control in mental health practice. Matriarchal power too, although rarely mentioned in the literature, could be as effective in gaining control over users as that of patriarchy. Indeed, history and literature describe numerous examples of manipulative women and domineering, insensitive female healthcare practitioners belie the stereotypical image of the gentle "lady with the lamp".

The most common manifestation of male power in mental health practice is that of paternalism, which has long been a part of medical culture. Medical ethics not only tolerated, but endorsed this and this endorsement is characterised by 'a remarkable degree of continuity and consistency from the days of Hippocrates until the mid-twentieth century' (Beauchamp and Childress, 1994, p3). Paternalism has been reinforced by the social status accorded to medical doctors over the last two hundred years, evidenced by the respect which they have traditionally been shown by the

general public and until recently been accorded in media and literary accounts of medical practice. Even those who were during this period proclaiming the need for patient-centred medicine, such as Balint (1957) seemed to endorse paternalism, except when the user showed 'mature responsibility' towards his/her condition, although how this would be recognised is not explained[10].

Is the use/abuse of this kind of power in the practitioner-user relationship ever justified? In mental health practice, in crisis situations in which the user is considered a danger to him/herself or others, many health care practitioners and, indeed, users believe that it is. Patient-centred medicine has recently been at the forefront of the movement against medical paternalism and in favour of user empowerment and autonomy, central issues in mental health practice. Stewart and Weston (1995) demand that doctors: 'renounce control that (has) traditionally been in the hands of the professional' (pxvi). The user's desires are now, at least theoretically, central to care plan decision-making.

Power, as implied earlier, is more complex than the issue of paternalism alone suggests. Dominelli and Gollins (1997) believe that male carers, professional and informal, simultaneously form part of a 'hegemonic masculinity' by virtue of their sex, and of a 'subordinated masculinity' by virtue of their role as carers. Such men are perceived as being in an ambiguous position in relation to power and, according

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[10] During the course of the fieldwork, I interviewed Dr. Phillip Hopkins, one of Balint's earliest disciples in Britain. Although very enthusiastic about patient-centred medicine, even he was not convinced that the user necessarily had a "right" to full information on his/her condition.

to these authors, when working in the public arena engage in 'power over' dynamics as part of the dominant group, whilst at the same time struggling against their own potential subordination as male carers engaged in what they themselves may consider "female" work. Awareness of this conflict within themselves perhaps also – at least in some areas of mental health practice – facilitates a greater ability to 'power share' with female health care workers (and possibly users). In patient-centred treatments, power must in all but the most exceptional circumstances be shared between carers and users, even when the practitioner ostensibly has far more structural or institutional power than the user, object of this care.

Central to flourishing is the maximum possible empowerment of the user, supported, not (except in emergencies) controlled by the mental health practitioner. As a result of this, a hegemonic male practitioner of the type just described as formally holding all the power could be said to be himself controlled (at least temporarily) by the challenges and struggles of a vulnerable and relatively powerless user, seeking to establish his or her own autonomy. (Users, too, are sometimes themselves remarkably efficient in attaining power over other users and, in some cases, practitioners).[11] When the caring relationship is satisfactory, the healthcare worker, regardless of professional status, will encourage users to develop their own agendas, retaining or recovering the power of individual agency and autonomy. In other words, to flourish and to be once again able to perform 'with some success the most perfect of all typically human tasks' (Barnes, 1976, p36).

As the relationship between practitioner and user develops, bonds which encourage this temporary mutual dependency in attaining autonomy should be established, fomenting the user's possibilities of self-empowerment. Power thus becomes a process of negotiation and the therapeutic tool by means of which previously disempowered users attain sufficient status to influence interactions between themselves and the more powerful health care workers (Dominelli and Gollins, 1997 and Campbell, 1998). Like Hochschild, Williams, S.J. (2000) seems to lend support to their views in suggesting that someone's social status determines their ability to construct and defend the boundaries of the self, thus countering 'the potential for invalidation by powerful and significant others' (p568).

Powerlessness of the kind described here and suffered not just by Marian Beeforth[12], but by many of the users interviewed, heightens the chances of experiencing emotionally disagreeable ways of being (Hochschild, 1983). Disempowered people are inherently handicapped in managing the social and emotional situations encountered in mental disorder, including, for example, the practical problems of being in a mixed sex hospital ward. These have, according to the 'Women's Psychiatry Group' of the 'Royal College of Psychiatrists'[13], attracted much negative feedback from female in-patients whose need for privacy and intimacy is not respected. These women can, according to this report, be greatly distressed by the proximity of physically and sexually uninhibited male patients.

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[11] Such situations are described in Chapters 7 and 8
[12] See Chapter 2

There have also been repeated and well-documented incidents of rape and sexual assault in what should be the 'safe' setting of the psychiatric ward. In addition, behaviourally disturbed patients may get all the attention, whilst sedated and non-assertive women are consequently neglected. Therapeutic activities such as movement therapies, in-patient groups and sensitivity meetings, important to many women, are, according to this report, sometimes "sabotaged" by male patients. This 'may contribute to existential fear, anxiety and neuro-physiological perturbation of many different sorts' (Freund, 1990, p466) particularly when, as is frequently the case, male users are in the majority on the ward. However, harassment is not necessarily something only perpetrated by males upon females. In mixed sex wards, female users have been known to harass males. The difference lies in the reaction of ward staff, who treat male upon female harassment as an aggression, but for some reason regard female upon male harassment as trivial, even amusing.

3.8. Caring and Emotional Labour

To satisfactorily examine the notion of care, we need a prior understanding of 'caring'. According to Webb (1996), to say that there is a lack of consensus about the definition of care is a major understatement' (p962). Ungerson (1990) indicates that the term 'caring' and the noun 'carer' have come to refer to a very specific kind of relationship, usually between two people, one highly dependent and frequently adult, and the other, traditionally female, who looks after the dependent person at home, unremunerated. Caring is traditionally not perceived as "proper", that is "public"

[1] See References

work, but rather as the result of innate female nurturing qualities (Porter, 1992). Dunlop (1986) describes caring as 'an interactive process requiring the carer to be responsive to the needs of the person cared for, the resources available and the context in which care occurs. This involves skilled assessment, planning, action and evaluation of the implications and nuances of all these factors' (p661). The same could be said of emotional labour.

That caring is a gendered, unrewarding and, in the domestic context at least, ultimately disempowering form of emotional labour has become accepted gospel in writings on the subject. Whilst accepted, it may not be entirely accurate. Describing the work of feminist philosophers such as Noddings, Alistair MacIntyre (1998) suggests that they have to a certain extent, acknowledged the enormity of our dependence upon one another, which stems from 'our vulnerability and our afflictions' (p3). They have also tried to remedy traditional moral philosophy's apparent refusal to recognise this: 'not only by their understandings of the connections between blindness to and denigration of women, and male attempts to ignore the facts of dependence, but also by this emphasis upon their importance to the mother-child relationship as a *paradigm* for moral relationships'. (ibid. My italics).

This gendered image has recently undergone a slow, but constant metamorphosis. It is now believed that looking separately at men's and women's positions in occupational and family structures may 'obscure some very gendered patterns' (Annandale and Hunt, 2000, p17), which have little or nothing to do with those previously described. Due to its traditional location within the domestic sphere, the

labouring aspect of care can be lost in a 'loving' image. It then becomes possible to perceive the type of domestic care, based on affection, as superior to the professional 'technical' care given by health care practitioners, male and female, in clinical settings. The need felt by some female professional carers to promote the former in the 'technical' setting might explain the highly emotional and 'quasi-psychotherapeutic' jargon employed by some recent female writers on 'new nursing', which caused one midwife to describe examining the placenta as: '…sorting the particles and waves in the spectrum of light' (Krysl, 1988, cited in Webb. 1996 p963). 'Managing emotions requires skill over and above 'natural' caring qualities and is different to love', says Smith (1992, p18). However, there exists an extensive and rapidly growing literature on how feeling in general and love in particular do 'enter the formal domain of care' (Ungerson, 1990, p12).

Is it true that women are 'loving carers', but men not? Should this not be the case, then an ethic of care which finds its roots in feminist critiques of the paternalistic and over-rationalist character of much contemporary medical ethics may prove to have very weak roots indeed. Feminist discourses such as those previously cited, which promote the image of women as more emotionally 'knowledgeable' than men should be approached with a healthy scepticism for they may over-generalise. Women's emotional competence may have its origins precisely in their socially allocated and constructed role as carers, rather than vice-versa. As Jackson and Scott (1995) claim, we should be wary of valorising what is merely a symptom of subordination, no matter how tempting it might be to scorn, as feminists have, masculine 'emotional incompetence'. Such stereotyping may be based upon erroneous beliefs. The

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emotions inherent to caring could prove to be socially constructed and managed – a thesis central to the notion of 'emotional labour'.

It may also be the case that, contrary to popular belief, men including those involved in caring for the mentally disordered, tend to spontaneously practice a form of emotional labour, or at least employ the same tools of affection, respect and empathy as females. They too may try to ensure the user his/her own 'space' in which to exercise a degree of autonomy, thus avoiding the situation in which 'the thinking of one party is reified, the thinking of the other party is stigmatised and the selection of which is which gets settled in a contest of social power, with the lower subject to social control' (Heise, 1988, cited in Palmer, 2000, p666). Compromise of the kind necessary to patient-centred practice is an inherent part of the caring process, regardless of whether this is administered by a male or a female hand.

Mental health practitioners, of both sexes, are required to control the user when necessary, as well as their own emotions. It has been claimed (Fineman, 1993, p19) that the 'benign detachment' displayed by healthcare workers is a defence against the 'loss of face' inherent in revealing personal feelings. Emotional detachment, or control, in this context, becomes a coping strategy since 'losing face' is perceived as involving a loss of control which would change the power relationship between healthcare worker and user. 'The professional becomes too closely linked with the ... user' (Hugman, 1992, p133) and the idealised image of the healthcare worker as calm and "in control" is consequently damaged.

The use of emotional "tools" is today considered to be central to good health care and to all forms of emotional labour. James (1992, a, b,) suggests that it will be increasingly recognised as part of health care, but what exactly is meant by "emotional labour"? In *The Managed Heart*, Hochschild (1983) employs Marx's notion of use-value and exchange–value, describing the expression of emotions as work insofar as thought and energy are expended in showing sympathy, trust, warmth, suspicion and so on. She first employed this term to describe jobs which 'necessitate contact with other people external to or within the organisation, usually involving face-to-face or voice-to-voice contact, especially in service work' (Steinberg and Figart, 1999, p.8).

Hochschild argues that emotions are social and can act as signals concerning the relationship between the environment and the self. In a sense, emotions are symbols. Our ability to manage them is based upon our expectations, which are, in turn, founded on experience. Emotions form part of the interpretative process, those which have become part of the social self being the means by which we interpret stimuli and develop a response. In the process of socialization, we learn the 'feeling rules' and proper expressions of emotion, although there is great flexibility in how these are managed. Men, for example, are not normally expected to show grief or sorrow by crying, but are allowed to express anger, whereas in women quite the contrary occurs.

Hochschild maintains that efficient emotional labour requires the employee to create or conceal feeling in order to achieve the 'outward countenance' that 'produces the proper state of mind in others'. This 'surface acting' is 'the body language, the put on

sneer ... the controlled sigh' (Hochschild, p35) whereas 'deep acting' is where

'display is a natural result of working on feeling' (ibid). This difference parallels

Goffman's (1959) front and back stage[14], although it expresses the presentation of the

self differently. The importance of emotional labour to good mental health practice

can be appreciated upon reading:

> 'I transferred to ... another hospital ... the nurses were very belligerent. They
> mocked us and they would say things like: "Oh, we're going crazy. We must
> have been on this ward for too long". You could be within earshot and they
> wouldn't care. There was no warmth ... they would try to maintain their
> distance and I really hated it' (USA user, 14)

Jobs involving emotional labour, such as mental health care, have three aspects. They

are face-to-face or involve voice contact; the employee must produce a particular

emotional state in others and since producing these feelings is part of the employee's

job, the employer exercises some control over the former's emotional activities. In

some cases, emotional dissonance can occur, tensions developing between the

employee's genuine feelings and what s/he is expected to portray towards the public.

Genuine expressions of emotion are hard to fake since smiles, anger, fear and so on,

all involve employing certain facial muscles which cannot be voluntarily controlled.

Whilst the most accessible signs of emotion are facial expressions, body language,

intonation and even syntax also help to reveal this. Lack of facial and corporeal

expression of emotion suggests that the emotions we declare in words or deeds are a

sham. From our own encounters with others we know that we tend to be vigilant for

faked expressions of emotion and put great faith in involuntary "give-aways". Given

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[14] Despite their similarities, Hochschild strays from Goffman's analysis in that she believes there is no
sense of inner 'self' in Goffman's writing. She considers his performances to be 'acts' untouched by

the importance of communication, awareness of these should be a two-way process between practitioner and user.

Jasperian empathy could be said to be based on this kind of observation, rather than on the patient's words alone and an awareness of non-verbal language would not only better the accuracy of practitioners' observations of the user's emotional state, but also better their own ability to communicate, thus improving their practice of emotional labour. In mental health practice as in any similar setting, as Pinker (1997) says, 'the agents may outwit one another with devious tactics' for self-control is 'unmistakably a tactical battle between parts of the mind' (p419) and several users report deliberately deceiving health care workers as to their mental and emotional state. The latter, too, frequently do the same when relating to users.

Central to both the ethics of care and flourishing, is the notion that the user should be made to feel not only physically cared for but also emotionally cared about by the practitioner. (See Chapter 2.5.1.). Whether practising an 'outward countenance' of caring could be classed as exercising the virtue of, for example, charity, is a debatable point. It could be said that Goffman's (1961) insights into the presentation of the self might be a more apt description of the mental health practitioner's need to present many different "faces" depending on the clinical context. Indeed, in spite of the fact that she is critical of some aspects of his work, Hochschild draws heavily upon Goffman in constructing her theory of emotional labour.

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feelings: 'Goffman's actors actively manage outer impressions, but the do not actively manage inner feelings' (Hochschild, 1983, p218; 1979, p262). They are carrying out "surface" acting

Merely presenting an 'outward countenance', whilst not necessarily virtuous, is surely better, from both therapeutic and ethical points of view, than offering no warmth at all. On the other hand, it cannot be overlooked that according to several authors (Larson, 1981, Mayer 1987) patients focus on technical expertise, rather than emotional caring as 'most important in making them feel cared for' (Gooding et al., 1993, cited in Webb. 1996, p964). In health care, the "rules" which provide the framework within which holistic caring is to take place must be based not only on emotional but also on clinical, technical, organisational, legal and social factors.

However, emotional labour, emphasises the relational, rather than task-based aspect of work in health care. It is labour and effort intensive work, the front-line service workers and paraprofessionals of which have been referred to by Cameron Macdonald and Carmen Sirianni (1996) as the *'emotional proletariat'* (Op.cit. p9). Other researchers in this field claim that emotional labour demands 'efforts made to understand others, to have empathy with their situation, to feel their feelings as part of one's own' (England and Farkas, 1986, p91). This resembles not only traditional definitions of caring, but also Noddings' 'engrossment' and reflects the attitude of the adherents of the 'new nursing' (Webb, 1988, Meerabeau and Page, 1998). Even the genuine expression of emotion is seen as work, for example, a practitioner's concern for patients expressed in consoling, comforting and empathic terms.

In performing emotional labour in health care, employees give something of themselves to others with whom they will normally have no ongoing personal

relationship. Whether they genuinely care or not, they must appear to do so. 'Emotional labour also requires a worker to produce an emotional state in another person, whilst at the same time managing one's own emotions' (Steinberg and Figart, 1999, p13). This may also involve the practitioner in what Goffman describes as an actor's ability to 'execute the double stance'. Whilst ostensibly adhering to the 'official definition of the situation', the actor simultaneously (and discreetly) shows that s/he 'has not agreed to having himself defined by what is officially in progress' (Goffman 1961, p133). This is an "invisible" task and in consequence the exercise of skill or effort which, as the previous sentence shows is involved, receives no economic remuneration. Lawler (1991) says that if nurses, for example, 'do not overtly acknowledge the real nature of their work and the extent to which it requires … considerable emotional labour, they have a double bind. To make their true feelings felt would clearly not be in the patient's interests, but not to do so contributes to the camouflaging and privatising of nursing work' (p169). Perhaps it is the lack of financial recognition, rather than an innate inability to care, which explains why relatively few men are engaged in the caring professions at the lower levels. It might also explain why, to judge by media articles and accounts of disciplinary proceedings, some so-called 'carers' no longer even pretend to care, robbing users of their possessions and their dignity.

The rethinking of ethics in the face of the technological onslaught in healthcare has also generated a growing literature 'on the linked concepts of emotional labour and caring…' (Meerabeau and Page, 1998, p296). Mental health care workers, male and female are, according to this view, deeply involved in emotional labour, because in

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addition to the physical care which they deliver, they are expected to control their own emotions whilst tending to the emotional needs of the client. 'Such emotional control is part of a ... professional approach, that is learning how to do body care and perform other functions in a manner typical of the occupation. The emotional control/labour may also be seen in the commitment which (they) are exhorted to demonstrate towards their patient whilst at the same time avoiding "over-involvement" (Lawler, 1991, p.126). On Noddings' view, this last term is nonsensical for the term "engrossment" implies an "over-involvement" of exactly this kind. Goffman's (1961) account of the merry-go-round in which:

> '... there is a circulation of feeling among participants and an "involvement contour" may emerge, with collective shifts in the intensity, quality and objects of involvement' (p139)

may, in view of what has been said so far, be a more adequate model for the mental health practitioner's emotional (and ethical) task of continually evaluating the level of involvement required in each individual user's case. Such judgements can only result from the exercise of implicit "feeling rules" acquired as the result of active participation in health care. This process seems to have little to do with gender – knowledge and experience are almost certainly more relevant. For Goffman, unlike Hochschild, carers do not simply connect and disconnect emotions, but move from one episode of "face work" to another, flexibly matching feelings and facial expression to the situation encountered, a notion of caring far removed from Noddings' 'engrossment'. Going 'public' with emotion, or what Goffman (1967) would term 'presenting a face' show how inextricably linked emotional management is with social life. Goffman's 'traffic rules of interaction' (Op. cit) ensure that actors

constantly monitor their own acts and those of others in order to sustain the 'predictability' of quotidian social interactions. Many routines, *qua* caring, virtuous agent, are discreetly carried out as a means of saving the user's of agent's 'face' and other agents reflexively (exercising *phronesis*) may adjust their own performances accordingly. Goffman's analogy of social action as 'performance' is, therefore, a useful description of how actors manage themselves (and their emotions) and reveals that these performances can become extremely polished. This is important in view of the claim made in Part Three of this dissertation, that virtuous agents can be educated to behave as such.

In the mental health context, the need for such emotional self-control may apply, for example, in the face of aggressive behaviour. The harsh reality of everyday clinical settings would seem to make such control difficult, but highly necessary. Describing her reaction to a situation which had occurred the night before, in which a user had broken a male nurse's nose, a female nurse respondent (PLN) says:

> '... we also get told as well that ... we're not allowed to inflict pain upon the patient in terms of, for instance, I got told you're not allowed to knee them in the balls. You know, to actually protect yourself ... but in my, obviously if I feel as though my life is at risk, I'm going to naturally do that and I'm going to do anything to get this man, stopping this man from killing you' .

Whilst a male psychiatrist interviewed, when asked about this, said:

> '... the best weapon that staff have to combat any sort of distress is talking things over and having adequate numbers of staff on duty' (PLR).

Curiously, the male psychiatrist's view seems closer to the ethos of the "new nursing", which involves a close partnership with patients and greater informality, in

which 'nurses may feel able to loosen this control' (Meerabeau and Page, 1998, p297) simply getting on with caring for and about the user in the fullest sense of the word. This is essential to flourishing, but whether the desired 'partnership' is likely to be viable is something which remains to be seen.

Several writers have discussed how caring is enacted in a technological environment. Ray (1987) argues for the equal importance of technical competence and humanistic caring, something which mirrors users' and mental health care workers' own desires. Others consider that the greatest future challenge will be to confront the dehumanising impact of technological advances on health care workers, to 'temper the insults of technology with care' (Cooper, 1993, p30). However, critics such as Dunlop argue that emotional labour theory has become disembodied insofar as 'it etherealises the body', removing 'the mess and dirt of bodily life' (Dunlop 1986, p664). For this reason, Goffman's 'presentation of the self' is also a more useful model than Hoffman's notion of emotional labour *per se*, for in health care work in all areas, not simply mental health, the division between the public and private worlds of emotion is not as clear cut as Hochschild's views imply. Practitioners need to exercise different sets of 'feeling rules' depending upon the circumstances. Presentation of a purely professional façade is not necessarily useful in dealing with the complex emotional and moral dilemmas encountered in mental health care. In this, the feelings of user and practitioner, are more than "commodities" to be managed or taught by supervisors. Whatever the case, in the technological environment of today's mental health care the subjective (emotional) experience of professionally interacting with users is inseparable from the objective (technical)

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criteria of prescribed therapies. whether medical, surgical, psychological or psychotherapeutic.

The emotional labour debate has changed the simplistic conception of the workplace as somewhere where, in a Cartesian type mind-body split, we left our emotions at the door upon entering the workplace. The emotional dimension introduces complexity into the analysis of work and its relationship to gender, and to physical and mental health.

3.8. Conclusion

A task central to this dissertation is answering three gender-related questions. The first is whether men and women function differently as caregivers, the former applying a rational approach, as compared to the latter's emotional one. (Or does the role of caregiver demand the same reactions, feelings and emotions, independent of sex and gender?) The second asks if there is anything necessarily 'fixed' in the relationship between gender and particular manifestations of psychiatric disorder, or whether this notion is a misapprehension based upon a lack of the communication described by Fulford et al. (2002) as central to ethical practice. The third is whether men and women adopt similar approaches to ethics specifically involving virtue and caring.

From the point of view of the first, as we have seen, cultural stereotypes surrounding the role of the carer in formal and informal settings endow this with 'feminine' qualities. Recent statistics (Miller, 1986, Sabo and Gordon, 1998) challenge this

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stereotypical assumption, showing that in addition to entering the caring professions in increasing numbers, male caregivers, informal and professional, are adopting emotionally expressive ways of being men that go beyond the traditional role of hunter-gatherer and protector. Men's increasing involvement in public and private care giving is part of a larger social change which could well result in a transformation of the social meaning of gender as such. If women can be socially conditioned to care, so can men. That is what emotional labour is about.

As far as the second question is concerned, an understanding of the relationship between gender and psychiatric diagnosis would demand 'a very careful unravelling of the complex branches of psychiatric ideas and practice as well as of gender relations' (Busfield, p25). Although such 'unravelling' is beyond the scope of this study on ethics, research such as that described here offers a means of exploring the relationship between social constructs, individual agency and gender differences, illuminating the ways in which men's and women's lives, ethical practices, emotions and mental health are moulded and experienced, in order to assess any hypothetical differences in these. In view of what has been said so far, what the fieldwork and subsequent analysis will reveal in terms of gender, rather than women, and caring could prove most interesting.

The third question is possibly that most relevant to this study. John Stuart Mill, a utilitarian philosopher, believed that intellect and virtue are gender neutral and that society errs in assessing women's intellectual ability and moral fibre as distinct to that of men. He wrote: 'I do not know of a more signal instance of the blindness with which the world, including the herd of studious men, ignore and pass over all the

influences of social circumstances, than their silly deprecation of the intellectual and silly panegyric on the moral nature of women' (Mill, 1811, p169). Mills believed that women's moral nature was entirely the result of systematic social conditioning and that to praise them for their feminine 'virtue' (that of being self-abnegating carers) was to praise them for having allowed a patriarchal society to convince them that they had a moral duty to sacrifice their lives to those of men and children and that men had a moral right to be served by women. He implied that male-female inequalities especially patterns of male domination and female submission made it almost impossible for women to cultivate what Galsworthy (1922) called 'that secret sense of self-esteem without which no one can live'. Mill also thought that power imbalance impedes the development of true human moral virtues and facilitates, in its place, the development of a range of negative masculine and feminine psychological traits. Tong (1998) echoes this in asking if it is not rather the case that each human being, regardless of gender, is responsible for their own moral character. Like Wolf (1996) and Parks (2000), she considers the possibility that only women are expected to practice self-denying altruism and benevolence. If this is so, she asks, as in essence does this dissertation, what kind of "virtue" self-denying benevolence is if only female members of society are expected to cultivate it?

PART 2

THE EMPIRICAL STUDY:
FIELDWORK AND FINDINGS

'Be a good craftsman; avoid any rigid set of procedures. Above all, seek to develop and use the sociological imagination. Avoid the fetishism of method and technique. Let every man be his own methodologist; let every man be his own theorist; let theory and method again become part of the craft. Stand for the primacy of the individual scholar; stand opposed to the ascendancy of research teams of technicians. Be one mind that is on its own confronting the problems of man and society'

<div align="right">(Mills, C.W. 1959, p224)</div>

Chapter Four: The Empirical Study: Research Methods and Study Design.

4.1. Introduction

The main purpose of the empirical component of the study is to explore and evaluate three specific areas. The first, is the extent to which the themes in the ethics literature, described in Chapters One and Two are identifiable in practice. I shall, for example ask, as does Smith, P. (1992), whether nurses (and other practitioners) can, in what would appear to be an example of an ethic for flourishing in practice, 'learn through experience and systematic training to recognise and use' their feelings to 'remain therapeutically involved' both for themselves and for the patient? (p15).

The second, linked to this, is whether the sociological beliefs and practices on gender issues in health care described in Chapter Three are identifiable in practice. A review of the literature on gender and caring in Chapter 3.5 implied, contrary to Noddings (1984), that male workers are capable of the same instincts for caring as their female counterparts. In other words, caring is not instinctive to either women or men, but is a form of emotional labour which social stereotyping has traditionally attributed as 'natural' to women, but which can be equally well performed by men or women, character rather than gender being the relevant factor in this. According to Williams, S.J. (2003), the gendered dynamics of care, whether formal or informal, raise a continuous series of dilemmas and debates about the role of emotions and embodiment in today's "rationalizing" climate. Nonetheless, 'any adequate analysis of the gender dynamic of emotion work and emotional labour should ... be alive to the pitfalls of perpetuating the 'emotional

woman'/'unemotional man' stereotype (Williams, S.J. 2003, p198). In attempting to identify the putative codes-practice gap described in Chapter One is, therefore, also necessary to ask whether this (should it exist) is a gendered phenomenon.

Thirdly, I investigate whether ethical issues in the user-practitioner context require re-examining the truth of MacIntyre's claim that when we think of those who suffer a disability, we are invited to 'think of the disabled as *them*, as other than *us*, as a separate class, not as ourselves as we may have been, sometimes are now and may well be in the future' (MacIntyre, 1999, p2). Levinas (cited in Williams, S.J., 2003) claims that ethics involves responsibility for other human beings and that it is the very alterity of the other which commands us as ethical subjects. 'Ethics, from this viewpoint emerge from facing the other, a radical alterity which disturbs the complacency of being through responsibility in proximity' (Op.cit.p199). Whether this dichotomy between *them and us* exists within caring relationships and, should this be the case, the effect which it has upon these is highly relevant to this work. User movements have made well-publicised claims that the adverse discrimination to which the mentally disordered as "other" are subject is the dominant topic in mental health today. For this reason, the experiences and attitudes of practitioners and users with regard to ethical issues, together with the question of whether gender influences these, are investigated in the field. The findings are subsequently subjected to qualitative and philosophical analysis.

Chapters One to Three constituted a detailed discussion, the themes of which can be summarised as follows:

- The research questions, their context and rationale

- The need to relate applied sociology and philosophy in research into practical ethics

- Duty-based and deontological ethics; consequentialism, casuistry and virtue and care ethics

- A positing of a normative ethic combining neo-Aristotelian virtue ethics and elements of care ethics in order to frame an ethic the end of which is flourishing in all aspects of patient-centred mental health practice

- Notions of caring in mental health practice as emotional labour, rather than a gender specific characteristic of women

However, relevant as this theorising is, more is required. A sociological empirical study is necessary because all interactions, "ethical" or otherwise, between practitioners and users, constitute social actions. In order to understand these we must engage with the relevant actors, observing, recording and interpreting their acts, experiences and opinions.

Planning, data collection and subsequent analysis of the fieldwork findings each had several phases. The methodology was informed by qualitative research grounded theory (Strauss and Corbin, 1990) which maintains that theory should be inductive, continuously re-thought and reformed on the strength of observations based on the fieldwork and qualitative analysis of the incoming data, rather than imposed in advance. This stage was always intended to be overt, in order to avoid what might be considered the ethical dubiousness of covert research. This is of particular relevance to a study which is itself on ethics in the potentially highly sensitive area of mental health practice:

'Sensitivity affects almost every stage of the research process from formulation, through design, to implementation, dissemination and application (Renzetti and Lee, 1993, p6).

A detailed description of the research methods and operalisation follows. This is intended to make the research replicable and sufficiently detailed as to be open to evaluation. Design choices, notably open-ended and semi- or unstructured, are now explained, prior to a general descriptive account of the study as a whole. The procedures used in data collection, coding and analysis are also explained and justified.

4.2. Reviewing the Situation: Literature, Websites and Media

Prior to the planning and execution of the research process *per se*, a reading list was composed, employing library resources such as OPAC and CD Rom sites, together with professional journal articles and reviews as a guide. This led (as Chapter 1.3. explained) to reading and linking literature on mental disorder and health, gender, ethics, social science methodology, and on relating philosophy to this. A detailed list of these sources is to be found in the References.

The World Wide Web (WWW) was also used to locate sites containing information pertinent to these themes and on mental health user and research organisations. Articles, on and off-line, from the popular press and professional journals in philosophy, sociology and mental health proved an invaluable source of topical information. Having accumulated a wide working knowledge of the ethical and sociological issues involved (although a study across three disciplines, requiring fieldwork, and to be completed within a limited time frame, could never hope to cover all of these as deeply as one based upon a single discipline might),

the research framework and subsequent means of analysing this were consolidated. It was then possible to commence the active processes of planning, executing, coding, analysing, and finally writing-up, the research.

4.3. Current Codes of Practice in Professional Colleges – Nursing, Social Work, Psychology, Psychiatry and Sociology

In order to prepare the ground for the fieldwork and subsequent analysis and interpretation of the data emerging from this, it was necessary to previously examine, analyse and compare those ethics and codes of good practice currently employed by the relevant professional colleges or organisations. Publications on professional conduct from the United Kingdom Care Council (UKCC, now the N&MW Council); the National Association of Social Workers (N.A.S.W.); the Royal College of Psychiatrists, (R.FC. Psych.); the British Psychological Society (B.P.S.) and the British Sociological Association (B.S.A.) as well as many other works on this subject, provided a working insight into the extent to which gender and class influence (or not) each particular college's style of promoting and defending good practice amongst its members.

To summarise, this analysis revealed that the U.K.C.C., whose members are predominantly female and lowly paid (although many now have university degrees in nursing), *tells* its members that they *must* obey the sixteen rules laid down in their code of professional conduct. The UKCC regularly produced guidelines on good practice and ethics for its members, all of which could be described as "altruistic" insofar as they emphasise caring and the "flourishing" of the user, rather than the rights of the nurse. The N.A.S.W., on the other hand, merely suggests that its members *should* and *may* act according to the

requirements of their own codes of ethics. This body adopts a much less exigent tone and conveys the impression that its guidelines are designed to help the social worker as much as protect the public, which is the declared goal of the UKCC publications.

The Royal College of Psychiatrists, like the NASW, has produced several official "guidelines", rather than codes on ethics for its members. In 1989, it published the *College Position Statement on Confidentiality* and in 2000, *Good Psychiatric Practice* and *Good Psychiatric Practice: Confidentiality*. These focus on providing practical guidance relevant to a variety of situations which could confront psychiatrists and other members of multi-disciplinary teams. Unlike nurses, neither social workers (a predominantly female profession) nor psychiatrists (still predominantly male) are apparently considered by their own professional bodies to need "rules". Suggestions and guidelines as to how to behave in an ethical fashion in the exercise of their task is considered sufficient. Could the difference lie in the fact that the UKCC was, as analysis of their official organ, *Register*, reveals disproportionately staffed by male administrators, making rules for a mainly female profession, whereas the R.C.Psych. and the NASW are administered by bodies in which the sex ratio between workers and policy makers is more balanced?

It should be noted that in the case of psychiatrists, the corresponding disciplinary body is that of all registered medical doctors, the General Medical Council (G.M.C). Their web site speaks of 'protecting patients and *guiding* doctors'. Fourteen key principles are stipulated, all of which, rather ironically, begin with

the injunction that: 'as a doctor you *must...*' which sounds far more mandatory than the word guidance would imply. Why the G.M.C. considers that medical doctors need mandatory codes of practice, whilst the professional college of psychiatrists considers that they need no such rigid rules is an interesting question. Are psychiatric patients not considered to need as much protection as other users, or do psychiatrists belong to a discipline which is considered inherently "ethical" in its treatment of users? In reality, the reason for this apparent disparity lies in the fact that the GMC and the UKCC (now N&MW Council), are regulatory bodies, whilst the R.C.Psych. and the Royal College of Nursing (membership of which is not obligatory) resemble unions in their function, protecting the interests of their members whilst, leaving regulatory bodies to protect the public and the corporate image of the profession.

The British Psychological Society produces an eighty-two-page tome entitled "*Code of Conduct, Ethical Principles and Guidelines*" (January, 2000), the first five pages of which constitute "A Code of Conduct for Psychologists". This is divided into five sections, covering such relevant areas as competence, consent, confidentiality and personal conduct. All thirty-four of the points raised here begin with the phrase: 'Psychologists (or they) *shall...*" (my italics). Apparently the B.P.S. considers that ethical behaviour can be commanded and rule-based. If this is so, then this thesis could prove superfluous.

The codes of the UKCC, the G.M.C. and the B.P.S. have in common lists of rules as to what healthcare workers must and must not, should and should not, do. However, if studies such as those of Watson (1999) and the statistics on

disciplinary hearings given in Chapter 1.5 are credible, the situation is less straightforward in mental health practice. The ethical dilemmas which arise in this context frequently fail to fit rigid rules, and contradictions constantly confront user and practitioner. Different practitioners may interpret different phrases such as 'safeguard the interests and well-being of patients' (UKCC Code of Professional Conduct, 1992) and '...inform clients to the extent possible', (NASW Code of Ethics) in quite distinct and yet perhaps equally well-informed and well-intentioned ways. These instructions might, in turn, clash with other recommendations such as, for example, that to 'foster independence'. In mental health practice, moral dilemmas abound and current codes apparently do little to resolve them.

The 'Proposed New Statement of Ethical Practice' for the B.S.A., originally examined because the research project is a combined sociological and philosophical study, rather than for its relevance to mental health ethics, adopts an entirely different and innovative approach to ethical "codes". The very use of the word "statement", rather than code or guidelines, implies the nature of the content. In this members are 'encouraged' to use the statement in order to 'educate themselves and their colleagues to behave ethically'. It does not 'provide a set of recipes for resolving ethical choices or dilemmas', recognising that these will be made 'on the basis of principles and values, and the (often conflicting) interests of those involved' (B.S.A., March 2002). This statement reflects many of the sentiments which find voice in virtue ethics and for this reason the nature and composition of the BSA statement is further discussed in Chapters Seven and Eight.

4.4. The Fieldwork Research Design

The empirical research investigates the previously mentioned dilemmas and the means by which they are resolved, asking whether this involves invoking professional codes or guidelines on ethics or good practice. Using qualitative, some quantitative, and philosophical analyses, I assess and interpret the answer to these questions, investigating how and why ethical attitudes are formed and whether there is, as feminist philosophers claim, a significant difference in those of male and female healthcare workers and users. Or is this difference a socially constructed myth, rather than an immovable social reality?

4.4.1. Context

It might be expected that, as a result of their common experiences as social actors, users' and practitioners' views would express not merely individual, but also shared ethical values, although variations based on personal and cultural characteristics must exist within these. As Weber (1947) says: 'Sociology ... is a science which attempts the interpretative understanding of social action in order thereby to arrive at a causal explanation of its cause and effects ... Action is social only in so far as, by virtue of the subjective meaning attached to it by the acting individual ... it takes account of the behaviour of others and is thereby orientated in its course' (p88). From Weber's point of view, the interactions, ethical or otherwise, between healthcare practitioners and users would constitute 'social actions'. These are motivated by the meanings held by the individual and take account of others' actions (Weber 1949, pp.136-147). In order to understand those social actions related to ethical practice in mental health settings, it is necessary to

not only record, but also interpret them. In the process of interpretation, given the cross-disciplinary nature of empirical ethics, after initial qualitative analysis, philosophical analysis and discussion are employed.

4.4.2. Validity, Reliability and Replicability

The criteria of validity, reliability and replicability must also be considered when deciding between methodological options. Validity of measurement requires that this genuinely does measure what it purports to. The process includes the accurate and complete documentation of the social actions in their context, for example, the exact recording of the words spoken at the interview, although:

> 'There may or may not be the need ... to transcribe all of your taped materials, or indeed every paragraph or line of each interview or taped field note. The actual transcribing should be **selective'** (their emphasis).
> (Strauss & Corbin, 1990.p30)

According to Shipman (1997), in assessing the validity of the evidence gathered it is necessary to ask:

- Does this reflect reality and reach the truth of the matter under investigation?
- Does it make a convincing case in the light of existing knowledge?
- Is it supported by other evidence?
- Does it explain current problems?
- Does it help to understand how and why the subjects under scrutiny act and react the way they do?

If, on these criteria, it is the researcher's responsibility to 'lay out the claim for review', the reader's responsibility is to 'take up the offer' (Shipman, 1997, pviii).

Reliability refers to the methods used and demands that 'applying the procedure in the same way will always produce the same measure' (King et al., 1994, p25). In research such as that described here, it must be stressed that test-retest reliability will not necessarily equate to the core concept of reliability, since each human

situation has different characteristics, a factor particularly pertinent to the study of ethics in mental health practice. It implies that 'the results from different occasions in a series of occasions of observation should confirm one another' (Robertson, 1998, p133). Data collection is considered complete, this source claims, 'when the rate at which new themes appear becomes very small' (ibid.). Sufficient information for the reader to be able to distinguish clearly between *evidence* and *opinion* is also essential.

Shipman (1997) claims that: 'Reliability and validity tend to be incompatible', particularly in research based on open-ended questions and qualitative accounts. For this reason, great care had to be taken in ensuring that the questioning In addition, in researching a sensitive subject, much thought has to be given to the interaction between interviewer and respondent. In this respect, the training in philosophical counselling proved extremely useful insofar as the techniques on this are based on listening in a friendly, yet relatively "dead-pan" fashion and asking questions which encourage the respondent to think about what s/he is saying and elaborate on this. A simple example might be as follows:

> Respondent: 'So he was a real bad 'un.'
> Interviewer: 'What do you mean by that?'
> Respondent: 'Well, he was always playing dirty tricks on you'
> Interviewer: 'Can you give me an example of a "dirty trick"?'
> Respondent: 'Well, like he'd have you up all night playing cards and that.
> Interviewer: 'You told me you like playing cards. So why was that a dirty trick?'
> Respondent: 'He'd make you play for money - and take every last fuckin' penny'. (Laughs).
> Interviewer: 'Why did you agree to play if he was doing that?'
> Respondent: 'Well, bit of a laugh at the time, weren't it? Made you feel, like, normal, I suppose. He was a nice bloke'.
> Interviewer: 'First you said he was a "real bad one" and now you've said he was a "nice bloke". Was he both? Or one more than the other?' ...

Assuming that the questions asked and the responses given are understood by interviewer and respondent in the way that each of these intended, employing this type of questioning is both valid and reliable.

Having said this, 'both intention and understanding can be affected by factors that may not even be appreciated by both parties' (Shipman, 1997) and the importance of awareness of the interaction between interviewer and respondent is discussed in the section on "Reflexivity" below.

The research project is interpretative and could therefore be described as constructivist, in that it makes no firm predictive claims, but instead describes generating grounded theory from observations in the field. This subsequently revealed what was irrelevant and what was central to the project, changing the focus of the research and, by creating an accurate picture of ethical policy and practice in mental health settings, revealing that values are inseparable from these.

4.4.3. Reflexivity

Ensuring that evidence obtained in the fieldwork interviews faithfully reflects the reality under investigation is vital. In interpretative research, the awareness of the subject and his or her interaction with the researcher means that 'the appropriate metaphor is not of actors playing parts written for them, but of actors constructing their own roles in a drama that they helped to write' (Shipman, p39). Both researcher and researched act reflexively.

At this juncture, a caveat is required in the interests of investigative responsibility. My experience as a psychiatric nurse, observing ethical practice in mental health settings at first-hand, almost certainly introduced an inescapable subjectivity in approaching the research. Fieldwork in an area as sensitive as mental health is experiential in a very significant way, insofar as it involves not only the researcher's physical presence but also his/her emotions. Indeed, a certain awareness of becoming insidiously "attached" to the research process could be said to develop. Part of qualitative research is recognising this relationship, given that achieving a maximum of objectivity must be a central concern to all research, although that objectivity can ever be totally assured in research of this nature is questionable. Particular care was therefore taken to ensure that the study was at least as objective as possible.

Perhaps it is relevant here to posit a redefinition of objectivity – the researcher could be said to be objective in recognising his/her own subjectivity (Coffey, 1999). When research involves human beings, controversy is inevitable. Bias can, according to Shipman (1997) enter at any of the three stages of research – the conceptual stage, the technical stage and finally, at the publication stage, when the findings might prove to be 'loaded down with views not derived from the evidence itself' (p18). It has, therefore, been essential to heed the latter's advice, attempting to go beyond merely technical issues to the assumptions behind the design of the research and the way in which the results are presented. Using one's own life experience in intellectual work may prove to a certain degree inevitable, for as Wright Mills says in *The Sociological Imagination*: 'You are personally involved in every intellectual product upon which you may work' (1959, p196).

My years of experience of mental health practice are undoubtedly one of the motivating forces behind this particular research project. Maintaining personal "betes noires" under check during the interviews and the later interpretation of the fieldwork findings was possibly the most difficult part of the research.

Although Shipman (1997) recognises that '...from start to finish, an open mind is impossible. All researchers have preconceptions that affect what they see and how they interpret it' (p42). That I was at least reasonably successful at keeping an open mind is perhaps illustrated by two things. The first, the fact that the initial interview findings surprised me to the extent that it was necessary to confirm them by means of a subsequent questionnaire survey. The second, that the subject of values eventually became central to answering the research question, although until analysing the fieldwork findings it had been of little relevance. Both represented a radical rethinking of the original research design – and an increased workload. Nonetheless, 'it is impossible to confirm objectivity ... when the research is about humans, there is always controversy.' (Shipman, 1977, p18). As this author says, most researchers accept that we construct our own knowledge of the world around us and realise that there is 'no detached position for neutral observation' (ibid).

4.5. Obtaining Information

Although structured questionnaires are commonly employed in the ethical and psychosocial evaluation of aspects of medicine, the validity of these is relatively poor in studies such as this in which the phenomenon in question is ill-understood and what is being measured ill-defined (Robertson, 1998). Questionnaire methods

fail to describe the context of the phenomenon under investigation and the conclusions drawn from the respondents' self-reporting. On the other hand, their reliability and replicability are reputedly high.

Semi-structured, interviews enjoy the advantage of allowing a balance of pre-set questions and more spontaneous contributions. Unstructured interviews are inevitably more spontaneous than these and data is frequently more valid insofar as respondents can clarify their definitions and comments. However, reliability is higher for semi-structured interviews than for those which are unstructured. Replicability is difficult in both cases, insofar as each interview is unique and, given the mental instability of some of the people interviewed, potentially unrepeatable.

Focus groups were not considered viable, since in these it sometimes occurs that one or two participants attempt to dominate the group, possibly suppressing or manipulating the views of the other participants. This could well have been the case in a mixed sex focus group of people suffering from mental disorder, given the evidence of the 'Women's Psychiatry Group'[1] to the effect that some female users feel threatened by the presence of male users (see Chap.3). In addition, the validity and replicability of focus group findings are notoriously poor. Consequently these may serve to supplement, but not replace other survey methods.

In order to obtain spontaneous information, questioning needed to be as open-ended as possible. This would encourage "unforced" answers which could, in turn, inform and possibly modify the content of later conversations with other users and practitioners. This technique was intended to encourage respondents to communicate their underlying attitudes, beliefs and values free of excessive inhibitions, possibly as short narratives, rather than providing glib, easy answers, or saying what they felt the researcher wanted to hear and thus giving "public" accounts, rather than the "private" genuinely personal accounts and opinions sought. An orientative protocol was prepared to be employed, if necessary, to open and assist the flow of conversation (see Appendix 1). However, excessive standardisation of questions was avoided since inherent to this is a lack of flexibility to explore unenvisaged territory, although the pilot interviews would make patent the importance of attempting to adhere to issues relevant to the research.

Given the situated identity of the researcher, previously acknowledged, keeping an open mind from start to completion of the study was not easy and awareness of the possible effects of this potential lack of objectivity upon outcomes had to be maintained. Consequently, the method of interviewing users and care workers was based on the notion that theory should be grounded, that is continuously re-thought and re-formed on the strength of interpretation of the interviews, rather than imposed on this in advance. What might be described as a process of oscillation took place, ideas and research questions moving into much sharper focus as the process developed. Initial concepts were constantly amended,

theories adapted to the new situation and the research modified in terms of the evidence gathered during the fieldwork. Grounded theory maintains that:

> 'the usual canons of "good science" should be retained, but require definition in order to fit the reality of qualitative research and the complexities of social phenomena that we seek to understand' (however) 'every mode of discovery develops its own standards – and procedures for achieving them ... What is important is that all of these are made explicit.'
>
> (Strauss and Corbin, 1990, p250)

4.5.1. Pilot Interviews

Prior to the pilot interviews, during the first year of the doctoral programme, I undertook a course in philosophical counselling techniques, run by the Society of Consultant Philosophers. Since my previous professional experience had involved interviewing users in a psychiatric practice, this was intended to ensure that neither the philosophical aspect of the interview process was lost from view, nor that the interviews themselves should slip into something more closely resembling a therapeutic intervention than sociological fieldwork[2].

The pilot study mentioned in the previous paragraph was considered necessary in order to test the interviewing technique in advance of the fieldwork itself. This would identify possible problems for respondent and researcher, a novice to sociological fieldwork. Two pilot interviews with users, one male and one female, were undertaken. It was neither difficult to recruit, nor interview these. The first pilot respondent, a middle-aged, working-class man with a long history of depression and suicidal attempts, was introduced by a patient advocate. The second, a middle-aged, middle-class woman, was diagnosed as suffering from depression. Her mother had committed suicide after many years in psychiatric

treatment. A professional acquaintance, she participated at her own request as a result of a long-standing personal interest in ethics.

In addition to testing and improving interview techniques, the pilot interviews were intended to gather basic information about the field, before selecting the exact methods to be used. The nature of topics to be raised at later interviews and how to approach these was also determined as a result of the successes, failures and *faux pas* ('You're not supposed to put the answers in my mouth') of the pilot interviews.

The "questioning", in both 'pilot' cases, was open-ended and although much information was obtained, the respondents also took the opportunity to address their personal interests and grievances, rather than yielding information relevant to answering the research questions. As a result, the interview was made more structured and an orientative protocol drawn up, in order to prevent the interview degenerating into little more than a "soapbox", from which the respondent denounced his/her problems with the mental health services. Whilst spontaneity was important if the atmosphere was to be relaxed enough to promote the uninhibited talk necessary to obtaining the sensitive information central to the study, the relevance of the material was of the essence.

The first pilot respondent, for example, illustrates this. He gleefully recounted an anecdote which revealed that he apparently considered it acceptable for him to publicly breach confidentiality in relation to other users, but that it was totally

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[2] Somewhat paradoxically, philosophical counsellors studiously avoid counselling, but instead encourage analytical thinking and the employment of philosophical tools in resolving dilemmas

unacceptable for practitioners to do so in professional settings. Whether the subject of his anecdote would have been happy in the knowledge that this respondent was telling people in their home town that she had been 'on the funny farm' with him is an interesting question, as is if and how this kind of situation could be avoided. The respondent, subsequently readmitted to hospital, was apparently gratifyingly "empowered" as a result of his interview, informing his care workers that they "better be careful what you do to me" due to the fact that he was "helping people at Warwick University with their research".

The second respondent described the ease with which some mental healthcare practitioners assume that a family history of depression predisposes one to this condition, without considering a differential diagnosis – and in spite of the user's protests. This particular user was initially misdiagnosed, another doctor subsequently recognising her condition as hepatitis upon observing her 'yellow eyes'. The first doctor, who had given her depressed mother 'repeat prescriptions of "Valium" for over twenty years', failed to apologise for his diagnostic error, something interesting from an ethical point of view, since a later respondent comments that it is gratifying to note that mental health care workers 'are beginning to admit that they do not have all the answers'[3]. Such relevant issues would have been unlikely to emerge had a more structured interview technique been employed.

An important factor in later listening to the interview tapes, prior to transcribing them, was ensuring that, in spite of a conscious effort to create a 'natural' situation, (mis)leading questions had not been asked and/or expected responses

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[3] See Chapter 5, p. for an example of a doctor doing exactly this.

elicited, albeit unconsciously, by means of either "loaded" questions or subtle hints or innuendo. The 'vulnerable can easily be led to answers in questionnaire and interview' (Shipman, p87) - particularly at the hands of an inexperienced fieldworker.

Following discussion of the pilot interviews and subsequent reflection, the interview technique was modified. It was decided that these should continue to be generally non-structured, but that lists of questions which related specifically to the subject of the research should be prepared (see Appendices 1 for the user questions and 2 for those employed with practitioners). These would be employed if the interview appeared to be deviating (as the pilot interviews had) excessively from the research questions. A previous list of topics had been prepared, but experienced researchers[4] considered this to be couched in excessively philosophical terms, not immediately accessible to the layman. Consequently expressions which might lead to confusion were changed, "flourishing" (the standard English translation of the Greek word *eudemonia*), for example, was replaced by "well-being" (a lesser used, but more prosaic translation). The final list of questions was successfully employed in subsequent interviews which were, as a result, richer in reflections upon ethical matters.

4.6. Research Ethics

Over recent years, the ethical and legal aspects of research have become important. Concern for individual human rights, including those of the research participant, as well as for those groups which could be affected by the research is

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[4] Many thanks are due to both Dr. Gill Bendelow and to Dr. Tony Colombo for their useful comments on this

growing (Renzetti and Lee, 1993). In thinking about the ethics of this research process, therefore, various factors had to be considered. What were the risks? How could they be balanced against the benefits of the research, in order to determine what was ethically justifiable? Could the requirements of informed consent be met in research involving the mentally disordered, and so on? Ignoring the ethical issues in sensitive research of this nature would have been professionally and morally irresponsible. On the other hand, to paraphrase Sieber and Stanley (1988), to shy away from controversial issues, simply because they are controversial, is also an avoidance of responsibility (p55).

Issues related to ethical risk involved matters such as informed consent. This was obtained from all those interviewed, each of whom appeared perfectly capable of giving consent, in spite of the fact that some respondents were taking large amounts of anti-psychotic medication and four told me that they were 'under section'. A detailed consent form was explained and signed prior to the interview. (Following the pilot interviews, a first, short version of this was modified and lengthened, to give the respondent more information about the researcher, the recording, storing and intended use of the interview material, and of the respondent's rights with regard to this. See Appendix 3). Another vital consideration was that of confidentiality, for whilst research participants can generally expect a right to privacy, anonymity and confidentiality, maintaining this scrupulously in the case of sensitive, intimate or possibly incriminating data, such as that collected during this research, is of particular importance. For this reason, all respondents were given three-letter "codenames" which consisted in the letter "U" (user) or "P" (practitioner); a second letter designating the place of

interview: Oxford (O); London (L); Northampton (N) and so on, and a third letter, the first of the respondent's name (or three letters in the case of respondents with the same initial letter, from the same place). All interviews and charts for analysis were marked with these, rather than with the respondent's full name and address.

4.7. Access to the Research Settings

Another ethical issue was the rights of not only the individual, but also of the institutions involved. A certain wariness on the part of the latter was not only likely, but also understandable in view of the possible repercussions of the research in terms of damaging disclosures. Johnson (1976) stresses the need for a multi-stage 'progressive entrée' and this was practised in the case of those institutions approached.

Illustrative of the "wariness" previously described is the fact that it had originally been intended to carry out the research in an overt ethnographic study, involving participant observation, within a psychiatric hospital ward. With this in mind, I made an application to "bank" nurse at a local N.H.S. Trust's psychiatric unit. The interview was conducted by two deputy ward managers who seemed immensely wary of my interest in research into ethics. Despite my years of practice experience with mentally disordered patients and current registration with the UKCC[5], the application was refused on the grounds that 're-training' would be necessary. Given this experience of what might be described as the 'defensive capabilities' (Cassell, 1988, p54) of the institution in question, the idea of an ethnographic study was abandoned. Not only would it apparently prove difficult to

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enter a hospital for this purpose, but the research itself was potentially vitiated and lacking in objectivity as a result of this experience.

The potential sensitivity of the topic, at least as far as some professional carers are concerned, was evidenced by this event and by another incident in which a senior male nurse agreed to arrange interviews with his colleagues. After several telephone calls to finalise the details, he cancelled these only hours beforehand on the grounds of his own ill-health. Having promised to reconvene them 'in the near future', he failed to do so or to explain the reasons for this.

Renzetti and Lee (1993) give a 'preliminary definition' of a sensitive topic as:

> '... one that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding and/or dissemination of research data' (p5)

They continue, saying that those areas of research most likely to be perceived as threatening are, amongst others, those which enter into '... some deeply personal experience', are 'concerned with social control' and impinge on 'the exercise of coercion or domination' (p6). These were, effectively areas upon which the project could have touched and this may explain why these particular "gatekeepers" were reticent in allowing access to their particular "houses".

All this resulted in a radical rethinking of the research strategy which, in turn, avoided the need for 'negotiating up' (ibid.) with a Research Ethics committee. This was possibly an advantage, since the demands imposed by ethical committees prior to research fieldwork in this particularly sensitive area could involve

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[5] The United Kingdom Care Council, which keeps a record of registered nurses, ensuring that their practice skills are up to date and that they have not been suspended from the register, either temporarily or permanently.

modifications of a kind which have been known to result in the abandonment of a project altogether, due to an inability to meet the exigencies of the committee within the stringent time limits of the research project. Restrictions are occasionally so numerous that it can become 'impractical or impossible to conduct valid evaluative research' (Bradburn, 1982 cited in Sieber, 1982, p94).

Another reason for not being discouraged by the prospect of abandoning the intended ethnographic study was that several accounts confirm that the reliability and validity of ethnographic research now trouble researchers (Burgess, 1984), the main concern being that of the impact of this upon the researcher, rather than on those being researched. Given the nature of the project and the results obtained, a study of this type proved neither necessary, nor in retrospect perhaps even desirable, since the final sample includes a wider cross-section of users and care workers in terms of geographic location, age, class, education, diagnosis and gender, than would have been possible in an ethnographic study.

However, detailed negotiations with team managers, research nurses and so on were, in some cases, still necessary. This typically involved an introductory letter, a subsequent telephone contact, followed by the submission of an outline of the project and a list of the topics to be discussed, before an interview could be arranged. In the case of the Survivor's Centre, after an initial written contact with the Manager, informal visits intended to gain the users' confidence took place before any interviews were requested or, later, questionnaires distributed. In the case of some practitioners too, the first respondent would arrange interviews with his/her colleagues, in a process of "snowballing". Two inner-city, out-patient

services contacted refused to participate on the grounds that they were already involved in research projects and, in the interests of their users, did not wish to participate, for the time being, in yet another.

On occasion, opportunities presented themselves. At congresses in London and Wales, through contacts in the Department of Sociology itself, and at a "Survivors' Fair" in Oxford, it was possible to discuss the research with and 'recruit' an interesting and highly eclectic sample of respondents for both interviews and the completion of the questionnaire. In consequence, interviews eventually took place with, and questionnaires were distributed amongst a wide cross-section of users and mental health practitioners over a geographical area which included London, Oxford, Coventry, Birmingham, Kendal, Wolverhampton, Derby and Northampton.

This research, apparently seen as threatening by some groups was, as Renzetti and Lee (1993) claim is frequently the case, thought innocuous by another. There was virtually no need for 'negotiating down' with user groups. 'Recruits' abounded and seemed enthusiastic and pleased to express their views and participate in a research project. In spite of initial reserves as to whether the few spontaneous "volunteers" were not perhaps typical of the groups involved, but rather people with a particular axe to grind, or merely the desire for (brief) recognition, it was decided that it is *de facto* almost impossible to speak of 'typicality' in dealing with mental disorder and they were included. However, one such "volunteer" dropped out upon discovering that he would not be remunerated for the interview. 'Some other researchers' from London were offering fifteen pounds an hour for each

user's time. Since his experience as a user was his only "capital", it was not difficult to sympathise with his claim that "user time" was in no way less valuable than "researcher time", something he assumed to be paid.

Anyone reluctant to participate at the 'formal' interview was encouraged to go away and think about it before making a decision. Only one possible user respondent dropped out as a result. The origins, aetiology and narratives of the final sample were most varied and the fact that some users were "volunteers", in the sense of having directly asked to participate, did not invalidate their contribution to this study.

To paraphrase Burgess (1986), leads were followed, others dropped, new key informants adopted and others neglected. Such switches had, as Burgess says, to be anticipated, even welcomed, although at times the volume of information offered was overwhelming and transcribing the interviews within the research period frequently appeared to be a task worthy of Sisyphus.

4.8. The Sample

Since there are no strict rules to follow in clearly defining the target population, it was necessary to rely on logic, judgement and contacts. Due to the sensitive nature of the research, it would have been inappropriate to seek the respondent sample amongst the local community, as this could have implied seeing or hearing of people known to me professionally, or socially, who might prefer to conceal their mental disorder. It was also important to avoid speaking only to those respondents, practitioners or users, "selected" by the gatekeepers and therefore potentially

presenting an excessively "rosy" picture of mental health practice.   Ideally, the

sample had to be as "uncontaminated" and, in view of its relatively small size, as

varied in terms of location and condition as possible, if it was to be in any way

representative of the larger community. Consequently, the participants were

identified by means of:

- Contacting user groups, either personally, or through an introductory letter
  from a friend who works with them

- Personal contacts through mutual friends and acquaintances, all either care
  workers, or users, or both.

- An advertisement in the professional press asking for collaboration. (This
  provoked no response whatsoever).

- Through web sites dedicated to research into mental disorder and development
  in treatment, or user groups.

- Participation at a congress on the Mental Health Act and in a Survivors' Fair,
  at which both users and practitioners were approached directly and either
  directly invited to take part, or informed of the need for respondents.

- The media. (A healthcare worker and a user who had featured in articles in the
  popular press were, in two cases, contacted and agreed to be interviewed

- Letters and phone calls to National Health Trust Mental Health Services

Given the limitations described, a sample of thirty respondents (see Tables 4. 1

and 4.2.), seven female and eight male mental health practitioners and fifteen

users, seven female and eight male, of as many different social groups and

locations as possible was considered realistic. Interestingly, although this had not

been specifically planned, approximately half the user sample was university

graduates, whilst the remaining eight had received a minimum of formal

education. This did not limit the latter's loquacity nor, apparently, their

understanding of the matters under consideration. In order to avoid problems

concerning the age of informed consent, the respondents were all over eighteen

years old. There was no upper age limit.

The mental health practitioners had a minimum of five years clinical experience (including training), and the users had first-hand experience of the clinical treatment of mental disorder on at least two separate occasions, over a five-year period. This ensured that both groups had sound first-hand knowledge of ethical dilemmas and practice in psychiatric settings.

Table 4.1. Groups included in the study

Interviews	Questionnaires
15 Users	30 Users
7 female/8 male	Anonymous
15 Care Workers	30 Care Workers
7 female/8 male	Anonymous
USA Accounts	Media accounts
9 users	32 users/users' families
4 female/5 male	16 female/16 male
	47 practitioners
	33 male/14 female

Table 4.2. Practitioner Respondents

Professional Discipline	Total	Male	Female
Nursing	4	2	2
Psychiatry	3	2	1
Social Work	2	1	1
Community Psychiatric Nurse	1	1	
Psychologist	1	1	
Psychoanalyst	1		1
Patient Advocate	1		1
Survivors' Centre Manager	1		1
Mental Health Foundation Executive	1	1	

4.9. The Interviews, Setting and Procedures

The interviews were carried out by me, usually alone with the respondent, or, in the case of users, sometimes in the presence of an advocate, friend or family member. Some reserves had been expressed by colleagues as to the possible "danger" inherent in being alone with someone suffering from a mental disorder, but demonstrating trust and confidence would, particularly in the case of the user respondents, subsequently be reflected in the 'openness' of the interview. Interviews took place at different venues: a survivors' centre, at coffee bars, over lunch at my own flat, or at the respondent's workplace. This depended entirely upon the latter's expressed preference. The only criterion was that it should be conducive to creating a space in which to talk freely and where neither respondent, nor researcher, would feel inhibited or over-impressed by the ambience.

Interviews at the respondent's own home were considered inappropriate, both in the interests of discretion and of possible legal and insurance complications should an untoward incident occur.

Every effort was made to create an atmosphere as informal as possible. In the case of most of the users, this involved meeting for lunch, or coffee, for an informal chat before subsequently recording the interview. This was intended to create a sufficiently relaxed atmosphere in which to discuss potentially sensitive and disturbing issues. Practitioners were usually, though not always, interviewed in their professional setting. This meant that interviews tended, at least initially, to be rather more 'formal', although establishing rapport rarely proved difficult. In this type of research the interviewer becomes a research "tool" insofar as the quality of the data obtained is inevitably related to the degree of rapport established. Having said this, over-involvement was also avoided given the difficulties inherent in becoming, to employ Nodding's term, "engrossed" with the respondent and consequently losing the distance necessary to objectively analyse and judge the data gathered.

The purpose of the study was explained at length before commencing each interview. The fact that participation was entirely voluntary and that the respondent could withdraw without giving reasons for this, and have his/her own material destroyed at any stage during, or after, the interview were also pointed out. A consent form was signed prior to this and again once the transcript had been read and approved by the respondent. The interviews were recorded on audiocassette and the transcript of the interview and the recording given to the respondent, or destroyed at the end of the research period. Should any respondent

have objected to the conversation being recorded, this would instead have been hand-written. As this could have limited the flow and spontaneity of the conversation, this option was never specifically previously mentioned prior to the interviews, the duration of which was approximately forty minutes to an hour. (In retrospect, it would have been interesting, and possibly useful for future fieldwork, to offer this option and, had the offer been taken up, compare the content in terms of the "frankness" of the observations and opinions made).

Interviews tended to commence by asking the respondents to clarify what they considered "good" practice in mental health settings, although occasionally some other topic from the protocol arose. Further use of this depended entirely upon the loquacity of the respondent and the relevance of the content of the discussion to the study. Any theme which was repeated, occurring in several interviews, such as, for example, discrimination, was 'investigated' in subsequent interviews by means of gentle 'probing'. There was minimal direction of the respondent, even if this was limited to the researcher's nods and affirmative mutterings. However, it was important to ensure that respondents felt free to define their own experiences of the topics discussed, so revealing an excess of interest in particular aspects of the conversation was carefully avoided, a reasonably detached, but friendly composure being maintained. There was frequently spontaneous shared laughter during the interviews. The nature of this in itself would have been interesting to research, had the word limitations of this type of study not made this impractical.

Particularly in the context of the Survivors' Centre, the respondents seemed genuinely gratified by the interest shown in their concerns and conversations were usually fluid and relaxed. Only in two cases were there moments of tension. In the

first of these, a female respondent became very angry upon considering that she was not receiving full attention, when asked to clarify a point. She responded by shouting: 'I've already told you that! Why aren't you listening? You're supposed to be interviewing me! You listen!' I apologised for not (in her opinion) so doing and the interview continued.

The second was a male user who took exception to the use of the word 'disorder', claiming that it was 'value-laden' and should, therefore, be replaced by the term 'condition'. Had this not been one of the final interviews, this term would have been adopted immediately for he made a very good point.

Upon conclusion of the recorded interview, conversation often continued in terms of asking the respondent if he or she was happy with this, with the way in which it had been conducted, and so on. Reassurance as to his/her right to correct the transcript and eventually dispose of the audiotape was also given at this time.

4.10. Secondary Sources

As Wright Mills (1959) says, whatever the hypothesis being studied, it is always useful to compare material insofar as the search for this can serve to open new perspectives, as well as confirm the information already obtained. One element of the so-called "sociological imagination" is the capacity to shift from one perspective to another. In this way, an enriched view of the group under study is constructed. To this end, other methods of investigation were also used to support and enrich the comparing, contrasting and analysis of the fieldwork interviews which are the nucleus of this work. These are now described.

The finding from the interviews that there did not appear to be a significant difference in attitudes to care between male and female practitioners is contrary to much social stereotyping, described in Chapter Three, which considers men ill-equipped for caring roles. In view of the willingness of most user groups and mental healthcare workers to co-operate, it was therefore decided that in order to confirm this finding a questionnaire, based on the major topics to have emerged, should be carried out. Questionnaires reduce bias insofar as the researcher's own opinions do not influence the respondent's answers and there are no verbal or visual clues to influence the respondent. A disadvantage is the inability to probe responses, but this was partially overcome by the fact that many respondents later wrote spontaneous comments on the questionnaires and in some cases these provided insights which might otherwise have been lost.

Separate questionnaires for users and mental health care workers (see Appendices 4 and 5) were drawn up and distributed, until thirty of each had been completed and returned. The questionnaires were anonymous as those with no identifying information are more likely to produce honest responses and respondents were asked to complete them at their leisure, returning them to the researcher in the stamped self-addressed envelope provided. Some users completed the form immediately and returned it within minutes of having received it. Mental health care workers, on the other hand, were slow to respond to interview requests and questionnaires. Once they did, their responses were frequently far more detailed than the form itself demanded and often remarkably frank, particularly in the case of the questionnaires. This was presumably the result of the fact that the latter were anonymous. The findings of the questionnaires, in terms of confirming those of the interviews, are discussed in Chapters Five and Six.

As was said previously, a search on the World Wide Web revealed nine first-hand accounts of the experiences of North American users of both sexes who have suffered from schizophrenia over several years. Their accounts were compared and contrasted with those of the English respondents and these comparisons are also discussed and illustrated in Chapters Five and Six.

Two of the interviews had been the direct result of monitoring the press, throughout the research process, for recent developments in mental health practice and legislation. This, together with the questionnaires and the North American accounts, became another useful tool in confirming the findings of the interviews. An analysis of over fifty press articles, containing seventy-nine personal accounts (see Bibliography) of mental health practice and/or experiences of this was made by means of a cross-referenced wall chart (see below).

Table 4.3. Illustrative Example of a Section of the Wall Chart Employed in Analysing the Qualitative Data Obtained from the Fieldwork

Respondent's Initials:	UOA	UGD	UOD
Topic identified			
Dishonesty in communication - practitioner-user	Psychiatrists feign friendship and concern	I wouldn't trust her, it would have been part of her job to tell the others	No-one's honest with you
Dishonesty in communication – user/practitioner	You just tell them what they want to hear	I withheld information	
Abuse of power – practitioner on user	Patients who misbehave usually end up being punished	Once you're sectioned no-one listens to you	The doctor said he'd call the security guard if I didn't behave myself
Abuse of power – user on practitioner	Some wards are controlled by bullying patients		

4.11. Coding and Measuring

These processes return to the issues of validity, reliability and replicability described earlier. Data collection and analysis necessarily overlap and as they were replayed and semi-transcribed, a superficial preliminary analysis, qualitative and philosophical, was made of the interviews. This helped to identify those themes or patterns which recurred, initially in order to facilitate closer examination of these in future interviews and later, in collating data for analysis. Important in this process was detecting and drawing out what Shipman (1997) calls 'the private meanings' of those interviewed, something he considers the 'skill of the interpretive researcher' (p44). This was not always easy, but the greater the variety of meaning observed, the more informative the research. The attempt to draw out private meanings revealed not only how mental health ethics are perceived and lived from a wide variety of viewpoints, but also ultimately indicated that in thinking of ethical practice in mental health the values inherent in attitudes to, and consequent management of mental disorder, must be considered from the perspectives of user and care worker. Field notes provided an (admittedly erratic) 'historical record' and a source of insight for writing up and further fieldwork.

Extract from the fieldwork diary, following a visit to the Survivors' Centre,

> 'J. lay on the sofa all day again. K. suggested that for Xmas they set the tables properly for lunch, as it's the only celebration most of them will have. J. said that it was too much trouble, they'll eat it off their laps as they always do. (Power???? Laziness???? Or is she just mean?). Whatever, it upset K., not the most mild-mannered of people at best. She'd been looking forward to something special. She said she would make a better manager than J., in spite of being sectioned (unlike J., who is paid to "look after" them all). Did the fact that I was there make any difference? J. seems virtually oblivious to my presence, but K. might have wanted to impress me.' (10th December, 2001).

Data, regardless of the form it takes, eventually has to be rendered meaningful. Grounded theory, which starts when the researcher embarks upon his/her task in full awareness of the situations most likely to be relevant to this, is, according to Glaser and Strauss (1967) the most influential strategy for this analysis. In the process of oscillation described earlier, the researcher defines and relates these situations by further observation and comparison, and as the work progresses, theory increasingly guides observation. Later, the researcher produces hypotheses which link the different categories. These hypotheses are then reduced, related and ranked 'into a simplified model of the complex reality of decision-making' (Shipman, p45).

The advantage of a grounding in specific data is that it cannot later be refuted by more data, or a sounder theory, because it is valid in relation to the cases upon which it is based. The disadvantage is that it is often very difficult to decide which data is theoretically important. Because of this, Hammesley (1984) recommends 'dredging data' in order to collect the maximum number of viewpoints possible. This recommendation was taken up not only in the continuous reviewing, comparing and contrasting of the interviews as they were transcribed, but also previously in the literature, media and "Web" searches and in the transcription and comparison of and with the interviews found on user sites there. The questionnaires were employed after the interviews, to confirm the findings of these. The analysis of media articles and the "Web" accounts served the same end.

This involved a previous analysis, from the perspectives of deontological, consequentialist, neo-Aristotelian and care ethics, of the key concepts such as "care", "goodness/the good", "rights", "obligations", "responsibility",

flourishing", "duty", "autonomy" and so on, employed in moral philosophy and ethics. With this information in hand, the answers given by respondents could be examined in order to assess whether a clearly "Kantian", "neo-Aristotelian", "virtue", "Utilitarian" or "Care Ethic" approach prevailed, or whether these were mixed and/or possibly indistinguishable. The answers given by males and females were also analysed to see if the claimed gender difference in attitudes to caring in fact exists. Ethical dilemmas in mental health practice were identified and listed (See Table 6.1). In assessing attitudes as "Kantian", "utilitarian", "caring", and so on, the following criteria were borne in mind.

The "Kantian type" ethical thinker adopts a deontological stance by suggesting that we rest our moral and ethical judgements on reasons that can be generalisable for all others who are similarly situated, be these users or practitioners. Moral criticism can, s/he would claim, only be based on this generalisable moral obligation. Any act not based on this, no matter how ostensibly praiseworthy, would, on this view, lack moral worth. What matters, to this type of ethicist is the act, not the agent. In strict Kantian terms, lying, for example, cannot be universalised as a norm of conduct without contradiction. Any practitioner or user who favoured this ethic would never lie, regardless of the consequences of this refusal to do so, and anyone else's lying would be judged unequivocally "wrong", regardless of his/her reasons for doing so.

A Consequentialist (see Chapter 2.2.2.), on the other hand, would say that actions are right, or wrong, only in the balance of their good and bad consequences, a belief, which many would consider perfectly reasonable and fair. The right act, in

any circumstance whatsoever, is always that which produces the best overall result – the greatest happiness of the greatest number – as determined from an impersonal perspective that gives equal weight to the interests of each affected party. It accepts only one basic principle of ethics, that of utility and it could be said, therefore, that being a consequentialist is apparently very simple. From a utilitarian point of view, shutting up a person diagnosed as suffering a psychopathic personality disorder, for example, in order to avoid the possibility of his/her perpetrating a murder would be perfectly justifiable in terms of the greatest potential happiness (and safety) of the greatest number.

As the previous chapters indicated, many feminist philosophers posit an ethic of care, in which only caring, protecting, and even loving one another is ultimately "ethical" (and, they claim "natural" to women). Certainly, the notion of caring, as such, is echoed in users' and many practitioners' views of what constitutes good practice and provokes flourishing. The "care ethicist", whilst sharing the Aristotelian view on compassion, would insist on working relationships involving caring for, as well as about the user. This involves responsibility, trust, fidelity and empathic sensitivity to the extent of what Noddings (1984) terms 'engrossment', so stress on these factors would indicate a preference for an ethic of care in practice, as would manifestations of a "maternalistic" approach to caring.

The neo-Aristotelian virtue ethicist would suggest that the agent and the excellence of his or her character are more important than the act, and that right motives and good practical intelligence (*phronesis*) reveal far more about the moral worth of a person than do right actions. The health care practitioner who

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embraced this type of ethic would believe that in a dilemma two virtuous agents could reach different solutions and yet both be "right", the differences lying in the prioritisation of values. Virtue ethicists consider the role model essential to ethical formation, and the reinsertion of the user back into the community as the ultimate end of good caring. As Beauchamp and Childress point out: '...rather than using rules and government regulations, to protect subjects ... some claim that the most reliable protection is the presence of an *informed, conscientious, compassionate, responsible researcher* ... virtues should be inculcated over time through educational interactions, role models, and the like' (1994, p65).

An ethic, the end of which is flourishing, combining neo-Aristotelian virtue and care ethics, would require that ethics be agent-based, that this agent should be a virtuous person and that he or she should be an informed, highly responsible, caring (but not to the point of engrossment) practitioner, who cares for and about the user. The only professional aim of such an agent is to provoke both the user's and his/her own 'flourishing' in the terms described in Chapters One and Two. Doing whatever is necessary to attain this flourishing is, of course, also the aim of the virtuous user.

Expressions of all these ethics are sought in the philosophical analysis (Chapter Six), which follows the sociological qualitative and quantitative analyses (Chapter Five). In Chapter Seven, what the findings reveal as actually occurring in, and necessary to, ethics in practice is interpreted and discussed in the light of what, according to professional regulatory bodies, should be occurring and through the grid of existing knowledge, or what Bourdieu refers to as 'cultural capital'

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(Fowler, 1997). However, 'the success of a research project is ultimately judged upon its product' (Strauss and Corbin, p252). Conclusions, summing up the research, its findings and the recommendations which can be based on these are to be found in Chapter Eight.

Chapter Five: Sociological Analysis of the Fieldwork Findings

5.1. Introduction

To paraphrase Wright Mills (1959), so we discovered and described. This chapter now presents the detailed results of the fieldwork research, users' and practitioners' views and a qualitative and quantitative analysis of these. It focuses initially upon users' opinions, desires and attitudes in relation to the research question, and subsequently on those of practitioners, in an attempt to answer the questions:

- What is the attitude of both users and mental healthcare practitioners with reference to care, professional ethics and codes of good practice and were the latter reflected in the clinical setting?
- Do males' and females' acts and functions (*ergons[1]*) differ in mental health care and in ethical practice, the former applying a rational approach, as compared to women's more emotional response? Is there a characteristic gendered way of engaging with ethical dilemmas in practice? Or does the fieldwork reveal similar attitudes and reactions, feelings and emotions, independent of gender?
- Is caring somehow instinctive to women in an essentialist form and can men be "instinctive" carers? Is caring a form of emotional labour and do practitioners themselves perceive it as such?
- What nature of ethical dilemmas arise in mental health practice?
- What do practitioners and users understand by "flourishing" (*eudemonia*) in mental health settings? How do they discern non-flourishing?

The answers inform later discussion on the ethic most suited to mental health practice and the importance of establishing a system of and education in values *prior* to the formulation of *any* ethic for this.

5.2. The Sociological Findings

Immediately they had taken place, and before making complete transcripts, interviews were replayed several times, the incidence of key concepts noted and a "spider" graph drawn of the main issues raised. (See Fig.5.1). Emerging patterns

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[1] *Ergon* = deed, function, product or result. See Chapter 3.

and trends in attitudes and ethical issues were thus identified, to be coded, recorded and explored in greater depth at subsequent interviews. This process facilitated extracting the 'essentials' with increasing certainty and relating these by making links such as those shown above. The consistency of the interview findings was remarkable, although they differed in some respects from the accounts given by users from the USA.

FIG 5.1. Reducing Topics to Essentials (an example)

5.3. Users' and User Groups' Opinions and those of Users from the Secondary Sources – a preliminary overview

Two thirds (10) of the users interviewed considered the attitudes and behaviour of mental health practitioners acceptable, although community care is better considered than hospital care, in spite of Frank Dobson's comment to the effect that 'Care in the community has failed...it has left many vulnerable patients trying to cope on their own (cited in Rogers and Pilgrim, 2001, p176).

There was no significant difference in users' opinions of the attitudes of members of the different healthcare disciplines, a finding which initially seemed surprising. Further examination of the results revealed that whilst one third (5) of user interview respondents did consider one particular group to have a more positive attitude than the others, there was no common agreement as to which group held the positive or negative attitudes described. When the findings of the user questionnaire, which gave an identical result (ten out of thirty questionnaire respondents considered one group of practitioners to have a more positive attitude to users than the others) were added to those of the interviews, these balanced one another out. A larger interview sample may have revealed significant differences, but on the whole, the user interview respondents (and this also applied to the practitioners interviewed) did not reveal any particular interest in this area. However, the findings did reflect a view widely held by user respondents to the effect that attitudes depend more upon the individual character of the practitioner than upon his/her professional discipline *per se*.

Equally interesting is the fact that, against the views of Noddings (1984), Gilligan (1982) and a large body of feminist moral philosophers and psychologists, (see Chap.1.3.1.) users generally concur that there is no significant gender difference in approaches to ethics and good practice, both considered by the latter to depend more on the individual practitioner's[2] character and users' personal preferences than upon gender. Thirty-three users (73%) across questionnaires and interview respondents indicate that although malpractice is not unknown in mental health clinical settings, the majority of practitioners are caring and do their best in circumstances universally recognised as difficult. In spite of this, perhaps because,

as was said in Chapter One, mental disorders are widely considered moral disorders, in-hospital care is often perceived by users, inspectors and (and the media) as punitive rather than therapeutic:

> 'The acute ward is at best non-therapeutic, at worst, damaging, degrading and dangerous. Disastrously understaffed, over-stretched and lacking basic amenities, many provide little more than medication and containment.
> (A. Faulkner, Guardian Society, 2.10.01. p104)

To summarise, before progressing to more detailed analysis, the major ethical issues and areas of contention from the points of view of users, survivors and representatives of users' associations are:

- Major dissatisfaction with hospital in-patient care and wide dissatisfaction with care in the community, particularly where this is based on hospital out-patient clinics and poorly resourced survivors' centres.
- In both settings, dissatisfaction is predominantly attributed to lack of resources rather than of concern on the part of practitioners[3] who are considered generally caring by 73% of user respondents. (Practitioners cared for and about me – 33%. Practitioners cared for me – 33%. Practitioners cared about me – 7%. Practitioners cared neither for nor about me – 27%).
- Adverse discrimination, stigmatisation and 'labelling' as a result of the diagnosis of mental disorder, resulting in a severely deteriorated quality of life. 79% of user respondents claim to have experienced issues such as disregard for their own culture and ideology.
- Disempowerment and loss of autonomy[4], including sectioning (compulsory admission to hospital); compulsory psycho-pharmacological treatment and the side-effects of this and informed consent and E.C.T. (Electro-convulsive therapy).
- Lack of communication, formal or informal, with qualified practitioners, as opposed to domestic staff and students (The 45 users completing questionnaires and interviewed answered as follows: Students, domestic assistants and others spent most time talking to me – 50%. Nurses spent most time talking to me – 30%. Social workers spent most time talking to me – 20%.). This lack of communication is claimed to cause mistrust and

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[2] Both these findings support the view that a virtue ethic, stressing character, rather than act, is that most appropriate to mental health practice

[3] This finding is echoed in Melba Wilson's study *"Ethnicity and Mental Health"* in which over half the users from ethnic minority groups who responded to her questionnaire, regarded their relationship with the key practitioner as favourable and 'those who did not ... suggested their workload was too heavy.

[4] According to Griffiths, M. (2002) in the context of mental health this term means 'much the same as independence. Both terms routinely apply to the self-rule of individuals ... "Autonomy" has the advantage that it is not so obviously related to dependence' (p49)

resentment. This finding reflects the anxiety expressed by a student nurse who says: 'I do love it when you have time for the patients. I get frustrated when there isn't time to ... chat ... but the other trained staff always make me feel as if I should be doing other things (Smith, 1992, p89).

Many, though not all of these concerns were echoed in the nine user accounts from the USA described in Chapter Four. Unlike *all* British user and practitioners, *none* of these considered hospital care, in spite of the incidents of malpractice which they describe, worse than care in the community care. There have during the last five years been many harrowing accounts of ill-treatment at hospitals in the United States of America[5], so the fact that the degree of general satisfaction with hospital care expressed by the (admittedly small) USA sample is so much higher might be considered puzzling. It could, therefore be the case that these nine user accounts are *not* altogether representative, but written in response to accounts of ill-treatment.

Like the fieldwork respondents, more than half of whom consider that they are not allowed sufficient participation, North American users describe being excluded from care plan decision-making, as are their families[6], as a focus of distress and frustration. In British mental health practitioners are increasingly aware of this problem and the emphasis in some successful community care centres is on both listening to users and, in a process of caring both for and about, including them as

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[5] The American Civil Liberties Union of Illinois published, in April 1997, an expert report prepared by psychiatrists and psychologists from Yale University on the treatment of the mentally disordered in state institutions in Illinois, accusing them of offences from intimidating and sexually abusing users to isolating patients for days on end without access to fluids or toilets; The Chaote Mental Health Centre, the Chicago Read Mental Health Center, the Elgin Mental Health Center and the Zeller Mental Health Centre have all also recently been the subject of similar reports (see Website list).

[6] '...the carers of people with mental health problems were especially critical of how little they were consulted about care plans for service users...' (NSF VI – Mental Health, p70).

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essential players in policy-making and, in some cases, the therapeutic team[7]. The U.S.A. accounts all confirm the evidence relating to the lack of time spent by qualified practitioners, as opposed to domestic staff and students, in talking to users.

British media accounts support the fieldwork respondents' views that (depending upon the catchment area in which you reside) out-patient care is better than the 'Cinderella' services offered by hospitals. This source also reports extensively on new projects in the community which empower the user and reduce the need for medication and incidence of suicide and self-harm, Communication has apparently been better than either practitioners or users recognise, for many of the features of care which the latter describe as desirable (the so-called "talk" therapies, aroma therapy and even "Reiki") have been successfully incorporated into new projects[8].

All groups of users share the view that nurses and social workers should be better informed regarding the more "scientific" aspects of their task, an interesting finding in an age in which technology is popularly supposed to be "taking over".

Although its importance is always stressed in professional codes of good practice, North American users, in common with many interview respondents, make no mention of breaches of confidentiality appearing, as some of the quotes given

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[7] Bradford Home Treatment Service, which employs an ex-user to help the team develop a genuine user-sensitive culture.
[8] There are also now several projects underway throughout the UK which promote communication. An example of this is "Northumberland User Voice" whose stated aim is to support "mental health service users and their families ... to express their views and to influence the mental health services that they receive"

later indicate, to assume that these are almost inherent to mental health practice. The result, as will be seen, can be a failure to disclose more sensitive (and potentially highly relevant) information. Like the latter, this group also describes instances of discrimination and labelling resulting from their condition.

A striking difference to emerge is in attitude to medication. That of the USA users is relatively positive, particularly insofar as new treatments are concerned, whilst that of the fieldwork respondents is generally negative. They are particularly aware – together with some practitioners – of the risk of adverse side-effects reducing quality of life. It is possible to speculate that this difference in attitudes is directly related to the fact that the USA users commonly describe their condition (schizophrenia) as a physical disorder and uphold the so-called "medical model" of mental illness, unlike their British counterparts, generally more convinced by social and psychological models, who often talk of "condition" rather than illness or disorder.

Little mention was made of E.C.T. in spite of very active anti-ECT movements in the U.S.A. Some interview respondents discuss this, but none was currently undergoing E.C.T. and those who had done so in the past hoped not to in the future. These all felt that they had not been sufficiently informed as to its side-effects before consenting to treatment.

> 'No-one in their right mind would sign up for that. The doctors want to try it themselves if they think it's so good for us' (UOBre)

5.4 Mental Health Practitioners' Opinions and those of Practitioners/Policy Makers from the Secondary Sources – a preliminary overview.

Practitioners' concerns concurred, in many respects, with those of users. The issues consistently raised by this group included:

- Professional dissatisfaction and demoralisation.

Sixty percent of the practitioners interviewed and responding to questionnaires were dissatisfied with their working conditions. This is particularly aggravated in hospital staff, due to short-staffing, excessive bureaucracy, under-funding, lack of resources and time to dedicate to their perceived professional task of caring for and communicating with users. When bureaucratic work is excessively demanding, the physical and emotional labour of caring relegated to untrained staff. Practitioners working in the community report less frustrations and consider attitudes to be changing, particularly in terms of increased user involvement. They describe this as both therapeutic and empowering for the user, and helpful in practical terms in that it can reduce the practitioners' own workloads.

- Fear of user and users' families aggression.

This is particularly evident in hospital settings, but also in community contexts. The consequence appears to be the excessive (and potentially litigious) employment of physical and psychopharmacological restraints and isolation.

- Discriminatory attitudes towards and stigmatisation of the mentally disordered and the mental health services generally, which, in the opinion of many practitioners, extends to those working in this area.

This is reflected in the media where mental hospital care generally is frequently described as the "Cinderella" of the health services and those who work in this depicted as "inferior" to practitioners in other branches of healthcare, hospitals

sharing 'the stigma which they attach indelibly to their patients' (*Guardian Society*, p2. 28.03.01). Many practitioners fear that the admission of potential offenders under the proposed new Mental Health Act will serve to reinforce this image.

- Disempowerment of the user as a result of present systems of care.

These encourage dependence, rather than the autonomy and increased independence essential to flourishing.

- Inappropriate admissions

These consist of people who are socially dysfunctional, substance abusers, or those suffering organic disorders such as Alzheimer's disease. This results in a lack of places for acute admissions and "real" cases.

- Lack of professional educational and training resources and research possibilities.

This is in spite of the fact that proof of continuing education and training are necessary to re-registration.

The questionnaires and media articles confirm the practitioners' opinions. When describing poor hospital conditions, including unprofessional staff attitudes, they also refer to a lack of user and family involvement in care planning in both in-patient and community settings. They highlight the problems of adverse discrimination, poor communication and stigmatisation, labelling and disempowerment as perpetuated by stereotypical depictions of madness. Both mention human rights issues relevant to 'sectioning' and the ethics of employing this to prevent a hypothetical crime. They discuss the ethics of 'covert' medication and the side-effects of both "old" pharmaceutical treatments and the

newer SSRIs[9] in negative terms, as sometimes reducing quality of life long after treatment has been discontinued.

5.5. A Comparison of Practitioners' and Users' Views

Although, due perhaps to the diverse sample of health care professionals interviewed, the fieldwork findings do not fully support this view, Spurgeon (2001) claims that the gap between practitioners'[10] and patients' perceptions of the quality of care is widening. However, his view that users are increasingly knowledgeable about treatment options is evident from this study. It became clear during the interviews that things have changed very greatly since Parsons (1951) spoke of the patient's 'technical incompetence in medical matters'. Thanks to increased press coverage and access to the "Internet" users today are often very well informed of the "scientific", "psychological" and "alternative" therapies available for the treatment of psychiatric disorder. Several users mentioned the possibility of obtaining treatments currently either difficult to obtain (psychotherapy and psychoanalysis) or not an option (aromatherapy, reflexology, hypnosis) in most National Health Trusts. Three respondents suggested the introduction of a system of vouchers which would enhance user autonomy and satisfaction by allowing them to undergo the treatment of their choice, in centres endorsed by the appropriate healthcare authority. One user believed that the benefit of alternative treatments lay not so much in the treatment itself, as in enjoying the therapist's undivided and apparently caring attention for a fixed period of time, something he considers an unattainable "luxury" in mental health

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[9] Selective serotonin reuptake inhibitors. Drugs known to cause adaptive changes in several CNS receptor systems provoking, amongst other things, the inhibition of serotonin (%HT) uptake (Price, L.H. 1990).

[10] In this particular article, doctors.

practice today. Indeed, according to Langewitz et. al, (2002) 'The average patient visiting a doctor in the United States today gets 22 seconds for his initial statement, then the doctor takes the lead' (p682-683).

Many practitioners (60%) too, particularly those in hospital practice, consider quality of care to be deteriorating. They report increasing workloads and bureaucratic responsibilities and this is recognised as a major problem by users themselves. The majority of practitioners (66%) also describe short-staffing, excessive bureaucracy and overwork as resulting in a lack of time to perform those professional tasks as they would wish. Sixty-nine percent of practitioners stress that this is particularly the case insofar as hospital care is concerned. This finding is reflected in the fact that in one Mental Health Trust alone in 1997, the majority of the 325 'official' complaints from users against practitioners concerned in-patient facilities. There is no lack of complaints against mental health care overall, but rather than against individual practitioners these are directed towards either the care team as a whole, or to the poor conditions prevalent in some psychiatric hospitals today. In the case of out-patient or community care, attitudes vary depending upon the NHS Trust concerned. A user from Gloucester (UGJ) had 'no complaints whatsoever about hospital care' (although she later went on to complain about the male consultants who had treated her as if she were 'stupid'). No-one from the neighbouring Oxford, on the other hand, considered hospital care entirely satisfactory.

Users' complaints are intimately related to those issues which mental health practitioners raise as contentious. Where users indicate that mental health care practitioners do not dedicate time to speaking to them, the latter unanimously

complain of a lack of time to do so. Where users suggest that nurses should spend less time in the nursing station and more interacting with bored, inactive patients, nurses bemoan excessive time spent on bureaucratic functions unrelated to their professional skills and of problems caused by a lack of activities for users. Both discuss discrimination, labelling and stigmatisation and the demoralising effects of these on practice. (One hundred percent of hospital practitioners consider those who have been diagnosed as mentally disordered to suffer adverse discrimination and stigmatisation as a result of this).

Understaffing, administrative overload, demoralisation and under-funding are considered almost unanimously by users and carers, regardless of their discipline or sex, to impede efficient, humane mental health care today. These are not all, strictly speaking, ethical issues but since they inevitably affect good practice and morale, may coherently be regarded as such. The ethical dilemmas which such problems indirectly provoke in mental health practice are now discussed in detail.

5.5.1. Communication and information-sharing with the user and his/her family

The importance of good communication to ethical practice lies in the fact that users feel disempowered and humiliated when their narratives and opinions are not apparently worth hearing, or relevant to the resolution of their disorders. A common complaint against practitioners is that they fail to dedicate sufficient time to listening (as opposed to talking) to users and their families. Psychiatrists, in particular, are described as regularly arriving late, or not at all, for pre-programmed visits. This offence is compounded by the fact that they neither explain the reasons, nor apologise for wasting the user's time although the latter

may have foregone other activities to await the promised interview, frequently considered the highlight of the user's week. Particularly when no real therapeutic programme is available due to lack of staff and resources.

> 'I would fire my first hospital psychiatrist. He was usually late, his appointments were short ... He met with me once a week – if he showed up – *for only ten or fifteen minutes'* (USA 21)

> 'My wife came to see me every day and never got to see the psychiatrist. He was never available. I don't think she saw him once' (UOBri).

> 'I just spent my time smoking alone or talking to the other patients. We were supposed to do things but they kept getting cancelled because there wasn't enough staff. The doctor's visits were the only interesting thing, but he didn't always turn up for those. You'd hang around waiting for hour and he just wouldn't show up and nobody ever said why' (UOBre)

There are exceptions to this:

> I was lucky, I had psychiatrists who were prepared to spend time with me. At least once a week, for an hour. (UCR)

Lack of communication is a problem recognised by the practitioners themselves. A recent conversation analysis (Langewitz et al.2002) 'of thirty-two consultations between psychiatrists and patients suffering schizophrenia or schizoaffective disorder' reveals that whilst 'patients actively attempted to talk about the content of their psychotic symptoms in consultations by asking direct questions', doctors responded by asking a question rather than giving an answer and 'smiled or laughed (when informal carers were present) indicating that they were reluctant to engage with patients' concerns about their psychotic symptoms'. This was, according to this study, 'a source of noticeable interact ional tension and difficulty'.

Female psychiatrists are considered more empathic and better listeners by 15% of users, but a female psychiatrist said:

'...more than the gender of the psychiatrist, it depends upon his or her philosophical or psycho-therapeutic orientation. Women should be better listeners, in theory, but I don't know if this is true or not. Are they really more empathetic? Some are but some men are even more so. I suspect it depends more, as I said, on their orientation and their reasons for doing psychiatry'. (PLC)

When discussing communication, users frequently refer to conversations with domestic assistants, student nurses, other professionals such as physiotherapists, and their fellow-users, all of whom were considered to be the prime sources of a friendly and often helpful ear. Nurses, of both sexes, were praised, although some interview and questionnaire respondents felt that they spent too long in the nursing station, interacting too little with users:

'The nurses should come out of the nursing station more and ... do more with the patients...' (USA15)

'The nurses never took a pro-active approach to get people to talk to them.' (ULD)

'The nurses are lazy. They just sit on their arses all day' (UOK).

Male user respondents tend to regard female nurses as more caring and 'friendlier', but made no complaint against male nurses, frequently praised as 'caring' by female users:

'... the male nurse would talk to you about your feelings, recommend a good, helpful book. He cared enough to get me a copy of the book ... that's not the sort of thing you'd expect a psychiatrist to do, they certainly don't' (UGJ)

This might be explained by the fact that, as a male practitioner says:

'Men generally find it easier talking to women about their problems'

(POJ)

Female healthcare practitioners can, against Noddings, apparently sometimes be highly unfeeling. This echoes Baier's opinion that the fact of having suffered

discrimination as a result of being a women does not necessarily imply that women are any more caring than men:

> '... they mocked us, they wouldn't care, there was no warmth. It was just a job to them and they would try to maintain their distance. I really hated it. I really did not feel that I could trust the nurses.' (USA 14)

Social workers are variously described as efficient and caring, or not, regardless of gender: Users were approximately evenly divided in their opinions of their work:

> 'If it wasn't for my father sending me a ticket, (when the social workers failed to find the price of a fare home) I wouldn't be here today' (USA16)

> 'They just weren't reasonable, too interfering' (UOK)

> '...always on my side' (UOD)

These comments reflect the importance of the emotional component of nursing to users. They greatly resent it when practitioners are "inaccessible" and perceived as maintaining a distance between "them" and "us". The emotional needs of the user are best met when carers create "feeling rules" which value the user's individuality, good social relations and emotions as part of the work of caring. However, this is not without its risks since, as Smith, P. (1992) points out, raising the profile of emotional care may put the nurse at risk of '... increasing her (*sic*) anxiety by removing the protection provided by task-orientated care' (p10).

In this context it may not be the loss of protection, but of power, which creates anxiety. As Nick Fox (2000) points out:

> 'The construction and strengthening of disciplinary markers of knowledge shift the balance of power away from clients and patients towards health professionals ... and achieve a distinctive 'care-as-discipline' p337).

He then goes on to compare this 'disciplinary vigil of care' with 'the gift of care' which draws on the work of the feminist H.Cixous, who contrasts 'feminine' gift relationships with 'the masculine realm of the *proper:* of property, propriety, possession, identity and dominance' (ibid). As Fox suggests, 'The characteristics of gift relationships would seem particularly apposite for relations entailing care and might include generosity, trust ... commitment..." (ibid). All the latter, in turn, could be considered virtues. Such a 'gift relationship' might, therefore, be considered an example of an ethic of flourishing in practice, but, as the fieldwork findings show, the feminine/masculine divide posited by Cixous, does not apparently exist to any marked degree in mental health settings.

Although there was no significant gender difference in the interview findings, in the user questionnaires, male social workers emerge as significantly better considered than their female colleagues whilst, *contra* stereotypical concepts of the social worker as female, none of the respondents specifically described female social workers as having treated them better than males. In 15% of the questionnaires, users and practitioners describe male social workers as more empathetic or better listeners than their female counterparts:

> 'I got on well with the blokes. There are things you don't want to talk about with women' (UOD).

This finding counterbalances that on psychiatrists which indicates that 15% of users and practitioners consider female psychiatrists to treat users better than do their male counterparts.

The lack of communication described by the majority of respondents is supported by the findings of the Maudsley Hospital study, (Pitarka-Circana, 2000). In this, most complaints refer to the 'perceived failure of mental health practitioners to explain treatment or diagnosis adequately' to either patients or their next-of-kin.

> 'I would have liked someone to explain X's illness to me. I always worried about doing the right thing. I asked our G.P. and he said he couldn't discuss it with me. And though he did lend me some books on depressive illnesses everything was in medical language, so that didn't help. I needed something understandable' (FLL).

In total, 50% of the user interview and questionnaire respondents and, more surprisingly, 60% of practitioners ("No" = 60%, "Sometimes" = 17%, "Yes" = 23%) considered that families were not allowed sufficient participation in care planning. Both British and U.S.A. users describe the lack of information given on treatment and diagnosis[11] as confusing and disempowering. On the subject of information-sharing, informed consent in clinical trials and prior to ECT is also contentious:

> '... there is never really informed consent. The full facts about E.C.T. are never made clear. There's inevitably a bias in favour of shock treatment and you can only know how horrible it is by undergoing it'. (UOR)

According to Baughman (2000), the legal obligation under informed consent is to provide the patient with all the information relevant to decision-making – not just about the treatment in question, but also about their condition. He claims that many psychiatric patients are never told that their alleged disease may be metaphorical and is theoretical, in spite of the fact that to say or imply that someone has a biologic disease when there is no proof (as in all psychiatric disease) is conscious deception and abrogates informed consent. That this has

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[11] Some psychiatrists no longer use traditional diagnoses as they consider that there is nothing to be gained by labelling as, for example, suffering from schizophrenia

become the standard of practice in psychiatry does not excuse it. The abrogation

of informed consent is, *de facto*, medical malpractice (cited in Breeding, 2000).

As Bridson et. al (2003, p1159) indicate:

> 'To make consent properly patient centred, clinicians need to ask patients what they want from treatment before they discuss treatment strategies'.

These authors go on to say that the British Medical Association's view that

clinicians should be more familiar with the guidance on consent may be right, but

their 'experience suggests that even full compliance with current guidance may

not prevent unnecessary procedures in some patients'.

Even at its scientific best, medicine is inevitably a social act in which '... the most

evidence crazed doctors have to translate their perception of "bio statistical truths"

into accounts that make sense to others' (Elwyn and Gwyn, 1999). The concepts

of doctor-centredness and patient-centredness have, these authors claim, had a

profound effect upon professional practice. They have led to studies on the effect

of communication styles on user satisfaction and clinical outcome which reveal

the importance of listening to users' stories. This seems particularly relevant in

treating mental disorder but communicating in depth with users is something

many practitioners lack time to do.

When they do talk, misunderstandings can arise and the user's account not be

given due weight by the practitioner. Such instances have occasionally had tragic

consequences. The murders committed by Michael Stone[12], the attack on the

"Beatle" George Harrison[13], and the suicide of Colin Williamson[14] prove this. In

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[12] See Noguera (2000) p158-168
[13] Psychiatrists refused to believe both him and his mother that he had mental health problems. See The Guardian, 24.10.01, p14

this age of patient-centred medicine, conventional studies of the practitioner-user

consultation still tend to focus on structure, rather than content, regardless of the

fact that: 'not understanding the language and rules is all very frightening' (Elwyn

and Gwyn, 1999), a sentiment expressed in almost identical terms by a user:

> 'Not understanding what's going on, not understanding the language and
> rules, it's all very frightening' (ULD)

Not that reacting to a user's narrative is necessarily easy for even the most

compassionate carer. A doctor records:

> 'I hadn't expected this: three deaths and a request to withdraw from
> antidepressants during a routine repeat prescription. Would that be all
> right? To participate in a shared decision about the end of grief, about a
> symbolic farewell to a son killed five years ago. I attempted to give her
> autonomy over her decision... But it wasn't enough. How could I tell her
> that I didn't know. That if I had lost a son I can't imagine surviving at all,
> never mind coming off tablets" (Op.cit.).

Users would prefer more honesty in this respect:

> 'The key element that's missing is honesty, to put it simply, you're spun a
> line ...It's the insidiousness that has got me. I've been suckered, if you
> like, into believing that they know best.' (UOA)

Honesty is an issue more important than might initially appear. A disturbing

finding concerning communication is that 77% of users claim to have withheld

information or lied to practitioners. The reasons for this vary:

> I've become distrustful. There was only one nurse that I could talk to, but I
> wouldn't trust her. It would have been part of her job to go and tell the
> others...' (UGD)

> 'I could fake the answers quite easily, which I had done before. I didn't
> want to stay in hospital any more. I was able to fake it and I got a ticket
> out of hospital'. (USA20)

> '... it's easy to deceive them, you just tell them what they want to hear'
> (UOA).

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[14] Repeatedly complained of hearing voices telling him to kill himself, but in spite of a family
history of schizophrenia psychiatrists ruled this diagnosis out. He committed suicide. See Private
Eye, 6.11.01

The predominant reasons for deceit were or fear of the consequences of telling the truth, in terms of sectioning or prolonged stays in hospital (42%), lack of trust in the practitioner's judgement (25%), to maintain control of the situation (15%), reasons of privacy or confidentiality (12%) or to be discharged from hospital (6%). The fact that over 70% of practitioners also recognise that users frequently deceive them by withholding information, or deliberately lying, is a particular cause for concern, given that no-one appears to have seriously addressed the lack of trust implicit in such a situation.

One reason for this is that users generally, and many health care practitioners, do not consider that confidentiality to be protected to an adequate degree. The phrase previously cited: 'it would have been part of her job to go and tell the others' summarises many users' and carers attitudes to maintaining confidentiality. Users are aware that the 'need to know policy' can be interpreted as 'just about anyone who asks' or can access the computer files, in the mental health setting, as long as this 'anyone' is a member of the profession. It is paradoxically far more difficult for close relatives to obtain information and 63% of practitioners admit to having withheld information from both users and their families.

When referring to the protection of confidential information, all the codes of good practice of disciplines connected to mental health practice suggest (or command) that information on clients must be treated as confidential and used only for the purposes for which it was obtained. They then indicate that given the impracticality of obtaining consent every time this information needs to be shared, practitioners should ensure that the user understands that that it may be made

available to other members of the care team. This, in the opinion of most users, provides *carte blanche* for breaches of confidentiality.

Practitioners also recognise that they cannot always respect confidentiality, although a strictly deontological (Kantian) code would demand just this. One in three mental health professionals admits to having breached confidentiality in practice at some time. In such settings there may be situations in which this is justified in the public interest (to protect someone from harm) or required by a court of law. A male psychiatrist says:

> 'Yes, I would have no hesitation in breaching confidentiality if a risk is present' (POK)

The mistrust and fear of the practitioner's power described in the previous paragraph are not conducive to a therapeutic relationship. Empowerment of the user, 81% of whom see themselves as disempowered, is therefore an issue in need of urgent consideration.

Many mental health practitioners (75%) share this view, considering that rather than fostering the autonomy necessary to flourishing of the user, treatment currently often creates reliance upon an already over-worked system. A female nurse says:

> '... I do feel that we create a lot of dependency with patients instead of empowering them to take control of their lives' (PCS).

In mental health care, given its unique power to "section", there is a potential for that which should be positive and empowering to become a possessive and controlling discourse. The user may well trust the therapist, 'reciprocating an investment on the part of the therapist to enable the patient to take control of

his/her situation' (Fox, N. 2000, p335). These may enable the latter to liberate him/herself from the constraints of suffering and dependency, but 'if these investments become codified within discourses of professionalism, or as is sometimes the case in caring settings, within a repetition of a parent-child dependency ... then what was an empowering relationship becomes disempowerment, what might have enabled such a growth becomes more to do with power and control' (ibid).

Users also wish to be more deeply involved in care plans, either personally, or in consultation with their families. More than 50% claim that neither they nor their families are sufficiently consulted, or involved in these, a belief shared by more than half the health care practitioners interviewed and responding to questionnaires, and confirmed by the media articles.

Some users describe what appears to be a virtual disregard for their opinions and desires from both psychiatrists and, to a lesser degree, nurses and social workers:

> 'The complaint that we made about the Social Services, it took two and a half years ... I was discouraged all the way along the line not to carry on. Nobody would listen because I'd been sectioned. Although at the time I was complaining of her ... because I am a man who will stand up in court and say my piece. Whether the people believe it doesn't bother me as long as I can get somebody to listen...'[15]. (UGD)

Even the most caring practitioners often fail in this, for some users believe that a certain "inauthenticity" exists in mental health practitioners' indifference or feigned interest in users:

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[15] This was a complaint made about the manageress of a Day Centre attended by this respondent. He complained to the authorities responsible for the centre about her irregular financial dealings with the clients for many months before an 'audit', resulting in a trial and conviction, was made.

> 'Psychiatrists often feign friendship and concern. When I said: "I no
> longer want to see you", he appealed to our friendship, but it was
> insidious' (UOA)

> '... as consultants, so I've only had seven minutes with them. No-one has
> ever asked me about my actual experience or feelings. There was no
> human interest. As an in-patient, you'd see a whole team who would ask
> you bloody stupid questions. You felt that your skills were somehow
> meaningless – there was no reference to your past' (UGJ)

Whilst a male psychiatrist, in a chilling example of what Crossley (2000)
describes as 'the narrowly instrumental sphere' of, in this case, medical
rationality says:

> 'Psychiatrists no longer think of understanding the whole person, but are
> there to realign our patient's neuro-transmitter, no matter what its
> configuration'(PLP)

He may not be typical, although his female colleague, speaking of psychiatrists
says:

> '... you would think that there are very few of the male ones who consider
> themselves anything but neuroscientists, wielding medications and not
> talking or listening to their patients at all'. (PGC)

In order to accurately assess whether this (ultra) medical model of treating mental

disorder prevails amongst psychiatrists, it would have been necessary to interview

a far larger sample of these[16]. However, taking the practitioner sample as a whole

indicates that it does not.

Alternatively, it could simply be that this kind of emotion work is not always

recognised as such, but taken for granted as integral to the caring for which

practitioners are assumed to be naturally endowed. Smith, P. (1992) claims, for

example, that many nursing students 'experienced anxiety and stress because

their emotional labour went largely unrecognised and undervalued' (p139).

Significantly, neither was it 'incorporated into the theoretical and practical

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[16] One of the disadvantages of a cross-disciplinary sample of only fifteen practitioner respondents
is that it is impossible to claim that the small sample from each discipline is necessarily typical of
that particular discipline as a whole.

organisation of their training' (ibid), which would imply that educators have until recently considered emotion management irrelevant to good nursing care. However, it may be that Smith (1992) is inexact in her application of the Hochschild's term, confusing the caring aspect of nursing work with Hochschild's 'emotional labour', which the latter considers to be an expanding part of labour in the "for profit" service industry. This is indicated in James (1989) when, in describing the nurse-patient relationship, she explains that the 'expression of emotions is a negotiated process involving mutual sounding out of what is acceptable' (p21). This is closer to Hochschild's (1979, 1983) 'equal emotional exchange' which permits the management of emotion to be enacted according to social 'rules', rather than organisational "prescription".

5.5.2. Adverse Discrimination and Stigmatisation

Although this analysis began by discussing communication difficulties, these are inseparable from the major ethical issue discernible from user and practitioner interviews and questionnaires, from media articles, and from the previous section: that of adverse discrimination and stigmatisation. Eighty-five percent of users feel labelled and dehumanised as a result of a diagnosis of mental disorder. They believe that practitioners, friends and family consider them "inferior", "different", "degenerate" and even morally defective following this:

> 'Discrimination is rapidly apparent and tangible and long-lasting. It may lead to disempowerment ... The big problem is that psychiatric treatment is like a net which is impossible to get out of once in. It's not just the stigma. It changes your whole life' (ULD)

> 'Even to this day in our family we don't discuss the word 'schizophrenia'. I use the words 'depression' and anxiety to describe my condition to my friends or relatives' (USA17)

> 'People with mental disorder are among the most socially and economically alienated, with heavy psychological toll' (L.Vileneau, Sainsbury Centre).

All the practitioner respondents shared this view and, statistically speaking, appear to be as aware of it as the users themselves. What causes suffering is not only the mental condition or 'emotional pain' as such, but the social discrimination or stigma, (words which appear in all the interviews and most of the press articles) associated with this.

Users describe the damage that suffering mental disorder wreaks on both job and social prospects. Of the seven graduate users interviewed, all mature people with previous work experience, only one had a full-time job and this within a mental health ambience. Two were studying, hoping to obtain work within this same milieu, convinced not only that their prospects of not suffering discrimination in other areas were slim, if not non-existent, but also of the fact that the best people to assist the mentally disordered are those who have themselves suffered in the same way[17]. The remaining user respondents were unemployed and living on state benefits, including all but one of the long-term disordered users spoken to during the visits to a Survivors' Centre[18]. The one exception worked as a driver for a day centre.

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[17] Two users suggested that instead of psychiatric hospitals, there should be crisis centres run by users for users. At the Survivors' Centre, the users' ability to tolerate and resolve situations which in a hospital setting might have demanded crisis intervention was certainly remarkable

[18] Which makes the £450 registration fee demanded for a recent meeting on changes in mental health policy and practice, organised by the Sainsbury Centre and sponsored by the "Guardian" newspaper, which was officially open to users, seem insensitive, if not ironic, and highly discriminatory, since, in effect, this exorbitant fee served to make the meeting inaccessible to most users and researchers, but open to government-funded employees in the form of policy-makers and N.H.S executives

User movements prioritise combating this stigma, so negative is its effect upon the quality of users' lives. Mental health care practitioners also complain of suffering similar stereotyping and discrimination. As Charles Kaye, once chief executive of the former special hospitals says:

> '... staff also share the fear and anxiety: their vulnerability, personal and professional is very real – and largely discounted. What they can do is not generally valued and what they are unable to achieve is written in headlines. Unfortunately, it is now impossible for the hospitals to operate out of sight, since they are established as a rich reservoir of material; they share the stigma that they attach indelibly to their patients' (Kaye,2002, pp2-3).

Hardcastle (2002) also describes staff in psychiatric units as 'victims in their own way'. Statements such as this are reminiscent of the views of Barthes, Foucault, MacIntrye on the construction of ideological concepts, used by the dominant to oppress the weak and vulnerable. They a draw a despondent picture of the value systems inherent in the treatment of and society's approach to mental disorder.

Although the issue of disempowerment as a consequence of suffering mental disorder is recognised by the majority of users interviewed, it is generally perceived as secondary to discrimination:

> 'Disempowering starts with the diagnosis. It's subjective and generally applied retrospectively. You don't go into a psychiatric ward and find hundreds of people clamouring to be empowered. The notion of empowerment in isolation is not something of huge relevance. The notion of discrimination is more interesting. Discrimination is rapidly apparent and tangible and long-lasting. It may lead to disempowerment, but as an individual, while you're there, it's meaningless' (PLD)

Indeed, disempowerment is not always totally rejected by users, 78% of whom consider that in a crisis such disempowerment, in the form of involuntary admission (sectioning) is sometimes necessary. However, none felt that it was

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admissible simply because the psychiatrist or social worker considered this to be the case.

"Free to kill – lunatics left to roam the streets butcher 90 people a year" (*News of the World*); "Mentally ill man detained for killing teenage sunbather" *(The Guardian, 11.12.01)* and "Beatles's attacker was kicked out of psychiatric unit" *(The Guardian, 24.10.01)* are just three examples of how mentally-disordered people are frequently represented in the popular press. It is, therefore, perhaps not surprising that several users comment that having been diagnosed as suffering a mental disorder is inseparable from being labelled "dangerous":

> You goes to the pub, or somewhere like that, they keeps away from you. They thinks you'll 'urt 'em' (UOD)

> 'They handled me with kid gloves, it was as if they were afraid of me' (The Observer Magazine, 21.10.01.,p57).

Such ignorance does not, fortunately extend to most

> 'Mental health practitioners (who) are far more aware of patients' relative inoffensiveness than the public at large, and of the fact that the number of homicides committed by the mentally disturbed would, contrary to popular opinion, appear to be decreasing' (Noguera, 2000, p163)

Not that the issue of dangerousness is irrelevant. Many practitioners describe the possibility of experiencing violence from a user and/or his/her family as a major fear. Some, unfortunately, also equate madness with moral degeneracy and consider their role to involve exercising power over the bad and mad:

> 'They (the carers) saw these people as actually evil. They thought they were doing these things to staff personally, to get at them, or hurt them'(Guardian Society, 11.04.01. p10)

For this reason, these particular nurses were 'swearing at patients, manhandling them, feeding them on the toilet and punishing them by locking them out in a veranda area without adequate clothing or blankets'. These were practices at the

former Garlands Hospital in Carlisle until November, 2000. However, it is important to note that such extreme situations are unusual. No respondent described similar incidents in recent times, although they were not uncommon in the past. There is, nonetheless, no room for complacency. More than one third of the practitioners included in the study claims to have observed 'unprofessional' conduct at first hand. This may take the form of a more subtle abuse of power:

> 'When I started to argue with the doctor, he got nasty. Said he's call the security guard if I didn't behave myself. I think I was behavin'. Not the way he wanted, perhaps, but behavin' ... I reckon they get scared ... I wouldn't hurt a fly...' (UOD)

> 'I can tell you from experience that patients who misbehave usually end up being punished by one means or another. When they are deemed to have learned their lesson, privileges are restored'. (UOA)

The problem of discriminatory practices and attitudes towards those suffering chronic mental disorder relates to the "self" – "other" dichotomy, referred to in discussing gender in Chapter Three. Users' own perceptions of themselves in terms of dangerousness are unlike those of large sectors of society informed by the sensationalist treatment accorded by some media to violent acts committed by mentally disordered people. It is possible to speculate that some such acts are the result of a self-fulfilling prophecy in which health care practitioners', family's and friends' expectations of and watchfulness for violence provoke a frustration which terminates in just that. Eighty percent of users report that their families' attitudes towards them have changed for the worse, post-diagnosis. Friends appear to be more tolerant, only 53% of these being reported as behaving differently. To return to MacIntyre (1999), it seems that, as a society, we clearly still think of the mentally disordered as "them" and other than "us".

Williams. S.J. (1987) points out that 'labelling' and 'symbolic assignment' of this kind can degrade its victim to the extent that 'the individual's stigma can come to dominate both ego and *alter's* perceptions' (p137). This view is verified by users' own descriptions of themselves as in some way deviant or sinful:

> 'I feel like I'm responsible for who I am ... you have to take responsibility... I don't blame myself for the illness, but I blame the choices that I make such as when I choose not to be productive ... is it really because of the illness or ... myself? Am I a lazy person to begin with or am I losing motivation because of the illness...? (UCO)

> 'Some faiths attribute mental illness to spiritual sickness' (NC, Ordained priest)

> '... it's a common belief in our society that good people don't have things happen to them' (UKL)

This illustrates Simon William's point that those who are stigmatised 'adhere to the same normative beliefs about identity' and have the 'same sense of being 'normal' human beings' (p140). Awareness of the shame of the 'stigma' of being labelled 'mad' causes them to become obsessed with the idea of 'acceptance' by 'sane' others. But what is stigmatisation, but the imposing of one ideology or dominant discourse as the 'norm' and all others as deviant, *ergo* threatening the fabric of society? Mental disorder is still considered in some sectors to be the product of a form of moral deviance and psychiatric hospitals little more than repositories for the "mad". In the same process of self-fulfilling prophecy described earlier, users treated by society as deviant and in need of "putting away" behind what are frequently locked doors, in a more or less agreeable "jail" come, in some cases, to accept the treatment they are given as their just "desserts" – and may be encouraged to do so.

The fact that carers described as treating users like children are considered "kind",
implies that these users have come to conform to this image of the person who
suffers a mental disorder as, at best, less than adult. Policy makers have
compounded this adverse discrimination by treating mental health as the
"Cinderella" of the NHS, and by implication mentally disordered people as
unworthy of the same standard of treatment and facilities as those who suffer
diabetes, for example[19].

The discussion on adverse discrimination, and some of the conclusions which
follow, centre on this notion of a diagnosis of madness resulting from deviating
from society's value 'status quo' and the concept of "normality" imposed by the
dominant socio-cultural ideology. It is apparent that there is not a single 'truth'
out there concerning the nature of 'normality', 'rationality' and indeed
flourishing. Their nature is a contested space in both psychiatry and society, in
which socio-cultural, medical and psychological discourses often collide. Just as
the mind is not a fixed entity, neither are mental health or illness. What 'normal'
society might see as pathological deviations in cognition and feeling are often
described by user respondents as a heightening of sensitivity to colours, sounds
and so on, a quasi spiritual experience, even perhaps a form of self-realisation,
which is lost as a result of 'cure'.

> 'Lithium is our sorceress's green liquid, the stinging nettle of our modern
> reality. My mother takes it each day and complains. Her hand tremors: she
> cannot fasten her ... skirts or stay up all night and never get tired'
> (J.Lyden, 1999)
>
> To be honest, everything's a lot better when you're high.' (UBR)

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[19] The implementation of NSF VII appears to be beginning to narrow the gap in certain areas, but
it is too recent for this to be evaluated accurately.

5.5.3. Gender and Class Differences

The "fact"[20] that more women than men suffer mental disorders was discussed in Chapters One and Three. Perhaps as a result of this, and because caring roles have traditionally been perceived as pertaining to the female domain, only recently have male and females been cared for in mixed wards by health care practitioners of both sexes. Whilst many women users and most practitioners have described allocating male and female users to the same ward as frequently distressing for the latter, analysis of the fieldwork reveals a highly positive attitude on the part of both users and carers to mixed sex staffing. Eighty-seven percent of users feel that there is no difference in the way male and female carers interact with them, and users and practitioners believe that in the ward setting some users find it easier to relate and talk to carers of the opposite sex.

Due to the word limit imposed upon a work of this nature, ascertaining the reason for this is beyond the remit of this dissertation, but the finding indicates that regardless of the speculations voiced in Chapter Three, no clear-cut picture of gender differences in values or attitudes towards caring is revealed, nor, *contra* radical feminist orthodoxy (and Dominelli and Gollins), do male carers demonstrate a significantly greater desire to exercise 'power over' politics in their practice than females.

No marked differences in terms of gender and caring emerge, at least at the level of quotidian care in the ward and community setting. Users and practitioners believe that a caring attitude is a question of character, not gender. This finding

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[20] This, as Chapter 3 indicated, is a hotly debated issue around social causation, social construction and biology, hence the inverted commas around the word "fact"

favours the combination of an ethic of care and virtue ethics insofar as if men are equally adept at and inclined to care as women, then their ethical practices can - and apparently do – reflect this.

Male users are slightly more inclined to complain about treatment than women. (A finding echoed in Pitarka-Carcani et al., 2000). None of the male user respondents was *entirely* satisfied with the treatment received, whereas two female respondents were. Women held a more favourable view of mental health care generally. This could result from the fact that, particularly in the case of older women, they consider it 'normal' to suffer and tend not to express resentment in interviews.

Rarely having enjoyed 'power' would arguably make the issue of disempowerment, real or perceived, less important to females. There is slight evidence of gendered hierarchal differences, insofar as male psychiatrists are characterised in two interviews as arrogant, uncaring and ill-mannered.

> '(in hospital) the male psychiatrist would ask how you felt and then interrupt, saying: "marks out of ten for how you're feeling today". I never did understand the question. I did find the attitude of the male psychiatrists, by and large, patronising. One person stood out, a female registrar. She was absolutely wonderful. She made you feel cared for, human'.(UGJ)

There are exceptions to this[21]:

> 'I came upon a male psychiatrist, but he was outside NHS practice. He sticks in my mind as very good to talk to. (UOJ)

A female consultant psychiatrist finds in favour of gender equality, but implies a public/private divide in terms of quality of treatment when she says of her male colleagues:

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[21] The admirable Pat Bracken, for example, is well-known for his pioneering work in Bradford on behalf of the user's rights, and for encouraging user-participation in therapy.

' I suspect they listen much more in private practice' (PGC)

Another hierarchy (and discrimination) related issue arises insofar as several users suggest that being middle-class, well-educated and white implied receiving better treatment, or being better able to "work the system" than other less privileged users:

'If you're middle-class, it's easier to get out of hospital' (UOA)

'If you're **white**, male, middle-class, and a graduate, it takes an awful lot of deviance to get yourself sectioned' (PLD).

Inequalities in the prevalence and the influence of both class (Mental Health Needs Assessment, 2001[22]) and race (Wilson 1997, Nazroo 1997, Sproston and Nazroo 2002) on diagnosis, length of stay in hospital have been well-documented.

5.5.4. Racial Discrimination

The statement above recognises one of the most common ethical problems in mental health practice in the U.K., that of racial discrimination. Associations between ethnicity and health status have been recorded since the beginning of qualitative data collection (Davey, Smith et al. 2000, p375) and mental health has not been immune to this since male adults from certain ethnic minorities are grossly over-represented in psychiatric practice. If it is very difficult for a white, middle-class male to find himself "sectioned", this is remarkably easy for a black man[23]. Indeed, as both users and practitioners pointed out, it is easier for a black person to get into hospital than out of it again. The principle reason (Wilson, 1997, Nazroo,1997, Sproston and Nazroo, 2002) for this discrimination is a lack

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[22] www.nelpct.nhs.uk/whatsnew/docs/publications/PublicHealth/AnRep2001/chapter3.pdf, accessed 24.11.03. at 20.00h.

[23] Nazroo (1997) found on the basis of 5,196 interviews with Caribbean or Asian people and 2,867 white people, that rates of psychosis for the former and the latter are approx. one in a hundred but that the former are more likely to be admitted to hospital. Rates of psychosis for women is, amongst Caribbean women, nearly double that of white women. Those people least likely to display symptoms of mental illness were Asians.

of cultural education on the part of the practitioners. Wilson, M. suggests a need for public education in racist attitudes, stereotyping and personal prejudice, and also draws attention to the malign influence of many media stories. Over 25% of users in her study believed that mental health professionals had treated them differently   because they were black: "Black people are treated as if they are not intelligent", "Being mixed race and in hospital meant that I was ignored, so I used to do mad things to gain attention', 'They ignore us as hopeless cases, as if we are more crazy', (Wilson, p3). Fifty-two percent felt that their own culture had not been considered at all. Unfortunately, none of the fifteen users interviewed was black, although two were from other non Anglo-Saxon ethnic groups, as was one of the practitioners. However, both user and practitioner respondents considered racism inherent to mental health practice, both in hospital and community. If madness is stigmatising, the combination of 'blackness' and madness is doubly so.

This type of discrimination supports the views of Foucault and MacIntyre on how local cultural beliefs become considered universal, to the detriment of ethical practice. Wilson's respondents claimed that care staff ignored the users' own cultures and were apparently unaware that 'what may be considered mad in one culture may not in another' (ibid). A 'moral blame' element of the type described earlier also results from such attitudes on the part of carers:

> '... differences were seen as negative; felt I had to disown my own culture and "act white" and felt guilty for making professionals feel uncomfortable or awkward for not understanding my culture' (ibid).

Not that racism is something to which only users are subject. Practitioners, too, can be subjected to this, both in and outside of the clinical setting (West, 2000)

and racial discrimination in the National Health Service has recently been the subject of extensive media coverage. However, none of the practitioners spoke this during the interviews.

Western psychiatry also frequentlyy excludes the spiritual dimension of care, overlooking the significance of religion in many users' lives. Where users do not have sufficient command of English to explain their religious beliefs and customs to staff, they frequently fear being 'labelled psychotic, compulsorily detained and forced to take medicine' (Guardian Society, 21.2.01, p120). One of the users interviewed commented that her own desire to fast during Ramadan had been construed as non-cooperation, rather than respected as religious practice.

5.5.5. Discriminatory Practices in (Un)Employment

In spite of the class, gender and racial issues previously discussed, job prospects were equally poor for everyone:

> 'Shortly after that, my employer found out that I had schizophrenia and I
lost my job. (UOD)

> 'Everybody knows that owning up to a mental health issue is like the kiss of death to your job prospects... my boss kept telling me to be grateful that they were so kind and understanding as to have me back.'
> (The Observer Magazine, 21.10.01. p.57)

Related to the notion of mental disorder as a moral defect is another problem, which hangs over almost every user unable to obtain employment - the potential diagnosis of malingering. The user finds him/herself in the obligation of having to prove that the condition is not contrived and express a wish to get well. One man whose companion was told by a male psychiatrist that he was a "malingerer" illustrates the point:

> 'I would have complained strongly, yeah, because it's the one thing I am not, a malingerer' (UGD)

Not long after the interview, this particular "malingerer" was admitted to hospital, having attempted suicide. Another user explained that he had only one set of somewhat dishevelled clothes, having no money to buy more, and could see little point in going to a job interview in such shabby attire. The homeless mentally-disordered who are unable to offer a permanent address find themselves in the same plight.

5.6. Emotional Labour

Complaints about practitioners were almost invariably tempered by positive comments implying that, overall, users consider carers' attitudes to be improving. This may relate to the fact that there exists a growing awareness of caring for the mentally disordered as emotional labour. Mental health practitioners, of both sexes, no longer expected to be completely detached (or devoted) at all times, are allowed to acknowledge feelings, both positive and negative, towards users, which do not necessarily conform to conventional and documented expectations of carers' feelings. Indeed, BAITS (behavioural analysis and intervention training and support), a new programme, has recently been introduced. In what appears to be a combination of emotional labour and training in virtue and care, this programme aims to improve health care practitioners' understanding of users whose disorders involve challenging behaviour, disruption, violence and extreme withdrawal. Instead of regarding these as in some way "evil" and reacting in consequence, practitioners are encouraged to discuss and analyse their own attitudes and think of means of improving these users' lives in order to diminish such behaviour by caring, rather than controlling. Whilst this does not imply that emotional labour is a virtue, it is arguably a good example of critical reflexivity and the consequent exercise of the virtue of *phronesis*, applied to caring in

practice – a "training" in becoming a virtuous agent, for as was said in Chapter 2.5. according to the Nichomachean Ethics, 'our task is to become good men'.

This training does not demand that reasoning or rationality is employed to "control" the emotions, but rather recognises that 'some emotional states are, to all intents and purposes, rational' (Crossley, 2002, p49) and that rationality and emotion can and do inform one another. Emotions are not perhaps something we are able to simply 'step out of' (Crossley, 2000), but there is no reason to suppose that practitioners cannot learn to recognise that even in mental health care settings, there is a place for the notion of 'rational emotion' (Op.cit.p142). This is also recognised by Goffman (1967) when he speaks of the 'traffic rules of interaction' which ensure that actors constantly monitor their own acts and those of others in order to sustain the 'predictability' of quotidian social interactions.

A form of emotional labour, based on an understanding of the notion of 'rational emotion' is important in the training of students and staff. Both Smith P. (1992) and Robertson (1998) claim that although students admire technical competency and medical knowledge, they also see their superiors as key in setting the emotional climate in the clinical setting. Questionnaire data cited by Smith shows that 'hierarchical and unfriendly staff relations were ... a major source of anxiety and stress for students because of the feelings they generated' (p69). An emotionally caring climate makes students feel cared for and therefore better able to care for others (Op.cit.p76).

Chapter Two described Nodding's 'ethic of care', echoing Gilligan (1982), as conceding a central role in ethical decision-making to feelings, situational conditions and a sense of personal ideal. On the strength of the research findings, whether these really are the nuclei around which ethical decisions are made appears debatable. In this age of evidence-based medicine, equal importance is given by many users, as well as practitioners, to technical expertise. Whilst the research findings reveal a predominance of interpersonal complaints, a desire for improvement in technical knowledge is also evident. As far as an awareness of and respect for the user's own desires and feelings:

> There's a move away from detachment. A relationship staff-patient is no longer considered a bad thing ... The human rights dimension is more widely discussed. Training now involves hearing the user...' (PLD)
> 'You're not born with a hostility towards mental health professionals, sectioning (the first time you don't even know what it is), being woken at six or seven, being told to make your bed, obliged to eat awful food, the lack of explanations, all generate this' (ULD)

Users, increasingly well-versed in the latest developments in diagnosis and treatment, not merely psychopharmacological but also in areas as sophisticated as eye-movement desensitisation and reprocessing (ESRD), expect greater technical expertise in their carers and sometimes value the former more than the latter. This is particularly relevant when the respondent in question adheres to the "medical model" of mental disorder. Users expect practitioners to be aware not only of the latest pharmacological treatments such as SSRI, but equally to recognise and discuss the well-publicised, often severe side-effects and long term consequences of these[24], respecting the user's right to refuse such medications. Some users wish

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[24] See www.socilaudit.org.uk for testimonies from about 500 people who suffered distressing side-effects and were usually not believed by doctors because of the absence of any warning from the manufacturer.

to partake in neither alternative, talk, not pharmaceutical therapies: 'They leave me alone and that's what I want' (UOS). In this case, practitioners apparently agreed to respect the user's autonomy, as long as he did not 'cause any problems'. An interesting question here is whether the practitioners "co-operation" was normal practice? To what extent does the user's attitude condition that of the carer? If the answer to this is, as the fieldwork appears to show, "in almost every case" this indicates that practitioners, particularly nurses, may be exercising a sensitivity which 'just is the virtue' (McDowell,1979), not simply caring.

It also raises the question of just how beneficial practising an ethic of care which allowed emotion a primary role in action and decision-making in mental health would be in practical therapeutic terms. The 'new age' nurse of the type described by Webb (1966), whilst undoubtedly caring and engrossed with the user, would not necessarily meet all his or her real needs, if these user respondents are typical of users generally. As Fulford (1996) argues, what is required for genuinely patient-centred mental health care is a model which, informed by the lived experience of the disorder and scientific knowledge of this, incorporates not only facts, but values (and emotions).

User awareness of technical and psycho-pharmacological advances, in mental health practice is constantly increasing:

> '...part of the problem is that you are so much better educated than they are. You know more about mental illness, too.' (UOA).

Many users, and some practitioners, claim that the side-effects of medication are worse than the disorder itself. They claim to have been helped by, or to employ, not only "talking therapies" but also alternative therapies and treatments such as

massage, aromatherapy, reflexology and so on. A new ethos in mental health practice which rejects the medical model of mental disorder, such as that of Pat Bracken's *Bradford Home Treatment Service,* which describes itself as "questioning traditional psychiatric approaches", rejects the medical model of treatment as excessively simplistic and adopts a holistic approach to care[25]. This has resulted in great reductions in the quantities of medication prescribed and in incidents of suicide, self-harm and violence[26].

5.7. Malpractice

Only 60% of users consider current codes of practice to be respected. Although today the roles of doctors, nurses, social workers and other practitioners are more closely interwoven, this does not prevent potential 'whistleblowers' from believing that, should they criticise their fellow practitioners for not adhering to such codes, they 'will be treated unfairly, particularly when they challenge the professional practice of someone who holds the position of authority' (Crossley and Abedin, 2000). A complaint against a fellow practitioner, at least in the case of one nurse reporting another, must take the form of a 'statutory declaration'. This itself might seem sufficient to deter many from drawing attention to malpractice. However, many nurses do overcome their reticence for 'The nursing profession has successfully maintained self regulation. The protection of the public is central to the process, as is evident when nurses who are subjected to disciplinary hearings by the UKCC are removed from the register, but doctors

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[25] Although holistic approaches have themselves been open to much criticism, particularly as a new means of surveillance and control (Armstrong, 1986)

[26] Bradford HTS reports using five times less medication, only treats users in their own homes, on a daily visit basis, and practices a user-professional partnership. Anem Cara, a highly successful project in Birmingham also adopts a holistic approach, reports that no violent incidents have taken place there

disciplined in similar incidents are reprimanded and left to practice' (Crossley and Abedin, 2000).

In spite of those cases which cause brief sensations in the media, whilst many practitioners claim to have observed malpractice at firsthand, the analysis of users' accounts reveals relatively little evidence of this and a practitioner says:

> 'I think they just try to defuse things as quickly as they can. Each situation is different. You can't say "they always do it like this. They think on their feet, really and, of course, (laughs) dealing with a violent fifteen stone man is not the same as dealing with a six stone girl!' (PNA)

Practitioners are more frank about malpractice and ignoring ethical codes in the anonymous questionnaires than in the interviews. Although they claim to personally obey the codes, their descriptions reveal that, in fact, they resolve most moral dilemmas by means of an immediate evaluation of the situation and the subsequent application of common-sense, informed by experience (or, occasionally, survival instinct) than by consideration of the codes of good practice.

They also disagree amongst themselves upon the best line of action in some cases. The "Prozac sandwich" in which medication refused by the user is concealed, is a good example of such disagreement as to what constitutes good practice. Older nurses considered such measures "contingent", younger nurses "deceit". Other practitioners, with the exception of the female psychiatrist and the female social worker, considered such practices 'common' and, whilst not desirable, sometimes necessary. The Nursing and Midwives' Council (N&MC) is currently preparing guidelines on 'covert medication' which will apparently condone it in certain circumstances.

Opinions on matters such as sectioning, informed consent and E.C.T. (electro-convulsive therapy), although briefly mentioned here, would require a separate study given the diversity of views on this subject. But, as far as informed consent is concerned, several examples of more or less subtle forms of malpractice and of discrimination amongst practitioners of all groups can be observed.

A recent study claims that: 'By far the most common complaint that patients make about physicians is that they were 'unspeakably rude' in the course of providing treatment' (Spurgeon, 2001; 323:771). This perceived 'rudeness' is occasionally reported by both practitioners and users. The complaints concern all disciplines of healthcare practice to a greater or lesser degree. Although practitioners were variously described as 'too busy to speak', and of 'rudeness', 'dishonesty' and 'inefficiency', tending to 'treat people like little kids', 'always shut in the nursing station, instead of mixing with the patients' and so on, many also merit the description of 'caring' and 'kind'. However, they are not, as a group, seen as identifying with the user as an ethic of care would demand insofar as their:

> '...ultimate responsibility is to management so the relationship is necessarily limited – the patient can't come first. The power balance and legislation is all wrong' (ULD).

Practitioners themselves, whilst expressing frustration at not being able to care as they would wish, see their principle problems as a lack of time due to chronic staff shortages and an excess of bureaucracy. This links to Hochschild's (1979, 1983) notion of 'equal emotional exchange', insofar as there are occasions upon which nurses and other practitioners are not free to negotiate their own rate of 'exchange'. Their position in the hierarchy of the division of labour may influence how nurses practice what James (1993) terms 'emotion management' given that

their work schedules may allow little or no time in which to negotiate a caring relationship with users (James, 1992). In this case, emotion management is no longer a 'gift' but rather part of the process of work and carried out under organisational and professional "feeling rules".

Nursing Practitioners in particular fear physical aggression, their own reactions to this and the professional consequences of over-reacting. Both their personal and professional vulnerability are evident and yet largely discounted. As one nurse says: 'Current codes of practice say far too little about protecting the practitioner' (PNA). The quality of life in clinical settings and the nature of practitioners' interventions in situations of violence are as important in preventing this as specific intervention strategies[27]. The cost of practising effective emotional labour when confronted by a potentially violent patient can be high and may result in spurious "illness" on the part of a practitioner who has not been trained in dealing with aggression and feels that having exhausted his/her resources for caring, s/he is no longer able to cope.

In the Maudsley study (Pitarka-Carcani, 2001) evidence was sought for the content of the users' complaints and the health care practitioners' response that psychotic symptoms were the basis for these. In only four cases out of fifty-six was there evidence that the complaints related to psychotic symptoms. The remainder were 'considered to be unrelated to delusional beliefs' (Op.cit.p372). This was also evident in the fieldwork interviews. The fact that in the Maudsley study psychotic symptoms were 'blamed' for complaints, even hypothetically,

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[27] See 'The recognition, prevention and therapeutic management of violence in mental health care, a summary' UKCC, Spring 2002.

implies arrogance and negative discrimination on the part of practitioners. The awareness of suffering discrimination, in many forms, which emerges from the research findings as the major ethical issue is not, therefore, necessarily a manifestation of paranoia, although it is easy for this diagnosis to be made in the psychiatric context[28].

Not that users fail to understand how difficult it is to be a mental health practitioner:

> 'I'm not sure it's a good role. You can't divorce the individual from the institution and the system. The best possible nurse can't make a difference if it comes to choosing between the job and the patient's interests. The key relationship is that between practitioner and employer' (PLD)

The necessary question here is why the practitioner should have to choose between *'the patient's interests'* and *'the job'*, when the latter, in theory, implies defending the former – and both should lead to mutual flourishing.

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[28] One of the users referred to the Bradford Home Care Service was a female diagnosed as suffering from schizophrenia and delusions of being attacked. The team's practitioners, upon visiting her home discovered that her husband was regularly beating her up.

Chapter Six: Philosophical Analysis of the Findings

6.1. Introduction

Following sociological analysis of the fieldwork, this chapter evaluates the current situation with regard to ethics in mental health practice. Chapter Five confirmed the claims made in Chapter One, that hospital care is generally considered far more negatively than care in the community. The relationship between user and practitioner in the context of the former is far more complex and practitioners' attitudes toward users can be paternalistic, even moralistic. The latter is revealed by a greater tendency for hospital practitioners, particularly nurses, to think of users as interacting with them in a negative fashion. This became manifest in the employment of vocabulary with negative value connotations. Practitioners' use terms such as "misbehave", "difficult", "naughty", "poor old Fred", "Trouble" and so on, whilst in some cases (presumably) intended as a form of affection, clearly implies that some of them continue to see mental disorder as a moral, as well psychological condition. Community practitioners, arguably less institutionalised, did not employ this vocabulary and it can be speculated that the "them" (users) and "us" (practitioners) attitude predominant in hospitals is less prevalent in community contexts. In hospitals it fomented, in staff and users of both sexes, interpersonal relationships and interactions reminiscent of those described by Goffman (1964) in *Asylums*, in which some users were "favoured" and others not

In order to evaluate these situations within the ethical parameters of the research, it is necessary to answer the questions originally posed in Chapter 2.4. Prior to this, the interview transcripts, questionnaires, media and WWW articles were

coded by type of ethical framework which they illustrated as shown in Tables 6.1

and 6.2. which follow:

Fig 6.1. Sample from the coding frame for ethical analysis

CODE	ETHICAL APPROACH	EXAMPLE
DEON	DEONTOLOGICAL	'Users who don't take or accept the treatment or the medicine they've been prescribed should be asked to leave, otherwise they cause problems' You either do as I say, or I'll section you
CONS	CONSEQUENTIALIST	'Public safety is more important than an individual user's rights' 'If a user is causing trouble on the ward, the best thing is to sedate them so that they don't upset the other patients'
CAS	CASUISTRY	'As long as we all agree that the patient needs to be admitted, the different agendas behind this reasoning don't really matter'.
C	CARE	'Covert medication is sometimes the kindest way to treat a distraught patient who won't take a tranquilliser. I know that's what I'd want in their situation. 'First the patient, second the patient third the patient, that's what caring really means'. 'I'd like to think they liked me, not just looked after me.'
VIR	VIRTUE	'The aim of community care should be to help people towards leading full and independent lives, not to contain and control them.' 'Before admitting someone to hospital, fairness demands that you consider every other possibility, as well as the well-being of everyone concerned.' 'I want to be treated as an equal and have my own views listened to and respected by the ward staff, eve if they disagree.'
DIS	DISCRIMINATION	Adverse discrimination is described
COM	COMMUNICATION	Poor communication is described

Fig 6.2 Ethical Frameworks in Practice, the Fieldwork Findings

Respondent	DEON	CONS	CAS	C	VIR	NONE	DIS	COM
UOK (F)	X	X				X	X	X
UOA (M)	X	X					X	X
ULD (M)	X	X	X	X	X		X	X
UOB (M)	X	X		X	X		X	X
UOBie (F)	X			X		X	X	X
UBR (F)				X	X	X	X	X
UOR (M)	X	X			X		X	X
UGJ (F)	X			X	X			X
UOD (M)	X		X		X		X	X
UGD (M)	X	X		X	X		X	X
UKL (F)						X	X	X
UBS (M)			X	X	X		X	X
UOJ (M)				X	X		X	
UCO (F)						X	X	X
UNS (F)				X	X		X	X
PLS	X	X					X	X
PBT (M)				X	X		X	X
PLC (F)				X	X		X	X
PLD (M)	X	X		X			X	X
PNA (F)	X	X	X				X	X
PBA (M)			X	X	X		X	X
PLN (F)		X		X	X		X	X
POJ (M)			X	X	X		X	X
POK (M)	X	X	X		X		X	X
PLS (M)	X	X	X	X	X		X	X
PLP (M)			X	X	X		X	X
PBH (F)	X		X	X	X		X	X
PGJ (F)				X	X			X
POBJ (F)			X				X	X
PLPH (M)	X	X			X		X	X

Key: Dis: Discrimination. Comm: Poor Communication. (M) Male (F) Female
Respondent: 1st letter = User (U) of Practitioner (P)
        2nd letter = Place of origin (O = Oxford, L = London, B = Birmingham, G =
        Gloucester, K = Kendal, N = Northampton).
        3rd letter = Initial of first name, e.g. C = Carole
        PLC = Practitioner, working in London, named Carole.

Coding of interviews, in terms of the type of ethic manifested in practice, and in practitioners' and users' opinions on ethics and good practice ensued. Once completed, the following questions could be reconsidered:

- Are there any significant differences in the approaches to ethics of male and female mental practitioners?

- What kind of framework prevails in dealing with ethical dilemmas – deontological, consequentialist, casuistry, care or virtue ethic? Or is none clearly discernible?

- What are the behavioural and attitudinal characteristics of carers in resolving ethical dilemmas?

- Do current codes of professional ethics or good practice influence carers' approach to and resolution of ethical issues?

- Could they be said to "lack the virtues" or exercise them?

- On the strength of the findings, which type of ethic would be best suited to the exigencies of mental health practice?

- Are virtue and care ethics less, more or equally relevant to mental health practice and the flourishing (*eudemonia*) of mental health practitioners and users?

- What are the character traits (virtues) considered necessary to carers?

6.2 Gender Differences in Ethical Attitudes to Practice

'The question of which attitudes should be encouraged is itself an ethical issue' (Dickenson and Fulford, 2000, p22). Practitioners: 'should be non-judgemental and patient-centred in their work', such a view representing 'a liberal ethic which requires respect for other people's values' (ibid). Can and do both males and females practice this? Chapter 1.4.2. pointed out that male and female roles in mental health practice are reputed to reflect different values and ethical positions, deontological, principle-based or consequentialist in the former, and an ethic of care in the latter. The fieldwork reveals that, to judge by those actions observed and described by interview respondents, this is not the case, although there may be differences in the reasoning processes involved.

The majority of male and female practitioners consider themselves, and are described as, concerned and caring for and about the user. Some were familiar

with the ethic of care and considered it particularly relevant to practice. In addition, practitioners of both sexes consider that lack of resources and staffing, and excessive bureaucracy, handicap good communication and good practice as they understand it. They also unanimously endorse the finding that discrimination is the major problem facing users and many practitioners in mental health today.

6.2.1. Malpractice and Gender

Complaints referring to malpractice are made equally against practitioners of both sexes, the difference being that, conforming to gender stereotypical concepts, users express greater surprise when describing lack of caring in a female practitioner: "She was a right bitch, you'd never have believed it!" (UOK).

Although, as explained in Chapter 3.1., there are proportionally more disciplinary hearings against male than female practitioners, this disparity in conduct was not reflected in the fieldwork owing, perhaps, to the slight predominance of males amongst the sample, and the fact that only two serious offences were described, one committed by a male, the other by a female.

Staff of both sexes were reported to have committed acts of minor malpractice, recounted by the users as rueful anecdotes, rather than complaints. One male user gave an account of male night staff playing cards for money with sedated users who could not sleep, whilst female staffs' "infringements" involved such acts as getting female users to do the formers' personal laundry, something with which bored, inactive users were reasonably happy to comply. Only the female manageress of a day centre was accused of a major criminal act by one male user

and was, after not a little prevarication, duly prosecuted. Other examples of malpractice described a lack of emotional control in some carers of both sexes, manifested by shouting, never apologising, impolite terms of address and "team" efforts to "punish" by means of isolation, increased medication and deprivation. At times, caring was remarkable for its absence in respondents' accounts of practice, as was the 'goodness' inherent to the term 'good practice'.

An example of this is the disturbing – and to the best of my knowledge previously unreported[1] - finding, that of the coercive behaviour of some "dominant" users, who knew how to 'work the system' to their own advantage, towards cowed (or indifferent) staff and other passive, or collaborating, users. This phenomenon, described further in Chapter Eight, reveals that, in some instances, ill-equipped and understaffed mental health workers are apparently, to use the colloquial expression, as much "sinned against", as "sinning", powerless as empowered – regardless of gender.

Another gender-related form of malpractice is the sexual abuse of male and female users in the hospital settings, something well-documented throughout the world, although male upon female rape is statistically more frequent. The President of the Citizen's Commission on Human Rights claims that she has *'personally documented and exposed thousand of cases of such abuse'* (Eastgate, J., 2002, p2). A recent review by the Scottish Executive of the Mental Health (Scotland) Act of 1984 reads:

   'Protection from sexual exploitation and abuse

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[1] Unreported in the context of mental hospitals. It is apparently commonly found in prisons.

> 125. The current provisions in the 1984 Act concerning the sexual exploitation of those who are vulnerable by reason of mental disorder are not satisfactory ... They should be replaced by two new offences: sexual abuse of a mentally disordered adult, and sexual abuse by staff and formal carers.'

This indicates that even in this age of improved "whistle blowing" (see Chapter 5.7), this problem is sufficiently grave for legislation (as well as ethical guidance) to be needed. One female user respondent spoke of having, many years earlier, been sexually abused by a male carer, subsequently dismissed. Whilst no female carers were described as participating in acts of this nature, a young male user respondent complained of continual harassment by a female user during his own stay on a mixed ward. Upon noting his discomfort, the nurses merely asked if he wished them to do anything, rather than actively intervening. This might imply a failure in their duty of care, for his negative, together with their non-intervention, could have exposed the woman in question to sexual exploitation, in addition to prolonging the male user's discomfort. Whilst it could be argued that user autonomy was respected, in both cases, the practitioners' non-solution is redolent of indifference, rather than care, insofar as it implies that sexual harassment, something conventionally considered intolerable, is treated as relatively 'normal' in the 'abnormal' setting of the mental hospital ward. This attitude is in itself discriminatory and contrary to the *N&MC Code of Professional Conduct (June 2002)* which states that nurses are:

> '...personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, sexuality... (2.2.pp3-4)

If males and females do not function differently when working as caregivers, what does emerge from the fieldwork findings is that amongst practitioners of both sexes there are examples of virtuous and non-virtuous agents who care for and

about, or fail to do either. The relevant factor in their attitudes and acts is that of the agent's character and is not gender-related. To claim, therefore, as Noddings (1984) does, that females are 'essentially' carers, whilst men are not is, at best, over-simplistic. Neither does there appear to be any real difference in attitudes to power. Although this is something which traditionally men seek to exercise, most users perceived little difference in treatment received from male and female healthcare workers of all disciplines. However, women are possibly more subtle in their exercise of power, in terms, for example, of being more prepared to use covert means of medicating the user than engage in direct confrontation with him/her.

Although Noddings (1984) and Gilligan (1982) consider the search for universal principles to be a male preoccupation, the research findings do not support this view. Male and female practitioners gave reasons for their acts in some ethical dilemmas, whilst in others – the majority – they pointed 'to feelings, situational conditions and their sense of personal ideal'. Sometimes they act on principles, at others on intuition, but rarely it would seem, with professional codes of good practice at the forefront of their decision-making and acts.

Communication skills, as the previous chapter indicated, are central to good practice. Ease of communication and trust have been shown to depend more upon the practitioner's character, amongst other things, than his/her gender. Therefore, whilst Gilligan may be right that women speak "in a different voice", this neither renders all men incapable of listening to and understanding women's narratives, nor vice versa. There can, therefore, be no legitimation of gender stereotyping in caring from the point of view of communication for men, on the whole, appear

capable of practising caring and emotional labour in this with no less skill than women.

It appears that Noddings' views were not informed by a previous empirical study but by social stereotypes when she says:

> 'An ethic built on caring is characteristically and essentially feminine – which is not to say that it cannot be shared by men, any more than traditional moral systems cannot be embraced by women ... But an ethic of care arises out of our experience as women' (1984,p8).

There may be differences in the way in which men and women communicate and reason in ethical dilemmas, but caring *per se* is, the research findings show, not significantly influenced by gender. 75% (6) of the male practitioner interview respondents appear to be "natural" (innate) carers, whilst 28.5% (2) of their female counterparts are evidently not: *'It's just a job like any other'* (POBJ). Over 70% of *all* practitioner respondents (in questionnaires and interviews) see caring, whether natural, or the product of emotional labour, as an important component of good practice.

Even if this were not so, after analysing the fieldwork findings, the definition of "caring" itself must be questioned. These show that Noddings' definition is excessively narrow in that it embraces only traditional "feminine" aspects of caring. In the right context simply changing a light bulb (traditionally a male task) can be construed as equally as caring as, for example, feeding. Unqualified support workers of both sexes now play crucial roles in assisting people suffering mental disorder in the process of their re-incorporation into community life. What

has been described as the 'ordinary humanity'[2] of these volunteers makes them aware of and prepared to help with simple daily tasks often overlooked by professional community practitioners more concerned with controlling medication, or unable to perform such acts due to health and safety regulations. Users greatly value the 'whole person, whole life' approach adopted by support workers who can be flexible in their means of promoting flourishing. In many respects, by caring both for and about these users in this way, these volunteers do more for the formers' flourishing simply by treating them as equals, than professional practitioners with their medical knowledge and psychological "expertise".

6.3. Ethical frameworks and the attitudinal and behavioural characteristics of practitioners in mental health settings

From Fig. 6.2. and what has so far been said, it is evident that there are instances in mental health practice in which *all* the ethical frameworks described in Chapters Two and Chapter Four are employed. In order to create a clearer picture of the situation as revealed by the fieldwork, examples of each will now be discussed, compared and contrasted.

The *prima facie* principles behind ethical reasoning are autonomy, beneficence, non-maleficence and justice. In a principles-based ethic, these are weighed against one another in moral decision-making, although this balancing is relative, depending upon the importance which the decision-maker gives to each. Whilst such an approach is an excellent means of evaluating the *pros* and *cons* of each case, it may be considered excessively rigid to be of use alone in resolving

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[2] Society Guardian 17.04.02 – Society Guardian.co.uk/story/0,7843,685237,00http

"irrational" dilemmas inherent to the daily reality of mental health practice[3].

Under deontological codes (and under the law), practitioners are considered to

have duties, such as a *responsibility* to "section" a potentially suicidal psychotic

user in terms of the user's *right* to protection:

> 'No-one can give consent on behalf of an incompetent patient. However,
> you may still treat such a patient if the treatment would be in their best
> interests. (These) go wider than best medical interests, to include such
> factors as the wishes and beliefs of the patient when competent... their
> general well-being and their spiritual and religious welfare...' (12 key
> points on consent: the law in England – Department of Health, 23618 1,p
> 250k, March 2001).

Such is the ethical framework behind, for example, the stringent rules requiring

that some (questionably) mentally disordered people be incarcerated in secure

hospitals for indefinite periods. These are outlined in a draft mental health bill

published by the Department of Health in June, 2002[4]. Under them, users living in

the community who refuse to take prescribed medication could be forcibly

detained and taken to hospital for prolonged treatment.

To take 'sectioning' or involuntary admission for hospital treatment, as an

example, both deontological and consequentialist approaches are appropriate to

this. The Mental Health Act (1983) requires the person to have a mental disorder

'of a nature or degree' that makes hospital treatment appropriate in terms of the

user's health and safety or for the safety and protection of others. It could be

argued that the notion of dangerousness pervades this framework and the rights of

the user questionably respected in a situation in which detention (effectively what

it is) does not follow a judicial process, but an application by a trained social

worker, or the user's relatives, supported by a medical practitioner.

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[3] For example, is a religious experience involving a message from God "real" or "delusional"?
[4] And subsequently temporarily "shelved" by Parliament

Beauchamp and Childress (1994) claim that the principles of autonomy (the user's wishes) and beneficence (his/her best interest, all things considered) are those to weigh against one another in this situation. Whilst the lack of rationality which is a necessary condition to some psychiatric diagnoses impairs the ability to make autonomous choices, these authors consider that beneficence can and should take precedence over autonomy and that sectioning 'in the patient's best interest' may be justified.

The problem here is that declaring someone "irrational" is a subjective value judgement and sometimes very hard to justify. Pat Bracken describes a case which proves this point:

> 'One woman was referred with a diagnosis of schizophrenia and delusions of being attacked. The team's workers discovered that her husband was regularly beating her up'. (Guardian Society, 26.01.00).

Most qualified practitioners (93% overall) consider themselves sometimes better able to judge what is in the user's (and possibly public's) "best interest" than the user him/herself and that involuntary admission is permissible "to avoid greater harm". However, whilst 78% of users agree that sectioning sometimes is necessary, the phrase 'best interest' frequently has little to do with their needs or values, much less rights. The fact that although 93% of their colleagues believe that involuntary admission to hospital is permissible "to avoid greater harm", 7% of practitioners consider it to be never "morally permissible" may reflect this view.

The latter claim that involuntary admission is more closely related to protecting the interests of the family or society than those of the user. When sectioning does

occur against the user's wishes but is, in view of his/her condition, considered in

the best interest of all concerned, what could be said to prevail are: the principle

of beneficence; the consequentialist greatest happiness of the greatest number;

caring and, arguably, the virtues of *phronesis* and charity. Clearly, the boundaries

between one type of ethic and another can, as philosophers such as Hursthouse

(1999) and Foot (2001) insist, be remarkably tenuous in practice.

To refer back to the quote which opened Chapter 6.2., although practitioners may

take what they consider the right action, regardless of the ethical framework, in

practice such choice must be tempered by the knowledge that their acts are

patient-centred, in the truest sense of this word, rather than overbearing or

designed to avoid possible litigation or disciplinary action (Noguera, 2000). This

is far from easy. The examples which follow illustrate the nature of the dilemma

which confronts practitioners when sectioning:

> 'Nearly two years ago, after a suicide attempt, I was sectioned and locked
> in a secure unit, the justification for this being that I was not taking my
> medication. This was a conscious decision on my part. I had already taken
> a number of different medication, which I believe contributed to my
> suicide attempt. I considered this to be my right. The psychiatrists
> demurred and locked me up. This is a terrifying and traumatic experience
> in which without ever seeing a court of law, you are taken from your
> home ...locked in what is, to all intents and purposes, a prison. Your
> distress at this experience is then cited as... a further justification for
> keeping you locked up. I was lucky, being white, middle-class and with a
> lot of supportive friends. With their help. I persuaded a tribunal to release
> me and have since lived ...without recourse to suicide. But if I needed the
> help of the psychiatric services, I could not possibly go near them for fear
> of ... sectioning again. This is a fear that the Government's proposals will
> make common.'(Anonymous, The Guardian letters page, 27.06.02).

> '...we believe (Christopher) Clunis did have a right to be detained and
> treated, having had contact with 43 different psychiatrists in a five-year
> period and having ultimately lost his liberty for a very long time ... we
> also believe that compelling him to take his medication might have ...
> allowed him to continue to live the dignified life he was clearly capable
> of... It seems we should allow people to deteriorate in the community to

the point where they become psychotic before intervention, because to intervene would be an infringement of their rights...' (Michael Howlett, Director, The Zito Trust, The Guardian letters page, 28.06.02.)

and finally, an interview respondent:

'I think you'll agree with me that sectioning should have, and has to some extent, all sorts of safeguards against abuse, but also that there are times when it is necessary to deprive a mentally disturbed person of his liberty. Is confinement enough? If so, doctors and nurses should make that confinement as pleasant as possible'. (UOA).

The ethical justification for involuntary treatment is inevitably based on facts, but not, as the points of view above illustrate, facts *per se* but on their interpretation by the different agents involved. Interpretation is inseparable from the personal values of the practitioner and for this reason, these are discussed in Chapter Seven.

Although no strict adherence to particular ethics or codes of good practice emerged from analysis of respondents' interviews, the behaviour which they describe did meet many of the ethical principles described in Chapter One. Most acts described by practitioners met the principle of rationality, insofar as they were supported by generally acceptable reasons. Not consciously based on ethical codes, or the notion of good practice *per se*, but on the subjective concept of the patient's best interest, or flourishing. *'We do not deliberate about the ends, but about things that are conducive to ends' (NEIII, 1112b11-12)*. This can be understood as what the healthcare worker concerned considered this to be in keeping with the 'duty of care' cited in codes of professional conduct, rather than a commonly agreed ideal, and weighed the interests not only of the user, but of his

or her family, and society in general[5]. The individual was almost always considered in the context of the community, an authentically Aristotelian notion[6] and practitioners frequently spoke of *'getting (the user) back to the family'* as a desirable outcome. However, the earlier example of the "Prozac Sandwich" shows that meeting the requirements of the principle of rationality does not necessarily imply agreeing with fellow practitioners on the means to a mutually desirable end. As Aristotle pointed out, two virtuous agents can disagree as to the resolution to a dilemma, whilst being perfectly justified in continuing to consider one another virtuous.

Another principle, that of "least harm" or nonmaleficence (sometimes linked to that of beneficence) includes various aspects of not harming and of the virtues of compassion, mercy and gentleness. According to Frankena, (cited in Beauchamp and Childress p190) nonmaleficence includes the obligation not to inflict harm, or that which is bad; the obligation to prevent harm; the obligation to remove evil or harm and finally the obligation to promote good. Inherent to the problem of defining "harm" is the difficulty in using the same work to describe harm to others and to self. Is it reasonable to describe self-neglect, in the form of refusing to eat, for example, as harm? There are also concerns about whether different concepts of harm should apply to the risk of the user harming him/herself or others. Harm,

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[5] This involves the employment of what in the philosophy of values are known as 'counterfactuals' explained in the following chapter.

[6] 'The student of ethics is unlikely to discover how a good man will act unless he has some knowledge of the general capacities and characteristics of human beings (see 1.13). It is anthropology ... which must provide that background knowledge and one of the most familiar utterances of Aristotelian anthropology is the truism that man is a 'political animal' 1097b8-11; *Politics* 1253a2): distinctively human activity is carried on in a social setting'. Barnes, J. (1976) p18).

of whatever kind, is usually situation-specific in mental health practice and this makes determining risk extremely difficult.

All practitioner respondents agreed on the importance of the principal of non-maleficence as an ideal for practice, whilst at the same time conscious of the fact that it is by no means currently all-prevailing. Modern writers on ethics have pointed out that it might be necessary to accept substantial risks to one's own safety to ensure that of others. It could be that mental health practitioners, too, cannot properly perform their professional function without undertaking some risk such as exposing themselves to a violent user, in order to protect other users. The obligation not to inflict harm under such circumstances is difficult to respect, but nonetheless it appear that most health care workers exercise great constraint, at least insofar as physical harm is concerned. However, 'subtle' punishments and 'chemical coshes' are arguably themselves intended to inflict at least some harm:

> 'I'm not sure how many psychiatrists would claim to be disciples of Watson and Skinner, but I can tell you from personal experience that patients who misbehave usually end up being punished by one means or another. When they are deemed to have learnt their lesson, privileges are restored. Is it wrong to deprive people of their dignity and privacy? Yes, probably, but in a psychiatric ward it can be arranged very easily. More easily than beating up the patients, for instance' (UOA).

It is more difficult to reconcile other principles, such as that of consistency with mental health practice, for moral actions in this clearly cannot be binding in the way which this principle demands. Even given the same relevant circumstances, the particular characteristics of mental disorder make it impossible to categorically state that the moral actions undertaken in one situation, and the reasons which provoked these actions, can justifiably be binding in all similar situations. Practitioners are aware that every moral dilemma in mental health

must be resolved on its unique merits and this casuistic framework is often also evident (see Fig.6.2.) upon analysing their descriptions of seeking a resolution to an ethical dilemma. To a certain extent, the casuistic approach is forced upon practitioners by the very fact that their professional codes offer no guidance on dealing with the "unusual" situations which arise in mental health practice.

The same can be said of the principle of impartiality, for in mental health practice there will frequently be good reasons for treating people differently to one another. This is not always adversely discriminatory, but rather a question of professional discrimination, of endeavouring to give each user what he or she requires in order to flourish. A practitioner says:

> 'You do try to be impartial, but we're only human'. (POBJ)

Whilst the General Medical Council states that:

> 'In all these matters you must never discriminate unfairly against your patient and colleagues' (G.M.C., London).

6.3.1. Casuistry

This has been described as a competitor to the four principles approach and indeed, the casuistic approach does, at first glance, appear well-suited to the idiosyncrasies of mental disorder. Mental health practitioners often resolve ethical dilemmas as a team, reaching common agreement on the best line of action without having specifically considered the route by which they did so. This is reflected in the incidence of casuistry found in the fieldwork analysis (see Fig.6.2.). But common agreement is not, as cases such as that involving covert

medication (see p333) reveal, always achieved in the type of dilemma which arises in mental health practice. This inability to "agree to differ" in ethical decision-making is only resolved in virtue ethics.

Owing to its lack of structure (see Chapter 2.2.), casuistry cannot meet the requirements of professional colleges for normative ethics or codes of practice. In addition, given that all those parties involved in resolving an ethical problem might embrace different values, reaching common agreement might prove impossible. Anyone spending time with a group of people suffering mental disorder will rapidly be made aware of how diverse, and yet equally legitimate, their values can be. Decision-making based on casuistry would frequently imply common values ultimately prevailing, everyone, for example, agreeing that medication would be a desirable action. In the present state of mental health care, the prevailing values are unlikely to be the user's:

> 'A psychiatric patient dying of cancer is being denied his wish not to be injected with powerful anti-psychotic medication. (He) has untreatable cancer in his abdomen and lower back muscles. He suffers such acute pain that he finds it difficult to walk... his family do not expect him to live longer than five months.... (he) has requested to be relieved of the Depixol injection ... He says that not only is it humiliating to have the compulsory injection into his wasted muscles, but it causes him additional pain... the powerful tranquilliser drains him of energy, preventing him from carrying out his one lifelong passion – painting. (He) has offered to take the medication in tablet form but two nurses and a psychiatrist last week drove to his flat ... to inject him. He was told that if he did not accept the injection, he would be taken back to psychiatric hospital. The treatment has angered local mental health workers and (his)family...(his) son, who has been caring for his father says: 'Since the injection, my dad's soul has been destroyed. He is hurt and depressed ... All I want is for my dad to spend his last few days with dignity'. (Guardian Society, 1.11.00.)

This kind of treatment might be qualified as based on a deontological framework, 'rational' practitioners, insisting on conformity to the rules implicit in

"sectioning" and unilaterally deciding the best interest of the 'irrational' user. It might also be considered an insensitive, even cruel abuse of power. That is not to say that there are no legal safeguards and the acceptance of the European Declaration of Human Rights will serve not only to strengthen further legal challenges, but will influence the implementation of the proposed new Mental Health Act (see Chapter 1.5.). Casuistry alone is clearly not enough in dealing with the 'bureaucratic knots' inherent to such situations.

6.3.2.Consequentialism

Rights, as such, have little relevance to consequentialist theory. This requires a careful balancing of the *pros* and *cons* of the situation under consideration in terms of maximising happiness. Unfortunately, this can (and often does) lead to the imposition of the practitioner's values and the public's opinions on those of the individual user. The QUALYS[7] system illustrates this point. This is based on the idea that 'the only objective of the health services is health maximization' (Beauchamp and Childress, p311) and involves asking users to evaluate health problems in terms of quality of life. The problem with this is that it disadvantages vulnerable minorities, such as the mentally disordered, for it prioritises what the majority wants over the needs of minorities (Crisp, 1994).

In the case of mental health practice, consequentialist theory has resulted in community care receiving far more resources than the already grossly under-resourced hospital practice (see Chapter1.5.1.) and many of the resources made available to the latter going, according to some practitioners, on acute beds for

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[7] Quality – adjusted-life-years (QUALYS).

people who have been "sectioned". The consequences of this a health problem already viewed as morally dubious are that:

> 'Many sufferers lack support. Many discover that family and friends, employers, are scared and not minimally sympathetic. It's as if the illness was the patient's fault. They fear taint by association and wish that he was suffering from diabetes or something they could talk about...' (PBT)

They are also manifest in the descriptions of the Mental Health Services as the "Cinderella" services and illustrated by user, practitioner and policy-maker respondents' views that these can be:

> '...at best non-therapeutic, at worst damaging, degrading and dangerous. Disastrously under-staffed, over- stretched and lacking basic amenities, many provide little more than medication and containment.'
> (A. Faulkner, a user cited in Guardian Society, 24.10.01.p104)

In the consequentialist quest for the greatest happiness of the greatest number, the happiness of society could involve provoking the distress, but arguably best interest, in terms of QUALYS, of the user. However, if the restriction of civil liberties is considered necessary, this should, in the opinion of practitioners and users, be matched by patient-centred healthcare services of a decent quality. Neither prevention of harm, nor admission as "asylum" can justify detention for treatment in the absence of adequate resources. Disregard for the user's needs and values sits uneasily with the notions of patient-centred medicine and human rights.

On the subject of rights, Dickenson and Fulford (2000) point out that these can result in genuine care 'becoming tied up in bureaucratic knots' (p38) and there is a common-sense intuition amongst most practitioners that severely disordered people who could be helped by treatment should receive this. Chodoff (1976) argues that psychiatrists "succumb" to prevailing fashion if they consider

involuntary admission to hospital to be in the user's best interest and do not seek to act in these interests. This may be the case, but users are increasingly aware of their rights, thanks to the efforts of user groups and lawyers. An ethic which equilibrates these with practitioners' professional expertise (or what Perlin ,1991, refers to as their notion that there is a 'higher morality' to which mental health professionals 'owe some sort of higher duty'[8]) is therefore essential.

6.3.3. Neo-Aristotelian Virtue ethics

Professional expertise combined with a "higher morality" might be thought to find a certain resonance in Aristotle's belief that the virtuous agent could be identified by his/her possession of *phronesis*, or undivided excellence in reasoning. In N.E.VI.5, he describes the virtuous agent as being 'able to deliberate nobly about what is good and expedient for himself, not in particular respects ... but about what conduces to living well as a whole'. Virtue ethics, in a case such as that described in the section on casuistry above, would require the agents concerned to participate in an exercise of practical wisdom *(phronesis)*, in which all aspects of the dilemma and its effect upon user's and practitioners' flourishing would be considered before a "virtuous" decision was reached.

Aristotle's virtuous agent is good at both choosing and doing, for in him/her desire and judgement agree. In acquiring the *hexii* or stable dispositions described in Chapter 2.4., the agent also acquires moral values *(ethike arête)*. The actions of such a person lie in the *golden mean* – a state in which the virtuous agent is 'neither excessively given to the various motivations prompting to action, nor

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[8] Perlin describes this notion as 'empirically , an extraordinarily important one' which is 'strangely under discussed' (Perlin, 1991). Research into such questions does appear to be lacking.

insufficiently sensitive to them, but responsive to the right extent, so as to choose each motivation to the right degree, on the right occasions, for the right reasons...' (Honderich,p540). It could be argued that, given casuistry's inability to frame a structured ethic, only virtue ethics is truly appropriate to patient-centred medicine insofar as it allows for respecting the user's autonomy, something Morwenna Griffiths, speaking of the psychiatric context, describes as having:

> '...the advantage that it is not so obviously related to dependence ... It carries ...the overtones of 'liberation' and emancipation more obviously than independence does'(Griffiths, 2000, p47).

This is totally and, in the context of patient-centred medicine, unjustifiably disregarded in the previous case. Whilst principles-based ethics presume to be capable of judging what is in other people's best interest and needs, virtue ethics demands not only *phronesis*, but also prudence, humility and justice (amongst other virtues) in the joint decision-making process. The virtuous agent would not necessarily oppose involuntary admission, or covert medication but would recognise that moral virtue cannot always be reduced to what is socially approved. The virtuous practitioner would have the courage to take a decision that the user, his/her family or even society itself might greet with reprobation if s/he considered that it would lead to flourishing.

However, seeking knowledge of user's and carers needs and values would be essential to virtue (and empirical) ethics for, as Campbell (1996) indicates, the values and priorities of the former and those of the practitioner could (as in the case described above) be totally opposed:

'He thought I should continue with the medication and was convinced that I'd go back on it... but I felt that my quality of life would be so much better without the dreadful side-effects'. (ULD).

As Chapter 1.5.3. indicated, scientific knowledge and values can blind practitioners to the user's less tangible emotional needs and personal scale of values. The virtuous practitioner, aware of this risk would endeavour to avoid such abuse. The ethical justification for sectioning turns, 'centrally, not on the facts but how the facts were interpreted and understood' (Dickenson and Fulford, p39). How the dilemma as a whole is conceptualised is 'ethically crucial' (Op.cit.p40) and the interpretation and understanding necessary to this depend upon practitioners' characters and ability to employ critical reflexivity and *phronesis*.

Although virtue ethics can embrace principle such as benevolence, it depends more upon character virtues than upon these. However, as was argued in Chapter 2.4.2., virtue ethics has sufficient in common with deontological ethics to be considered normative and therefore capable of informing codes or guidelines for good practice. 'Properly motivated persons often do not merely follow the rules; they have a morally appropriate desire to act as they do' (Beauchamp and Childress, 1994, p64). Actions are only virtuous if performed in the right state of mind for virtuous actions consist in right action *and* right motive. They must also involve experiencing the appropriate feelings. However, moral discernment and moral integrity, two very important virtues in mental health practice, given the vulnerability of the user, have no clear link to motives, or feelings *per se*. In them, 'behaviour and psychological properties are paramount' (ibid) and the same could be said of emotional labour and the ethic of care.

6.3.4. The Feminine Ethic of Care

Campbell (1996) has pointed to the relevance of care and virtue ethics in the promotion of autonomy in healthcare generally. In biomedical ethics and care ethics, critical voices have described the principles-based approach of deontology and consequentialism to ethics as excessively limiting and inflexible in resolving ethical dilemmas. There is no provision in them for the analysis and consideration of important variants such as gender, culture and power and they disregard the context of the situation and values of the relevant players.

Practitioners of care ethics may appear more impetuous, or intuitive, in their decision-making, but this is no reason to doubt that their acts are informed by a prior process of rational reflection, particularly when the practitioner's view is based on long experience of ward practice. Deliberation of one kind or another lies behind every moral decision, even those not reached by some form of *explicit* calculation, or reference to a deontological code. In Book II of the *Ethics,* Aristotle insists that moral decisions are always choices (*proairesis*) and consequently supported by deliberation, by which he means that they are always backed by reasons which constitute a deliberative argument in favour of the particular decision. Although he was not referring to women at the time, since in the context of ancient Athens "femaleness was symbolically associated with what reason had left behind" (Lloyd, 1984,p2), the same must apply to women's reasoning today. Or not quite, for Noddings suggests that:

> 'Women enter the moral realm through a different door ... although (they) can
>
> construct hierarchies of principles and argue deductively, they are apt to regard such displays of reasoning as besides the point. When it comes to deciding whether to withhold further medical treatment from her dying

child, for example, a woman is not likely to approach this intensely personal decision as she would an extremely difficult math problem. ... She will need to consult her feelings, needs, impressions and sense of personal ideal'. (Noddings, 1984, pp3-4)

An analysis of the male respondents' transcripts gives the impression that most of them would react in the same way in similar circumstances. Neither feeling, nor emotion are, the fieldwork analysis shows, the prerogative of women, nor is reason that of men.

6.4. Generational differences

The only noteworthy difference insofar as attitudes to ethical practice are concerned is inter-generational, rather than gendered. Young practitioners tend to be more idealistic, identify more with the users and appear more committed to them emotionally. Older ones, although concerned for the users' well-being, are far more pragmatic about *'keeping a quiet ward'* (POBJ) and ensuring that *'... the troublemakers don't disturb the others'* (PNA)[9]. When asked, for example, about handling a crisis, a young nurse considers that talking to the disturbed user should be enough, but would use pharmacological restraint if absolutely necessary, responding '(I) can't answer that one, it depends on the situation'(PBA). However, an older colleague says:

> 'If a patient is psychotic, talking is not always a viable option, but is usually tried first, although we have to protect ourselves. Nobody seems to think about us, our position in these situations. You've been talking about flourishing[10]. It's hard to see how anyone here could flourish if the nurses were all in hospital with broken bones! ' (PNA).

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[9] A similar generational difference is reported between medical students and more experienced doctors in Robertson, 1998.
[10] I had earlier asked what the person in question understood by the term 'flourishing' or 'well-being' in the context of mental health practice

Aristotle claimed that the young, because they lack experience of the world, could not exercise moral wisdom (Ethics VI-1142a8). In view of these quotes, it could be argued that what mental health practitioners develop with experience is pragmatism, rather than wisdom. Perhaps in the context of the present lack of resources in mental health services, these are the same thing. Whatever the case, whilst context and value clearly do have a role to play in evaluating good practice and ethical codes, situations such as those described, involving the unpredictable and "irrational", sit uneasily with rigid codes of any kind.

6.5. Do Current Codes Influence Good Practice?

Sixty percent of users considered current codes to be respected by practitioners. The latter also describe them as satisfactory and pay lip service to obeying them , but analysis of their comments reveals that the majority of carers interviewed tend to rely on intuitive common sense, rather than codes and rules, when confronting ethical dilemmas. Only two interview respondents - a male psychiatrist and a female nurse – openly admitted that they were not always followed. Practitioners responding to the questionnaires had less inhibitions, nine (30%) of these describing current professional codes as unsatisfactory. Eighteen (60%) of these practitioners had also seen a colleague behave in a 'cruel and unprofessional' fashion towards a user. One left this question unanswered and eight (26.6%) replied that this had never been the case. This data, if reliable (and in the light of the fear of surveillance evidenced in accessing the sample, anonymity may have encouraged greater frankness) supports Pritchard's opinion (2001) and the fieldwork finding, that in mental health practice current codes are widely 'more honoured in the breach than in the practice' (see Chapter One).

Whilst aware of their professional college's codes of good practice, all practitioners indicated that behaviour towards users could and should depend more upon the contingencies of the situation than upon specific rules or regulations. They considered these "guidelines" rather than mandatory, in spite of their wording, and not particularly helpful:

> 'We get told ...we're not allowed to inflict pain upon the patients ... but if I feel my life's at risk ... I'm going to do anything to get this man' (PLN)

With regard to medication, too, two female carers felt that covert medication, in the form of concealing drugs in food (a "Prozac sandwich") was justifiable, whilst male nurses were less convinced of this, regardless of the fact that new N&MC[11] guidelines condone this practice in certain situations. The males' objections were based on the fact that (in a nice mixture of metaphors) they would not themselves wish to be treated with chemical "coshes" by staff who saw their role as "babysitters", preferring to try reasoning with the user in such matters.

This example belies the stereotypical images, described in Chapter Three, of controlling males as natural "coshers" and women as caring, natural "talkers". In this case, male practitioners reveal themselves as caring, empathic and virtuous agents, at least in terms of justice and honesty. They see no reason to deceive and chemically control users who are no threat to others. The female carers demonstrate a degree of maternal over-protectiveness characteristic of Noddings' "Feminine Ethic of Care" in wishing to sedate and "tranquillise", as they might a fractious baby. Given that they are overriding user autonomy, a consequentialist (rule utilitarian) approach involving deceiving the user in the interest of the well-

being of the greatest number – family, practitioners and eventually, perhaps, the user him/herself - is also manifest.

Such deceit would not have met with the approval of Kant, or the virtue ethicist, for neither deontologist, nor virtuous agent, would contemplate such deceit. There is, nonetheless, a distinction to be made between the refusal of medication and refusal to cooperate with psychotherapy or group activities. It is possible to enforce physical treatments, such as medication, and expect a positive outcome, whereas it would be impossible to force anyone to co-operate with psychotherapy and movement therapies. How to distinguish between the duty of care and coercion in such cases is a debatable point, as is whether covertly medicating a user, albeit in the name of treatment, is a form of "battery".

6.6. An ethic for flourishing, combining neo-Aristotelian virtue and care ethics

Users' and practitioners' views on what constitutes good practice, such as those described in this and the previous chapter, should be taken into account in framing the codes which regulate this. Although it has been impossible to consider every aspect of these, what their views and the spontaneity with which, in many cases, they expressed them, undoubtedly reflect certain inherent truths about ethics and practice today. In addition, as the fieldwork shows, if professional codes or guidelines are drawn up independently of these views, they will ultimately be 'more honoured in the breach than in the practice'. Given the combination of the uniqueness of many of the ethical dilemmas encountered in mental health

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[1] Nursing and Midwives Council

practice, the pragmatic approach adopted by many practitioners and growing awareness of human rights, compromise must be considered the goal, rather than a "second best" outcome in the formulation of professional college's codes of good practice. These should be guidelines, not rules, for given the current state of play in mental health care rules will inevitably be "bent" if not ignored in practice. More confidence needs to be placed in the practitioner's judgement as a virtuous, caring agent and education in ethic for mental health practice must be a means to this end.

Gregory Pence (cited in Beauchamp and Childress, 1994) also contends that a virtues framework is that most suited to health care insofar as 'almost any health professional can successfully evade a system of rules' (Op.cit.p65). Pence recommends creating a climate in which health professionals have no desire to abuse the system (or their patients). This is, as this chapter has shown, a very sound reason for incorporating virtue ethics into the creation of codes of good practice, but making these both user and woman "friendly", as neo-Aristotelian ethics would wish to do, also requires incorporating aspects of the (not so) feminine ethic of care.

This is because an aspect of all ethical codes criticised by Noddings is the relative paucity of their valoration of caring. She believes that this is a natural feeling which impels us to help our fellow human beings because they are important to us, and we wish to be important to them. This caring is a human condition, a truly Aristotelian 'good' which we cultivate as we grow older if we are genuinely caring beings. Tong (1998) describes it as 'the virtue without which true human

community, and, therefore, bona-fide moral relationships are impossible' (p168). If this is so, then it is not only possible, but also important, to 'recover' or 'create' a caring attitude in all practitioners of both sexes.

Alisa Carse specifies 'true care' as 'highlighting concrete and nuanced perception and understanding - including an atonement of the reality of other people and to the actual relational contexts we find ourselves in'. She claims that care ethics stresses 'the importance of an active concern for the good of others' (Carse, 1995, p10). Carse, like Lawrence Blum, who considers it to be based on altruistic emotions, believes care to be the very core of morality and this clearly applies to medical ethics. *Pro* Aristotle, and against deontology and consequentialism, these authors believe that it is 'neither desirable nor feasible to separate the agent from his or her action' (Tong, 1998, p162). To quote Aristotle:

> '...virtuous acts are not done in a just or temperate way merely because they have a certain quality, but only if the agent also acts in a certain state, viz: (1) if he knows what he is doing, (2) if he chooses it and chooses it for its own sake and (3) if he does it from a fixed and permanent disposition'. (Ethics, Book II, 1105a25-30).

Carse's and Blum's, like that of Nodding's, are arguably emotional responses to ethics and naturally lead to the question of the emotional aspect of the respondents' answers. Which practitioners displayed action *and* emotion and which felt that only action, often in the form of emotional labour, was required of them? Female practitioners, the fieldwork shows, do not hold a monopoly in caring. Men are equally capable of this. It is also necessary to consider users' preferences. Some preferred the attentions of the skilled technician who is an emotionally detached carer. However, the majority described the ideal carer as someone, of either sex, who performs the necessary clinical tasks, but also

demonstrates an emotional attachment to the person receiving these attentions, making him/her feel cared for and about, regardless of whether this caring is spontaneous or a form of emotional labour. Can users, in any case, detect the difference between one and another if the latter is sufficiently skilful? The fieldwork reveals no evidence of this.

It has been repeatedly stressed that in the context of patient-centred medicine ethical codes must prioritise users' values, wishes and psychological and social circumstances. This notion, far removed from the requirements of a deontological code, conforms closely to an ethic of care and neo-Aristotelian virtue ethics. Whilst it has been shown that the user's values, wishes and flourishing are not unfailingly prioritised in practice, society's own values and the discourse of the "medical model" often taking preference, the fieldwork does reveal that many health workers clearly do care *and* display the qualities required of a virtuous agent:

> 'There's freedom here, compassion, understanding. It's different from hospital, the staff will do anything within their power to make you happy' (PBT)

These qualities are the same whether described by user or practitioner: compassion, justice, technical skills, kindness, love, patience and good humour. Far from totally lacking these virtues, what many mental health practitioners lack is far more fundamental: resources, time and morale. This causes a deterioration in user-practitioner-public communication, a major ethical issue since it can result in disempowerment, dehumanisation and discriminatory treatment of users and, to a lesser but nonetheless palpable degree, practitioners. The result is a moral "malaise" in mental health practice which current codes of good practice may

sometimes alleviate, but do little to cure. Caring and curing are required of an ethic for mental health practice, for such a combination will lead to the flourishing of demoralised carers, users and practices. These, in turn, are linked to values and value judgements, discussed in the following chapter.

PART 3

OUTCOMES:
DISCUSSION & CONCLUSIONS

I may disagree with what you have to say, but I shall defend to the death your right to say it'.
(Voltaire, 1694-1778)

CHAPTER SEVEN: Discussion

7.1. Introduction

This dissertation has revealed that the possibility of practitioner and user flourishing may, paradoxically, be forestalled, rather than facilitated, by existing codes of ethics and good practice. Their inadequacies are various, but the *prima facie* widening gap between ethics or codes developed by professional bodies for their members, and the latter's and users' views of what constitutes "good" practice in the context of day-to-day clinical work is evident. If current 'ethics may be bad for good practice (see Chapter One) the question which this thesis must answer is: What type of ethic is "good" for this?

Rules and laws do not always evolve in harmony with the society which they are supposed to protect and this is also true of codes of professional practice. Recent criticism of the predominant deontological codes suggests that whilst these provide an excellent means of evaluating the *pros* and *cons* of ethical dilemmas, they are excessively inflexible (see Chapter Three) to be of use alone in resolving the problems and "irrational"[1] situations which compose the daily reality of mental health practice (Beauchamp and Childress, 1984; Barker and Baldwin, 1991; Campbell, 1998). Neither are they sufficiently adaptable to meet the exigencies of patient-centred medicine in terms of increased user participation in care plans.

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[1] In terms of "rationality" as defined by medical psychiatry, although describing something as "rational", except in terms of strict philosophical logic, is inevitably a value judgement.

Deontological and consequentialist codes often tend to favour absolute principles, to the detriment of humanity, good sense and compassion (Compte-Sponville, 2003). They also ignore several topics which any ethic for mental health practice needs to address today. These are motives and moral character; moral education; moral wisdom or discernment (*phronesis*); friendship and family relationships; flourishing (*eudemonia*) in the sense of achieving the objectively desirable life described in Chapter One; the role of the emotions and, finally, the questions of what kind of person we should be and how we should live (Hursthouse, 1999). All these topics, as has been explained, are discussed in Aristotle's *Ethics*, a work which has been shown to be particularly relevant to good practice in mental health care.

Another highly influential ethic in nursing is the feminine ethic of care. Tong (1998) describes caring as 'the virtue without which true human community and, therefore, bona-fide moral relationships are impossible' (p168). Influenced by this definition and the fieldwork findings, this study suggests that the combination of neo-Aristotelian virtue and care ethics - an ethic for flourishing – could provide the ideal framework for moral guidance in mental health practice. Caring is, effectively, a virtue central to this but Nodding's person-centred approach and respect for user autonomy, whilst recognising the mutual dependence of human beings, overlooks something central to virtue ethics, the very fact of belonging to the 'true human community' described by both Tong and Aristotle (see Chapter One).

Noddings also forgets that genuine caring for a fellow human being requires great sensitivity, something considered by McDowell (Chapter Two) to itself be a virtue: 'the sensitivity just is the virtue'. The empathy and sympathy implied in the term "engrossment", whilst enabling recognition of another's suffering, give no guidance on how to constructively respond to this. Indeed, such "engrossment" could cause practitioners to act in an irrational, excessively subjective fashion, ultimately causing more harm than good to the user. Given conditions such as these, the ethic of care *per se* must be rejected as inadequate to flourishing of the kind desired for mental health practice. However, the virtue of caring may form part of a neo-Aristotelian virtue ethic for flourishing and, indeed, some feminist philosophers have already described the ethic of care as, in fact, a virtue ethic (Tong, 1998, Conly, 2001). As the previous chapter suggested, in view of the fact that practitioners of both sexes have been shown to be "carers" and users express a desire to be cared both "for" and "about", the "care" element of Nodding's ethic can be incorporated into a neo-Aristotelian virtue ethic in which the hypothetical perils of "engrossment" are mitigated by the wisdom of *phronesis*, by virtues and by values additional to those inherent to mothering.

The fieldwork has revealed that as an evidently gender-neutral component of a virtue ethic, a care ethic does not guarantee any particular resolution to ethical dilemmas, but ensures that the interests of all involved parties are considered in terms of values, fairness and beneficial outcomes, rather than rights and duties. It emphasises both user autonomy[2] and the practitioner's role in including the former

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[2] As stated previously the definition of autonomy employed here is that given by Morwenna Griffiths (2003), who takes autonomy to mean much the same as "independence" (p49).

as the primary agent in care plans, something which would make such an ethic particularly apt to patient-centred medicine and also amenable to user groups.

7.2. Gender, Caring and Communication

The sociological fieldwork analysis revealed that being a good carer depends on character, rather than sex, or obedience to rules or codes, although there exists amongst practitioners a palpable awareness of the duty of care. Some of these consciously assume the role of "professional carer", treating their task as emotional as well as technological labour. Others care in a more maternalistic/paternalistic fashion, closer to the caring described by Noddings. Users clearly expect practitioners of both sexes to be well-trained and technically and culturally knowledgeable, but also seek from them a real interest in their personal flourishing. They wish to feel cared both for and about and whether this is "love" (see Chapter Two,) or a(n) (emotional) labour of love seems, like the sex of the carer, a matter of indifference as long as the source of this love is also clinically proficient.

A pre-requisite for caring "about" is good communication. This has an important role in patient-centred practice since various studies show that users' perceptions of what happens within medical consultations are more valid than measurements based on coding structures (Elwin and Gwyn, 1999) and that finding common ground is a matter of perception rather than a quantifiable finding. However, achieving this requires excellent communication, so the relatively poor levels of this manifest in the research findings urgently need addressing if good practice is to be a reality, rather than an ideal. Evidence also suggests that the increased user participation in decision-making and care

planning for which most respondents clamour would reduce health service costs, emphasising the critical but neglected part that the user-practitioner interaction plays in the efficient employment of the scarce resources of mental health practice (Rogers and Pilgrim, 2001).

The research findings reveal that a crucial element in communication "breakdown" is, according to seventy-one percent of practitioners, a lack of time to talk with users, something regarded as central to their professional commitment. Becoming experts in communication could facilitate a more constructive interpretation of users' stories and the creation of a "democratic arrangement of voices" (Elwyn and Gwyn, 1999). Many patients consider telling their "stories" an integral part of treatment, which makes them feel respected and valued, factors essential in flourishing. However, listening takes time, a commodity practitioners of all disciplines lack. Understaffing and overwork are questions of policy, rather than ethics, but chronic under-resourcing (Rogers and Pilgrim, 2001) implies a discriminatory attitude on the part of policy-makers towards the "Cinderella" mental health services, which are evidently themselves (relatively) cared for, but not about.

When discussing communication, it must be remembered that no common language is necessarily available to *all* users and practitioners, whatever their gender and ethnicity. Often limited at best, communication with users from minority groups who do not necessarily speak the same language, or at least infer the same meanings, as their carers is especially difficult. This can result in the involuntary admission and excessively prolonged hospitalisation of users such as Afro-Caribbean males, whose use of Iritical

or patois instead of English, which they regard as a "downpresser"[3], may be interpreted as a hostile act, or manifestation of psychosis. Communication is a vital ethical issue, for it is inseparable from linguistic discrimination. This, in turn, causes other problems of malpractice, including loss of autonomy, disrespect for religious and cultural differences, disregard for the user's views and, in some cases, treating the latter as stupid, or dangerous.

7.3. Discrimination and Stigmatisation

Considering respect for the 'story' or ideology of the mentally disordered "other" leads to another branch of philosophy not previously discussed. The fieldwork findings indicated that the major source of dissatisfaction in mental health practice is adverse discrimination, in all its forms. Users and practitioners frequently claim that the former are labelled as 'different', 'lacking' or 'dangerous' following diagnosis and subsequently treated as such. Due to this self-other dichotomy, (see Chapter One), regardless of their education and experience, once "labelled" mentally disordered, users describe their opinions and aspirations as no longer being accorded any serious worth. Previously respected teachers, lawyers, accountants and mechanics can, following diagnosis, be treated as principally belonging to the sub-category "mad". From Aristotle's point of view[4], this would disqualify them from flourishing (see Chapter Two) and indeed, the loss of self-esteem initiated in the disorder is frequently compounded by stigmatisation, resulting from the changed attitudes of practitioners, family, employers and public servants, which cause users to feel 'shame and disgrace' (Williams, S. 1987, p136). Stigma disrupts 'the maintenance of a given, official self'

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[3] Language of oppression
[4] Not shared by neo-Aristotelians.

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(Lofland, 1980:41 cited in Williams, 1987, p137), a self which user respondents have revealed as already in a parlous state following diagnosis.

Giddens' theory of structuration claims that social life is more than random individual acts, but is not determined by social forces. He suggests that human agency and social structure are in a relationship with each other and it is the repetition of the acts of individual agents which reproduces the structure. This means that there is a social structure – traditions, institutions, moral codes, and established ways of doing things - but these can be changed when people start to ignore, replace, or reproduce them differently. Goffman, too, '… notes that the attribution of a stigmatisation' such as that described in Chapter Five, stems from the definitional workings of society, for 'before a difference can matter much it must first be conceptualized by society as a whole' (Williams,S.,1987, p139). The research findings describe some sectors of society as considering mental disorder most undesirable. Avoiding this process of defining psychological or social difference as "alien" and deserving of stigmatisation, should therefore be a principal aim of good practice and ethical formation. How can it be achieved?

Discrimination and stigmatisation are based on the application of an ideology, a scale of values. The problem with any ideology is that it represents only the views and interpretations of experience of the particular culture or group embracing it. For example, saving life, or killing are simply events until we label the former 'good' and the latter 'bad'. To label anything in this way is to make a value judgement. By the same criteria if, for example, referring to a piece of music as 'beautiful', or a form of

behaviour as 'rational' is to be justified, they must first be perceived as such. Values are not expressed by facts, but by judgements. Subjective participation and the conclusions drawn from this are essential. Since, as the fieldwork findings show, discrimination in mental health practice (and in society) appears to be founded upon popular, but ill-informed value judgements, it is essential for practitioners to be made aware of this factor of personal participation in the formation of these. It is, this dissertation has argued, value judgements, not ethics or codes of practice, which cause tensions in the user-practitioner relationship. It is therefore these which must first be addressed. Since owing to their personal values human beings are often unable to agree on significant issues for any length of time, it follows that no ideological code can provide a universal, much less permanent answer to moral dilemmas, including those inherent to mental disorder. Policy makers, practitioners and society generally need to recognise this.

Adopting a pragmatic point of view, if our views on what constitute 'rational' behaviour and good mental health are based, as has been said, on an ideology and dominant scale of values, it becomes necessary to consider the nature and characteristics of values, specifically moral values, in understanding the dynamics of moral attitudes and promoting the merits of an ethic for flourishing.

7.3.1. Values and Mental Health Practice

Two main issues arise insofar as the role of values in the context of good practice in mental health is concerned. The first, how to recognise relevant moral values. The second, how to distinguish between values and ethical norms. They can be resolved by exploring the following four questions:

- To what extent is a process of value change taking place in patient-centred mental health practice?

The fieldwork findings reveal that in community care there is a greater emphasis on user autonomy and the notion of the user as a "partner" in the therapeutic relationship, in spite of what Rogers and Pilgrim (2001) describe as a prevailing 'professional inertia'. This emphasis is likely to increase under the National Service Framework guidelines, unless the proposed Mental Health Act becomes law, in which case users admitted as involuntary patients may experience less, rather than more autonomy. Accountability is also greater, causing a certain stress in those practitioners who feel "threatened" by what they see as over-interference with their task, but empowering users, who are less vulnerable as a result. However, the major change, is that due to the efforts of user movements (Crossley, N. 2000. p133) and critical psychiatrists, patient-centred mental health care is gradually becoming, as the adjective implies, more aware of the needs, values and rights[5] of the user.

- What is the meaning, status and relevance of the value concept in changing perspectives on ethics and good practice in mental health?

There is growing awareness of and respect for users' values, which means that expressions such as "must" and "shall" are becoming redundant in ethics and codes of good practice since the research findings show that, as a rule, decisions are made according to the context of the situation and the experience of the practitioner. For this reason, mandatory codes are currently extensively disregarded, practitioners tending to employ intuition, empathy and common sense in resolving ethical dilemmas.

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[5] But see Rogers and Pilgrim (2001), Chapter Five for a more pessimistic account of this.

- What distinct value orientations can be empirically documented? Are there indications of new ones? What are the social and gender antecedents of specific value orientations in practice?

Paternalism, although not unknown, is ceding to a more 'democratic arrangement of voices', whilst an equally disempowering "maternalism" is to be found amongst some female practitioners. There is evidence of a move towards greater respect for the user and a less "moralistic" attitude amongst practitioners and public, but this is far slower than users would wish. Many sectors of society still regard mental disorder as a "bad thing" in more than one sense.

- What is the impact of notions of values and rights on policy and behaviour amongst users, practitioners and managers?

The Mental Health Services are grossly under-resourced by comparison with other branches of health care. This policy of relative neglect implies discrimination against both users and practitioners, perpetuated by the stigmatisation of mental disorder prevalent in many sectors of the popular media. However, this situation is increasingly recognised as untenable and very real steps are being taken to improve mental health care[6]

What are the implications of these findings about values (and changes in these) for mental health practice today? Discussion of this ensues. It will conclude by claiming that in relating education on values and virtues to notions drawn from the ideals of love and care expressed in Noddings' ethic of care, a middle way or neo-Aristotelian "golden

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[6] See DoH (2001) *Making it Happen: A Guide to Delivering Mental Health Promotion*; National Service Framework for Mental Health; Mentality.net.uk.

mean"[7], can be achieved. This could cause practitioners and policy-makers to replace codes of good practice with more flexible ethical 'statements' or guidelines, which give expression to the values necessary to flourishing, caring and the "good" life for which practitioner and user must ultimately strive, helping to promote this in practice.

Scales of value are also relevant to the development and expression of emotion. Clarity of feeling is vital in this context given that both the lowest and the highest value are indefinable. Appreciating them, therefore, depends upon our sense of value. Feelings and emotions are clarified when we develop, through awareness of difference and detail, a wealth of differentiated feelings. Emotions can be very intense in mental health settings in which a single feeling such as joy, or anger, can completely overwhelm someone and consequently falsify and colour their thinking and acts. Value judgements often comment as to the "wonderfulness" or "awfulness" of a situation, but if emotions are to generate knowledge it is necessary - in an exercise of emotional intelligence inseparable from effective emotional labour - to differentiate and discriminate these in a constructive fashion. Scales of value assist this process by increasing attention to detail and contradictions, thereby serving the simultaneous development of feelings and knowledge. In considering contradictions, it should be remembered that values normally develop from the common domain, but that the user, by virtue of his/her disorder is excluded from this commonality. This is a major problem since it can involve a process of reduction of the individual or the particular, to the universal - a form of discriminatory "pigeon-holing", which fails to take account of such exclusion. An explanation of how an ethic for flourishing could remedy this situation follows.

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[7] In this, Aristotle describes the extremes of excess and defect (NEII 1104a-10-27)

Because of the problems emerging from and associated with adverse discrimination, it is impossible to speak of ethics in isolation from values. Almost everything related to deliberate human behaviour has an ethical dimension. Consequently, it has been claimed that we should educate in freedom, for freedom, as a base for an ethical life. In the case of mental health practice, this would imply that it is not sufficient to know what professional and personal moral values are, but also necessary to incorporate them into carers' and users' lives, together with the awareness that they can be diverse, without those of the 'other', mentally disordered or not, being necessarily labelled 'perverse'. As Voltaire (1694-1778) said: 'I may disagree with what you have to say, but I shall defend to the death your right to say it'.

A moral value is essentially the stable belief that something is good or bad, positive or negative. People are moral beings insofar as under normal circumstances they appear to possess an innate knowledge of the objective difference between good and bad. They are equally aware of the possibility of committing "good" or "bad" acts. The "goodness" or "badness" of these depends not upon their physical realisation, but upon the end sought and the way in which this is construed by the agent. This is why, in the disagreement over covert medication (see Chapter Six) it is impossible to claim that either opinion was definitively good, or bad. Both ends, although different were, given the situation, rationally justifiable and both sets of agents virtuous in their way. In the context of a virtue ethic disagreements are resolved by balancing such legitimately different perspectives. An act is simply "good" when its end is to promote flourishing or well-being and "bad" when it reduces or terminates this.

The list of things having value is endless. Many do so because of the special role they play in our lives. However, this should not be confused with a subjective theory of the nature of value. It is an objective truth that something that holds a special *significance* in someone's life will have *value* for that person and this cannot be overlooked in decision-making. Many philosophers (Moore, Brentano and the previously mentioned Scheler), recognise a variety of things other than pleasure or satisfaction as having intrinsic value. This is why "flourishing" refers to a full, rather than happy life. In addition to certain kinds of pleasure, these philosophers count some, or all, of the following as intrinsically good: consciousness and the flourishing of life, knowledge and insight, moral virtue and virtuous actions, friendship and mutual affection, a just distribution of goods, and self-expression (Audi, p830). They are all things that virtuous, caring practitioners would wish to promote in the quest for flourishing.

7.3.2. Subjective or Objective? Mistaken or Divergent Gazes

On the other hand, although personal participation is required in the formation of values, they somewhat paradoxically refer to something objective. This is shown by the fact that in mental health practice - as in other walks of life – judgements can and frequently are mistaken. A person may, for example, be clinically depressed, but those around him/her consider that s/he is simply lazy, a malingerer who should 'pull himself together', whilst s/he is painfully aware of a total inability to do this. It is the quality of a life which makes it 'good' (or flourishing), not the judgements of others as to the factors which make it so.

Dangerousness, to give another example prevalent in mental health practice, does not lie only in the often prejudiced 'gaze' of the beholder, but in the object of this gaze, too. Value judgements about human behaviour, 'abnormal' or otherwise, can be right, in the sense of well-grounded, or wrong, that is, groundless. This shows that values possess a foundation which is independent of us. Both subjective and objective elements must be considered, for failing to achieve a balance between them could lead to unsatisfactory ethical practice.

Because of the subjective elements, as has been said, it is often erroneously claimed that values are *purely* subjective, therefore potentially different for each individual, a question of personal preference and inclination, which cannot be fruitfully discussed. This is true of one type of value, such as, for example, in the aesthetic evaluation of a controversial work of art, but implies a serious underestimation of human intelligence to extend this attitude to all values. This is particularly the case insofar as moral values are concerned, for to label a person, or his acts, 'evil', 'dangerous' or 'mad' is not a mere question of taste and most judgements in mental health practice are based on moral, rather than aesthetic evaluations, although these could form part of the problem since people are sometimes labelled 'mad' on the strength of their appearance.

Practitioners therefore need to understand that because of these objective elements, the embodiment of a value tends to be confused with the value itself, or at least as an integral part of this. Many people, for example, would still appear to believe (if biological psychiatry and the proposed new Mental Health Act are anything to go by) that it is not only therapeutic to shut up – either physically or pharmacologically –

people who are potentially harmful to themselves or others, but that the very concept of therapy is thus being 'shut up'. This particular representation becomes the embodiment of the value itself. Values do not exist independently, as do objects, but must be embodied. We cannot know 'sanity' or 'dangerousness' in the abstract, yet the research findings reveal that many inoffensive users are aware of being considered both insane and dangerous by others. Since these concepts have to be embodied, we often think of the embodiment, rather than the value *per se*. When saving someone from committing suicide, we think of that person, not of the virtues inherent in our act.

That such identification is wrong becomes clear when as, according to the research findings happens in practice, the significance of such a value becomes relevant only because opinions concerning one of its embodiments change. Those who identify therapy with the notion of physically or pharmacologically 'shutting up' the user allow the disappearance of this when this notion cedes to the intention to talk to, consult and collaborate with users, allowing them to have their say in care plans and 'flourish' in accordance with their own values, rather than those imposed upon them.

To value something is to consider it preferable to something else; one could for example prefer respect to riches. Value beliefs are never isolated, but organised in the psyche in such a way as to create scales of relative preference of this kind. Each person, practitioner or user, has his/her personal — but not unmodifiable - scale of values and true values, those which most intimately guide people through life, are few. Some are claimed to be universal, in that there is a group of intrinsic or basic values (friendship, self-esteem, equality, peace, etc.) which, like some emotions, are common to most of

humankind. What makes moral attitudes and acts differ is not the value system *per se*, but the degree of intensity with which these values are lived out. For whilst it is true that our values reflect our personalities, it is also true, as both Foucault and MacIntyre have indicated (see Chapter Three), that they are influenced by the institutions in which we live, the culture in which we move and by prevailing social ideologies. This is why in some non-scientific cultures people experiencing hallucinations are revered as oracles, whilst in more "sophisticated" others labelled schizophrenic and despised.

7.3.3 Embodying Values in Practice and Ethical Codes

Ethics, in mental health practice, must be founded upon an awareness of both practitioner's and user's values. Decisions in this are constantly made as to what is more or less disagreeable, for example, the side-effects of medication or florid hallucinations. Many users appear to prefer the hallucinations to the side-effects, whilst practitioners might consider this preference itself a sign of 'madness'. What is better or worse, for example pharmacological restraint (sedation) or physical restraint (straps, or straight-jackets)? Several users claim to prefer the latter, for at least that way they retain the ability to think clearly, yet pharmacological restraints appear more acceptable to practitioners and families, perhaps for aesthetic and emotional reasons which reflect values distinct from those of users:

> At least if you're physically restrained you can still think, your mind is still your own' (UOA)

> 'There's not a lot of difference between medicating people and tying them to the bed. At least if you do it physically there's an honesty that bio-chemical sedation lacks' (ULD)

In spite of such differences, decisions frequently have to be made as to what is right or wrong. Judging the value of things, events and actions is as unavoidable in practice as the attempt to discover causal connections in considering the aetiology of the disorder. With values 'go a series of humanistically important elements of medicine – meaning, significance, understanding, empathy, responsibility, intuition, subjectivity and an individual perspective' (Fulford et al. 2002, p6). MacIntyre (1985 and 1999) indicated that individuals, communities and societies lacking value systems are insecure. Indeed, it has recently been widely suggested that not having a coherent value system upon which to establish their personality, particular *modus vivendi* and way of relating to this world is a source of great anxiety for young people The same could apply to those (mal)practitioners and stigmatised users discussed in this thesis, hence the importance of *a priori* education in values, if practitioners are to recognise and practice the virtues.

To facilitate this, it is necessary to examine the process of evaluation itself, considering the different types of value. This aids discernment and understanding of values important to mental health practice, as they are closely interconnected. Some general characteristics apply to all values. Regardless of whether these are 'lower', such as charm, or usefulness, or 'higher', such as goodness, or truth, values express the significance which someone ascribes to matters related to a particular experience or to their life in general. They provide guidance for that person's behaviour. Values are established by personal judgements, regardless of whether these are of things, qualities, events, or actions. They therefore contain differentially related subjective and objective elements, according to kind of value involved. Things must be valuable to us, or not, otherwise, whilst we might know facts, we do not know values. Consequently, the way

in which practitioners "judge" the ethical dilemma with which they are confronted is something to which reflexive consideration is essential in both training and practice. It is the process of attributing values which must be addressed prior to the consideration of a code of any kind. Ethics and codes of good practice uninformed by an awareness of the values implicit in these may become rules to be bent, rather than guidelines to be respected.

We only develop awareness of the role of values when judging an act *a posteriori*, or *a priori* in choosing between treatment plans leading to future action. But the embodiment itself (the shutting up of the mentally disordered, the happiness of a life, the saving of the patient) far from being the value, does not form part of it. An embodiment has value and in order for this to be recognised, must be judged. Values are canons of judgement through the application of which we become aware – correctly or fallaciously – of certain qualities in an action, object or person. These, in turn, produce in us an appreciation of the values they embody. Our power of appreciation may increase or decrease, or, and this frequently is the case, we may err.

But erring does not affect the value *per se*. The value of nursing is not diminished because a user encounters an abusive nurse, any more than the value of collaboration is diminished because in a care plan the user has not collaborated to the degree previously agreed. It is, therefore, important to distinguish values, as such, from their manifestations because, to refer back to Chapter Two: 'Perhaps practice cannot be perfect, but we should nonetheless strive for perfection'.

7.3.4. Binary Opposites, Positive and Negative

In the case of values, the relevance of the negative is obvious. As has been shown, there are always binary opposites in values: mad and sane; rational and irrational; dangerous and harmless; useful and useless; intelligent and stupid; good and evil, and so on. All are equally 'real'. The negative quality both indicates the absence of the positive one and its own presence. If you are not "sane", you are "mad", if not "rational", then "irrational" and so on. It is very important to understand that any value is grasped by seeing both its negative and positive forms. We tend to apply both, or neither – and in doing so often assume too much, such as that the mental health practitioner is "rational" and consequently sane, good and wise, whilst the user is "irrational" and consequently mad, sometimes dangerous, frequently foolish, and so on. Such generalisations are excessively sweeping, quite apart from the fact that, as the research findings indicate, they fail to represent the real situation. As the causal factor in the discrimination which results in so much humiliation and suffering, their effects are detrimental to practitioner, user and to flourishing mental health practice generally.

In considering binary opposites, practitioners must be aware that in the absence of another kind of value, the denial of a positive value not only dismisses this, but supports its negative opposite. The paternalistic attitude of 'my values or none' is detrimental to the user-practitioner relationship, stifling dialogue and inhibiting effective user participation and patient-centred practice. The user who recognises this attitude in the practitioner, the fieldwork findings show, lies and pretends to conform to these values. When the practitioner recognises it in the less powerful user, on the other hand, it can result in an increase in medication or compulsory admission to hospital. We tend to

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imagine that negation enables us to remain neutral and escape commitment – that, for example, by disregarding ethical values we can avoid them entirely and rely instead upon 'psychological' arguments. However, this is not the case, for the denial of unconditional moral standards undermines morality. To explain morality only in terms of its psychological, historical and sociological elements, although these are important, replaces genuine virtue with obedience to custom or codes of good practice, something which an examination of the disciplinary proceedings of professional organisations related to mental health practice shows occurs. Relying upon these elements as the only arbiters of good practice can lead to the unjustified complacency, or indifference to such matters as those described previously, in which merely meeting the requirements of professional codes of good conduct is seen as ethical practice enough (see Chapter 1.2).

In teaching ethics, any illusion that practitioners can constructively concentrate upon the positive values or virtues in isolation, disregarding the negative ones, or vices, must be dismissed. The fieldwork findings reveal this. 'It is not possible to develop the capacity to see beauty without developing also the capacity to see ugliness, for they are the same capacity' (Macmurray, J., 1962 pp46-7). If someone implied that everything was good or bound to work for the good, and we became aware of his/her ignorance or refusal to admit anything bad in mental health practice, we should be inclined to dismiss these views as unrealistic, even prior to the research findings. In practice, too, in recognising and promoting the good, practitioners must also be aware of and aim to eliminate the bad.

The denial of a *personal* ethical responsibility of this kind does not simply mean managing without this concept, but can lead to what might be described as an ethical nihilism. It makes no difference that a practitioner merely intended to be cautious in, for example, insisting that a user takes a medication which he no longer necessarily needs and which seriously damages the quality of his life, or that /he wished to avoid the responsibility of making a personal judgement by adhering to a code of practice. Commitment cannot be escaped by cautious or sceptical negations and, as has been pointed out, the negation of a positive value supports a corresponding negative value. From many of the respondents' comments, it is clear that a dualistic and rather simplistic approach frequently prevails in practice. If refusing medication is not 'good', it must be 'bad', if hallucinations are not the mark of sanity, then they are that of insanity and so on. Why? Whilst this function of negation is relatively insignificant as far as 'minor' values are concerned, its importance is greatly enhanced in proportion to the values with which this study is concerned. The prior study of value scales and how these are created is therefore, inseparable from and essential to good ethical practice in mental health.

7.3.5. Counterfactual Desire Theories

Other value theorists, unconvinced by the view that value depends upon a subject's actual interests and theories, have proposed various alternatives. These include theories which hold that in fact the value of a thing depends upon what the subject would desire, or have an interest in, if he were *fully rational* or if desires were based upon full information. This claim is particularly relevant to issues such as involuntary admission and informed consent in mental health practice. Such theories are called

"counterfactual desire theories" (Audi, p831) since they take value to be dependent not upon a subject's actual interests but upon what a subject would desire if certain conditions, which do not currently prevail, were to prevail, for example when rational thinking is restored after a psychotic episode. Counterfactual desire theory is evident in much mental health practice and legislation, in which it usually known as beneficence.

In terms of human rights there is something deeply disquieting about practitioners and family members deciding what someone would desire "were circumstances not as they are". However, counterfactual desire theories do have their uses in good practice, for sometimes there is no alternative but for the practitioner, together with users' families, to make decisions for them. Indeed, some ethicists would condemn them for not doing so.

Linked to counterfactual desire theory, some philosophers[8] would deny that sentences of the forms "x is good" or "x is intrinsically good" are, strictly speaking, either true or false. As with other forms of ethical discourse, they claim that anyone who utters these sentences is either expressing his emotional attitudes, or prescribing or commending something. The phrase 'in the best interest of...' (understood as "good for") so frequently employed in the proposed new Mental Health Act, is an example of this. Whilst a value expresses the significance which someone ascribes to matters related to a particular experience or to his/her life in general – and this includes rights and autonomy – in mental health practice, respecting the rights and autonomy of the user

may, in certain circumstances, not represent either good practice or be in the user's best interest.

7.4. Practice and the Law

Acts relating to healthcare are frequently regulated in law and codes of good practice, and morality and law are closely related in certain areas of mental health care. In the interest of user and practitioner flourishing, it is important for morality to guide legal processes such as involuntary admission, but it would by no means be desirable for these (quasi)-legal processes to be the arbiter of ethics, for it is the exercise of the conscience which judges the morality of our acts.

On the whole, law does not, in spite of what has been said of the proposed new Mental Health Act, deliberately limit civil liberties, but endeavours to maintain the kind of society in which these can be exercised. The Act itself is intended as a means to these ends, although user and human rights groups see it as potentially breaching both human rights and civil liberties. Acquiring moral habits, indeed moral education of any kind, inevitably involves forming habits of obeying the law, or professional codes, and this applies to both practitioners and users. This may provoke moral dilemmas because, as in the case described in Chapter Six (p317), law and freedom are often seen as opposed to one another, an increasingly controversial topic in mental health practice.

" Charles Stevenson is the best known exponent of "the emotive theory of ethics", which claims that moral judgements do not describe properties of people or actions, but express approval or disapproval and

7.5. The Values-Virtues Link

Today, many positive human characteristics, such as courage, gentleness, justice and kindness, are considered to be values. This is partly because, in common with these, they must be embodied to become more than merely abstract concepts. They can be included in value judgements of actions, as for example, when we say that an act was caring or courageous, but the qualities themselves, if present, have to be acknowledged as pertaining to the agent's character and they are, therefore, considered embodiments of *values*. Strictly speaking, this is not the case. They are not values, but *virtues*. The virtues are our moral values. 'They are values we embody, live and act' (Compte-Sponville, 1996, p4). Today, the word 'virtue' no longer bears the connotations it once did, but has acquired misleading nuances, which is why it is often replaced by 'value', although its opposite 'vice' continues to be widely used. It would, therefore, be pedantic to insist upon the value-virtue distinction. Virtues can be said to be values put into action. Hence the inseparability described earlier – and the possibility of the efficient practitioner of emotional labour being considered a virtuous agent, since manifesting the appropriate affect in working with users could be claimed to be the result of exercising the virtue of practical wisdom *(phronesis)*, which is the 'ability to judge changing circumstances and choose ends and means wisely' (Fleming, 2000), with the intellectual virtue of theoretical wisdom *(sophia)*.

Psychiatry has, according to Fulford et al. (2002) traditionally been considered value-laden because it is less scientific than other branches of medicine, and Boorse (like Giddens and Goffman) claims that it is inclined to make "social value judgements a test

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seek also to influence the feelings of approval or disapproval of others (Honderich, 1995, p851).

of normality" (1977, p380). In mental health practice, these and other authors cited throughout this study agree that value judgements are present at all stages of the clinical encounter and explicit in diagnostic criteria. Thomas Szasz (1972 & 2001), suggests that the fact that psychiatric diagnoses are so value laden proves that mental disorder is, in fact, a metaphor for a moral, rather than medical issue. In so doing, it could be said that he confuses descriptive language with real phenomena. Simply because the medical model is not universally accepted, it cannot be discarded, for like the (caring) heart, the (rational) brain is an organ. Many users clearly *do* benefit from pharmacological treatments and some users, such as those in the USA sample, would prefer to believe that they have an organic, rather than psychological disorder.

In formulating an ethic for the flourishing of user and practitioner in mental health practice, the values upon which this is based are, therefore, necessarily of prior consideration. Moral value represents man's "*raison d'etre*" and affects the behaviour for which the person in question freely assumes responsibility. It is the most influential factor in the formation of the individual personality and herein lies its complexity, for in mental health practice, as in all areas of life, it must realise a universally valid ideal without prejudicing the individual peculiarities of the person in whom it is incarnate.

7.6. Key Claims and Recommendations

Human beings - possibly none more than those who suffer mental disorder - constantly query the meaning of life, man's function, and the nature of the world in which we live. Socrates, according to Plato (*Dialogues, The Apology*) recognised the worth of this, saying that the unexamined life is not worth living. This indicates that as human beings, including practitioners and users, in order to flourish we need to find meanings to life,

to work towards specific objectives, knowing not only where we are going but also, following a process of reflection, why. This is particularly relevant to mental health care, in which, as cases like those which have been described show, choices are often not clear-cut. Exercising as a virtuous agent requires adhering to a scale of values which facilitates choosing between different paths. It need not be consulted continually, but should be borne in mind as useful to and influencing in the resolution of ethical conflicts. Awareness of the role of values will, in each case, generate and guide the ethical principles and codes of good practice employed in decision-making and encourage a balancing of the views and values of all the parties involved. Mental health practice requires not inflexible and dogmatic deontological codes, but a normative statement or guidelines based on virtue and care ethics, informed by the principles (which are also virtues) of non-maleficence, beneficence, autonomy, justice and so on.

Ethical statements should also maintain, reinforce and promote both user's and practitioner's self-respect. Having one's values ignored as unworthy of consideration, as many users feel is the case, or rejected as "inferior" to those of a more powerful "other" is seriously damaging, for I only know who I am if I know my own preferences, and have clearly defined at least some life (or professional) goals. In the same way, I can only know what I want (personally or professionally) after having assimilated values which help me understand, give meaning to and express my (albeit unconventional) relationship with the world and its contents in an integral fashion, achieving a certain inner harmony. To this end, good communication is essential. However, in many mental health settings today, as in Goffman's time '... the passage of information (*is restricted*) especially that on staff's plans for inmates. Characteristically, the inmate is excluded

from knowledge of the decisions taken regarding his fate' (Goffman, 1968, p9). Even today, the research findings show that in patient-centred practice not all users are consulted in the formulation of their care plans. A virtue ethic informed by an ethic of care would promote flourishing, autonomy and the restoration of self-respect. This is important, for suffering a mental disorder can leave the user's personal scale of values in complete disarray. S/he and those around him/her may come to conceive the condition as a socially deviant act and the resulting stigma 'can come to dominate both *ego* and *alter's* perceptions (Williams, S. 1987, p137):

> 'There's something particularly awful about being tagged mentally ill. You think you'll never belong anywhere again. That's quite horrible' (UGJ)

In mental health practice, an ethic, which genuinely puts the patient at the centre of the therapeutic community, is therefore urgently needed.

Both practitioners and users have many (although not only moral) potentialities[9]. They therefore need ethical aims at which to direct their efforts. This dissertation has shown that these must not, for such attempts are relatively fruitless, be established in what has been described as the inflexible fashion of deontology and consequentialism. It is essential that unprescribed areas of choice of action and decision-making are left open so that the agents involved, whether users or practitioners, can reach their own informed choices, based upon individual scales of values, rather than having decisions imposed upon them by social, clinical or political "others"[10]. Flexible ethical statements, or guidelines, informed by notions of virtue and care and whose end is flourishing will, the

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[9] Best understood as used in such sentences as "The boy is the potentiality of becoming a man" (Oates, 1962,p90).
[10] Although there may be necessary exceptions to this rule – see 7.3.4.

fieldwork findings reveal, better serve current mental health practice than rigid deontological codes.

It is also necessary to be aware of the degree to which practitioners fail to recognise that, far from lacking a value system, users' values may simply be different from their own, or those of others. This explains the situation previously described in which 'The values of psychiatric patients are all too often eclipsed by those of the service providers' (Fulford et al. 2002. p12). It is not necessarily the user's best interest which is served, even when this is ostensibly the case, if the service provider's criteria are based on what might be called "trivial" values such as meeting political objectives, unlike the personal values of the user, sincerely held perhaps, but having no firm foundation in hard, statistical fact.

This dissertation stated, in Chapter One, that anything genuinely in the best interest of either user or practitioner must necessarily have as its end flourishing or *eudemonia*, which is the ultimate justification for morality. Aristotle begins his works with an account of flourishing and then argues that the best means of achieving this is the cultivation and exercise of the virtues. In some cases, ethical *eudemonism* is combined with psychological *eudemonism*, which is the view that all free, intentional action is aimed ultimately at the subject's happiness, or flourishing. Such action provides a very sound basis indeed for good practice.

Aristotle's view links to that previously given which argues that individual behaviour is determined by behavioural intentions shaped by values. A common feature of ancient

discussions on ethics which distinguishes them from most modern ones is the view that an agent would not be rationally justified in taking a course of action that promised less flourishing than some alternative open to him/her. In mental health practice, this point is debatable and could be considered contrary to the ethos promoted in Chapter Three, in which it was argued that different forms of flourishing are in play in this context. Whilst ideally an ethic for flourishing would encourage this in both user and practitioner, beneficence and caring would, all things being equal, demand the prioritisation of that of the user.

Indeed, in Aristotle at least, some of the virtues are dispositions to act from primarily "other-regarding" motives. Although he regards the agent's personal flourishing as the ultimate justification of virtuous action, it is not this which necessarily motivates such action, but principles or values – and it is these, as has been indicated, which in one form or another inform all codes of good practice and ethics. Since *eudemonia* (flourishing) is regarded by Aristotle as the ultimate end that justifies our actions, his ethical theory seems teleological. This means that right or virtuous action is construed as action that contributes to or maximises the good. This initially appears to support the consequentialist stance, but this is not the case, for ancient Greek philosophers typically regarded virtuous action as inherently valuable and constitutive of the agent's flourishing, regardless of the consequences. This freedom to disregard the consequences in terms of the greatest happiness of the greatest number is essential to good practice in mental health, in which, for example, the user's own desires might be preferred to those of his entire family, or vice-versa.

Mental health practitioners are often not confronted by clear-cut choices between good and bad actions, but with dilemmas presenting a choice between better and worse. Scales of value/virtue can contradict one another. There are conflicting loyalties (the user's 'best interest' or that of society?); there is the 'lesser of two evils' (medicate and ignore the user's wishes or fail to do so and upset his family?). Consequently, ethical decision making must be based on a balancing of varying degrees of value.

In practice, it is essential that such balancing is as clear and well-informed as possible. This is often hazardous, for it can only result from real communication between practitioner and user, which has little to do with ethical codes and much to do with mutual respect. Goffman 'suggests that a major problem confronting a discredited person is that of "managing tension" generated during social interaction, and hence the need to manage the impression others have of him or her: a management of spoiled identity.' (Williams, S., 1987,p141). When communication fails, as given the tensions inherent in such situations it often will then, as media coverage of suicides and crimes committed by the mentally disordered shows, the consequences may be dire. Goffman also talks of 'managing information', something which links to claims made by both users and mental health workers during the fieldwork research, that they mutually lie and withhold information from one another:

> 'To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, when, and where' (Goffman, 1968, p57)

Awareness of these contradictions must be maintained in ethical decision-making, for it will help to achieve a solution genuinely in the best interest of everyone concerned. In dealing with values, contradictions could be said to be the natural rule, for this reason

the phrase 'ethical dilemma' is a commonplace in moral philosophy in general. However, like virtues, values are not invalidated if contradicted by one another. To the contrary, attempting to unify value scales by basing them on a common denominator – something promoted by current codes of practice promote – distorts ethical judgements. Nevertheless, in order to select the scale of values to be applied, a value hierarchy is necessary. Those relevant to mental health practice need to be evaluated and placed on a scale. When values conflict, this reveals their relative importance.

This is important because we should, for instance, know the relationship between what practitioners and users really need, and what they desire because it gives them pleasure. Circumstances may arise in which it is impossible for a practitioner to act with the loving care demanded by Noddings' ethic of care, and at the same time act responsibly in terms of duty to society, colleagues and (perhaps) health insurance companies. Difficult choices continually have to be made and it is in this kind of decision-making that counterfactual value theory and the virtues of *phronesis,* courage and justice have much to contribute.

When practitioners breach professional codes of conduct, they frequently do so in the name of good practice and in the exercise of a principle such as beneficence. Principles, as has been shown, are not inseparable from either virtue ethics or caring. Consequently, since the fieldwork reveals that both users and practitioners seek an ethic which promotes user autonomy, makes him/her feel cared both for and about, and is based on mutual flourishing and respect, a care-informed neo-Aristotelian virtue ethic for flourishing appears most adequate to the exigencies of mental health practice today.

This could facilitate both a normative professional statement of good practice and professional education in ethics.

Whilst based upon what Hursthouse showed, in Chapter Two, to be normative principles, this ethic would be flexible enough to meet the specific needs of mental health practice, hence the description "statement", rather than code or rules. Like that of the British Sociological Association referred to in Chapter Four, the aim of this would be to develop mental health practitioners' awareness of the need for reflexivity in resolving professional conduct issues. Such a statement would not 'provide a set formula' for the resolution of ethical dilemmas, but 'recognise that it will often be necessary to make choices on the basis of principles and values, and the interests of those involved'[11]. This is precisely what the majority of the fieldwork practitioner respondents already do in practice. If they are educated in virtue and care ethics and live out their professional lives aspiring to be virtuous agents, promoting flourishing in every aspect of mental health care, the words "shall" and "must" will come to have no place in the lexicon of mental health ethics.

None of the practitioners interviewed, or responding to the questionnaire, systematically referred to existing codes of ethics in resolving ethical dilemmas in practice. Ethics, therefore, needs to be perceived as, and become, an inherent part of practice, a lived experience rather than another factor in accountability. Practitioners must be familiar with the codes of their own and other disciplines, understanding their purpose and the common values upon which they are based. However, ethics cannot, given its

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[11] From "Good Professional Conduct" – notes circulated to members by the B.S.A.

importance to good practice, be reduced to yet another subject on the curriculum. It is neither an acceptable outcome, nor bodes well for good practice for students to leave training, or qualified practitioners to work, with little or no genuine understanding of ethical responsibilities or standards of good practice. A systematic approach which can be confidently applied in daily practice, in awareness of promoting flourishing of the kind described in Chapter One is required. Recommendations for such an approach, which puts a virtue and care ethic for flourishing at the centre of good mental health practice, follow.

CHAPTER EIGHT: CONCLUSIONS

8. 1. Introduction

Having emphasised the essential centrality of values to ethical guidelines and education for mental health practice and suggested that virtue and care ethics can better inform the latter than deontological codes or casuistry, this chapter summarises the conclusions which may be drawn from this doctoral research. Although in a cross-disciplinary study (and this research has, of necessity, included those of philosophy, applied sociology, mental health policy, gender studies and even law) it has been impossible to engage with individual topics in as much depth as might be desirable to conclusively prove this, the results appear to indicate very clearly that values inform virtues and good practice and that the latter could "flourish" if guided by an ethic based upon neo-Aristotelian virtue ethics informed by the notions of caring inherent to the ethic of care.

Although Chapter Two showed that such an ethic can meet professional colleges' requirement for a normative ethic, this is not, strictly speaking, a necessary or sufficient condition for this. It has been shown that a set of rigid formulae for resolving moral dilemmas overlooks the , mental health practitioners do not feel that such codes respond to the needs of their profession and that it is desirable to allow flexibility and a degree of choice in resolving dilemmas. As an integrated conception of ethics, the virtue and care "ethic for flourishing" includes users and their families and mental health

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practitioners in a model of caring based on a deep awareness of values and virtues, rather than rules, obligations and rigid principles. This moves away from the limitations of the technological 'curing' versus emotional 'caring' debate by recognising that both aspects of treatment are equally necessary. Ethical practice based on the notions of virtue and care ethics, informed by a deepened awareness of, and respect for, the individual values of practitioner and user could, unlike other ethical theories, encourage the maximum 'flourishing' of both.

In mental health practice, the beneficent love which is caring for and about the user necessarily includes respecting the values of the 'other'. It was previously said that '... this attitude of "my values or none" appears to be greatly detrimental to the user-practitioner relationship' (Chapter 7, p354). Certainly the right to refuse treatment is often subsidiary to the issue of the user's competence, questioned more often owing to a refusal of treatment than any professionally assessed lack of decision making capacity leading to this refusal. Applying the right to refuse in this way is hardly "democratic". On the other hand, Fulford et al. (2002) observe that basing healthcare ethics on a recognition of diversity of values, including those of the mental health practitioner and the user, 'opens up crucial issues of methodology and practical application' (p4). This dissertation has shown that such recognition is desirable, but is it also possible? How can awareness of the diversity of values form the foundation for good practice and ethics education in mental health care?

8.2. Practical Recommendations

8.2.1 Education in, and the practical application of, a virtue and care ethic for flourishing

A virtue and care based ethic for flourishing must, the previous chapter indicated, be *a posteriori* to, or at least simultaneous with, education in values. Right conduct, it has been said, 'should come from the inside out' and the discussion on values explained that these are generated 'inside'. If virtue is knowledge and getting it right and based on a sensitivity to the demands of the particular situation, as McDowell claims, the virtue/value judgement is the manifestation of this sensitivity. Since no consideration of an ethical dilemma can be value free and the ascription of virtues explains behaviour, how may practitioners develop the sensitivity necessary to virtue, value judgements and good mental health practice? This dissertation concludes that this can be achieved by a combination of the following:

- Education in the nature and formation of values and virtues, based upon the notion that virtues are values put into action.

- Exercises in reflexivity, as an aid to developing *phronesis*.

- Increased emphasis on the responsibility of experienced practitioners as role models and mentors in fomenting good practice in their more novice colleagues.

- Habituation, empathy and emotional labour

- Increased user participation and an emphasis on user-focussed care in the community, rather than in institutions (see also Pilgrim and Rogers, 2001).

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- The replacement of existing mandatory professional codes of good practice and ethics, by non-mandatory guidelines similar to those of the B.S.A. briefly discussed in Chapter 4 (p217) and later in this chapter...

8.2.2. Education in the Virtues

To quote Aristotle: 'We have the virtues neither by nor contrary to [our] nature ... we are fitted by [our] nature to receive them' (Nichomachean Ethics 1103a24-6). This claim that we are 'fitted by nature to receive them' implies that having acquired them through the 'sort of moral education and self-improvement appropriate to rational social animals' (Hursthouse, 1999, p251) we enjoy exercising them. We can, as a result of these processes, become "habituated" to behaving in a virtuous fashion. In the case of mental health practice this process of moral education, self-improvement and habituation can be encouraged in training and practice. Many expectations concerning professional health care centre on the way in which practitioners 'manage' their emotions. Nurses and doctors, for example, must learn new set of 'feeling rules' which help them to maintain a professional demeanour whilst performing deeply unpleasant tasks (Lawler, 1991). Fineman (1993) labels these the 'implicit feeling rules' of a professional discipline, but Salamen, more in keeping with the recommendations of this and the previous chapter refers to the as 'a professional value system'.

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In answering the question "what kind of life should I lead?", Chapter Two explained that, according to Hutchinson (1986), virtue ethics must describe specific human virtues to which individual users (in spite of the fact that their responsibilities are rarely discussed in mainstream medical ethics) as well as mental health care workers can aspire. '... showing values for what they are, taking them out of the closet ... is a key function of ethical reasoning in healthcare matters' (Fulford,1994, p162). Sound knowledge of the values and culture of those with whom they work is essential to all mental health professionals if good communication is to be established. Its absence promotes a situation which, rather than promoting the flourishing of the user, adds to the inarticulatable "angst" of the experience of the disorder, inarticulatable in the sense that s/he might have no common cultural capital with a practitioner versed in the western medical model:

> '...many important issues are not adequately covered in training programmes. These include cultural sensitivity, gender issues, traumatisation of the patient and sensory impairment' (N & MC News, Spring, 2002, p16)

8.2.3. *Phronesis* and Reflexivity

Loyalty to the group continues to be generated when social structures are characterised by interaction rituals. In some mental hospitals, and to a lesser degree in the community, a "them-us" dichotomy continues to exist between users and practitioners. This is founded upon value based notions of paternalism, or moral judgements representing the mentally disordered person as in some way "defective". Shared interaction rituals, such as the "ceremony" of giving out the medication, perpetuate this dichotomy. Treating

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the user as "other", as would be the case in applying a deontological ethic[1] in, for example, a case in which the user refused to take his prescribed medication and was forced to do so, makes the practice of an ethic for flourishing impossible, given that the aim of this is to achieve the user's own flourishing *qua* respected member of the community. Not just users, but mental healthcare professionals in hospitals, too, have been shown by the research findings to feel stigmatised and undervalued. Demoralised practitioners may project their frustrations onto equally demoralised users. Practitioners should therefore be taught reflexive practices in which they are encouraged to think about the personal and professional values necessary to flourishing of the kind described in Chapter One.

Whilst *phronesis* has been a constant theme in this work, reflexivity has so far merited only a brief mention (Chapter Five). It is essentially self-reference and in the context of mental health, requires that practitioners recognise themselves not as external to the ethical dilemmas with which they are dealing but as active, possibly causative, participants in these as members of the therapeutic (or not) community. Reflexivity manifests itself most oddly when individuals unwittingly enact the very behaviours being criticised. In the ward context, for example, the research findings reveal that this may involve confronting bullying behaviour with (equally or more) bullying behaviour.

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[1] In the case of Kant, for example, anyone who failed to conform to the Categorical Imperative was automatically excluded from the realm of ends

Learning to exercise reflexivity in practice is particularly important for in-patient hospital care as in this, a relatively neglected staff group is caring for a relatively neglected client group. Programmes such as BAITS (described in Chapter Five) have been highly successful in teaching health care workers of all disciplines to practice reflexivity. Having acknowledged their own negative thoughts and feelings, by combining *phronesis* and reflexivity, to arrive at an understanding of their own reactions to challenging behaviour, as well as those of the user in question, mental health practitioners are better equipped to think constructively about the dynamics of violent or disruptive behaviour, or negative relationships with (or amongst) users. Rather than considering this kind of situation to be exclusively the users' problem, exercising reflexivity increases practitioners' awareness of the numerous factors involved in its genesis.

The nature of mental health practice is more emotionally complex that that if the air stewardess described by Hochschild and informed by completely different motivations. This means that their emotion management performances cannot be categorised under one heading. Recognising that practitioners move in different frames of action, in which they 'perform' according to different sets of feeling rules, reveals multi-situated systems of activity (Goffman, 1961). The type of training offered by programmes such as BAITS gives staff the confidence to intervene in a confrontational situation, thus avoiding, or at least diminishing the frequency of incidents potentially highly damaging to the flourishing (in the sense described here) of either

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practitioner and user. This does not imply that practitioners learn to 'transmute' (Hochschild, 1983) their private feelings. It is simply that their emotional skills become developed to the degree that they can mix and manage different styles of emotion management according to the rules which they have developed for themselves, rather than those imposed upon them by the profession or organisation.

Further reflection, following resolution of the incident, enables user and carer to benefit from an otherwise negative situation. It also involves considering ways in which, in order to avoid recurrences, users' lives can be enriched and autonomy encouraged. Promoting practitioner flourishing by promoting *phronesis* in this way also pays incalculable dividends in terms of user flourishing.

8.2.4. Role models: the virtuous practitioner

Deontologists and consequentialists have been described as thinking that it is possible to separate questions about the rightness of an action from those about the goodness of this. However, virtue ethicists would claim that this is neither desirable nor even feasible. How we act is as important as what we do and who, we are determines how we act.

It was suggested that role models are the ideal form of fomenting good practice in training mental health professionals. Various studies (Salvage, 1985, Smith, 1991, 1992, Svenson and Rothsteen, 1996, Robertson, 1998b)

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find that students learn professional feeling rules as a result of being immersed in the professional culture and by observing the behaviour of more senior staff, rather than in training schools. Aristotle himself, in *Nichomachean Ethics* (1142a. 12-29) says that moral knowledge is unlikely to be found in those lacking prudence and experience of life, and this cannot be achieved merely by attending lectures. The introduction of clinical mentors, who have the character and experience necessary to demonstrate the values essential to good mental health practice, as guides and role models for students would be one way of achieving this.

Robertson (1998), in his study of patient-centred medicine and medical school training, describes social research as showing that medical students view clinical role models as key influences in their own learning of skills and values. However, such models require careful selection, for the fieldwork findings reveal that practice does not always ensure perfection. Indeed, many mental health practitioners claim to have observed malpractice amongst their older colleagues. Nonetheless, users and practitioners also describe caring, "flourishing" practitioners. Mentors and role models should be recruited from amongst these.

The fact that not every agent in this context is virtuous is an important problem. How to redefine and recognise the virtuous agent in terms of mental health practice is the next objective. What is sought in the virtuous mental health practitioner is not *all* those virtues required of Aristotle's virtuous

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agent, for an ethic for flourishing must specifically meet the needs of mental health practice, not those of the Athenian *polis*. The practitioner "agent of flourishing" requires specific and "special" virtues, those necessary for completing the professional task well.

What it means to complete a task "well" is defined from within the particular practice discipline, for whilst the common aim is flourishing, this demands a variety of tasks and qualities from different mental health practitioners. Deciding the "special" virtues for each of these could require observing those who are considered particularly good at their job (the previously mentioned role models) and identifying the character traits which they possess.

Patience, technical expertise, kindness and honour would be desirable in all healthcare professionals and the majority appear to possess some or all of these virtues. However, those nurses in close contact with potentially violent users, for example, might require more courage than the doctor who spends little time with these and is not likely to be involved in dangerous situations at first hand. A highly developed sense of justice, in terms of human rights would, on the other hand, be necessary to doctors and social workers responsible for "sectioning", and so on.

This is not to trade off the question: "How do I live a good life?" with a question on professional skill: 'How do I be a good X?" where X is whichever discipline is being considered. In good practice these notions are inseparable.

When discussing the virtues necessary to the virtuous agent, Hursthouse (1999, pp167 & 247) describes what she terms 'Plato's requirement on the virtues'. This claims that the virtues, as we have seen, not only benefit their possessor, enabling him/her to flourish and both be and live a life which is *eudemon*, they also make him/her a good human being. These two features are interrelated. Wright, S. (1996) evaluates students' requirements in seeking role models and finds that that these are a combination of clinical skills and ability and a compassionate personality, characterised by concern for the users and their families and attentiveness to the needs of the students and other healthcare workers. Essentially, students value role models who value patient-centred medicine.

The relevance of this stress on agent, rather than act, in ethics is illustrated by the fact that although generally sympathetic to practitioners, users complain not so much of treatment decisions *per se* but of the manner in which these are delivered or acted upon. No expression of regret or concern seems considered necessary once practitioners have made the morally "right" decision, regardless of the user's feelings. But if the user suffers, or feels humiliated and undervalued by the decision (as for example, in the case of "sectioning"), even if it were unquestionably correct, something which is always a moot point in mental health practice, surely some kind of regret, or respect for the user's own feelings, views and values is required? Exercising an ethic for flourishing in the manner described above might make health care workers

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concentrate more on their responses, less complacent in the knowledge of having made the "right" decision.

8.2.5. Habituation and Empathy

Male and female practitioners are described as generally caring and empathetic. In some cases this is attributed to an inherent desire to care, in others the adoption of the expression of emotion appropriate to the moment was considered to be a form of emotional labour and part of the professional task. That empathy (or at least an efficient "performance" of this) is a teachable skill (Platt, 1992, Fine and Therrien, 1997) is a view which concurs with both Goffman's (1959) 'presentation of the self' and Hoschschild's (1983) 'emotional labour'. It may be learnt in the sense of reaching, through reflexivity and practice, an intellectual understanding of the user's feelings and emotions. Whilst classes on ethics are desirable, they will be insufficient unless preceded or accompanied by a training in emotional labour and presentation of the self which also promotes intellectual understanding of user's and practitioner's values. Ethical theory alone makes of this a dry, abstract discipline, unrelated to practice.

Howard Spiro (1992) claims that in order to empathise with users, the practitioner must recover his/her ability to emotionally identify with them, a skill he believes to have been neglected, rather than fostered, during an excessively 'scientific' training process. For practitioners, 'being value-pur-blind can be an effect of a dominant role model' (Fulford 2002, p12) Spiro

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suggests that practitioners are taught humanities in order to foster this empathy. These views are echoed in Moore et al. (1994), Platt (1992) and Robertson (1998) all of whom recommend the fostering of the empathic skills of emotional labour in medical school curricula and believe that these can be learnt by practice.

The care component of an ethic for flourishing asserts the importance of an active concern for the good of others and of community. It also requires a capacity for sympathetic and imaginative projection into the position of the other (empathy) and of situation-attuned responses to other's needs. It therefore meets Aristotle's community requirement for virtue, as well indicating some of the characteristics to be desired in the professional role model.

8.2.6. Increased User Participation: Alterity and Discrimination

It was pointed out in Chapter Two that the concept of *universal* flourishing is questionably realisable and that good practice is only as good as its practitioners, regardless of the codes of practice stipulated by professional bodies (and against deontology and consequentialism, which favour act, rather than agent). It is apparent that if mental health practitioners are to be educated in what to strive for in good practice, this aim must be clear. "This-ness", as described in Chapter 2, must be considered and there can be no rigid prescriptions or rules of good conduct in dealing with this or that particular sufferer from schizophrenia or psychopathy. The "good" practitioner should be

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capable of discerning the individual interest and values of each individual user, whilst the "good" user would, in awareness of this, participate fully in informing family and practitioner as to his/her aspirations and fears, and in the treatment plan which has been mutually agreed between him/her and these.

As the research findings reveal, users consider their own views and agendas vital to any care plan and, indeed 'doctors' attention to them can ... result in symptomatic and even health status improvement' (Robertson, D, 1998, p9). However, the fieldwork findings show that mental health workers often fail to appreciate and understand users' own agendas in terms of values and priorities, whilst at the same time creating tensions amongst themselves for the same reason. Nurses, for example, may feel that although due to their close contact with them they possess real expertise as far as the user is concerned, they are not consulted enough by the psychiatrists treating these. They frequently also see themselves as advocating for the user (caring versus curing) and in consequence may be perceived as threatening the authority of doctors and social workers, as well as "owning" the users. (The use of the possessive pronoun is prevalent – "my patients", "my ward"). There could, therefore, be said to exist a democratic deficit in health in which professional knowledge is seen as pre-eminent.

Ethical practice, in terms of a virtue and care ethic for flourishing, is not about neglecting one's own interests in favour of those of others, as in the traditional "female" role of self-abnegating carer described in Chapter Three, but about

serving both simultaneously. When practitioners engage in good caring, they are acting to fulfil a natural desire to be and remain related.

8.2.7. Guidelines, not Rules or Codes

In order to promote flourishing, it is essential to leave unprescribed areas of choice of action and decision-making. Decisions should be based upon ethical alternatives, not rigid codes. The virtuous, caring agent does not need these, but sufficient flexibility to be able to exercise virtues and caring, *phronesis* and love, professional expertise and legal considerations appropriately. This requires a universal concept of *eudemonia* (flourishing) for collective practice and its antithesis for the individual (see Chapter Two). Guidelines, or a statement, are necessary, but these must be realistic if they are not to be impracticable and possibly even opposed to the interest of the user and/or society. At the same time, they must not be so low-level as to impede good practice. In theory, a dialectical process comes of good practice, but given the nature and peculiar dilemmas inherent to mental disorder, it is necessary to remember that this must also be enshrined in law.

In view of what has been said so far, current codes or ethics, since they contain requirements ultimately impossible to obey in every possible ethical dilemma in mental health practice, should be rewritten as "guidelines" such as those described of the British Sociological Association (BSA). 'The guidelines do not provide a set of formulae for resolving choices or dilemmas surrounding professional conduct, but recognise that it will often be necessary to make such

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choices on the basis of principles and values, and the interests of those involved'.[2] This study has shown that in mental health practice this stance is particularly relevant, for rules cannot be categorical or imperative where the situations with which they are intended to cope are not only distressing, but frequently highly disconcerting. Practitioners must be educated to assume responsibility for their own ethical practice and where good practice would appear, as it frequently does, to clash with procedures or codes established by professional colleges, should seek to change the latter, in the interest of the former

However, as far as law is concerned, the question is one of whether autonomy becomes overvalued when it conflicts with other values. Mental health practitioners must necessarily be concerned with whether the user is truly competent to make decisions in a complex situation. They must endeavour to combine the Aristotelian virtues of *phronesis* and justice with caring for and about the user **and** society. Their interests are not always compatible.

Some philosophers, as has been indicated, dissatisfied with the view that value depends upon a subject's actual interests and theories, have proposed *inter alia*

theories which hold that the value of a thing depends entirely upon what a subject would desire or have an interest in *if s/he were fully rational, or if desires were based upon full information*. Such theories (the counterfactual desire theories described in Chapter Seven) take value to be dependent, not upon a subject's actual interests, but upon what they would desire if certain conditions, which do not obtain, were to obtain. 'The intuitive weighing of values to which principles reasoning points is, in the end, a matter for individual (value) judgements' (Fulford et al. 2002, p10).

As long as one is aware of the possibility inherent in them for abuses of power, counterfactual desire theories may have their uses in good caring practice and, indeed, in promoting the flourishing of the user on those occasions of crisis which occasionally occur in mental disorder. It has been argued that there may be times, for example, when "sectioning" is necessary and in spite of the fact that this is rarely something users desire at the time, the research findings show that retrospectively they are often prepared to admit the need for such measures. Acting as an "agent of flourishing" occasionally requires doing something when the user would prefer that one did nothing. When this occurs, the flourishing of the practitioner in question also requires ensuring that s/he is legally and morally empowered to act in this way, and not likely to later be abused or blamed for having so acted.

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[2] Taken from a statement entitled "Good Professional Conduct", approved on the 1st March 2002 and circulated by the BSA to its members in the form of notes.

8.3. Practical Steps towards Flourishing.

Given the stigma attached to mental hospitals, a first practical step in eliminating discrimination, achieving good practice and user's and mental health care worker's flourishing, would be to accelerate the excessively slow closure of these (Rogers and Pilgrim, 2001). There is wide agreement today that these institutions are the "dustbins" of the health service (see Chapter One) and that this status is endowed upon those in treatment and those who work in them. Custodial institutions of this kind provoke power dynamics and hierarchical structures which foment the representation of mental disorder as a moral, rather than physical or psychological disorder. Users in hospital settings are often at best infantilised by excessively maternalistic or paternalistic staff and, at worst, treated as "prisoners" by the power-drunk. In both cases users claim to feel humiliated and disempowered.

However, this is not inevitably a one-way process. Power is a more insidious notion than is immediately obvious. Some users report the powerlessness of practitioners themselves, in an alarming reversal of conventional hierarchies in which a particular user, as likely to be female as male, will 'tyrannise' both staff and other users by means of manipulation and subtle forms of bullying. The weaker user in this situation feels safe in being allied to the "boss" figure, whilst nursing staff, unable to control the situation, "hide" in the nursing station. To quote:

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"It is very difficult to control a ward [in these circumstances] unless the users are so zomped[3] that there's no problem' (UOA).

Consequently excessive "zomping" and restraint are also not uncommon. This kind of situation creates an image of mental hospitals as remarkably similar to prisons and, indeed, much of the vocabulary and imagery reinforces this. In a recent publication for nurses and midwives, the management of violence in health care was discussed in the following terms:

'Sixty-one percent of respondents reported that they were trained in the application of controlled pain to induce compliance in resistant patients'

'Specific concerns were raised about training in the use of the figure-four leg lock' (N&MC News, 2002)

One could be forgiven for thinking that these are techniques for prison guards, rather than mental health practitioners caring for the "ill". It is not surprising that even users who have not undergone in-patient hospital treatment for many years may describe returning to hospital as one of their greatest fears.

However, the concern of health professionals for their own safety are also legitimate. For every assault on a user, there are two on members of staff. But whilst hospitals do exist, so does a duty of care to those who are being treated. Although the attitude and approach of carers is widely considered a question of character, rather than gender, several women expressed discomfort at sharing wards with male patients. At least during periods of acute crisis, men and women should be separated, in the interest of both. Sexual harassment is

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[3] By "zomped" was understood sedated, although this was, perhaps unfortunately, not clarified at the time.

not unique to men and for this reason, returning to single sex wards is widely considered to be desirable. However, since most users and practitioners believe that communication is often better between members of the opposite sex these should, somewhat paradoxically, be staffed by mental health workers of both sexes

If a hospital is not a place of asylum, in the truest sense of the word (although some clearly are seen as places of "safety" by users), but of fear and manipulation, then it fails in its duty of care. Whilst custodial care is necessary for users in crisis, the potentially violent or self-harming, who cannot adequately be cared for at home, ideally they should be attended not only by trained professionals, but also by other users who know their experience, share their values and are not caught in hierarchical nets which enmesh the more powerful 'us' and the vulnerable 'them'. Any threat of violence is often far better resolved by users amongst themselves than in the clinical context, in which staff anxious to preserve their personal integrity and the smooth-running of the ward "control" the first sign of disturbance by means of drugs, restraint and isolation, possibly exacerbating rather than defusing the situation[4] by their manifestation of power, rather than good practice.

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[4] Whilst carrying out fieldwork interviews at a survivors' centre, a severely disturbed man entered. The other users, without raising their voices, told him that he must leave as he had been "banned" from the premises until he was less disruptive. Initially, he refused to go, but after a cup of coffee with some of the regulars, he agreed to leave and did so quietly. During the half-an-hour or so in which he was there, the only person apparently alarmed or frightened by his behaviour was me.

Not that all types of in-patient care should be abolished. For users who need to be protected from themselves and their own destructive acts, crisis units staffed by professionals and users and providing psychopharmacological, psychotherapeutic and alternative therapies, are considered the ideal model by users and many practitioners. These offer a safe, appropriate and more socially acceptable alternative to hospital in-patient care and could be designated to meeting the needs of specific vulnerable groups, such as for example, women with small children[5].

Many 'critical' practitioners, as well as users consider conventional care so inadequate that they suggest that people in crisis survive better if they avoid it altogether. They recommend alternatives offered by user groups or volunteers in the community, employing a minimum of medication and a wide selection of alternative therapies. "Anam Cara", a four-bedroom house in Birmingham, offers this kind of approach and is enormously successful, in spite of the reticence which greeted its opening. The Mental Health Foundation opened this project because research amongst service users (in keeping with that described in this thesis), indicated distrust and dissatisfaction with hospital care, something they saw as punishing them for being in crisis. They sought alternative care centres and moral support from others who had undergone

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[5] A highly successful example of this is the Drayton Park Crisis Project. This is a 12-bedded unit for stays of up to 4 weeks for women with children. The staff work together with community workers, encouraging them to continue regular contact with these women whilst they are at Drayton Park, helping to ensure continuity of care and support after leaving.

similar experiences. Of these projects, staffed or managed by service users, the director of Mental Health Foundation says:

> 'We can now say with confidence that our projects were
> and are successful, favoured by the service users and well
> integrated with mainstream care. Others must now be developed
> along these lines and the values which underpin them must also
> inform the long overdue overhaul of hospital in-patient care'

The Sainsbury Centre for Mental Health formally evaluated the scheme and its report reveals 'startling benefits for a severely troubled client group', most of whom were on enhanced CPA"[6]. One hundred percent of users felt that the service had met their needs. This appears to be a fine example of flourishing practice

Such examples of genuinely "flourishing" practice show that traditional hierarchies can be avoided. The therapeutic team needs to be exactly that, the user forming the nucleus of a caring community which moves into him/her, rather than removing an already isolated person from familiar surroundings. Community care, when not in the form of a conventional hospital out-patient clinic, provides a way to establish valued lifestyles and social relationships for people in care who have been devalued by institutional care. To flourish, as Aristotle knew, we need to form part of the community, not be isolated from it.

8.4. Overcoming Adverse Discrimination

Adverse discrimination has been the topic central to discussion and conclusions. Flourishing mental health practice necessitates particular sensitivity to this issue. Inequalities described in the context of employment and education prevail in mental health, in which, as has been shown, class, gender, and ethnicity can exacerbate discriminatory treatment in terms of diagnosis, communication or length of stay. An ethic for flourishing must, therefore, give serious consideration to resolving questions of discrimination which impede this.

It is also necessary to remember that such inequalities pertain not only in coercive, but also in consensual relationships, The fact that some users "don't mind" being treated as children by "kind" practitioners, does not eliminate the undesirable inequalities inherent in such a relationship. Being known *"fondly"* as "Mad Barry"[7] does not make this kind of labelling any less discriminatory. "Concessions" or "privileges" afforded to users by mental health practitioners often serve the interests of the latter, rather than the former insofar as they impose a kind of "moral obligation" upon the user. This can result in coercive exchanges which although sometimes going under such sophisticated labels as "therapeutic alliance" are little more than means of persuading the user to "cooperate" with the treatment plan in exchange for their "right" to continued "privileges".

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[6] CPA is the care programme approach, advanced CPA is the more rigorous version of this clinical protocol.

Such discrimination, as opposed to coercion, is always the result of not conforming to the dominant social ideology. Such conformity should not be a necessary condition for flourishing. Integration and well-being, even public acclaim, are possible without conforming to an ideological mainstream. A new breed of users is emerging 'up-front and radicalised people with mental health issues who are working to change perceptions, legislation and services' (*The Observer Magazine*, 21.10.01., p58) and who refuse to accept that the only valid and socially acceptable ideology is that imposed by a white, male, middle-class hierarchy.

Many users and practitioners, including some of those of those interviewed in the fieldwork, describe their "madness" as heightening sensitivity to experiences of all kinds, colours are brighter, music transports to celestial heights – and all this is lost once "sanity" is restored. Little wonder that some users no longer wish to take medication and/or have learnt to disguise or not disclose their hallucinations or delusions to an unsympathetic public. One of the respondents talks to his "voices" with impunity by pretending to use a mobile phone as he does so, whilst another has continued to experience exactly the same delusions for which she was "sectioned", but simply keeps quiet about them. As a result of such or insight into the workings of the system, neither of these is any longer considered "mad", nor in need of medication. Both are, by any criteria, "flourishing".

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[7] The Times, Times 2, 3.7.01, p5

Given that so many users do speak of heightened (flourishing) creativity and sensitivity in mental disorder, the suggested use of the word "condition", described earlier, rather than "disorder", would be ethically and "politically" correct. As would therapies designed to harness and foment these gifts. Encouraging flourishing invites the re-thinking of all pre-conceived notions on mental illness. Whilst not rejecting pharmaceutical treatments, in addition to these users would greatly benefit from talk therapies and physical treatments such as massage and Reiki. They also speak highly of drama, art and bibliotherapy as a helpful means of communicating that which cannot be expressed easily in words – even when there is someone there to listen.

Nothing, it would seem, is so therapeutic as a good listener and caring practitioners can "listen" with their eyes, as well as ears. All forms of expression and communication are valid in the treatment of the troubled mind and in eliminating stereotypical images which provoke "alterity", the notion of the mentally different as a "them" who fail to conform to the dominant ideology, compared to "us", who not only conform to and defend this, but stigmatise and label those who do not.

Restoring the user's faith in him/herself is one of the aims of the flourishing practitioner, for this forms part of that of the user. The interpretation of mental illness as a moral disorder is a causative factor in users' symptoms being treated as "bad" and worthy of punishment. If mental disorder is a crime, or a moral defect, then hospitals and clinics are not the place to treat it. Whilst they

are, any kind of moral discourse in relation to it should be avoided for it is instrumental in creating the stigmatisation so damaging to users' (and practitioners') lives.

For some users (and carers), too, religion is a very important issue, and a potentially highly sensitive one. Some faiths attribute mental illness to "spiritual sickness" and it is possible that religious crises are wrongly diagnosed as mental disorders in today's lay society. Religion is inextricably bound with culture and as such is fundamental to the lives of many users. For some, secular and spiritual are indivisible. However, in an example of either insensitivity or malpractice, mental health care traditionally overlooks this spiritual dimension, both in diagnosis and in treatment.

Officially, the development and delivery of culturally and spiritually appropriate services is now an obligation, but as any Muslim wishing to fast during Ramadan and eat at sunset, or "dreadlocked" Rastafarian will testify, this is far from being the case. Religious observance and taking medication with food can be reconciled where there is a will to do so – and the virtuous, caring practitioner, as a virtuous agent, would so wish. Today's multi-cultural psychiatric *polis* requires respect for all ethnicities and creeds if it is to be *eudemon*, and flourish.

An ethic for flourishing (and everything said so far) is essentially about respect, based on recognising the values and beliefs of the other as equally

legitimate as one's own, regardless of how dissimilar. It also involves respecting the views of other practitioners, for in ethical dilemmas, as in treatment plans, these are often different. Flourishing practice requires a care team whose very strength lies in the diversity of the points of view – including those of the user and his/her family - considered in the care plan.

Practitioners, too, need an appeal which can awaken their personal and professional potentialities (see Chapter 7) in such a way that they, in turn, provoke moral actions, for all human beings. Both they and users have a multitude of potentialities, something recognised by Aristotle. Technical knowledge, in the form of familiarity with recent developments in pharmacological and physical treatments, the desire to promote flourishing inherent in the practice of the virtuous agent and the love of the ethic of care are all necessary to practice. If these factors are combined, practice will not only be genuinely "good", but encourage the maximum flourishing of practice, health care worker and user, as described in Chapter One.

Finally, mental health ethics must necessarily be considered in the context of the law. There has been a recent tendency, exacerbated, perhaps, by the proposed new Mental Health Act, towards a withdrawal of user rights, towards qualification of these or 'toward the affirmation of symbolic rights without any concrete existence' (Susan Stefan, cited in McCubbin and Cohen, 1999). From the fieldwork findings, it is clear that users' rights are "interpreted" or ignored by many health care professionals and policy makers. The right to

treatment may be interpreted as the right to receive forced treatment, even if this was not the original intention. Informed consent, for example, when that process is actually made explicit, is frequently little more than a bureaucratic gesture to meet the needs of the practitioner's conscience and the possibility of future litigation.

In addition, the notion of dangerousness, which should be a severe test for justifying the exceptional deprivation of liberty of a severely psychologically disturbed person, has been shown to be employed in practice as a need for treatment. One user (UOA) who ran away from home one night rather than harm his mother, was arrested (and physically assaulted) by the local police, waking up sedated and 'sectioned', in hospital. He would have been prepared to voluntarily enter a hospital the previous night, had anyone thought to ask him. This incident illustrates the tendency of institutions and the general public to act in accordance with stereotypical notions of "madness", independently of the law, much less the user's rights. However, in defence of hospitals, another did confess that, having experienced both, they were 'much better than prison' (UOD).

Those users in "continuing care" rarely have the possibility of defending their rights. The advocacy service is limited in its powers and users often have only the most meagre financial means. In consequence, it is difficult, if not impossible, for them to afford legal assistance from experts in health law or civil rights. Equally, if not more difficult, is finding a psychiatrist who is

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prepared as an 'expert witness' to contest the views of a colleague, invariably given more weight than the conflicting evidence of other care professionals.

The law currently does little to promote users' flourishing. It is not sufficient to simply "give" rights to users. When rights are given, rather than grabbed, they can be distorted beyond all recognition and in the case of chronic users of mental health services, it is too easy to identify the attributed needs of users, as defined by experts and families involved in their care and treatment as being their "rights". This is a category error in values similar to that described in Chapter Seven in which the embodiment of a value is confused with the value itself.

Respect for the values of justice, as well as for the user as an independent adult implies that some of the power currently invested in institutions and mental health professionals must be ceded to the users themselves. Tentative steps made in this direction have proved far more successful in terms of users' and carers' flourishing than could ever have been imagined. There is now sufficient evidence that in being allowed some power and autonomy, individuals and groups learn better ways of exercising it. However, responsibility cannot be learnt in the absence of trust. If practitioners and policy-makers can demonstrate a willingness to cede much of their power to the users themselves, they will be showing that as "flourishing" practitioners they are ready to make a "gift" of freedom, in freedom, for freedom. This

"gift" will be motivated by a recognition of values and virtues based on sound moral reasoning (*phronesis*), caring and a true desire to see the user flourish.

8.5. Concluding Thoughts

Jonathan Glover's book *Humanity* (1998) examines the psychological and political sources of the twentieth century's worst moral tragedies. In this work, Glover discusses the way in which our moral resources are undermined or overcome, allowing us to perpetrate vile acts. Moral resources (in mental health practice, as in all other aspects of life) are undermined and disappear when we fail to comprehend that as a consequence of such processes we forfeit both a "good" life and the means to human flourishing. Glover appeals for the cultivation of moral imagination and a programme of 'tentative, exploratory and partly empirical research' that will base morality on 'human needs and human values' (p406). He supports the cross-disciplinary approach adopted here, believing that empirical sciences, such as applied sociology, should inform understanding of human flourishing, thus assisting philosophers in what he conceives as their "public role", that of keeping alive the critical examination of beliefs, to encourage independence and rationality in others and the incitement not to defer to authority or to conventional views' ibid). His words are a blueprint for the empowerment of the mentally disordered and the attempt to reconsider mental health ethics which has just concluded.

APPENDIX 1

Possible questions for interviews with users

1. What do you understand by the terms "duty" and "obligation" in the mental health practitioner-user relationship? What do you think the duties/obligations of the people who care for you are, for example?

2. Do you think that you as a user have any specific obligations or duties?
   If yes, what are these?
   If no, why not?

3. What, in your opinion, is the main role of the practitioners who attend you?

4. Do you think their first duty is towards you, society, the place at which you are being treated, or something or someone else?

5. Is it your impression that practitioners' are aware of and put into practice the codes of ethics of their professional colleges?

6. Do you see any one obligation as being more important in mental health practice than another?

7. Do obligations ever conflict? Can you describe such a dilemma in your own experience? (For example, confidentiality being breached because the practitioner felt that an employer/family member should know about a user's condition.)

8. Do you think that practitioners are "obliged" to ensure that the user always complies with prescribed treatments?

9. What do you see as being the "rights" of the mental health service user?

10. Are there, in your opinion, any circumstances at all in which a mentally disordered person could justifiably lose those rights, as in "sectioning", for example?

11. Do you feel that users' rights and views are generally respected in practice?

12. Are there any circumstance in which it is morally permissible for the practitioner to knowingly override the patient's rights?

13. If the patient and his family want one thing and the mental health practitioners another, how should this situation be dealt with? (And in the case of the family and the practitioners wanting one thing and the patient another?)

14. What are the most important character traits of a "good" mental health practitioner?

15. What are those of a "good" user?

16. How would you describe yourself as a user?

17. Do you feel that you are (or have been) empowered, or disempowered as a result of your experience as a user?

18. Do you remember any practitioners, amongst the more experienced of these, whom you consider to be the kind of person who would make a good "role model" for student practitioners? If so, what were his/her special characteristics?

19. Is there anyone you remember (from domestic assistant to psychiatrist) who was particularly supportive or helpful?

20. It has been said that genuine caring involves caring both for and about the object of care. What do you understand by this in the mental health context?

21. Would you describe the practitioners with whom you have been involved as generally "caring"? If so, why? If not, why not?

22. Do you think that practitioners should become personally involved the user's situation, or should they be objective and "stand back"?

23. What do you think are the best things your practitioners can do for you?

24. How do you personally envisage the "good life" for you? What would it include?

25. What do you understand by the term "happiness"?

26. Do you think that maximising the clients' well-being is this the main priority in mental health practice?

27. In what ways do you personally believe the user-practitioner relationship could be improved?

28. Is there anything you would particularly like to say about the treatment which you have received/are receiving from mental health practitioners (psychiatrists, nurses, social workers) generally?

APPENDIX 2

Possible questions for interviews with PRACTITIONERS

1. What do you understand by the terms "duty" and "obligation" in the mental health practitioner-user relationship?

2. Do you think that you as professional carer have any specific obligations or duties?

   If yes, what are these?
   If no, why not?

3. Do you think your first duty is towards the user, society, the place at which you work, or something or someone else?

4. Is it your impression that you and your colleagues are aware of and put into practice the codes of ethics of your professional colleges?

5. Do you see any one obligation as being more important in mental health practice than another?

6. Do obligations ever conflict? Can you describe such a dilemma in your own experience?

7. Do you think that practitioners are "obliged" to ensure that the user always complies with prescribed treatments?

8. What do you see as being the "rights" of the mental health service user?

9. Are there, in your opinion, any circumstances at all in which a mentally disordered person could justifiably lose those rights, as in "sectioning", for example?

10. Do you feel that users' rights and views are generally respected in practice?

11. Are there any circumstance in which it is morally permissible for the practitioner to knowingly override the patient's rights?

12. If the patient and his family want one thing and the mental health practitioners another, how should this situation be dealt with? (And in the case of the family and the practitioners wanting one thing and the patient another?)

13. What are the most important character traits of a "good" mental health practitioner?

14. What are those of a "good" user?

15. How would you describe yourself as a practitioner?

16. Do you know any practitioners, amongst the more experienced of these, whom you consider to be the kind of person who would make a good "role model" for student practitioners? If so, what were his/her special characteristics?

17. It has been said that genuine caring involves caring both for and about the object of care. What do you understand by this in the mental health context?

18. Do you think that practitioners should become personally involved the user's situation, or should they be objective and "stand back"?

19. What would be the best thing a user could say about you as a carer?

20. How do you personally envisage the "good life" for the user? What would it include?

21. What do you understand by the term "happiness"?

22. Do you think that maximising the clients' well-being is this the main priority in mental health practice?

23. In what ways do you personally believe the user-practitioner relationship could be improved?

24. Is there anything you would particularly like to say about the treatment which users receive from mental health practitioners (psychiatrists, nurses, social workers) generally?

CONSENT FORM FOR PARTICIPANTS.

Name of project:

Name of researcher:

Please read the guidelines below and, if you are happy to take part in the project, sign the consent form at the bottom of the page.

I understand that

My participation is voluntary.

I am free to withdraw at any time, without giving any reason.

Interview tapes will be wiped when the interviews have been transcribed and following the writing up of the report, the interview transcript will be destroyed.

This project involves and open-ended interview technique where the precise nature of the questions to be asked has not been determined in advance but will depend upon the way in which the interview develops. Should the line of questioning develop in such a way that I feel hesitant or uncomfortable, I may decline to answer any particular questions and/or may withdraw from the project without any disadvantage of any kind.

All information in this project will be confidential. The only people who will read the interview transcript are the student whose name is above and the supervisors, Prof. K.W.M. Fulford and Dr. G. Bendelow. (University of Warwick). All information will remain anonymous. No real names of places or people will be employed, and all identifying features will be removed from the transcript and the final written report.

I understand that I shall be shown a copy of the transcript of my interview and that this will be altered, or certain items removed, should I not agree with any or all of its contents. I shall have access to the interview data and the written report, at any time, should I require this.

I agree to take part in the above study.

---------------------------   ------------------------   --------------------
Name of participant.   Date   Signature.

I have read the transcript of my conversation with Anita Noguera and consider that it is

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CONSENT FORM.

Departments of Philosophy (PEMH) and Sociology
University of Warwick,
Coventry CV4 7AL.
Tel: 024 765 23523

POST GRADUATE STUDENT RESEARCH PROJECT

INFORMATION SHEET FOR PARTICIPANTS

Title of the Project: An Ethic of Flourishing in Mental Health: A Combined Philosophical
and Sociological Study.

Name of Researcher: Anita Noguera.

Thank you for agreeing to consider taking part in this study. Please read the following
information carefully before deciding whether or not to participate. If you should decide
to participate, thank you. If you decide not to do so, there will be no disadvantage to you
of any kind and thank you for having considered doing so.

What is the aim of the study?
The study is essentially an evaluation of the ethical practices and attitudes which prevail
amongst both practitioners and users in mental health practice. Using both philosophical
and sociological theory and research methodologies, and speaking with experienced users
and practitioners of both sexes will provide an opportunity to learn at first hand about
their experiences and views, and the implications and concerns which these have for good
mental health practice.

Who can participate?
Anyone over the age of consent, of either sex, who has either been in treatment for a
mental disorder on more than one occasion, or worked as a mental health practitioner
during the last five years and is willing to talk to Anita about some aspects of this. You
are invited to participate if you are willing to contribute to this area of study and to
discuss your experiences of either caring, or being cared for and how you feel about this
experience. The research study has been approved by Anita's doctoral supervisors.

What will participants be asked to do?
Should you agree to take part in this project, you will be asked to meet with Anita to be
interviewed by her. Usually, this will be on one occasion only, for approximately one
hour. Should you wish, someone else, such as a friend, relative or advocate may also be
present.

The project involves an open-ended interviewing technique. This means that the precise
questions have not been decided in advance, but will depend upon the way in which the

interview develops. Should the line of questioning develop in such a way that you feel hesitant, or uncomfortable, you are reminded that it is your right to refuse to answer any particular question.

Can participants change their minds and withdraw from the project?
Your participation in this study is entirely voluntary and no payment is offered. If you do choose to take part, you may withdraw at any time and have your interview material destroyed. Just contact Anita or call one of her supervisors to indicate that you do not wish to continue. There is no need to give a reason for this should you prefer not to do so.

What data or information will be collected and what use will be made of it?
The information collected will be on the topic area of Anita's research project, that is 'ethics in mental health practice'. In talking with you, Anita will make notes and/or audiotape the interview, if that is acceptable to you. You will be shown a transcript of the audiotape, or given the tape itself, so that you can, if you wish, verify this personally. Anita will use this material to help her gain an understanding of current ethical practices in mental health, by qualitatively and philosophically analysing and evaluating the information which you and other participants provide. She will write an account of her work, which will later be submitted for assessment of, amongst other things, its accuracy and credibility. She may also submit some parts of her study to an academic journal for publication.

Confidentiality.

I wish to assure you of confidentiality in all matters relating to the material that you provide. The data will be securely stored in such a way that only Anita and her supervisors may have access to it. Original material, including audiotapes, will be destroyed or erased upon completion of the project. Your name, or any other identifying information will not be used in any written account of this work. You may read Anita's notes at any time you wish and request deletions or changes.

What if participants have any questions?

If you have any questions about the study, either now, or in the future, please feel free to contact either:

Anita Noguera,
Post-graduate Research student,
Tel: 024 76 572739

Or her supervisors:

Prof. K.W.M. Fulford,
Dept. of Philosophy,
University of Warwick,
Coventry CV4 7AL

Dr. Gill Benedelow
Dept. of Sociology,
University of Warwick,
Coventry CV4 7AL.

Tel: 024 765 23523.

Should you decide to work with Anita, thank you for your contribution. Your involvement is one way in which we may develop our understanding of mental health ethical practice and research thought and strategies in this area.

If you agree to take part in this project, please complete the form attached.

QUESTIONNAIRE ON MENTAL HEALTH PRACTICE

1. **Were you generally satisfied, or dissatisfied with the treatment/treatments which you have received: (please circle)**

   a) In hospital? (Satisfied/Dissatisfied)
   ✓ b) In the community? (Satisfied/Dissatisfied).

2. **In treatment, have you felt that practitioners: (please circle)**

   a) cared for you?   b) (cared about you?)
   c) both?   d) neither?

3. **Was there any qualitative difference in the way in which doctors, nurses and social workers treated you?**

   (a) Yes)   b) No

4. **If you have answered "yes" to the previous question, which do you consider to have treated you best?**

   (a) Nurses)   b) Doctors   c) Social Workers

5. **Which word would best describe most of the nurses, social workers and doctors whom you have met during treatment?**

   a) Nurses ...*friendly*....   b) Doctors ...*Superior*......

   c) Social Workers ....*bossy*........

6. **Do you think that you were allowed sufficient participation in decisions about your treatment?**

   a) Yes   (b) No)

7. **Do you think that your family was allowed sufficient participation in decisions about your treatment?**

   (a) Yes) *   b) No.

8. **Have you ever consciously withheld information from your psychiatrist?**

   (a) Yes)   b) No

9. **If you answered "yes" to the previous question, please briefly give your reasons for having** ......*didn't think he would*............
   ......*let*...

* but they were not well- informed
other approaches to make informed decisio

10. Did/ do you feel discriminated against or stigmatised as a result of your mental disorder?

(a) Yes)   b) No.

11. Did/do you feel disempowered as a result of your mental disorder?

(a) Yes)   b) No   c) Both

12. Of all the carers encountered in the hospital setting, which spent most time talking to you?

(a) Nurses)   b) Doctors   c) Social workers   (d) Domestic staff   ,e) Students

f) Others (in which case, please state their role) ......Patents..............

13. Was there any difference in the way in which male and female practitioners treated you?

a) Nurses: Yes/(No)   c) Social Workers: Yes/No   N/A
b) Doctors: Yes/(No)   d) Students: Yes/No   N/A.

14. If you have answered "yes" to any of the above, please briefly say in what this difference consisted.. male Doctors....tended....to...be.........
..............less......approachable..

15. Do you feel that suffering a mental disorder leaves you in some way negatively "labelled" as different from other people?

(a) Yes)   b) No

16. Has suffering a mental disorder changed the attitude of your family and friends towards you?

a) Family attitudes have changed: for the better/for the worse
b) Friends' attitudes have changed: for the better/for the worse
(d) Nothing has changed)(except He)

17. Do you think that compulsory admission to a psychiatric centre ("Sectioning") is ever admissible?

(a) Yes, in a crisis)   b) No, never.

18. Do you think that compulsory medication is ever admissible?

a) Yes, if the doctor considers it to be necessary, in any circumstances
(b) Yes, in a situation of crisis, but not once this has been resolved)
c) No, never

19. Do you think that the medication which you have been prescribed for your
condition has negatively affected the quality of your life?

were — I do not now use it.

a) Yes   b) No

it did temporarily — but long term weight gain is on-going

20. Do you think that the current codes of good practice are observed by
practitioners?

a) By Nurses: Yes/No   b) By Doctors: Yes/No

c) By Social Workers: Yes/No

Finally, how would you like to see the mental health services improved?

I would like to see a greater questioning of methods, treatments used. Perhaps a greater reliance on talking therapy. Also follow-ups of those who recover — and why they recover.

Thank you very much indeed for taking the time to complete this questionnaire.

Anita Noguera,
Dept. of Philosophy and Ethics of Mental Health,
University of Warwick.
CV4 7AL.
e-mail: pyrhf@warwick.ac.uk

PS.

PRACTITIONERS' QUESTIONNAIRE

1. Are you: a) a nursing practitioner? ...✓.....
   b) a social worker? .... (Tick where appropriate)
   c) a psychiatrist? ....
   d) other ....

2. In which of the following settings do you work?
   a) Hospital ...✓......
   b) community care ..... (Tick where appropriate)
   c) other..........

3. Are you satisfied with your working conditions? Yes/No

4. If you have answered "no" to the above question, please state
   briefly why you are dissatisfied
   Feels unsafe, inappropriate admissions - to few
   staff to deliver appropriate levels of care
   To much paperwork

5. Is the treatment given to the users in your practice satisfactory, in
   your opinion? Yes/No

6. If you have answered "no" to the previous question, please state
   briefly why you consider it unsatisfactory.
   To few staff to deliver care. To much paperwork
   that diverts from hands on care
   inappropriate admissions which diverts from
   those who genuinely need the service.

7. Which, if any, of the following do you consider to be problems in
   mental health practice today? (Please tick)
   a) Understaffing ..✓......
   b) Lack of time to talk to users ..✓.....
   c) User violence/aggression towards practitioners .✓....
   d) Inadequate training/education ....
   e) Demoralisation .✓.........
   f) Other (please state) ....

8. Do you think that users are given enough information and allowed
   sufficient participation in decisions about their treatment?
   Yes/No Depends on the situation unable to
   answer a direct yes or No.

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9. Do you think that users' families are given enough information and allowed sufficient participation in decisions about the proposed treatment? Yes/No.   As N° 8.

10. Have you ever consciously withheld information from a user or his family? Yes/No.

11. Do you think users sometimes deliberately withhold information from or lie to practitioners? Yes/No.

12. Have you ever consciously breached confidentiality in your professional practice? Yes/No

13. Do you think users who have been diagnosed as mentally disordered suffer discrimination/stigmatisation as a result of this? Yes/No.

14. Do you spend as much time as you would like in talking to users? Yes/No.

15. If you have answered "No" to the above question, please explain the reasons for this:
    - As previous stated in Question 14 & 6 ....
    ....
    ....

16. Do you feel that the time you spend in bureaucratic functions is:

    a) Excessive ...✓....
    b) Reasonable ......   (Please tick as appropriate)
    c) Insufficient ......

17. Do you think there is any difference in the way male and female practitioners interact with the users? Yes/No - Depends on the Practitioner.

18. If you have answered "Yes" to the above question, please explain what this difference is:
    ....
    ....
    ....

19. Is compulsory admission to mental hospital ever morally admissible? Yes/No

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Dendrite – a public Internet alert system about human rights in psychiatry sponsored by Support (7.08.02)
Depression Alliance (depressionalliance.org.uk) (12.10.02)
First Step Trust (ww.fst.org.uk) (07.07.02)
Glasgow Association for Mental Health (www.gamh.org.uk) (28.10.02)
International Society for Mental Health Online (ISMHO) http://www.ismho.org/suggestionss.html (07.09.02)
Mad Pride (www.madpride.org.com.uk) (28.10.02)
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