A Social Psychological approach to Coercion in Psychiatry: Exploring the Relational Dynamics

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About the PhD project

What's the problem? Increasing coercive incidences in Denmark[1], poor conceptualizations of formal and informal coercive measures and actions[2], and a difficult balancing of human patient rights and institutional demands makes coercion a 'wicked problem'[3].

What's the 'solution'? Interdisciplinary research and multifaceted angles of investigation[4] (from a scientific point of view).

What's the aim of PhD? Understanding the **relational**, **societal** and **historical conditions** under which coercion is understood and performed, thereby presenting a novel perspective on coercion.

What's the approach? A social psychological approach, drawing on symbolic interactionism (Erving Goffman), socialization theory (Norbert Elias), institutional theory (William R. Scott) and theories on subject models (Simo Køppe, Kurt Danziger).

Design and Dissemination

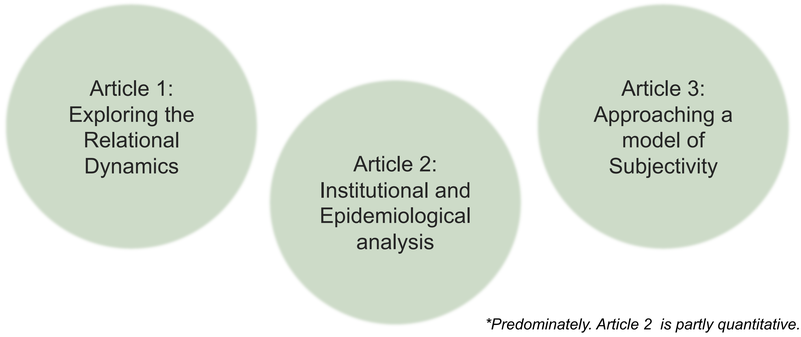
Qualitative methodology*:

1) Ethnographic participant observations (48 days at 3 integrated wards in Region Zeeland)

2) Interviews with 2 patients and 10 professionals (at the same wards)

3) Register data on coercion in Denmark

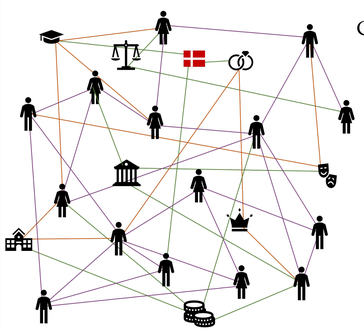
Centres around three articles, where the first "Exploring the Relational Dynamics" is ongoing and at the centre of this poster



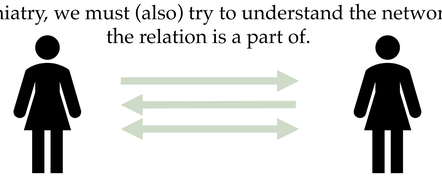
*Predominately. Article 2 is partly quantitative.

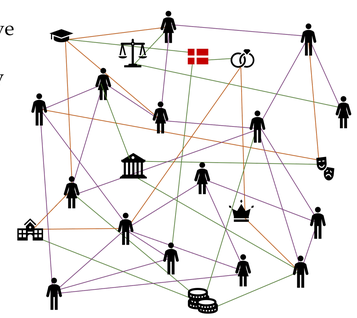
Approach in Article 1: Exploring the Relational Dynamics

A figurational[5] approach: Exploring the the relations between professionals and patients as 'networks of interdependencies'.



Claim: In a relation, there exists more than the intersubjective interaction (<->). The relation is also made up of networks in the persons' past and present, in their physical proximity and abstract distance, and through their meaning-making in those networks. If we wish to understand relations in psychiatry, we must (also) try to understand the networks the relation is a part of.





Exploring the relational dynamics - paradoxes, favoritism and elephants*

A good relation between the patients and the professionals is in research and practice presented as a protective factor for coercion. But what is it, that gives (good) relations a de-escalating function? For whose sake do we strive for it? What conditions does the possiblity of developing good relations have?

Means-ends dilemma

After a conversation with a patient about discharge, I asked the doctor why he had asked the patient to elaborate on his present delusion, which concerned that he had bombarded himself and that a pizzeria should repair him. The doctor answered: "Well, the medical student who joined us, had never seen a patient like that before, so it was for her".

One ward refrained from regular contact persons for patients: "Then they [patients] will only have conversations if that particular contact person is present, at that is very inflexible"

Desirable and undesirable relations

Nurse at a ward with regular contact persons: "Some patients don't even have a contact person". Another nurse whispered: "Because no one wants them".

Nurse on 'difficult' patients: "Giving leave is a typical pattern of smallest-means-principle here, because then we can get them out of sight".

Power as the elephant in the room

Once a week there was psycho-education. I asked if I could join, and the responsible psychologist said: "Sure, as long as there are enough patients. I don't like it if there are fewer patients than professionals. It's a power thing".

In the beginning of the fieldwork, I always asked the doctors and psychologists, if they thought, it was okay with the patients, that I joined interviews and conversations. Not once, did they say anything but: "Sure, there are always students joining anyways, so we'll just let the patient know, that that is how it is".

**Preliminary 'results' – in the midst of analysis*

Discussion

What is the purpose of a (good) relation?

A predominant purpose for a good relation is to de-escalize and create a calm ward-atmosphere. How can we understand and nurture good relations, if and when the purpose of the relation lies *ouside* the relation it self? What kind of relation becomes possible?

Inequality in work with relations

Some patients become more or less *desirable* to connect with, and develop a relation to and with. How can we understand these tendencies? How do we face this equality issue?

Power in (certain) relations?

Efforts to be sensitive to any power-dynamics the patients might experience seemed arbitrary at times. Is the indisputable asymmetri that exists in the meeting between the patient and professional difficult to address in the practice? By talking about it explicetly and trying to understand if and why some patients could find it difficult, could we then nurture a more authentic (and 'good') relation?

A question of conceptualization?

What is a 'relation' – and in particular a 'good relation'? Is it one of trust? Faith? Symmetri? Compliance? Mutual understanding and respect? And, if so, how is a good relation different from a good alliance? Or from a 'fruitfull' or 'constructive' relation?

References

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