Moral Dynamics in Psychiatry

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Summary

While the use of coercion is allowed in psychiatry under certain strict circumstances i.e. to avert dangerous behaviour that is caused by a mental illness for protection of others or of the patient himself or herself, coercion has a large impact on patients as well as practitioners. Therefore, prevention and reduction of the use of coercion and restraint are important policy goals. In the last decade, reduction of seclusion has got a lot of attention in Dutch mental health care. Patient and family groups as well as professionals and others, have argued for the need for transitions in organisation, culture and routines around coercion. Comparative international studies showed that the use of seclusion is more common in the Netherlands than in other countries; patients are locked up in seclusion rooms more often and longer. Bottom up as well as top down, a sense of urgency developed regarding the need for change and improvement. This resulted in funding by the government for projects in psychiatric institutions to reduce coercion in general, and seclusion more specifically.

Our research group was invited by several mental health care institutions to monitor and evaluate projects to reduce coercion. The studies were primarily process evaluations. Research questions included: What are successes, what needs further improvement, what kind of barriers are experienced (from different angles) and how could these barriers be dealt with. The responsive research methodology aimed to facilitate dialogue and shared ownership regarding aims and successes of the projects. The qualitative studies were based on participation and interaction with participants, and developed a specific focus on moral issues related to coercion and restraint in psychiatry. They aimed to map the common morality within practices, to develop openings for responsive analysis and to stimulate dialogue on moral improvements.

This thesis consists of five published articles on the moral dynamics within institutions that started projects to reduce the use of coercion and restraint and improve the quality of care. The articles show which moral perspectives regarding coercion and reduction of coercion were leading, what kind of (moral) changes developed, how barriers were experienced and how they were dealt with. The aim of the studies was to develop insights on moral dynamics within practices of coercion and restraint and to foster improvements through mutual dialogue and reflection on central values.

The theoretical framework of this thesis is based on the view that moral knowledge is socially constructed in processes of negotiation between stakeholders. Practices are regarded as inherently moral, requiring moral work from participants that can be supported by research interventions. An important source of inspiration is the moral epistemology of Margaret Walker. She emphasizes that morality and moral judgments cannot be detached from social backgrounds, and cannot be singled out from specific (personal) contexts and experiences. Morality develops in interactions between people. Through dialogue and participating in social settings, people learn from and through each other what is morally important and why, and what they may expect from each other. Often these are implicit processes which people are not aware of; yet, the choices that are made and the way people interact, reflect what is considered valuable. Dominant values and visions regarding attribution of responsibilities might express tensions. Stakeholders might have different ideas and motives. Practices can be improved, by fostering insight in mutual perspectives and willingness to recognize different viewpoints as valid. This thesis makes different views on responsibilities around coercion explicit and describes interventions aimed to stimulate processes of reflection and change.

Chapter 2 introduces a critical view regarding the biomedical model of psychiatric diseases aimed at pharmaceutical solutions. This model implies a neurobiological view on recovery (i.e. repairing the dysfunctions of the brain) that can justify the use of coercion on these grounds. In this article, we discuss whether neurosciences and new psychopharmacological solutions really support patients who suffer from mental illnesses. To answer this question, we focus on the perspective of patients and their experiences with psychiatric (coercive) treatments. The analysis of an ex-patient's story shows that beside appropriate medication, other issues are important for recovery from a mental illness. In daily life, issues such as coping, rehabilitation and social support are of major importance for a patient suffering from psychiatric disease. A patient's recovery is dependent, not only upon the process of finding the appropriate medication and trust between the psychiatrist and the patient, but also upon relational aspects, such as being recognised as a person, belonging, accepting responsibilities, developing friendships and trusting others. These findings lead to the conclusion that dealing with psychiatric diseases is more complex than the biomedical model of neuroscience

suggests, and that the social context of the patient should be included in the recovery process. During the analysis and writing of the article, the storyteller and ex-patient, Jolijn Santegoeds, was closely involved. Therefore, she became co-author of this article.
Chapter 3 illuminates the perspectives of nurses. It discusses the relations between patients, family and professionals in psychiatry. The central question of the chapter is how nurses deal with family and important others of patients, and how they value the concepts of privacy and confidentiality. This question came up in projects to reduce coercion, in which the need was experienced to involve family more actively in reducing and preventing coercion. Privacy and confidentiality were experienced as barriers in this process. In this chapter four narratives of nurses about their experiences with family of patients are presented. The nurses all worked at different wards in the same mental health institution. The stories illustrate differences in how family is involved and is considered important in relation to the care and treatment of the patient. Some nurses value family mainly as instrumental. Family is considered as source of information to optimize care. Others express an intrinsic value for family i.e. family as valuable on its own. If family is considered as intrinsically valuable, the concepts of privacy and confidentiality are not experienced as insurmountable barriers and more options to collaborate regarding the prevention and reduction of coercion are considered.
Chapter 4 describes and analyses the moral changes during a project to reduce coercion at a closed inpatient ward of a psychiatric hospital. An important finding of this study was that nurses reported that their roles had changed. In retrospect they attributed this change to the emergence of reflection, openness and dialogue. During the project, a dialogical process came forth within the mental health institution to engage nurses to think about their practice in general and coercion more in particular. As a result, the relationship between patients and nurses and among professionals (nurses and ambulatory workers) fundamentally changed. The new focus was on mutual understanding, collaboration, contact and trust. Before, dealing with risks was only a concern of the nurses at the ward. Gradually, ambulatory care workers were seen as possible partners, who can help to develop a better, mutually shared perspective on safety-issues. Regarding the relationship between patients and nurses, patients are now approached and involved as partners in care. While formerly the practice of nursing was organized around the value of safety and guarding control on the ward, now the essence of nursing is defined in terms of sharing responsibilities with others. Nowadays the

nurses see their identity as that of being a co-worker. Nurses at the ward recognised that, in taking responsibility for safety at the ward, they need not take the role of guardians. Sharing responsibilities with patients and with ambulatory nurses provides new opportunities to reduce coercion and foster good care.

Chapter 5 reports on a study about the interaction between 'theory' and 'practice' in clinical ethics support services and empirical ethics. Moral researchers use theories to understand and analyse moral practices and processes. Theoretical notions assist practitioners to understand their situation and make them aware of moral dynamics in their practice. From practical findings and empirical data, new theoretical concepts can be developed. This is illustrated in this study by an example from the evaluation research of one of the projects to reduce coercion and restraint. Within a psychiatric hospital, practitioners experienced difficulties and reluctance to imagine how they could reduce the amount of seclusions at the closed inpatient ward. The common method to interview stakeholders and organize focus groups did not naturally result in a mutual conversation on opportunities for improvements. The researchers needed to look for alternative and creative options to seduce practitioners to reflect on the urgency to reduce coercion. As the practitioners showed great interest in football strategies, the researchers invited them to compare their working routines with their preferred strategies in football. The use of this metaphor put their practice in a new light, and stimulated them to change. It created openings to discuss their common practice and reflect on underlying values regarding the use of coercion and their views regarding the meaning of 'safety'. This example showed that empirical ethics need creative tools and concepts to come up with analogies and comparisons that break free from daily routines and working methods.

In **Chapter 6,** another intervention is described which can stimulate moral deliberations on the use of coercion. The study focuses on the significance of introducing external perspectives in a context where nurses do not automatically experience an urgency to change their common practices. From the start of the project to reduce coercion at this hospital, nurses were critical about the possibilities to reduce coercion. They felt criticized for not doing their jobs well enough. They emphasized they did not use coercion unless it was absolutely necessary. The evaluation study aimed to motivate them to reflect on the necessity of the use of coercion from concrete cases. Two nurses working within another hospital were invited to share their experiences in a focus group

meeting. These external colleagues had much experience with reducing coercion at their wards. The group discussed cases in which at first, prevention of coercion seemed not possible. The input of external nurses helped the nurses at the ward to develop new insights on how they experienced safety and created openings for reflection and change. In the chapter, this process is analysed with the use of the moral psychology of Jonathan Haidt. The reluctance towards the project that initially existed is explained as a result of group thinking and the influence of group norms. People look for harmony and recognition of their moral decisions, and are not used to look critically at their own practices. We conclude that social processes play an important role in moral deliberations, and that bringing in new perspectives in the dialogue can foster moral development.

In Chapter 7, the studies presented in the chapters are summarized and the central research questions of this thesis are answered. First, the main findings of the studies are recapitulated. After that, the studies are viewed in light of the moral epistemology of Margaret Walker. The findings are analysed in terms of moral understandings and moral responsibilities. This analysis leads to the conclusion that critical reflection regarding the assignment of responsibilities between stakeholders is required to reduce the use of coercion and improve the quality of care. Improving care entails a shift in the relationship between practitioners and patients, a change in identities, and new views regarding dominant values in practice. A second conclusion is that changes in assignments of responsibilities cannot be enforced top down without causing resistance and practical difficulties, especially when it is not clear for stakeholders at the work floor what these changes might entail for their practice. Joint reflection and shared deliberation on goals and acceptable risks are needed. A third insight from the analysis is that changes in the distribution of responsibilities imply accepting certain risks and (temporary) experiencing a situation of uncertainty. Changes take time and require on-going reflection. New dilemmas and challenges will rise. Responsive research may provide support by elucidating the responsibilities experienced by different stakeholders and facilitating a dialogue between stakeholders regarding barriers and opportunities.

Next, the role and responsibility of the researcher is discussed. Again the moral theory of Walker is used as reference point. Walker distinguishes different tasks for moral research. These tasks are related to the methods that have been used in the studies; i.e.

constructing ‘counter stories’, ‘thick descriptions’, fostering reflections and dialogue using a metaphor as well as using external perspectives in a focus group meeting. These different methods all contributed to fostering transparency and creating openings for moral (re)considerations. They helped illuminating implicit motives and values within practices. The researcher aimed to give a voice to persons who were disempowered or oppressed within the dominant moral discourse and questioned existing moral positions responsively. The contribution of the researcher does not include providing moral justifications of concrete practices or designing new assignments of responsibilities. Moral decisions are mutually constructed in interactive processes of reflection and dialogue between stakeholders. Research contributes to the moral dynamics in psychiatry by fostering reflection and dialogue in the process of reducing coercion and restraint.