

The personal in the professional in mental health care: Ethical and Methodological considerations

Introduction

The context for the paper is an evolving study exploring how use of coercion informs mental health care professionals and their practice. The immediate background for the study is that use of coercion within mental health care in Norway, and other countries, is under increased scrutiny. Attention has been brought to a variety of practices and different degrees of transparency related to use of coercive measures among service providers. This leaves pressing questions, which call for exploration: What informs the moral deliberation made prior to using coercion and how does the experience of using coercion inform the self-understanding of the professional and thus future decision-making processes pertaining to the use of coercive measures?

Moral issues and value judgements present themselves within the context of their actual occurrence (Zaner, 1988). This actualizes the limits of principle ethics (Beauchamp & Childress, 2013) and calls for phenomenological ethics. Hence, the first part of this paper will elaborate on where the two complement one another, where they contradict and why coercion as a clinical ethical issue in mental health calls for “moral particularism”. The second part relates to the first, but focuses on how it is possible to extrapolate from a narrative account, not only ethical positions, but manners of moral reasoning.

The paper introduces two different approaches that can be applied in order to explore phenomenologically the experience of mental health professionals using coercive means as part of their professional role. It presents and discusses how “expressive writing” in combination with “biographical narratives” may serve as a methodological approach which allows for both the self-report of the narrator, but also an extrapolation of tacit unarticulated meaning (that which for the individual has not yet been said and may be unsayable).

Toward a phenomenology of clinical ethics

There is an obvious ethical side to this study, as it relates to one of the most morally contested questions in mental health care. Use of coercion in mental health is a conflicted issue. It provokes heated discussions that divide professionals, professions and disciplines. It evokes different feelings and actualizes opposing moral positions - among patients, relatives, professionals and policy-makers. Of particular interest of this project is not so much the different moral theoretical positions that can be applied, but rather to elicit the relation between the professional’s choices and practical

involvement in a particular situation or incident involving use of coercion and his or her self-understanding. The latter is not something s/he "has in mind"; rather it is about how s/he acts in the "world", his or her "referential totality" (Cerbone, 2008, 41). To explore how moral attitudes evoked in a particular practical ethical issue involving use of coercion relate to deeper strands of moral thinking and an overall self-understanding calls for methodological approaches that offer interpretive means to explore how being in idiosyncratic ways is an issue for the individual through his or her engagement with different "world(s)".

The meta-ethical issue of how moral thinking is constituted, which is of utter importance, will be thoroughly addressed elsewhere. Still, in order to reflect responsibly about what methodological approach the above briefly outlined existential phenomenological understanding of self-understanding entails, we will allow for a more brief addressing of the question; a linking of moral particularism to methodology. Part of the latter is a discussion of whether and how exercising Expressive writing and undertaking biographical narrative interviews respectively and together may allow for an exploration of different manners of moral reasoning.

Moral truths, hermeneutic-phenomenology and moral particularism

David McNaughton, in his introduction to ethics (McNaughton, 1991), outlines two possible and often debated positions in regard to the fundamentals of ethics. The moral-philosopher points out that there are other possible positions, but finds the two mentioned "the two most plausible theories about the nature of ethics" (McNaughton, 1991, 15). The positions outlined below respectively resemble, but doesn't totally overlap with, those of Immanuel Kant and David Hume. In the following we will lean on McNaughton's discussion, not only because it elicits the pressing issues any discussion on fundamental ethics must deal with, but also because it serves as a background for why Biographical Narrative Interpretive Method (BNIM) and Expressive writing are relevant approaches to explore the research question in focus.

McNaughton stresses that neither of the two positions shows up in pure form and that one may be inclined to favor one and then the other, depending on the situation. The main and fundamental question separating them is whether morality is an invention or a discovery (ibid. 3). If siding with the former one takes the position of moral realism, while as agreeing with the latter one is a moral irrealist, a moral non-cognitivist.

Both positions are vulnerable to criticism Moral irrealism, because it appears so counter-intuitive to our notion of moral values as "out there", part of the identifiable and observable objects of this world. But also counter to our notion of value statements as true or false and thus related to facts.

Its claims imply no room for moral fallibility, as there is truth and no moral facts by which any statement or act can be judged (ibid. 52). The claim that values are not facts seems to align with scientism, implied in which is a positivist stand in regard to science – and that it can provide an exhaustive account of what there is (ibid. 36). Is moral observation an oxymoron, a contradiction in terms, as suggested by Hume and the non-cognitivists?

If what can be observed is limited to whatever our five senses can provide us, it would be fair to answer in the affirmative. Yet, such reasoning runs counter to experience and the many non-materials we observe on a daily basis. The moral realist would claim that it is no more questionable to observe moral values than it is to observe esthetic values, such as the beauty of a sunset (ibid. 56). Another charge against non-cognitivism is that it breeds skepticism toward moral claims, as there is no justification for them beyond the feelings of the one who has uttered them: Doesn't moral irrationalism imply that any moral position, conviction or act is equally valid? Who, if holding such a position, is to say that one moral attitude is better than another?

Moral realism is no less a target for criticism, not least due to it coming along as implying a privileged position, as if having an access to truths not available to opponents. Whereas within moral irrationalism there is no experts as “what I need to know is what I feel”, which of course brings us round to the arguments against emotivism. Still, the moral realist is left with the challenge to provide an explanation of just how it is possible to identify moral values (ibid. 35).

In order to take on the objections against a non-cognitivist position, McNaughton expands its philosophical ground and brings in areas such as the explanation of action and theory of language. To come to terms with the relation between moral conviction and action is the sine qua non of any moral theory. Hence, seeking an explanation for intentional human action is an appropriate place to start. McNaughton claims that in order to make an agent's action intelligible one has to come to terms with the phenomena of motivation, which it is impossible to explain without bringing both belief and desire into the equation. “Desires without belief is blind. Belief without desire is inert” (ibid. 21). Mere knowledge doesn't suffice; it takes an affective state, in order for anyone to act. This is an underpinning of a non-cognitivist position and a possible blow to the realist claim that moral convictions are merely cognitive in character.

A realist response to the question of motivation (ibid. 46f) is that cognitive states can move a person to take action. This point is underscored by how moral demands are triggered by certain situations, and often can be traced to particular beliefs, but are not necessarily accompanied by desire on the part of the agent. Quite to the contrary, moral demands may trigger all kinds of negative feelings.

This of course does not rule out that desire can play along or be an outcome, but it is not required, as it is sufficient that one or two beliefs are present for action to take place.

The quest for consistency and the problem of moral principles

Another disputable claim made by a non-cognitivist position is that any moral position is legitimate as long as it is consistent and whoever claims it is willing to live by it. This manner of justifying moral convictions triggers the question, not only whether any consistent and coherent system is as good as the next, but also if consistency is a viable and sustainable criteria for morality? One may feel obligated toward different ethical conviction that in a given situation or incident become incompatible. Working on a mental health unit, I may be both committed to securing the confidentiality of the one patient, but also to preventing any harm to any of the others.

In a particular situation, the one patient may confide to me thoughts about doing harm to one of the other patients. It is a dilemma in which one of the convictions has to give and in order to act responsibly I will have to give up the aim of consistency. If making consistency the virtue of a moral system, there is an implied understanding in regard to clinical situations raising ethical questions that they carry the same set of features that makes it meaningful to apply same set of moral evaluations to them (McNaughton, 1991, 61). As the example above illustrates, a non-moral property is not always and everywhere relevant in the same way and to the same degree (ibid. 62). This actualizes the limits of *principle ethics* and underscores the importance of *moral particularism*.

The above suggests that moral truths, as aesthetic truths, are very different in character from truths established in and through the natural sciences. The moral truths outlined above corresponds with the notion of truth we find in Gadamer's outline of *Geistwissenschaft* (Gadamer, 1989). This is an understanding of truth that doesn't imply pretensions of generalizability or predictability, but rather what Gadamer calls "truth-events", an "uncovering" (*aletheia*) of why something appears to be true (Gadamer & Holm-Hansen, 2010, p.12). The truth thus understood resembles what happens when encountering art and great classical texts. It is not about confirming or expanding common experience to attain knowledge of "a law" about "how men, peoples and states evolve – but rather to understand how this man, this people, or this state has become what it is, or, more generally, how it happened that it is so" (Gadamer, 1989, p.5).

Moral particularism and Particular Incident Narratives

Moral issues and value judgements present themselves within the context of their actual occurrence (Zaner, 1988). This calls for continuously taking steps to get as close to the experiences of the interviewee as possible. Patricia Benner, nursing theorist and educator, underscores this point when

she links meaning making – changes of assumptions, values and beliefs – in a professional context, to emotionally charged professional situations. She uses the concept “paradigm cases” about the kind of experiences that becomes precedents for later practice – foundational incidents marked by challenge, success, failure or emotions that make the health professional reflect in a way that changes assumptions, values and beliefs (Benner, 1984).

Phenomenological ethics, or moral particularism, if we stay with McNaughton`s terminology, serve both as a critique of principle ethics, and at the same time it may offer a viable complement to it. “Phenomenology can be used either to inform the application of principles by way of describing the lived experiences of moral dilemmas or to criticize the contemporary set-up of bioethics and offer alternative approaches” (Svenaeus, 2017, 16). Its main contribution lies in that it shifts focus from what “ought” to be done to what “is” the case.

Phenomenological ethics doesn’t come with a set of new rules, but is dedicated of identifying what is meaningful to the person(s) involved in, or feels an ownership to, a moral dilemma pertaining to a particular clinical situation or incident. Phenomenological ethics broaden the scope as it accounts for a philosophical anthropology that moves beyond the notion of the individual as a rational agent. As it engages questions pertaining to meaning and what it means to be a human being, it contributes to “a wide reflective equilibrium” (ibid. 15), expanding the dialectic between moral intuitions and moral principles. The latter is in danger of ending up making ethical principles foreign measuring sticks that misses the mark.

A phenomenological approach is committed to understanding how the other understands; it is all about seeking the first person perspective, “the natives point of view” (Geertz, 1973). The aim is thus to get a grasp on how “strong evaluations” (Taylor, 1989) is made evident and informs the questions in focus, paying attention not only to his or her self-report, but how s/he is “being-in-the-world”. As the aim is understanding rather than explaining, phenomenological ethics goes beyond mere description. A part of this is descriptive accounts of the reports and self-reports pertaining to a question, situation or incident.

It is the aim of this study to make space for, and interpret, such particular incident narratives. How accessible are they for research, one may ask. Even though it is possible to pinpoint paradigm cases the existential aspect of the experience will be partly hidden to the health professional herself, because her meaning making faculties are placed on her “nose” as a pair of “glasses” through which existence becomes real to her (Heidegger). But it may also be hidden due to its emotionality, suppressed to the unconscious and defended against, because the emotions evoked are too painful or difficult to face and relate to consciously (Hollway, 2006).

Hence, the present study will employ hermeneutic methods which can interpret interview texts to indicate both tacit unarticulated meaning (that which for the individual has not yet been said and may be unsayable) and unconscious impediments to meaning (which get in the way of saying it). Paying attention not only to what is said, but also the manner of saying it. BNIM rests on “an extreme end of the research interview intervention spectrum” (Wengraf, 2001, 13), allowing for silences in order for the unsaid to surface, for the sake of “a full gestalt to emerge”. The insistence on the uninterrupted telling of stories may be regarded the sine qua non of BNIM approach. Yet, as will be elaborated through the Dina case below, it may not do away with the sense of narrating to a particular audience.

Biographical Narrative Interpretive Method (BNIM)

Biographical Narrative Interpretive Method (BNIM) (Wengraf, 2001) is an approach aiming at reconstructing both the experiencing and the interpreting subjectivity of the biographical agent. The interview method and the interpretative procedures distinguish the historical record of the life as lived by the interviewee and the story (s)he tells about the same. The BNIM interview is made up of three sequences (Wengraf, 2001):

1. The first starts with a single question inducing narrative (SQUIN) framed by my research question:

"As you know, I am interested in how health professionals as persons have changed, or not changed, due to working in situations involving use of coercion.

Therefore, can you please tell me your life story: all those events and experiences, which were important for you personally?

Please take the time you need! I will just listen and won't interrupt you with questions. I will just take notes so that I can remember what I want to ask you about when you have finished telling me about it all. Take the time you need. Start wherever you like."

The invitation is intentionally left open, and not restricted to clinical experience, in a realization that there is no strict boundary between the personal and the professional in relationally intense profession (Skovholt & Trotter-Mathison, 2011). In this session, there will be no interruptions from the interviewer.

2. In the second session, the interviewer takes the Long Narration from the first phase as point of departure and push for Particular Incident Narratives (PIN). Instead of being satisfied with a thematically whole narrative the BNIM, through the focus on PINs, is continuously taking steps to get as close to the empery (the experiences of the interviewee) as possible. When

searching for PINs the interviewer is asking deepening questions related to the order and language of the narratives told, but without introducing themes not raised by the interviewee.

3. The third session is optional. It can be based on a need for further clarifications or a place of introducing themes key to the project.

A key part of BNIM is the use of interpretative panels. The panel is a heterogeneous, diverse group of people, and creates a space in which the individual researcher and members of the group dialogically develop hypotheses. The use of a panel gives the advantage “to ensure the surfacing of sleeping assumptions, blind spots and misrecognitions on the part of the researcher” (Wengraf, 2001, p.231). The panels will include members with user-experience, former patients who have been at the receiving end of coercive measures (see below for an elaboration of this point).

The analysis work will follow a twin tract in that it will focus both on life as lived and experienced and life as narrated; in other words, lived life and told story, experience and the meaning made of it. The analysis of the lived life and told story will then be brought together to write case studies which will have distinct structural traits that can then be compared. From the comparison I will be able to extrapolate how each of the professional groups integrates experiences involving use of coercion. Each case analysis will examine the ways in which the professional culture manifests itself in how the interviewees put their stories into words; personal stories can that way be emblematic to a professional discourse.

One obvious reason for letting the interviewee talk uninterruptedly at length during sub session-one of a BNIM interview – “to hold the floor beyond the limits of a usual turn” (Mishler, 1986, 74)– is in order to allow the narrative, whether a life story or critical incident, to flow - to allow for the native’s point of view. Still, my BNIM interview with the palliative care physician Dina, part of another study (Moen, Forthcoming (2018)), may be illustrative of how even in a non-interruptive, minimalist-passive approach to interviewing the narrative is presented to an audience.

Dina – a case in point.

Dina (Moen, Forthcoming (2018)) and I met in the hall just outside the palliative unit where she worked as a physician. After initial greetings, we went downstairs to the main entrance. As we stepped outside, we were greeted by the sounds and smells of spring. Life was making a return, at least outside the hospital. Dina took me to the next building and, as we walked to her office, she probed me about my professional background as hospital chaplain, more so than the previous interviewees had done.

Her particular interest in my background did not strike me until later, when she shared how she sought out male pastors with whom to process her experience of oppressive religiosity. The latter was a theme that ran through her narrative, suggesting that encountering a male who was also a chaplain carried particular meaning for Dina. It seemed equally clear, however, that Dina did not see me as typical of the cast of characters that had inhabited the oppressive religious environment of her childhood. Rather than being a symbolic figure linked to the religious oppression of her past, she seemed to link me to the emancipatory process of the present.

The question remained, of course, whether Dina would have told another story at another time to another person. One might ask whether unconsciously I regarded the encounter between us as one that could counter her previous experience with clergy. Did I take this upon myself? Did I take non-verbal signs as proof that I did not represent what she despised? Could this, combined with my sensitivity to her use of terms like “traumatic”, be a reason why I did not push harder for Particular Incident Narratives (PINs) that might complement her dominant narrative and bring in more stories from her long clinical experience? Was it the dynamics playing out between the two of us, or was it rather Dina's way of expressing exhaustion from encountering so many dying patients, that made her narrative one with so few stories of her encounters at the border between life and death?

How would a narrative space without an audience, allow for a different set of stories? A question that brings us to expressive writing.

Expressive writing

“Expressive writing” denotes non-directed “stream-of-consciousness” writing. The concept originated with Professor in psychology James Pennebaker and his interest in the relation between confession and health. In his book *Opening up* (Pennebaker, 1997), he discusses the benefits and risks of disclosure and argues that the latter in most cases outweighs the former. Inhibition, keeping emotions and thoughts to one self, Pennebaker argues, is physical work that affects one`s health and has an impact on one`s thinking capacities (ibid. 9).

Confronting experiences, feelings and thoughts through talking or writing, reduces the effects of inhibition as it provides both an emotional catharsis and a re-thinking of the events. In this Pennebaker aligns with psychotherapeutic traditions (non-directive talking cures) that originated with Freud. What he contributes is a systematic exploration of the *sine qua non* of talking cures – the value of disclosing self. It is an underscoring that the suffering of the patient, more than anything, is related to his or her inhibition, and that the healing more than anything is related to the disclosure undertaken by the patient.

Pennebaker undertook a number of different research projects, primarily among college students, but also among professionals (ibid. 38ff). He provided non-directive writing assignments and monitored the bodily changes that occurred during the exercise as well as the health benefits following it. Typically, the participants were invited to write about traumatic experiences for 20 minutes for four consecutive days. One group was to write more superficially, focusing on what happened, while the other group was invited to “let go” and share their deepest feelings and thoughts related to the traumatic incident. The studies indicated that the latter was more beneficial – by far (ibid. 37).

Pennebaker identifies “low level” and “high level” reflections among the written pieces. He then discusses how the writing styles reflect different thinking styles among the students. The latter may relate to personality, but perhaps also to contexts, according to Pennebaker. He convincingly makes the case that most of us would respond quite differently to an invitation to share in writing our deepest thoughts and feelings about an experience or issue, depending on whom we assumed the reader to be (ibid. 173).

Pennebaker claims that Expressive writing may have an impact of the progress of a grieving process and help speed up coping after loss (ibid. 73ff). His findings and perspectives have been both applied and challenged in more recent bereavement studies (Stroebe, 2008).

«Thus far there seems to be little evidence that disclosure of emotions to others leads to better adjustment following bereavement. Showing overt negative emotions is associated with a poorer outcome, both in absolute terms and relative to initial levels of distress. Furthermore, avoidance of one`s underlying emotional state may actually help subsequent adjustment» (Stroebe, 2008, 55)

One of Pennebaker`s main points though is that the cognitive restructuring that takes place during Expressive writing is of outmost importance for longer term health benefits. He relates this to it responding to the human inherent need for meaning (Frankl) and for completion, where disruption has taken place (Pennebaker, 1997, 90). Expressive writing slows down the process, brings structure to it and makes space for a less emotionally laden assessment of it (ibid. 95). The importance of the search for meaning is a position echoed in Aaron Antonovsky writings, not least his focus on coherence as a premise for salutogenese (Antonovsky, 1987). According to this position, a mere expressing of emotions, which can also take place through non-lingual activities such as dance or art, will not to the same degree “promote self-understanding” (ibid. 93).

Concluding remarks

How can Expressive writing complement the data provided through BNIM, and in what form and manner should it be used in order to serve such a purpose? Expressive writing is in significant ways congruent with BNIM and other narrative endeavors (ref). Even though originating as a therapeutic tool, it has been used in various research-projects, but, to my knowledge, only once in Norway (Haga Gripsrud, 2014) and never, as far as this researcher knows, in regard to professionals.

One main reason for adding Expressive writing to the endeavor is that it may provide experiential accounts of situations involving use of coercion. Expressive writing shares with BNIM that it allows for an expressing of thoughts and emotions, on the part of the interviewee, that is more open, free-associative and non-directed than other, more structured, methodological measures. It thus allows for the unique voice of the narrator and an “outlet for issues not expressing to others” (Haga Gripsrud, 2014, 5). The question is whether this is even more so the case in regard to Expressive writing than BNIM.

The invitation implicit in the SQUIN is broader. Hence, the telling that takes place as a response to it may mirror the open-ended invitation, which is intentional and serve important methodological purposes such as allowing the narrator to share significant stories both from inside and outside the clinic. A potential downside though is that it, almost as a matter of course, invites a total or in part rehearsed narrative(s). A particular incident narrative, through a session of Expressive writing, on the other hand, may provide an invitation that induce the narrating of experiences that are not yet processed and thus the narration of which is not yet rehearsed. It will also be narrated in solitude, and one may assume – in void of an audience.

Yet, Haga et al point out how the writers in their study, even when in their own solitude, report having a hard time escaping the sense of writing to an audience (ibid. 5). Having been delivered the task by the researcher, chances are that the professionals will picture the researcher and might even adjust their writing according to what they assume is his or her expectations. One way, perhaps, of minimizing a sense of the researcher being the audience could be providing instructions in-absentia, through a letter.

The letter may provide the following instruction, which is adjusted from Pennebaker's own (Pennebaker, 1997, 167):

Over the next four days, I want you to write about your deepest emotions and thoughts about the most upsetting experiences involving use of coercion in your professional life.

Really let go and explore your feelings and thoughts about it. You can write about the same incident every day or a series of different incidents. Whatever you choose to write about, however, it is critical that you really let go and explore your very deepest emotions and thoughts.

Pennebaker also includes the following in his instructions (after the second sentence above): “In your writing, you might tie this experience to your childhood, your relationship with your parents, people you have loved or love now, or even your career. How is this experience related to who you would like to become, who you have been in the past, or who you are now?” I plan to leave this out, as it requires a theorizing and filtering on the part of the narrator that may result in “thinner” descriptions. Whether the interviewee is to undertake the sessions of Expressive writing before, after, or instead of, the BNIM interview, will have to be discussed elsewhere.

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