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”it is a bit like being a parent” – a discourse analysis of how nursing identity can contextualize patient involvement in Danish psychiatry

Abstract

During an ethnographic fieldwork in Danish psychiatry taking place between 2011 and 2013, the emergence of an exemplary textbook symbolized a dominant perception of the relationship between psychiatric nursing professionals and patients that contextualized their ways of involving the patient in clinical practice. Drawing on the discourse theory of Laclau and Mouffe, this article elucidates how this particular textbook articulates the relation between two gendered subjects; a dominant and caring mother and a childlike, male patient. This article takes up the discussion about how the nursing discourse is embedded in a range of ideological structures about gender, theory of science and ethics of the psychiatric field. It proceeds to discuss what space of possibilities and problems it delineates for the nursing profession, for patients and involvement and recovery of patients in daily clinical practice.

Keywords: *Psychiatry, discourse, identity, gender, involvement*

Introduction

During an ethnographic field work that strived to clarify dominant constitutive premises for, and effects of, recovery and involvement of relatives in care and treatment in Danish psychiatry (1), the author (JO) studied how psychiatric professionals such as nurses, nursing assistants, psychologists and, at times, doctors commonly talked about psychiatric patients at the two psychiatric hospitals. The investigation of their widespread views of psychiatric patients and the professionals' understandings of involvement relied on two months of observations of daily practices, gathering texts and interviewing professionals in these psychiatric settings (ibid.). A common view of the patient as an infantile person emerged in many forms during the field work and in interviews with the psychiatric professionals. For example:

Ina: *"This Kirsten [a thirty year old patient of hers]. She has brought her mother along. I think that her mother. Well, she is, still, very much a mother to her"* (Psychiatric nurse, 48 years old)

As in many other cases, this nurse suggests that she sees her adult patient as a childlike and helpless person given that the patient brings her mother along to treatment sessions at an outpatient unit. Moreover, this view of the patient and the subsequent conception of the relation between relatives and patients also came clear during a psychoeducational session when a psychiatric nurse depicted involvement in the following way: *"it is a bit like being a parent"* (Field note, November 2012). This common articulation echoed the idea that patients are identified as weak and childlike whereas relatives' and nurses' identity is characterized as strong, mothering and caring in relation to the patient (1;2). This emerged clearly during an interview about involvement with another psychiatric nurse:

”[The female relative to a person diagnosed with depression] *is organizing everything at home. And takes care that appointments are kept, makes sure to purchase commodities and makes sure that the dishes are done and to tidy up those things. That is, structure. Takes care of her. Looks after and.... I suppose that it is a little feminine. Mother.*”

Given that the diagnosed persons were often depicted as weak and incapable, this view of the patient also legitimized the professionals’ and relatives’ authority and, in fact, obligation to rule out the patient’s own understanding of his or her health (1;3;4). In order to gain a deeper understanding of the professionals’ views of their possibilities for working with recovery, involvement, anti-stigmatization and social inclusion, the author made several inquiries about the origins of the professionals’ understanding of the patient. The nursing staff at the two hospitals recurrently referred to a pivotal textbook on psychiatric nursing, “*From chaos towards unification, coping and harmony - psychiatric nursing for psychotic patients*” (5), when they talked about their relation between the patient and the nurse (2). Taking the empirical point of departure in this textbook on psychiatric nursing (5), this article proceeds to elucidate how the relation between a professional nursing identity and a specific view of the patient is depicted in the textbook.

Background

The portrayal and possible reenactment of the parental relationship between professionals and patients should, however, be understood in the context of the history of Scandinavian psychiatric nursing, in which clinical practices, at least predominantly, have relied on psychodynamic and relation based perspectives, rather than on biomedical perspectives during the last century (6-8). This understanding is highlighted by a range of international and Scandinavian field studies that

echo a comparable parental understanding of the professional-patient relation (9-11). For instance, the field studies in psychodynamic ward settings showed that the psychiatric nursing staff articulated the social interaction between patients and professionals using family metaphors. Corresponding to the aforementioned excerpts, their analysis suggests that the treatment of adult patients as children can be considered a normalizing subjectivation, conditioning childlike behaviour in the patients (12). In the context of Danish forensic psychiatry, the field work by the Danish nurse Gildberg equally indicated how professionals' use similar techniques of normalization relied on their personal sense of normality (13). The ethnographic work of the Danish anthropologist Bredahl Jacobsen (14) had also shown that the interaction between nursing staff and patients relied on a paradox. That is, the professionals expected the psychiatric patient to become adult and normalized, while holding the patient in a childlike social position. These subjectivating techniques constituted a situation in which the patients were expected to become self-managing, adult subjects, by controlling their own behaviour, thoughts, and feelings. This coincided with a situation in which they were not considered capable of acting like adults (14). Taken together, these studies suggest that a dominant discursive understanding of psychiatric patients may frame an institutionalized and stigmatizing relationship between nursing professionals and patients in Denmark and other parts of Scandinavia. Recently, ethnographic research on involvement by the Danish psychologist Ringer has shown that dominant understandings of patients' subjectivity may also be constituted by a range of antagonistic discourses about mental illness that are at play simultaneously in psychiatric practice in Denmark (15;16). However, these studies not only indicate that it historically has been difficult for patients and nurses to resist the dominant (hegemonic) understanding of the relationship between patients and professionals (17). Given a rather strict empirical focus on staff-patient interactions,

normalization and involvement in Scandinavian psychiatric settings, these studies have largely disregarded how the clinical discourses and interactions are tied up in a wider range of ideological structures about gender, theory of science and ethics. A reading of 12 Norwegian textbooks on psychiatric nursing and psychiatry does add to this understudied area in the literature (18). This work suggests that the nursing profession attempts to attain independence and position outside the shadow of the medical profession by emphasizing humanistic and social subject areas in the field of psychiatry (18). However, the investigation of the underpinnings for the professional identity in psychiatric nursing, and how the different aspects of it come into play in practice, still remains largely unexplored (18). This analysis of the nursing textbook contributes to the qualitative literature on the intersection between professional identity (2;18) and patient involvement in psychiatry (1;3;4).

Aim

The analysis of the textbook (5) elucidates how it represents a widespread understanding of the relationship between nursing professionals and psychiatric patients. Subsequently, the article takes up the discussion about how the textbook's depiction of the parental relationship is embedded in a wide range of ideological structures about gender, theory of science and ethics in and around psychiatry. By doing so, the article aims to contribute to the literature on involvement in psychiatry by putting into perspective how this psychiatric nursing discourse might underpin nursing professionals' ways of working with involvement within psychiatric institutions today.

Method

This analysis is based on a nursing textbook (5) drawn from an ethnographic field work (4). But one might ask how a textbook can represent (aspects of) psychiatric practice? According to the anthropologist Riles (19), a textbook, like other documents such as policies, can be seen as “*a paradigmatic artefact of modern knowledge practices*” (p. 2) that can reflect the logic of and ideals for the knowledge practices. In seeing the textbook as an artefact, it provides “*a ready-made ground for experimentation with how to apprehend modernity ethnographically*” (ibid.). In this sense, an analysis of the textbook can disclose contemporary ideals for modern knowledge practices. By analysing the textbook as an ethnographic artefact, this article casts light on the ideological underpinnings for the professional identity and patient-professional relations that are foundational for nursing professionals’ ways of working with involvement of patients and relatives within psychiatric institutions (19).

The textbook: The context for and importance of investigating the book’s discourse was emphasized by the fact that textbook was often referred to as “*the bible*” by nursing staff during the field work in the psychiatric settings (4). This equivocal articulation of the textbook not only signalled a professional affixing to Christian moral philosophy but also emphasized the acknowledged status of the book’s nursing discourse among the professionals. The common consent to its status proved to be evident as the textbook, in its 16th printing (5), was an integral part of clinical education in psychiatric nursing in the Region of Southern Denmark where the hospital settings were located (20). Its number of prints also exceeds that of comparable but competing textbooks on psychiatric nursing in Denmark and other parts of Scandinavia (18;21). With nursing professionals constituting the majority of the total work force in the psychiatric system in Denmark, the discourse articulated in the book possibly represents a dominant way of conceptualizing and organizing psychiatric nursing practice today (19).

Theoretical perspective: The discourse analysis of the textbook relies on a constructivist perspective. This constructivist approach is based on the claim that social reality is conceived as a symbolic order that structures the organization of meaning, identity and daily practice (22). When inquiring about the order of social reality, it is productive to draw on discourse theory as explicated by the political theorists Ernesto Laclau and Chantal Mouffe (22) who define discourse as “*any practice establishing a relation among elements such that their identity is modified as a result of the articulatory practice*” (p.105). Their notion of discourse, which is called articulation, encompasses that discourse is a symbolic structure. Their inclusive and broad understanding of discourse not only entails written and spoken language but also involves acts of speech, such as material practices encompassing gestures, practical arrangements, social organizations and self-presentations (22;23). A discourse “works” by temporarily fixating a specific meaning to the practicing of an identity within a particular field (22;23). Then, discourse analysis clarifies how articulation, consisting of specific ways of talking, writing about and acting towards certain subjects, is constitutive of subjects’ positions and how they are given specific meanings within the discourse. This understanding of discourse relies on an anti-essentialist understanding of the subject’s identity (23). That is, the subject is decentered which implies that the identity of the subject is considered as an effect of the coherence between the chains of equivalent symbols, words and metaphors (i.e. a chain of equivalence) (22;23). In this sense, the subject’s identity is given a specific meaning within the articulation. However, the meaning of a subject’s identity is also fixed by its relation to the articulation of other identities in the surrounding the field of discursivity, consisting of rivalling discourses. This implies that a subject’s identity is given a specific meaning in contrast or opposition to its binary subject position(s). Taken together, a discourse symbolizes a specific understanding of several identities

which delineate the specific space of possibilities and constraints for the practices of the subjects within the symbolic structure (23).

Analysis: The analysis encompassed an investigation of the common articulations of the nurse and the patient. It was carried out by looking for the chains of equivalence (composed by a coherence of signs, symbols and metaphors) used to depict their identities. Specifically, the analysis was conducted by investigating how their identities are signified (characterized) in the textbook. This work relied on a coding of the specific words and quotes that are used to characterize the nurse and patient, and it highlighted that the nurse's identity is articulated using three types of signs called "Faith", "Gender" and "Inadequacy of Science". Given that the book is only available in hard copy, the coding was conducted manually. In short, "Faith" accounts for equivalent signs of demanding, controlling or surveilling the patient whereas "Gender" refers to signs of being warm, loving, capable, intuitive, natural or gifted. Despite that "Faith" and "Gender" are both used to depict the nurse as a parenting subject, the coding showed that the nurse is pronounced as "she" throughout the entire book. By contrast to the subject of a medical doctor, who is denoted by signs of masculinity and rationality (see below), the nurse is, then, depicted as a demanding and mothering subject for whom rational and scientific knowledge is inadequate ("Inadequacy of Science"). Despite that the nurse and the patient are articulated in contrast to each other within the book's nursing discourse, the coding and analysis of the book also revealed that the subject of the patient is not only presented in contrast to, but also as being inferior to, the demanding, mothering and capable nurse. This implies that the chain of equivalence, that constitutes the nurse's identity, frames the depiction of the patient. By contrast to nurse (whose identity is framed by the subject of the doctor), the identity of the patient is the articulated using the exact opposite of the signs that characterize "her" identity. In the book, the

patient is, then, characterized by lack of “Faith” (e.g. control and boundaries) and lack of the qualities associated with the gender and motherliness of nurse. In this sense, the patient subject is articulated as a male child.

Discourse analysis

Drawing on discourse theory, the analysis specified how the textbook’s articulations of the nurse and patient symbolize the specific understandings of their identities that bring into effect that the nurse and the patient have a parental relationship. In the first two sections of the analysis, the nurse and patient identities are presented in turn. In the final section, it is presented how the book’s articulation of the identity of the nurse and “her” relation to the patient is articulated in the context of the bio-medical perspective in which the subject of the doctor holds a dominant position.

The identity of the nurse

In the textbook (5), the nurse is articulated as a cohesive and privileged subject in contrast to the patient. This appears in the quote presented below:

”The mere fact that the nurse is present as a relatively unwavering, distinct and coherent person will be a reality guidance for the patient. When one spends time with the patient and tries to contribute by compensating for the failing functions of the patient’s ego, it is called working as an assistant ego.” (p.113).

The quote signals that the nurse by her very presence is considered as someone having a beneficial effect for the patient’s ability to function. Unlike the patient, the nurse is considered as a reasonable and competent subject as she is articulated as an assistant ego. The unwavering,

clear and coherent character of the nurse connotes her reason and competence. However, the identity and function of the nurse is characterized by a paternal and a maternal principle. In turn, these principles are explicated in the following quote:

“The nurse can both contain and use the maternal principle (good, loving care) and the paternal principle (setting boundaries, rules, demands, structure)” (p.69).

Drawing on these principles, the significations of the nurse suggest that the character of the nursing subject is constituted by a normative, paternal rationale and an essentialist maternal rationale, which, in coherence with each other, characterize the identity of a dominant and caring nurse. These two principles correspond with the categories of “Faith” and “Gender” outlined above.

“*Faith*”: In the textbook, the understanding of the nurse is established around a Christian, paternalistic concept of care. For example, it is stated that:

“The nursing anchorage of this author is bound to the ideas that hopefully run as a common thread in this chapter and as an undertone through the rest of the book. The ideas circle around a focal point - the idea of Caritas” (p. 24).

The quote highlights the articulation of the psychiatric nurse as constituted by ideas rooted in Christian moral philosophy. This philosophical affixing to Christian ethics is evident throughout the book. Time and again, the nurse is articulated by drawing on metaphors such as “*a spiritual dimension*” (p.22), “*the mystery of life*” (p. 67) or “*to become an ally of the light*” (p.23). With direct reference to the idea of Caritas, the concept founds the paternalistic rationale in the history of medieval Christianity. This implies that Caritas refers to a divine and descending love or charity that comes into effect through the conduct of faith and confession in human interaction in

and outside the church (24). The normative undertone of Christian ethics, constitutive of the nurse, can then be seen as an implicit reference to the history of confessional practices of the church.

The history of pastoral power has been described by the philosopher Michel Foucault (25). He described its confessional tradition as a productive form of power. From that point of view, all Christian sinners are compelled to confess to their moral shortcomings and weaknesses through self-examination and development of their inner thoughts and emotions, in order to be redeemed. This implies that the individual is obliged to bear witness before God, or someone representing God, but against himself to achieve salvation, happiness or good health (ibid.: p.211).

Analogously, the nurse's identity is characterized as someone to whom the patient ought to confess his weaknesses, thoughts and emotions in order to achieve good mental health. In the textbook (1), this rationale is implied in the presentation of the paternal principle:

“The paternal principle symbolizes “a nudge” out into the world. It contains an offer of activity and a demand to develop, learn things, become vigorous, be effective, become capable”(p.80).

From the perspective of pastoral power, the quote suggests that the nurse has a legitimate position from which to demand that the subject of the patient confesses his problems to her. The rationale implies that the patient is compelled to subject himself to a certain relation with the nurse in order to develop, learn, transform and improve his mental health, capabilities and happiness.

“Gender”: Within the articulation of the nurse, the paternalistic demand for the patient to submit himself to the nurse is explicated in coherence with a maternal, essentialist rationale about the gender of the nurse:

“The maternal principle symbolizes a base and a protection where continuity, loyalty and absence of demands are pivotal. The mother lets the child exist, just letting it be, letting it grow without intervention. Such an all-embracing protection is a prerequisite for all new life to develop.” (p. 80).

This statement indicates that the motherliness of the nurse is a necessity for the existence, being and development of the patient. This articulation of the subject of the patient grants legitimacy to the subject of the nurse, as the nurse’s femininity and motherliness are conceived as prerequisite for the transformation of the patient. In this sense, the articulation of the nurse’s femininity constitutes the nurse’s natural authority to assist in the development and transformation of the patient.

This characteristic of the nurse’s identity refers to what can be conceptualized as a “second wave”, standpoint feminist perspective that preconceives that women, in contrast to the view of the cold, rationalistic man, are considered as warm, authentic, intuitive and with a deep understanding of people’s lives and true needs (26;27). This common, essentialist characteristic (28) of the nurse’s professional identity is underscored by the fact that the nurse is continually articulated as “she” or “her” throughout the entire book (1):

“The fact that the nurse endures the projections of the patient may also be seen as a “restoration” [of the patient]. That she is willing to remain passive – to receive and not “break”. For this, it is essential that she has a special knowledge telling

her that the patient cannot sustain his inner pressure and therefore projects his own raw material.” (p. 112)

As the excerpt exemplifies, the nurse is constituted by the idea that she is considered as a mothering and passive woman, assisting the needs and pressures of her counterpart; a male, childlike patient. This implicitly gendered perspective, then, frames her position in symbolic differentiation from masculinized subjects who, according to gender research, are commonly seen as cold, outgoing and untamed within a standpoint feminist position (26-28). In contrast to masculinized subjects such as patients and doctors, this articulation of the nurse implies that she is considered as a feminine subject who is characterized by natural understanding, intuition and ability to take children or weak, childlike patients in hand (26;29). The articulation of the nurse's natural understanding, intuition and insight into the world of the patient is also apparent in the following excerpt from the textbook (1):

“Despite that it can be difficult to make sense of what the patient says, there is often a veiled or open affective meaning in the statement. That is what the nurse can explicate”(p. 122).

In this sense, it is articulated that the nurse is characterized by a natural, and superior, capability to understand and explain the patient and his way of expressing himself. The nurse's privileged understanding of the weak, childlike patient is constituted by her warmth, authenticity and intuition, established by her femininity and motherliness. This is indicated in the following:

“[...] but if one can only imagine or understand what the patient experiences – if one does not have an additional understanding – one cannot provide sufficient help” (p. 15).

This suggests that the ability and intuition of the nurse provides an additional understanding of the patient's perspective. The nurse's legitimacy and position to demand, that the patient confesses his problems to her, relies on her superior understanding of the patient because her identity is constituted by what can be seen as an essentialist feminist notion of her femininity, in which women are seen as being intuitive, and more in contact with the natural world, than men (26). Taken together, these two characteristics of the nurse set her apart from the masculinized childlike identity of the patient as he and his characteristics are presented as the nurse's counterpart.

The identity of the patient

Due to the persistent absence of a patient voice throughout the book (1), the articulation of the patient is implicitly framed by the articulation of the nurse. By contrast to the unwavering and coherent character of the demanding and mothering nursing subject, the patient is considered as a male, inept and childlike patient subject with a “*weak ego*” or core (p. 8,37,48):

“When he is challenged by something stressful for him, he cannot compensate for his poor ego-function (ego-weakness) but decomposes and falls into psychotic chaos” (p.37).

The articulation of the patient as weak portrays the patient as fundamentally being in need of constant assistance and/or regulation; something that is presented as “*ego-strengthening nursing*” (p. 15) or “*ego-strengthening therapy*” conducted by the nurse (p.77). Despite that the book specifically addresses “*psychiatric nursing to psychotic patients*”, it is articulated that ego-strengthening forms of interventions are transferable to patients suffering from borderline, manic-depression [bipolar disorder], anxiety, schizophrenia, cognitive disturbances, dementia

and “other ego-weak [individuals]” (p. 8). This suggests that the weak patient refers to the identity of a generalized mentally ill patient that relates to the nurse in the same way. Given that the nurse is signified by “Faith” and “Gender” (i.e. a paternal and maternal principle), the patient is presented in opposition to these characteristics: As the addressee of the nurse’s fatherly demands and motherly love and charity. In this sense, the patient is obligated to confess his weaknesses, thoughts and emotions to the nurse.

“*Faith*”: The coherence of these characteristics then constitutes, that the patient is described as a subject that ought to confess the truth about himself to the nurse. For instance, the patient is explicated as cut off from reality and incapable of individually understanding and coping with reality:

“The ego of the psychotic patient is not capable of handling the principle of reality and therefore it is important that the nurse tries to assist the patient with reality guidance in a good way [...] (p. 113).

This exemplifies how the understanding of the patient is conditioned by his need to submit himself to the nurse’s “reality guidance”, as well as how he should cope with reality. This is instigated by his assumed deficits in learning and development, and thus needs to “*become vigorous, be effective, become capable*” (p.80). This need for development, regulation and guidance is justified in the next articulation:

“In many respects, I consider the psychotic man as not free. He is at the mercy of his impulses” (p.90).

“*Gender*”: In this sense, the patient, who is presented as “he”, is considered as held back by lack of self-control and inability to master his weak character. This suggests that the debilitating

character of the patient's illness is due to his lack of competence and capability to restrain himself. Thus, the understanding of the patient's deficient self-restraint is established by the fact that the patient is understood as unable to understand and explain his own thoughts and emotions. Paradoxically, the patient is, therefore, considered as "not free" because he is considered incapable of expressing himself in accordance with the nurse's "additional understanding" of him and of what is at stake for him.

Taken together, the portrayal of the patient's lack of understanding of his thoughts and emotions is constituted by the articulation of the nurse as precisely having a superior understanding, and a capability to unveil the shadowy meanings of the patient's discourse. This complex signification of the nurse and the patient as each other's counterparts thus positions the patient as someone in need of regulation, for his own sake:

"Someone in psychotic chaos often really needs someone to take over" (p.90).

The patient is depicted as being obliged to submit himself to the maternal care of the nurse. The submission to this particular relation subjects the patient into the position of a male child. Since the patient is considered weak, incompetent and incapable, the quote implies that the patient ought to develop the "right" sense of reality, by submitting himself to the care of a strong nurse.

The nursing identity in the psychiatric field

Throughout the entire textbook, a hierarchical relationship between the nurse and the patient is portrayed. Then, the book represents a discourse about the nurse-patient relationship that signals an understanding of a relation between a mother and a child. As indicated in the introduction of this paper, this articulation of the nurse and the patient was also identified in the talk and practices among the psychiatric professionals in clinical practice. The articulation may then be

considered hegemonic. According to the political theorist Torfing (23), hegemony refers to the predominant consent to a discourse that frames our “*social orientation and action*” (p.101). The present dominant articulation of a demanding, mothering nurse is established through her relation to an inept, male, and childlike patient. Then, the analysis highlights how the book’s presentation of the nurse-patient relationship discursively brings into effect a disenfranchised patient and a dominant, mothering nursing subject. But given that the patient’s voice is notably absent (2), the textbook primarily articulates a position of what can be called a “Hege-mom”; a professional nursing identity with the legitimacy to subject the patient to *her* understanding of reality, under the veil of loving care. This suggests that the book can be seen as an attempt to justify a privileged position of a “Hege-mom” in Danish, or perhaps even in Scandinavian, psychiatry; but in the context of the bio-medical perspective. This implies that the textbook’s discourse upholds the legitimacy of the intuitive, warm and loving nursing professional by declaring that science is inadequate for the understanding of the patient because the nurse is seen as being intuitive and more in contact with the natural world than, for example, the doctor (26;27). In doing so, the characteristics of the nurse are, implicitly, articulated in opposition to the bio-medical perspective in which the doctor is denoted by signs of rationality and scientific knowledge (2). This surrounding bio-medical field of discursivity is composed of contesting articulations that are in turn rejected within the limits of the nursing discourse in order to uphold unequivocality and stability for the position of the nurse. This interpretation relies on the theoretical understanding that “the social” or social reality is characterized by constant conflict and contestation of signification within any field (22;23). In this sense, the subject of the nurse is constituted by the external field of discursivity in a struggle with a competing bio-medical discourse about the patient. This struggle is about the true understanding of the patient which,

simultaneously, mirrors a social struggle between antagonistic articulations about recognition, status, privilege and position among nurses and doctors (22;23). Thus, the articulation of the identity of a “Hege-mom” may be conceived as an attempt by the feminized nursing profession to set the premises for psychiatric practice, founded on a relation-based perspective rather than on a masculinized biomedical one. But whereas Andersen and colleagues (18) concluded that the Norwegian nursing profession is understood as subordinate to the medical profession in nursing literature, this analysis suggests that the textbook symbolizes a power struggle among the ideologies for the nursing profession and the one’s represented by shadowy presence of the medical profession in Danish psychiatry.

Discussion

The identified valorisation of femininity, motherliness and intuition within this psychiatric nursing discourse is not entirely new. As these feminist and nursing virtues are articulated as a warranty and necessity for the true understanding of the patient, it bears resemblance to Christian moral philosophy, characteristic of a dominant nursing discourse in Denmark and Scandinavia (30). This Christian articulation of nursing care as a primarily ethical and holistic phenomenon (18), represented especially by the Norwegian nursing philosopher Martinsen (29;31), can be seen as a much broader nursing and feminist discourse that has contextualized the textbook’s portrayal of the professional identity of the psychiatric nurse (30;32). However, this nursing discourse effectuates problems for the nursing profession, for patients and the possibility for their involvement in psychiatric treatment and care. These issues are discussed in turn below.

Professional problems: By drawing on an archaeological approach to knowledge, the critical health researcher Paley pointed out that the understanding of care as a holistic phenomenon in

nursing accounts for an aggregation of an endless series of arbitrary associations and categorizations. Parallel to the textbook discourse, which may frame practices in many places in Scandinavia, this aggregation of associations rules out the possibility for empirically based applications of care in nursing (33). From a genealogical approach to morality, and inspired by Nietzsche, Paley prolonged his analysis by putting into perspective that nursing care represents a form of slave morality. This implies an attempt, by the nursing profession, to invert the belief system of the ruling medical profession by proclaiming that the cold, reductionist, positivistic and evidence orientated position of the medical profession is mistaken. Rather, the bio-medical outlook should be replaced by a holistic, phenomenological, and anti-research orientated approach to love and care for the patient (34). These perspectives support the suggestion that the articulation of a dominant, loving nurse signals a hegemonic discourse in the Danish psychiatric field and beyond. Consequently, as Paley (33) points out, the nursing profession's abidance to an anti-research orientated position may, paradoxically, result in a reproduction of the social order in the field of psychiatry, because it rules out the possibility of being recognized. In the case of psychiatric nursing, the recognition of this profession would, then, imply attaining the status of a proper and scientific discipline in the eyes of the medical profession.

Patient problems: But, perhaps more importantly, this discursive power play for position, status, and recognition also effectuates a wide range of consequences for patients, their relatives, and all of their involvement in psychiatric care. The aforementioned range of Scandinavian field studies from psychiatric hospitals suggest that the ward settings and milieus often are structured in accordance with a somewhat uniform discourse about the nurse-patient relationship (10-17). Such strong alignments with the textbook discourse suggest that it can be very difficult for patients to avoid being subjected to the miscrediting category of the weak, despite the fact that

some patients actively try to resist (14;17). In line with our analysis, previous studies have also established that a patient's refusal to identify with the professionals' categorizations of their condition may, in fact, reinforce and justify the necessity of the professionals' insight and categorization. For example, studies on the interactions between psychiatric professionals and individuals diagnosed with borderline disorder or substance abuse highlighted how difficult it was for individuals to resist the professionals' stigmatizing categorizations of them as a group (14;35). Paradoxically, the refusal of the diagnosed individual to identify with professionals' categorizations of their borderline or abusive character was interpreted as signs of that very category (ibid.). Despite it being well-known that psychiatric professionals add to the stigmatization of diagnosed individuals (36;37), this analysis indicates that the social construction of the relationship between a mothering nursing subject and a disenfranchised patient serves to uphold the legitimacy for the nursing professional. However, this idea has also been identified in several comparable textbooks on psychiatric nursing (18). As such, this discourse about the professional identity in psychiatric nursing that emphasizes the need for nurses to take over for patients' deficient understanding and ability can possibly be at play in a variety of psychiatric settings in Scandinavia today despite that the discourse was identified in Region of Southern Denmark in 2013.

Involvement problems: As in most other western industrialized countries (38;39), involvement, recovery, anti-stigmatization, social inclusion, citizenship and empowerment of users and relatives have become pivotal ideals in current strategies for the deinstitutionalization of the psychiatric system in Denmark (40). In this line of thought, previous work suggests that concepts like recovery and involvement have been colonized by political ideals, turning them into political tools that compel the diagnosed persons and their relatives to take over treatment responsibility

freely and willingly (1;39). By contrast to previous studies of involvement and recovery as political imperatives (ibid.), this analysis suggests that the nursing discourse may frame a rather restricted space of possibilities for involvement of patients in daily psychiatric practice.

Given that professionals commonly articulate the patient as weak, childlike and thus as essentially unable to make valid decisions about his or her health, the discourse proposes an ethical stance for the professionals to protect and safeguard the weak and incompetent patient from self-inflicted harm and unnecessary involvement of others. However, Danish psychiatric practice is founded on medical ethics in which autonomy is a fundamental principle. The principle of autonomy centres the recognition of the rights to self-determination of the individual suffering from mental illness. It is, however, based on the individual's ability to consent to informed decisions about his or her health, care and treatment (1;41). Yet, as the medical ethicist Devisch points out, the principle of autonomy is constituted by the claim of "oughtonomy". That is, the patient *ought* to be autonomous, which affirms that he or she cannot choose not to make decisions about health, treatment and care (42;43). As such, autonomy works as a decisive premise that grounds the professionals' responsibility for making sure that the patient makes decisions about health, treatment and care. It then morally forces the patient to consent to the professionals' requirements because he or she is considered incapable of making such considerations on his or her own. In this sense, professional's ways of making patient involvement work is framed by their identity of a Hege-mom. This professional identity places them in a situation where they are morally obliged to demand that the patient identifies with the category of weakness and his or her subsequent treatment needs; a requirement that, paradoxically, enforces the patient's disempowered position rather than empowering the diagnosed individual.

An example of this logic emerged during the aforementioned field work when a patient diagnosed with depression invited JO along to participate in a treatment session with a psychiatric nurse at an outpatient clinic. Despite that the patient and the psychiatric professional had voluntarily given their consent to let JO participate in treatment sessions and psychoeducation during the field work, the psychiatric nurse suddenly denied JO the opportunity to participate. After an email correspondence and a telephone conversation with the nurse about her reasons for overruling the patient's consent, JO also received a telephone call from a psychiatrist from the hospital where the field work took place. By stating "*do not take yourself too seriously, now!*" (Field note: Outpatient clinic 12/7-13), the psychiatrist explicated that JO was not in a position to question the professionals' authority by considering the validity of their denial of patient's consent. Subsequently, the phone call was followed up by another email laying out the rules:

"When your project requires that you join in on conversations with professionals, you must inform us at least three days before you consider participating with the patient or the relatives. Given that it is not possible for you to participate on the day, you have planned, the reason why must be stated in your field notes. We look forward to your participation in our professional conversations but planning is an absolute necessity. You are, of course, welcome to use this statement as a field note as it explicates the underpinnings of our system" (Field note: Email correspondence with, Psychiatrist, Outpatient clinic, 12/7-12)

This incident was exemplary for the ways that the professionals were very protective of the hierarchy between them and their patients because it works as "the underpinnings of our system". It indicates that the professionals consider themselves as being in control of the

patient's right to determine the relevancy of his or her health issues and consent to involve others of significance in these issues. The display of the professionals' frustrations and somewhat aggressive behaviour stresses this because JO's initial emphasis on the patient's right to be listened to, and to decide to involve others of significance, tinkered with the professionals' sense of importance, authority and position. Given that the patient's voice was considered invalid by the professionals, the excerpt can be seen as an example of the professionals' way of articulating the professional-patient relationship; i.e. a relation that strongly resembles the aforementioned nursing textbook's depiction of an inept child and a strong and caring mother.

Conclusion and future perspectives

This article poses a critical stance towards psychiatric nursing culture (44) in the sense that it clarifies how an exemplary textbook, which was identified during an ethnographic field work and singled out for specific analysis, articulates a dominant professional identity, underpinning the relationship between nursing professionals and patients in psychiatry. The analysis puts into perspective how this nursing discourse contextualizes nursing professionals' ways of involving patients and relatives in clinical practice. The professional identity and view of the patient might, then, explain how or why the field notes and interviews from the field work show that professionals time and again articulated patient involvement using different terminology in an equivalent manner. For example, several professionals stated that patient involvement implied that the patient should "*accept*", "*consent to*" or "*comply*" with treatment (3;4). This elucidates how the nursing discourse frames an authoritarian and paternalistic understanding of involvement which, ironically, turns the traditional emancipatory understanding of involvement upside down. This perversion of the emancipatory perspective of involvement and likeminded approaches like recovery, social inclusion, empowerment and citizenship is brought into effect

by the combination of the disenfranchisement of the patient and the emphasis on contemporary, health political ideals for autonomy (45;46). Instead of aiding the politically driven process of deinstitutionalization in Denmark (1;47), professionals' ways of working with patient involvement therefore become a strategy for reproducing the social order within the psychiatric institutions. Paradoxically, this professionalized understanding of involvement and likeminded approaches emphasizes that nurses and other professionals can remain positioned as the experts who define the needs of psychiatric patients and manage their problems (3). Then, this article calls for a rehabilitation of the current professional views of diagnosed persons and a development of approaches that not only ensure his or her civil rights but also enable diagnosed individuals to recover a meaningful identity and the opportunity to be socially included in community and working life (38;45).

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