An observation to a premise

A qualitative study concerning the interactions between professionals employed on Danish psychiatric wards, their peers, and the patients they care for. Establishing an understanding of the professional's views concerning the relevance of tackling hospitalized patient's social and personal problems, as a part of their treatment as an inpatient.

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Abstract / Resume

Opgaven er skrevet på et tidspunkt med stor turbulens, og usikkerhed på grund af den globale epidemi Coronavirus/COVID-19. Den Danske regering har indført særlige regler, som betyder at de fleste danskere skal blive hjemme, efter regeringens særlige regler.

Formålet med opgaven er for at undersøge og forstå de faglige professionelle og patienternes erfaringer, opfattelser af menneskers årsager for at blive indlagt, og hvis årsagen skal orienteres og blive til en del af en behandlingsproces, imens en patient er indlagt på en Dansk psykiatrisk afdeling.

Sundhedsdatastyrelsen rapport fra 2017 - Genindlæggelser i det psykiatriske sundhedsvæsen rapporterer, at der var 11000 genindlæggelser i 2015, der repræsenterer 23% af alle indlæggelser på de danske psykiatriske hospitaler. Den samme rapport informerer om at ca. en halvdel af udskrevne patienter ikke er forbedret på livet efter indlæggelse. De kommer hjem, til de samme udfordringer de har haft inden indlæggelse. Andre kilder rapporter at patienter er indlagt i mindre tid på de danske psykiatriske hospitaler, men et større antal patienter skal genindlægges inden for 30 dage, efter udskrivelse.

En præmis, og drivkraft til den problemformulering er, hvis sociale problemer er en medvirkende årsag til hospitalisering, vil de fortsat være sociale problemer, medmindre de behandles?

Omkostningerne for den person der kontinuerligt behandles for psykisk sygdom, eller forsømmer deres behandling kan være kolossal. Fremmedgørelse, afstand fra social kontakt gennem egne personlige valg eller valg af andre. Den enkeltes psykiske lidelser kan skabe udfordringer for deres bekendte og samfundet generelt i helhed, der skaber sociale problemer.

Flere mennesker har brug for psykisk hjælp i Danmark, et problem der vokser. Sundhedsstyrelsens publikation Styrket indsats for mennesker med psykiske lidelser fra 2018, Nævner at der eksisterer en forvirring omkring hvad psykiatri er for en størrelse, mange havde et problem med at forstå, hvordan man får adgang til behandling. Samt; at sikre at dem

der har kontakt til psykiatrien, blive taget hånd om så de ikke bliver tabt, efter udskrivelse fra en psykiatrisk afdeling.

Den problemformulering reflektere de ovenstående. Dansk oversættelse;

Hvordan søger fagfolk, der arbejder på danske psykiatriske hospitaler, at interagere med indlagte patienter, der er indlagt på en psykiatrisk afdeling med det formål at forstå og tackle de medvirkende årsager, der kan vedvare og førte til, at individets behov for behandling.

Formålet med denne undersøgelse er at præsentere en forståelse af de professionelle medarbejdere og patienternes interaktioner til at svare på den ovenstående problemformulering. Gennem disse interaktioner skaber man en forståelse af, hvad fagfolk mener er relevant i pleje og behandling af en patient.

De overvejende teoretiske positioner af opgaven er Hermeneutik, plus en forståelse af Anthony Giddens begrebet dobbelt hermeneutik beriges den forståelse af hermeneutik.

Under forberedelsen af de kvalitative interviews blev Robert K. Mertons The Focused Interview den primære kilde til at planlægge de interviews, især hans forståelse af retrospektion. Erving Goffman's The Presentation of self in everyday life og en symbolsk interaktionistiske tilgang brugt til at analysere de modtagende svar

Efter analysering af de svar modtaget fra de fagfolk, var det muligt at Etablere og konkludere at; en grundlæggende konsensus om, at fagfolk burde forsøge at løse problemer, der er personlige såvel som sociale forhold.

Fordelene ved at integrere et kursus med socialt arbejde eller social orientering i den planlagte behandling af indlagte patienter, ser det ud til at være en kilde til uudnyttet potentiale, ligesom den umiddelbare nærhed af General Practice til den ex-patient, der kræver støtte i samfundet. Disse observationer er af stor interesse og værdige til yderligere undersøgelse, som forfatteren af denne afhandling agter at undersøge, når muligheden opstår.

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1. Introduction

The thesis is written at a time of turbulence in Denmark, under the lockdown due to the pan epidemic known as coronavirus/COVID-19. The restrictions that the Danish Government have imposed to reduce the impact of the viruses' and spread amongst the general population. Restrictions which have impacted on the ability to interview people in person for the purposes of this thesis.

The original intention of the study was to focus on the recollections and conduct several qualitative interviews with ex-patients who have had an experience of being hospitalized in a Danish Psychiatric Hospital. People who have received treatment for a mental health issues. COVID-19 and The Danish Government's guidelines as stipulated by the Ministry for Health (Sundhedsstyrelsen, 2020) complicated this task, making it untenable. Hospitals and any association with hospitals at the time of researching were very much regarded as being places to avoid, due to risks associated with contracting Covid-19. Danmarks Radio reported that "*Fewer mentally ill people will be hospitalized under the Corona Crises because they are afraid of being infected*" (Rahbek & Hansen, 2020). The strategy shifted to focus upon professionals working in Psychiatric hospitals. Due to this the focus of the qualitative study is heavily weighted in the favour of the professional's insights and understanding the issues of interest and ultimately answering the research question.

Several reports point to what appears to be a growing problem in Denmark. A greater number of people need help because of issues affecting their mental health. Unfortunately, these

reports show that a rising number of patients admitted to psychiatric hospitals are patients that have been recently discharged from a psychiatric hospital. In 2015 *Genindlæggelse I det danske sundhedsvæsen* reports that readmissions occurred approximately 11,000 times in Denmark (Sundhedsdatastyrelsen 2017, p.7). Readmissions are one of the contributory factors burdening the Danish Health Systems bed occupation capacity levels, affecting the ability to deal with mental health issues within a hospital setting.

This thesis intends to present an understanding from the professional's perspective. The thesis wishes to address an interest in researching how professionals feel that they play a part in a patient's treatment. At the same time learning about the factors that they think are relevant to address when understanding the reasons for the patient's hospitalization and their thoughts about patients care and rehabilitation process. The reason for this line of enquiry lies in the fact that on average a patient spends less time than before as an inpatient. Discouragingly a greater number of patients are readmitted to hospital shortly after they have been discharged. Sophie Hæstorp Andersen (Jakobsen, 2018), Chairman for *Psykiatri- og Socialudvalge*t in Danske Regioner names this problem, and points to the lack of quality and help that exists at local level. Andersen (Jakobsen, 2018) also points out that kommunes have the responsibility to ensure that psychiatry at a local level is providing the services required to support people suffering with mental health issues. A Kommune is roughly the equivalent of a Local Government Council in the United Kingdom. Whilst researching the professionals perspective, so the thesis will attempt on a limited scale to present the previously discharged patients experiences of their hospitalization, the treatment they received and the help received to adjust to life after hospitalization, ultimately to continue their process of rehabilitation.

Professionals and patients' interactions, understandings and perceptions of the treatment provided is done so within parameters that are predetermined. A Psychiatric Hospital, as an institution comprises of many constitutes. The sum of the constitutes impact upon the professional's ability to interact with the patient, and ultimately the patient's treatment. These constitutes are amongst others physical (structures), or omnipresent in the form of Laws, accepted behaviour patterns, all of which can influence the relationship between the professional and the patient. It is within this arena that professionals and patients interact with one another. Erving Goffman (1990b p.28-82) explains this in *"The presentation of self in*

everyday life" in which he demonstrates how interactions can be seen in the light of stage *'performances'*.

The patient perspective in this thesis focuses on their interaction between themselves and the professionals directly involved their treatment, on a ward in a psychiatric hospital, hopefully helping them prepare for the time when they will be discharged from hospital. However, this does not always seem to be the case. The LUP national report shows that arguably under 50% of patients are properly informed of the possible side effects of their treatment, as well as being properly prepared for life after they have been discharged (Hansen, Holm, Dahl, Svendstrup & Witzel. 2019 p.36).

2. Introduction to the area of study

2.1. The Social Problem

The Social Problem arises through the widely accepted admittance that medicine can help people live a life whereby they can contain and manage their mental illness. However, medicine alone cannot always cure their condition. A rise in the use of psychotropic medicine as well as a rise in people requiring hospitalization. (Jakobsen, R.2018). Suggests that Life experiences and social interactions could have an influence upon a person's mental health.

According to the earlier reference from Sundhedsdatastyrelsen about 50% of discharged patients are not prepared for life after hospital, which in turn suggests that there is a risk for a high number of readmissions, as is reflected in the amount of readmissions shortly after discharge, 23% of all admissions in Denmark are readmissions, of those 23%, a quarter occur within the first 3 days after the initial discharge (Sundhedsdatastyrelsen, 2017 p.7-10).The connotations for not treating a person in need of hospitalization can be many, just as there can be for persons leaving hospital before their treatment is completed.

A high number of readmissions impact upon the prioritizing of resources available to the Danish Health Service, as well as the local kommunes, communities, families and the person suffering from mental illness. Readmissions mean that a person needs to be treated more than once, extending their course of treatment, repeating procedures that have only just been completed. Extending a patient's treatment impacts upon the available bed capacity and increases occupation rates within the systems of psychiatry, meaning that others with mental

health issues have problems accessing treatment. These difficulties highlight structural problems that exist within psychiatry and health care in general, namely that demand is close to exceeding supply. There are a limited number of beds available within Danish Psychiatric hospitals. These beds are having to cope with a rise in the number of inpatients, figures from 2010 - 2017 showed a 14% rise in people requiring hospitalization. (Jakobsen, R.2018).

The cost to the individual that is being continually treated for mental illness or neglects their treatment can be colossal. Alienation, or distancing from social contact is quite normal, through own personal choice or the choice of others, amongst others family members as the publication from the Danish Ministry for Health alludes to '*Styrket indsats for mennesker med psykiske lidelser'* (Sundhedsstyrelsen, 2018), roughly translated as Improved help for people suffering from mental illness is very quick to point out the individual cost and the social impact of failings in treatment of mental illness. People suffering from mental illness are very likely to die younger. All too often problems related to lifestyle are not addressed. A generalised public 'phobic' view of the understanding of mental illness, as well as unfair bias in the understanding of somatic illness as compared to mental illness are just a few of the social problems that this publication names (Sundhedsstyrelsen, 2018 p.5).

2.2. Motivation and Prejudices for the line of research

The interest for this line of enquiry derives from the practical experience of working in different psychiatric hospital wards. A desire to set those experiences up against existing knowledge and observations derived from reports surrounding mental health issues accompanied by a general inquisitiveness in understanding what drives and motivates individual professionals involved in a patient's treatment. Learning about what they think should form a part of a patient's treatment. With the hope of comparing the professional's understanding against patient's experiences and recollections of the relevance of their treatment. Ultimately comparing these understandings from both perspectives against existing reports and investigating the issues described in *the issues of interest.*

The hope is that in researching these interests that the thesis creates knowledge that is of value in understanding the professional person's interactions and how the interactions impact upon a patient's treatment. Incorporating the professional's thoughts of the relevance of addressing a patient's social problems during the period of hospitalization. The root of this

lies in the consideration that earlier presented figures suggest that there may be a difference in the patients recollection of their experiences and advice received as opposed to professionals working on psychiatric wards (Sundhedsdatastyrelsen, 2017 p.7-10). My own personal understanding of a patient's causes of illness and their need for treatment can differ from my colleagues. Professionals working within Psychiatric Hospitals often have educations that focus on how the immediate health of an individual can be stabilised. Their holistic understanding of a patient's problematic can differ from a professional educated to focus upon social integration and participation. Giddens (1979 s.238) explains this in his book *Central Problems in Social theory.* Whereby a more traditional scientific positive approach could just dismiss social elements to a problematic as irrelevant.

From my own perspective, a social worker, employed in a Psychiatric Hospital the causes of hospitalization are of interest, especially how social influences and interactions that can contribute to a person's mental condition are fascinating. Enjoying the privileged position of being employed in the area of which I choose to study, I have been able to observe and interact with patients, and professionals on a regular basis.

Due to this privilege, I have come to believe that many people are hospitalized due to problems that occur in their daily activities, and interactions, or lack of, as the case maybe. Alternatively, they can be hospitalized directly or indirectly because of a reaction to an experience in their life, or a realisation of how their life has developed. A reaction can be triggered by something which is unique to the individual. Without knowing a person's life story or their own perceptions of their own situation, the trigger may seem to be trivial to others, or to lack meaning. However, this trigger was the persons tipping point. The only person who can understand it and explain it, is the person it happened to. Indeed, in Merton's quote *"If men define situations as real, they are real in their consequences*" (Merton, R. 1995, p.384). It is for these reason that I have chosen a qualitative approach to my thesis.

2.3. The issues of interest. (problemstilling)

The intention of this section is to offer an understanding and reasoning for the formulation of the research question and to explain the importance of answering the research question.

In Denmark, Psychiatry is broadly speaking divided into two distinct areas Regional and Social Psychiatry. Regional Psychiatry is administered by the five-regional health authorities, and for this thesis is best and broadly described as treatment for mental illness within a hospital setting. This being the stage, at which the interactions are of primary concern to the thesis. Social Psychiatry is the responsibility of the 98 kommunes in Denmark. Social Psychiatry for the purposes of this thesis is best and broadly described as psychiatric care in the community, without the need for hospitalization. These definitions will be broadened later in the thesis in chapter 2.6.

The Danish regions are also responsible for providing care for those that have been sentenced to Psychiatric treatment. Maybe they have been found to be guilty of criminality or are suspected of committing a criminal offence, that could be attributed to the person's mental health at the time of the offence. Alternatively, a sentence to treatment can be judged necessary if a person is deemed to be a danger to themself, or others, meaning that they can receive treatment against their own will. An area of psychiatric care known as Retspsykiatrien, (Danske Regioner, 2020). For purposes of this thesis, patients that have received or have been hospitalized within a Retspsykiatrisk ward, are not considered as appropriate subjects to study. This is because their associated / administrative Regions and kommunes possibilities to interact with the individual patient would have been / or can be limited by the court that sentenced the individual to psychiatric treatment.

There is another player involved in the treatment of persons requiring treatment for conditions associated to mental illness '*Almen praksis'*, translates in English to General practise. The function and relevance of General practice will be explained later in chapter 2.6.1, although it will not be actively investigated.

2.4. The Confusion in accessing mental health care

People suffering from mental health issues appear to have a problem in understanding how to access treatment for mental illness or speak about their current state of mental health. There are many factors that can influence a person's need to act upon their current state of mental health. Unfortunately, in Denmark there appears to exist a tendance that people do not deal with mental issues until there mental health becomes a problem that begins to consume the individual. This being reflected in the publication *Styrket indsats for mennesker med psykiske*

lidelser (Sundhedsstyrelsen, 2018).Where there exists recommendations to both and Regions and kommunes to make mental health services easier to access at the point where it relates to the person's current state of mental health (Sundhedsstyrelsen, 2018 p.38).

It should of course be noted that the Ministry of Health refers to its own National Strategy from 2009, whereby its goals that it chooses to highlight are *"It should be easier to be mentally ill … get help earlier ... get the correct help … be a psychiatric patient ..."* (Sundhedsstyrelsen, 2018 p.13).

All too often negative influences, and problems are all too prevalent in the treatment and understanding of mental health in Denmark. Sophie Hæstorp Andersen notes the shortfall in quality, and quantity in Social Psychiatry. (Jakobsen, R. 2018).According to the publication, *Mental Sundhed – Bedre behandling til mennesker med svær psykisk sygdom* Danske Regioner, (2018) only a sixth of patients admitted to a hospital, do so as a direct result of their treatment. Suggesting that over 80% of admissions occur independently, without prior planning. It also suggests that the number of patients admitted for acute treatment that have not contacted a psychiatric hospital prior to hospitalization is as high as 90%. This report also comments on a hardcore of patients suffering from disorders that are associated with a repeated need for hospitalization. This report specifically names three groups of adult patients that are problematic, conditions related to schizophrenia, bipolar disorder, disorders affecting the individual's personality. (Danske Regioner, 2018, p.2-8).

Regional and Social psychiatry are two separate entities, helping patients suffering from mental health issues. *Mental Sundhed,* Danske Regioner, (2018, p.6) reports that up to a fifth of hospitalized patients, should be in the care of Social psychiatry. The primary cause for this appears to be a lack of relevant specialized housing and support, in Denmark. Kommunes are responsible for providing these services. Patients that are deemed to have completed their course of treatment can be forced to remain in hospital due to capacity problems in kommunal level social service. Social Psychiatry's under capacity places a strain on Regional Psychiatry's ability to orientate and guarantee the quality of inpatient treatment as well as slowing the persons process of rehabilitation. (Danske Regioner, 2018, p.6).

Genindlæggelser i det psykiatriske sundhedsvæsen, (readmissions in the psychiatric health service) Sundhedsdatastyrelsen (2017, p.4). Implies that when a patient who does not

complete their course of treatment the risk of readmission to a Psychiatric hospital rises. The same publication broadly speaking defines a readmission as a need to be readmitted to a psychiatric hospital after the patient has been discharged for a period of no less than 4 hours and within 30 days of the date of discharge. As a publication, it has many results in relation to readmissions, some of which have been chosen to support the understanding of the research question. Readmissions often occur, shortly after discharge, younger people have a higher frequency of readmission, as do people who live alone, or deemed to be unable to work. The time of discharge is a crucial factor, as is the time spent as an inpatient. A shorter time spent as an inpatient increases the chances of readmission, as does the lack of contact to the patient's general practitioner, or social psychiatry after the patient's initial discharge. (Sundhedsdatastyrelsen, 2017, p. 6-9)

According to Sundhedsdatastyrelsen (2017, p.5) there are many other factors that contribute to the need to be a readmitted to a psychiatric hospital. A critical point in the report, under the definition of readmission, suggests that if a readmission is acute, then it could be a sign for the initial treatments lack of quality or that the treatment was inappropriate. However, *Genindlæggelser i det psykiatriske sundhedsvæsen* Sundhedsdatastyrelsen (2017, p.15) does not point to problems that are a direct consequence of the treatment of patients with medicine. The significant factors that contribute to readmission appear to be more akin to their individual lifestyle as well as where and how they live. Patients that are working or have a relation to the Job Market are less likely to be readmitted than patients that do not have a relation to the job market. The report also shows that there is an increase in the likelihood of a person's chances of being readmitted to a psychiatric hospital if they have had contact with a psychiatric hospital several times in a course of a year.

There are several ways in which Danish Law attempts to provide a continuity of service to some of the persons that have been hospitalized. Under certain circumstances, these can be seen in *Bekendtgørelse af lov om anvendelse af tvang i psykiatrien m.v* Retsinformation, (2019) what can be best translated as The Law of Coercion in Psychiatry. Paragraph 3, *Bekendtgørelse af lov om anvendelse af tvang i psykiatrien m.v* Retsinformation, (2019) comprises of many aspects, amongst others that the inpatient is willing to enter into agreements about their treatment. The patient should understand the treatment's content and how it is intended to help them. The Consultant Doctor on a psychiatric ward should ensure a

treatment plan exists for every patient and where possible including them in the formulation of the treatment plan. If it is deemed appropriate including people who have a close connection to the patient. If a patient's immediate condition impairs them from being heard in the formulation of their planned treatment, so they must be offered this opportunity as soon as is reasonably possible.

Bekendtgørelse af lov om anvendelse af tvang i psykiatrien m.v Retsinformation, (2019). The Law of Coercion in Psychiatry can ensure that certain persons, that have been diagnosed, or judged to compulsory treatment have to interact with the relevant authorities, and health services after they have been assessed by a consultant as being able to receive their treatment as an outpatient. This is most notable in paragraph 13 a-c. Retsinformation, (2019) This means that a small group of those treated in a psychiatric hospital can be coerced into a form of treatment that is deemed appropriate to their needs, against their free will.

Paragraph 4 in the same law, explains that It is possible to force treatment upon people if they are deemed not to be rational. This could be because they are displaying symptoms of or are in a state of psychosis at the time of their admission for treatment. This also applies to people who appear to be in danger of endangering their own or other people's lives. After the initial diagnosis the psychiatrist can decide to detain the patient and treat the patient up to that point where the patient is stable and there exist no further legal grounds for the continuation of treatment against the patient's own free will as stipulated in This however is the only time when a patient's condition can be controlled. A patient receiving treatment for a mental disorder, retains the same rights of any other person to decide upon their own actions, within the confines of the Danish System of Law (Retsinformation, 2019, §4).   Most people that become inpatients in a psychiatric hospital, do so at their own request, without coercion and are technically speaking free to leave at any time they wish.

The five Danish Regions are responsible for their own hospital wards and orientation of the patient's treatment. Region Midtjylland, *Psykiatrien i Region Midtjylland* (2020) offers an individual treatment plan, interviews, talks about medicine, therapies as well making decisions on whether other aspects concerning the patient's health should be investigated. In Region Nordjylland*, Psykiatrien i Region Nordjylland*. (2020), for those patients that have experienced an episode with psychotic symptoms, they offer a treatment plan that includes medicine, meetings with different health and care personnel, setting focus on the patient's

lifestyle and possible treatment as an outpatient. The three other regions, Regions Syddanmark, Sjaelland and Hovedstaden, offer treatment and have processes designed to help the patient that resembles those found in region Midtjylland and Region Nordjylland.

2.5. The Dilemma

- In turn the basic rights of an individual realise a dilemma for the Danish health system and the systems of psychiatry. As in any society that holds personal freedoms in a high regard. Without very good ground, you cannot force people to take medicine and live a controlled lifestyle, against their own free will. The consequence of this understanding is that a person receiving treatment for mental health issues as inpatients are technically free to walk away from their treatment at any given time. If a person chooses to do this it can often mean that they voluntary end their treatment as an inpatient. Consequentially meaning that they cannot be referred to further treatment in local social psychiatry, or their general practitioner. Thus, rendering continuity in the individual's treatment after hospitalization as unachievable.

During the time a person is hospitalized, the risk for absenteeism places an emphasis on the working relationship between professionals and inpatients. Especially, when considering the report from Sundhedsdatastyrelsen, (2017 p.6-9) stating that approximately 50% of patients believe that were not prepared for life after their period as an inpatient and the number of patients that are readmitted shortly after they have discharged

2.5.1. An observation to a premise

If, social problems are a contributing factor to hospitalization, they will continue to be social problems, unless they are addressed. The time in which the patient is hospitalised, is the only time when professionals are guaranteed to meet the patient, maybe the only time when it is possible to aid the patient with a course of social work designed to lessen the effects the patients social problems.

2.6. Social Psychiatry's identity crisis

Indblik I Psykiatrien og Sociale Indsatser, Sundheds- og Ældreministeriet (2018, p.3-5) raises questions about the accuracy of figures relating to Psychiatry and the social work related to the field of Psychiatry. Indeed, the report finds it hard to define its intended target / focus

group, to a point where it concedes that its results reflect what is best described as patients that have most probably been in contact with Regional Psychiatry. The same report from Sundheds- og Ældreministeriet (2018, p.3-5) points to the reel problem of finding a conclusive definition of Social Psychiatry and what it entails. Indeed, the term social psychiatry is used to describe the actual course of health and social care that is afforded to the individual person with mental health issues within their local kommune. It also points to the fact that the statistical recording of how Danish health and social care is recorded does not allow for a precise monitoring of the exact cost of care or service related to a mental illness, as well as not allowing for an understanding of the comorbidity of problems affecting the individual in need of care and services within their kommune (Sundheds- og Ældreministeriet, 2018, p.4).

2.6.1. General practise

Too muddy the waters further, it was previously explained how psychiatry in Denmark broadly speaking consists of two entities. However there exists a third player, general practitioners that are operating in *'almen praksis'* the English equivalent of General Practice. In common with the United Kingdom general practices are independently run concerns. They are businesses with agreements to offer general medical advice, services and prescribing of medicine services offered within the realms of their general competence as general practitioners and within a given location. The agreement *'overenskomst',* Praktiserende Lægers Organisation (2018, p. 8) recognises the fact that general practice is the most common form of contact for all health-related issues, typically being the first point of contact. Also recognising general practises importance and role in a coordinated treatment of patients.

General practice seems to experience similar problems to those presented earlier in the description of patients experiences of continuity of service within regional and kommunal psychiatry (Praktiserende Lægers Organisation,2018, p.10-11). General practises communication with the other actors providing mental health care is far from adequate. Although there is an existing agreement and expectation of collaboration between all relevant actors involved in a patient's course of treatment. Committees are set up in every kommune to set focus on health problems within local communities. The committee members represent the kommune and practising doctors within the kommune. Regions and kommunes have a duty to provide and help the general practices fulfil their role in the working relations

between the different health sectors. This agreement is reciprocal. (Praktiserende Lægers Organisation 2018, p.10).

In Denmark it should be remembered that, *'Overenskomst*' is a phrase that is associated with the financial reimbursement and working conditions for persons working in a specific occupation. (Praktiserende Lægers Organisation, .2018, p.31). General practise is no different and it should be recognised that all services offered by general practitioners to persons suffering from mental health issues are rewarded financially. These are described as honorary payments in the document *'Overenskomst'*. (Praktiserende Lægers Organisation, 2018, p.31).

Indblik I Psykiatrien og Sociale Indsatser, Sundheds- og Ældreministeriet (2018, p.5) reports that in 2013, it was estimated that on average over 500,000 people a year living in Denmark were in contact their general practitioner due to suspected mental issues. In 2016, 690,300 people were using medicines prescribed that are associated with mental health issues. This figure is derived out of the recorded treatment of patients with the use of psychotropic medicines as specified within this report.

In order to receive psychotropic medicines, it requires a consultation with a professional, that has the competence to prescribe medicines, the first time is often through general practice. "*A psychotropic drug (medicine) can be described according to the way in which it influences ... the cellular sites of its pharmacological actions. These drugs ... influence a large number of brain systems.*" (Schulz & Steimer, 2000, p.177-182).

In 2019, The figure of 704,000 people was reported by (Bedrepsykiatri.dk, 2020). Meaning that in Denmark 704,000 people needed help to regulate their mental health with medicine. The figures referred to suggest that the population of Denmark is becoming more dependent upon psychotropic medicine.

The possible increasing dependency upon psychotropic medicine, according to Sophie Hæstorp Andersen unfortunately comes at a time when there exists a capacity problem within regional and social psychiatry, which is accentuated by an apparent lack of quality as social psychiatry. (Jakobsen, 2018).

With rising rates of people using psychotropic medicine (Bedrepsykiatri.dk, 2020), paired with structural problems, that appear to have existed for several years in the field of

psychiatry, means that the importance of finding the correct method of treatment for the individual becomes more urgent. Understanding the individuals need for continuity in their treatment both as an inpatient and in their process of rehabilitation, becomes more prevalent.

The time spent on a Danish psychiatric ward, is the only time when professionals are sure to meet the patient, unless the patient has received a judgement to receive Psychiatric treatment. Once the patient leaves the hospital it is the individual's choice alone that determines if they will receive treatment or not. For this reason, researching the professional / patient interactions and relations within a hospital setting is of importance. It may be the only time when it is possible to achieve a holistic view of the person and help them with problems that contribute to their mental health issues, and the ultimate reason for the formulation of the research question.

2.7. Research Question

How do professionals working in Danish psychiatric hospitals seek to interact with inpatients, that are hospitalized on a psychiatric ward, with the purpose of understanding and addressing the contributory causes that can persist and led to the individuals need for treatment.

2.7.1. Contextual clarifications

The research question contains phrases that can be misleading if not explained. A short explanation is offered to help the reader understand what is meant when referring to, Professionals, inpatient and contributory causes.

Professionals

Professionals in this, and the thesis context should be understood as to be a collective term for the different groups of professionally qualified persons involved in the treatment of a patient. These professions are predominately Doctors, Nurses, Social and health care workers, social workers.

Inpatient

An inpatient is a patient, that is actively registered as being hospitalized for the purposes of treatment or observation within a hospital. In the case of the thesis a Psychiatric hospital.

Contributory Causes

Very loosely defined, as factors that have had an influence upon a person's mental health resulting in a need for hospitalization. These factors stand independently from the diagnosis, though they could be the cause, or contribute to the nature of a diagnosis. A very simple example could be a person receives a diagnosis of depression. Three months earlier the person was fired from their job. This event alone could be the contributory cause, that triggered the depression because the person has no work and has lost a significant part of their identity.

3. Reflections over research design

3.1. Delimitations

During the time of writing and due to the Covid-19 outbreak and the social controls that have been implemented in Denmark. I have made choices within my own personal control, others I have not, and they are described throughout the thesis, as are other limitations, when appropriate. The situation surrounding Covid-19 has been a contributory factor in the processes surrounding my research, the approach, and the construction of my thesis.

As a study the main focus point is to draw attention to the importance of the interactions that occur with and around the inpatient during the period that they are hospitalized on a Psychiatric ward. The interactions that the study wishes to understand occur within hospital settings, that have been influenced by organisational, leadership and political decisions. These influences are acknowledged as factors that can be omni-present and can have an impact upon interactions. However, they are not the focus of the research.

The study does not address a specific organisation, region or kommune because it was felt that, there could run a risk of the study becoming a study focussed on an organisation, which in turn meant that the focus on interactions risked being lost to an understanding that focuses upon structure and organisation.

It is important to note that when employees representing the different professions partake in interdisciplinary cooperation. Andy Højholdt describes it in Danish as *Tværprofessionelt samarbejde Højholdt* (2016), that is roughly speaking the cooperation between the different professions, this is explained in Chapter 6.1. *Front.* The focus of the study lies not on the interdisciplinary interaction / cooperation and how it can be improved

The thesis's focus lies upon the individual persons recollection and their perception of the relevance and effectivity of the interdisciplinary interactions, that they have experience of. In writing this, as previously named in the section ***An observation to a premise*** the realisation that the only time when the different professions have a definite chance of interacting with a person suffering from mental illness, or with symptoms or suspicions of mental illness is when they are hospitalized. Therefore, the study is focussed on this time when the interaction within the psychiatric hospital can take place. It is the professional's interactions and understanding of patient contact within this period that the study takes an interest in. These interactions as well as understanding the individual professionals' attitudes towards the contributory causes and reasons surrounding the patient's need for hospitalization and establishing their understanding of when social support should begin. These are seen as particular areas of interest.

The questions that were asked to all of the interviewees were designed to aid in the delimitation of the thesis. Before the interviews began, an effort was made to ensure that the interviews would take a relative short time and would focus on the specific planned questions using Merton's The Focused Interview as inspiration in this procedure (Merton, Fiske & Kendall, 1990).

3.2. Intended purpose of the thesis's qualitative study and its approach in understanding the social problems and the relevance of social work

The purpose of this study is to present an understanding of the professional workers and patients' interactions. Through these interactions the thesis establishes an understanding of what professionals believe to be relevant in the care and treatment of a patient. At the same time providing an opportunity to record individual professionals position with regards to addressing contributory causes and relevant social problems, as a necessary part of the inpatients care and treatment. The relevance of this establishes a position concerning the

thoughts about the patient’s condition and needs at the time when a patient is discharged from hospital, from a professional perspective. This something the recent report from Defactum, calls for, a better understanding of the patient (Defactum, 2019, p.21-23).

All patients that are hospitalized should expect to be treated, in a way that is unique to themselves, the treatment is described in a ‘*behandlingsplan’* Retsinformation, (2019, §3 stk.3), the English term for this is treatment plan. The patient should be an integral part of the treatment plan and should be involved in the formulation of this plan. This is done in conjunction with professional personnel, although it is ultimately the Chief Physician that has responsibility to ensure this is done.

On the hospital ward a *plejeplan* (care plan), which forms part of the Treatment plan should be implemented in cooperation with the patient. It is at this point a course of social work could become relevant, or at the very least there could begin an orienteering of the contributory causes that have been a factor in the inpatients need for hospitalization, as the guidance to *Bekendtgørelse af lov om anvendelse af tvang i psykiatrien m.v.* §3. stk 3 indicates (Retsinformation, 2019).

The importance for psychiatry to address these issues can be argumented for by the confusions surrounding many patients condition at the time of discharge, as reported that about 50% of patients believe that were not prepared for life at the time of discharge from a psychiatric hospital. (Sundhedsdatastyrelsen, 2017 p.6-9). The Defactum (2019) report, repeating many similar concerns.

Social Work presents possibilities during the time the inpatient is being treated and hopefully prepared to be discharged from the psychiatric hospital. Possibly helping the patient to orientate contributory causes that can be hard for an inpatient to regulate alone, especially at a time when they are beginning their process of rehabilitation. A competent Social Worker, with the competences described in the description of their education, should be able to identify ways of helping the patient (Retsinformation, 2011).

The qualitative approach to the thesis research can provide an insight into the professionals views of patient’s and what they believe to be the most relevant aspects of their work, when they are helping the patient in their course of treatment, at the beginning of the inpatient’s

rehabilitation process. It also enables the designer of the researcher to experience and influence the research through *"interconnection and interaction amongst the different design components."* (Maxwell, 2013). This information can be set in light of existing reports and previous accounts that comment on the relevance of treatment within psychiatric hospitals. Providing an insight into professionals understanding of what treatment within a Psychiatric Hospital entails, as wells learning about after their own thoughts of what it should entail. This in turn establishing views upon social works relevance within psychiatric hospitals.

The study would like to be seen in the light of opening a debate on how social and personal problems affecting inpatients should be orientated and if possible dealt with as an integral part of the patient's treatment plan, whilst the patient is under the care of a Psychiatric hospital.

3.5. Literature Review

The guidelines recommended by Aalborg University's Library 'search techniques', *Søgeteknik*, Aalborg Universitetsbibliotek (2020) where used to try and ascertain and obtain information about previous studies and information that had similarities to the area of my intended research. My reasoning for using Aalborg University's portal was that they have many agreements with libraries, organisations, and other actors, accompanied by the fact that I had received tuition in using the portal. Aalborg Universities libraries search functions enable a researcher to search many databases with a single search.

The searches I have tried are primarily linked to phrases or individual words such as '*professionally trained staff's interaction with psychiatric patients*. This proved not to be particularly fruitful, therefore I chose to change my strategy to searching for *social work in a Danish Psychiatric Hospital and in Danish ' socialt arbejde på et psykiatriske hospital*' this found some very informative articles primarily focused on the profession of psychiatry and presenting a quantitative understanding of the patients experience or condition. *Treatment profiles in a Danish psychiatric university hospital,* Okkels et.al., (2017) is one such report. This report like the earlier named reports from the Danish Ministries presented a quantitative understanding, although it was a more medicalized quantitative understanding. Nordic Journal of Psychiatry was of interest however this success was curtailed when the search was reduced to include qualitative reports / information.

My literature search continued, in hindsight, with a check on my research question focusing on contributory causes, *medvirkende årsager*. This again, showed similar results to the previous searches, with an understanding from more traditional healthcare perspectives associated typically nursing, or psychiatric. This pattern continued throughout my searches using other search engines, predominantly Google.

After conducting my literature review. I believe that there is a wealth of information and understanding from scientific and medical perspectives concerning psychiatric patient's and the treatment of medical conditions, however there exists a lack of understanding of the dynamics that exist between the professionals and patients interaction, that could have an influence upon the underlying social factors that could affect the rehabilitation and outcome of a patient's ability to recover from, or cope with their mental health issues.

The Literary review produced results that I perceive to show a limited amount of existing knowledge in the understanding and relevance of the interactions that occur between inpatients and professionals. This was a motivation in forming my Research Question as well as providing inspiration for the theories that will provide the foundation for my line of enquiry. It should be noted that for a large part of the time, that I spent writing this thesis, access to any library in Denmark was not allowed because of the restrictions surrounding Covid-19 Sundhedsstyrelsen (2020)

3.6. Theory of Science

This section is written to provide an understanding of the thesis's theoretical position, and progression leading to what is to be understood by the term's ontology and epistemology, and their relevance to the thesis. An explanation of Hermeneutics is presented as it is the predominant theoretical position of the thesis, an understanding of Anthony Giddens concept of double hermeneutics is offered to enrich the understanding of Hermeneutics.

The approach to this thesis as explained is hermeneutic. In words attributed to Gadamer, so in the very essence and act of writing, choosing to write and argument in a certain way, shows that the thesis is written by an *"interpreting being."* (Vilhauer, M. 2010 p.2).

With these theoretical reflections and opportunities, allowing for my own personal motivations and understanding of what I conceive to be worthy of study, relying on my own

interpretations and inclinations have I chosen to focus on the individual interactions that can occur between professional persons, their peers as well as hospitalized Psychiatric patients.

3.6.1. Ontology

Joseph Maxwell is very concise in his understanding of what ontology encumbers *"...ideas about reality"* (Maxwell, 2013, p.42). It is important to remember that Maxwell is very specific with the word *'ideas'.* What lies behind the ideas of reality is not a single entity as Maxwell alludes to in writing about the *" ... participants in the methodological 'paradigm wars' in the social sciences ... each embodying very different ideas about reality"* (Maxwell, 2013 p.42). Liv Egholm explains that Ontology and the understanding of it as at being *"The Doctrine of the Being"* (Egholm, 2014, p.25). Egholm, (2014, p.25-27) presents different ontological positions of which one of them has relevance to the theoretical direction of the thesis, that is the idealistic form of ontology, with an emphasis upon Culture, freedom of thought and ideas, traditionally based on a more spiritual understanding of a person as an individual. Whereby a person is free to think and adopt their own interpretation of what they see, and experience. This understanding is associated with hermeneutic and supports the choice of Hermeneutic as the main theoretical foundation for the thesis.

3.6.2. Hermeneutic

W. Dilthey, writing in the latter half of the 19th Century is often credited with being one of the people, who developed the need and reasoning for a hermeneutic approach. This being built on a belief that people have the ability to think, adapt because their understanding develops throughout their lives. Dilthey's recognition differed from the prevailing traditions of the time where a positivistic here and now understanding of the human condition was most prevalent. Dilthey's understanding of a person's ability to think independently as an individual, places an emphasis on the fluidity of a person's identity and circumstance as a opposed to the positivistic approach largely based on scientific methods (Hammerlin & Larsen, 2012, p.127-128).

Max Weber places emphasis upon the importance of why people choose to act and thus how societies are formed through the individual's motivation, and their importance in developing communities, with an accepted rationale for participating in a community. Weber believes that that people choose the way that they interact by using their own motivations and the way

that they appropriate their methods of action, accordingly, depending upon the given situation or purpose. The term and concept in understanding the individual and society that is associated to Weber in describing this is *'Verstehende Soziologie'* (Hammerlin & Larsen, 2012, p.160). Crudely said, an individual's actions are likely to be influenced and based solely on their own feelings and understandings, when an outcome solely affects the individual. In contrast, the influence of others weighs greater upon the individual, if there is interaction between different actors that are trying to achieve a consensus (Hammerlin & Larsen, 2012, p.160).

"*In its most basic terms, hermeneutics can be defined as the theory and practice of interpretation"* (Vilhauer, 2010, p.17). Gadamer's understanding of knowledge craved a wider understanding than offered by the Natural sciences, and what is encumbered by the term Verstehen. People's ability to interact, through amongst other things, their experiences with others, observe and the way that an inanimate object can communicate / interact with an individual after the individual's own premise. It is Gadamer's understanding that the individual is not limited to a positivistic, pre-ordained regard of circumstances and life in general. Gadamer's explanation is that *"… the very being of the human being, who is in fact an understanding being and an interpreting being."* (Vilhauer, 2010, p.18). According to Gadamer, this understanding of *'the interpreting being'* (Vilhauer, 2010, s.18). is reflected in the way that he describes how social science investigation methods differ from those attributed to natural science. A person adopting natural scientific methods seeks to neutralise their own personal influence upon any outcome or investigation, as opposed to a person adopting an approach associated to social science, because the investigation methods have an understanding that the person seeks to understand the motivation and thinking behind a given phenomenon, or interaction and thus includes their knowledge gained through life experiences in the act of interpreting the subject to be studied (Vilhauer, 2010, p.20-21).

Gadamer's understanding of hermeneutic, requires that the researcher that chooses to use hermeneutic research methods does so by using their pre-understandings and life experiences; Firstly and foremost to decide what and why they think that a subject or phenomenon is worthy of study, secondly how they will approach their research, thirdly their motivation and expectation of what they believe the expected result will be on completion of the course of study. Afterwards contemplating the use of the results obtained. (Vilhauer, 2010, p.18-25).

"It is Gadamer's purpose in Truth and Method to show that there is an alternative to modern scientific method, neither inferior to, nor derivative of it, which brings forth genuine knowledge of genuine truth and has a structure all its own—a structure which must be accounted for if we are to have an accurate understanding of what knowledge and truth really are." (Vilhauer, 2010, p.25).

3.6.3. Epistemology

As with ontology so is Joseph Maxwell almost as contrite with his short explanation of Epistemology "*... how we gain knowledge of it (ontology)"* (Maxwell, 2013 p.42). With the explanation offered of Ontology. If there exist different ideas about reality, the way of recording and approaching the collection of data to support differing ideas of reality, could be different. This is can present problems surrounding the ownership and creation of knowledge as Olesen & Monrad point out (Olesen & Monrad, 2018, p.21-28). The person who reads the accrued knowledge can just accept knowledge as unquestionable fact. There exists the possibility that the person choices to adopt a more epistemologist approach whereby they question the reasoning behind the production of the knowledge. In short has the knowledge been produced in a way to create a specific knowledge for the benefit of somebody or a group to gain a specific advantage. Knowledge is created or recorded for a purpose, is the reason for the collection and production of knowledge neutral or otherwise. (Olesen & Monrad, 2018 p.21-28). This is addressed by Mitchell Dean (2006, p.41-50) in his understanding and explanation of Michel Foucault's concept Governmentality. It is not to say that it is always negative, however there is a connection between how people are managed and conducted collectively through the application of knowledge obtained for a specific purpose. An individual, who is able to think freely and act out of their own free will, also has the ability to create knowledge, and apply that knowledge to the purpose they chose to do so, within the confines of a predetermined acceptance.

3.6.4. Double Hermeneutics

The Double Hermeneutic, is a concept that Anthony Giddens uses to address the differences and the complexities surrounding the relation of social sciences and the *natural sciences* as well as the differences between them. A major difference being that "*...Natural science is not mediated by mutual knowledge."* (Tucker, 1998, p.53). Social sciences are not easily

governed by rules as Natural Sciences often are. Giddens arguments for the way social actions and interactions occur, meaning that it makes it unrealistic to adopt fast methodological rules. When the researcher engages, observes, or interacts with persons or objects they should be aware that their knowledge and behaviour are "*pre interpreted*" (Tucker, 1998, p.53). Laws that could be applied to social sciences, would be and are under constant review because of the nature of how new knowledge is produced. Tucker, (1998, p.53). Giddens understanding of this is absolute in his explanation of how interactions are entwined into the complexities of interaction and their relevance to methodology. *"The continual interaction of the individual and society makes any methodological distinction between structure and action, micro and macro inadequate for social theory."* (Tucker, 1998, p.54).

Giddens explanation of the concept of *'Double Hermeneutics'* explains that an understanding of existing knowledge can be re-adapted to the appropriation of the researcher's research and research question. Although Giddens explains *"Because of the double hermeneutic, there can be no objective accumulation of knowledge apart from its social use, as in natural science."* (Tucker, 1998 p.53).

This said, and in reference to Giddens interpretations of the methodological worth of the individual's constant interactions with others and society in general (Tucker, 1998, p.53). It is worth referencing to Giddens use of Popper's understanding of *"Methodological individualism ... social phenomena ... social institutions ... should always be understood as resulting from the decisions , actions, attitudes, etc. of human individuals ... we should never be satisfied by an explanation in terms of so -called collectives"*(Giddens 1979, s.94-95; Popper, K,1966, p.98).

This understanding of Double Hermeneutic is offered to help explain the thesis's epistemology approach and a background for the choice of theories and research method.

3.7. The Structure of the research

The research approach towards answering the research question is very influenced by the hermeneutic perspective, allowing for the understanding of double hermeneutics influence upon the hermeneutic.

The structure of the research revolves around the central point's relevant to the research question. Researching the interactions between professionals and the inpatients, as well as the interactions between the professionals and their peers. This is done with the intention of establishing how professionals together with their peers choose to act upon the knowledge acquired through their interactions and observations with and of patients. Whilst adhering to the earlier described epistemologist approach to the research.

To paraphrase Morten Frederiksen, the structure and design of the research study are guided by the research question, and the decisions made reflect this. (Frederiksen, 2018, p.83-106). It has been earlier described in the section 'Introduction' that the thesis would have wished to have included more than the single qualitative patient interview. Unfortunately, because of the situation surrounding Covid-19 virus this has not been possible. On a positive note it has been possible to interview a number of professionals employed on psychiatric wards.

After deciding upon the research question and the points of issue that the thesis would focus on, it was considered how the chosen concepts would support the understanding of how questions and methods should be applied. Appreciating the relevance of language as well as acknowledging the way in which theories / concepts can impact on the way questions should be designed and approached. Time was a key factor in considering how the qualitative interviews could take place, where they could take place and how they could take place Time as a concept is relevant to how a researcher chooses the approach and how to tackle the research question. (Frederiksen, 2018 p.83-106).

In taking height for Giddens' Double Hermeneutic' and its relevance to the thesis approach. Giddens viewpoint is that *"...as all social laws are historical. They can be altered by social action..."* (Tucker, 1998, p.53). This by inference ascertains that the information gathered, and any knowledge gained by the information will have a historical value as soon as a new social action takes place. Retrospection plays a key role in the interview techniques described in what is known as The Focused Interview. The hope is that retrospection can help those interviewed reflect in the most actual manner. (Merton, Fiske, Kendall, 1990, p.21-40).

In accounting for retrospection and the constrictions surrounding the qualitative interviews, as has been previously explained. (Merton, Fiske, Kendall, 1990, p.21-40). A decision was made that all interviews should be documented and conducted in a manner whereby the

interviewee can be interviewed in a style that requires so little interpretation as possible. The goal being that they could be completed and recorded in a way that the interviewee's recollections would be presented and used in the most actual way in reference to, as well as answering the research question. (Monrad, 2018, p.107-144).

The retrospective nature of the structure of the research and qualitative interviews holds true to the Hermeneutic tradition of researching from a historical perspective as was explained earlier in the thesis. Shown in the researchers desire to investigate previously presented knowledge, amongst others from The Danish Ministry of Health. Interpreting the previously presented knowledge, then choosing to investigate it further adopting and applying the researches own perspectives following the interpretation (Monrad, 2018, p.114-117).

The structure of the research is constructed to understand the interviewees perspective and their own recollections of situations within the pre-defined framework and boundaries that the researcher has imposed upon the interview. This is done after the interviewer has determined what should be studied and how specific questions should be conducted to understand what Merton describes as *"Range, specificity, depth and personal context"* (Merton, Fiske, Kendall, 1990, p.11-12).

The answers received to the questions asked are contextualised, against the researchers' intentions, and interpretations of the data received. This is done to form the knowledge that the researcher will use to answer the research question. The questions asked to both professional's and the ex-patient are detailed in Appendix 1 and Appendix 2. Gadamer explains this in the concept of understanding of the researcher's '*horizon'*. The standpoint of where the researcher with their previously acquired knowledge and understanding chooses to view the situation that they wish to study from. (Kristiansen, 2017, p.158).

Data collected from the interviews has been done so in an active manner, whereby there has been an active control of the interview and the interactions surrounding the qualitative interviews. The purpose being of controlling time, and in some respects answers to hold focus, to avoid possible confusion under the interview (Monrad, 2018, p.107-144). The style of questions that were designed to be used in the interviews of the professionals, provided a basic understanding of who the person interviewed was. After that was established the focus centred on the professional's perceptions and recollections of their interactions, observations,

and their understanding of contributory causes. This explanation of data collection is presented throughout Merton's book The Focused Interview. (Merton, Fiske & Kendall, 1990).

The thesis and general methodological approach to the research has been abductive. That would imply that as a researcher there has been an attempt made to investigate the research question with the intent of applying a deeper, fuller theoretical understanding of the issues of interest that the research question consists of and attempts to answer. (Olesen & Monrad, 2018, p.19-20). Providing a qualitative understanding to the issues of interest that were in part derived from several quantitative sources.

3.7.1. The Focused Interview

Merton's Focused interview was first published in 1956, and its inspiration to this thesis derives from what Anthony Giddens, later describes as *'"double hermeneutics"* (Tucker, 1998, p.42). The focused interviews origins come as a result of wartime propaganda and communications analysis (Merton, Fiske & Kendall, 1990, p.5).

During the preparation of the qualitative interviews Merton's thoughts and motivations were taken into consideration. The interviews are prepared against the prior self-analysis of situations that the interviewer would like to understand from a perspective, that the interviewer thinks can help create a better understanding of a given situation, or in the case of this thesis, experiences set against the research question (Merton, Fiske & Kendall, 1990, p.3-20).

Merton uses the term retrospection to help with the understanding of the focused interviews purpose as well as the interviewer's role in the interviews. Retrospection is an attempt to recreate conditions and reactions of the original experience that is to be recalled. The construction of the interviews both considers and include Merton's *"Criteria of the Effective Focused interview ...Range ... specificity ... depth ... personal context"* (Merton, Fiske & Kendall, 1990. p.12). That would say that they are constructed to achieve the best possible recollection of events and impacts upon the individual actors that were interviewed. Increasing the potential of the interview's quality and content for the purposes of the thesis intention of creating useful knowledge. In the cases of the individual interviewed

professionals, this was done at their place of work. Before interviews commenced, it was agreed in every circumstance that the interviews may take place, however the identities of the interviewed and their employers would not be revealed.

As a researcher it is important to remember that relative neutrality should be maintained, to avoid prejudicing the outcome or the investigation of the research. Points that could cause concern were presented previously in the section *Motivations and Prejudices*, and at all times have been prevalent in the research and presentation of the knowledge that the thesis has created. This is best defined by Merton in his explanation of a *nondirective approach* (Merton, Fiske & Kendall, 1990, p.13-15).

An interview adopting a non-directive approach, can help avoid any potential pitfalls regarding prejudice. Pre-planned questions allow the interviewee to express themselves within the pre-planned boundaries defined by the interviewer's questions. Thus a well thought question allows for the motivation of the question, as well as attempting to obtain new knowledge that the interviewer can use, and not just simply dismiss as not relevant (Merton, Fiske & Kendall, 1990, p.13-15).

The conducted interviews construction and questions are focused on the concept of retrospection as described by Merton (Merton, Fiske, & Kendall 1990). Combined with an appreciation endearing to Giddens understanding of the historical nature of social actions and interactions as explained in the section Double Hermeneutics.

The subject matter under interview can provoke strong feelings, therefore as an interviewer the style of the interviews are largely constructed, in the case of the ex-patient, it could be argued that they are semi-constructed. As well as this due to time restrictions, confidentiality, and the impact of Covid-19 the conducted interviews were at they were largely constructed, thus complying to the constrictions of circumstance. All these dilemmas were catered for at whilst preparing what Merton calls *"The interview guide"* (Merton, Fiske, Kendall, 1990, p.3). The exception to the rule was the interview conducted with the ex-patient, of course allowing for ethical considerations (Brinkmann, 2009, p.79-98). This was done with the intention of allowing the ex-patient to express their own feelings as well as develop an understanding of the patient's treatment and what they considered to be contributory causes.

An interview guide was prepared in a constructed manner, although time was not constricted, meaning that the interview was more free flowing, and more personal.

3.7.2. Ethical considerations

This Thesis, as many studies do consider aspects of the human condition. Ethical considerations must be made to avoid negative outcomes upon the people who have been kind enough to participate in the research. Exposing the person's mental condition, as in the case of the ex-patient, could encourage what Erving Goffman termed as a Stigmatization of the person's character, especially if the identity of the person enters the public domain, risking damaging the person's social identity (Goffman, 1990, p.11-15).

Ethical considerations are also extended to all professionals that have been interviewed. This largely entailed using the description of ethical questions to be asked at the beginning of the preparations for an interview, understanding the possible consequences to the person who is to be the subject of an interview. (Brinkmann, 2009, p.79-98). Amongst these are, how can I access this person's knowledge without damaging the integrity of the person, professionally or personally? How can I achieve this and at the same time answer the research question? As a problem, this was easy to overcome, because the thesis does not investigate or research an organisation, it researches a generalised problem. This in turn made it possible to obtain their personal consent and use the information that they shared under interview for research purposes. The decision to anonymise all participants, that agreed to be interviewed was taken at an early stage, and the questions asked where designed to avoid any need to publicly identify the persons interviewed. (Brinkmann, 2009, p.91).

Initially, there were problems in finding professional personnel to interview, due to the earlier mentioned restrictions surrounding Covid-19 virus. These problems meant that for purposes of the research, there were few opportunities. As researcher an approach to persons known to me, was made to ask for permission to interview persons that the researcher has professional connections to. This was requested and agreed upon with the agreement that it should be clear that the research, is an independent project and in no way represents the views of any organisation were interviews have taken place. The ethical considerations surrounding this decision, were many, primarily that the questions to be asked to the professional's working in the organisation could not prejudice anybody, or the organisations. Importantly avoiding bias

in the nature of the research's questions and questioning, at the same time retaining both the researchers and thesis' integrity (Brinkmann, 2009, p.79-98).

The ethical quandaries preparing for the qualitative interviews, have had an impact upon the nature of the study. Anonymizing all actors means that in writing the thesis, that personalizing, and presenting the data collected requires a diligence that would not always be required, if persons and organisations where not anonymized, indeed to a point where the nature of the study has altered. This is what Brinkman refers to in his understanding that to act ethically impacts other areas of research, and can create an uncertainty in researching society, amongst others social problems or social interactions (Brinkmann, 2009, p.91-93).

3.7.3. Who to interview?

As was earlier explained in the section *intended purpose of the study*. The studies intentions are amongst other things to understand how the professional's interactions with patients can provide an understanding of how the patient can benefit from their interaction with the professionals, while they are hospitalised. More particularly, the understanding of how the patient should be cared for and how much detail should be given to *contributory causes* affecting the patient.

Covid-19 virus has had a negative influence upon people's willingness and ability to meet others in a public setting (Sundhedsstyrelsen, 2020). This of course was understood and fully respected. With this understanding and the need to produce research data and knowledge that can be considered ethically sound, at the same time preserving a healthy relation to the persons that had given permission to be interviewed. Key elements in what Brinkmann, (2009, p.34) describes in his explanation of '*the social production of knowledge'* as well as observing the power balance between interviewer and interviewee. The questions to be asked are both personal to the person willing to be interviewed and of great significance to the researcher wishing to answer the research question.

The sole ex-patient interview that was conducted, came as the result of a consideration, and thought, due to the unforeseen effect of COVID-19. It was with good fortunate that I was able to access a closed Facebook group, that is primarily for people who have experience of mental illness. The ex-patient volunteered their services to me, in response to an

‘announcement’ placed within the group. After establishing that the person to be interviewed was genuine, a decision was made to conduct an interview with them. A part of the process in what Brinkmann describes in “*Den sociale konstruktion af validitet.”* (Brinkmann, 2009, p.267). In English, the social construction of validity. Other ex-patients made an approach to be interviewed, however they were not interviewed because of their current condition of mental health. The sole interview was conducted over the telephone.

Again, because of the problems surrounding the Covid-19 virus. The options to meet professionals working in hospitals was dramatically reduced. Therefore, a decision was made to interview professionals that could have a relation to the researcher, in a way that was as unobtrusive as possible, at the same time retaining the integrity of the research. People representing three different professions were interviewed in situ. These were nurses, health care workers and social workers, 13 people in total. All of whom were working within a psychiatric hospital at the time of interview. An introduction to those interviewed continues in the section, An introduction to the personnel and their professions.

An introduction to the person who has experience of being an inpatient.

As previously explained the identity of the person interviewed has been anonymized for the purpose of preserving the person's own personal integrity from this point the interviewed person will be known and referred to by the pseudonym Pat. The age and other aspects that could compromise Pat’s identity have been altered slightly, retaining their authenticity. Pat is a woman, about 50 years old and was most recently hospitalized about 2 years ago. This represented the fourth instance that Pat required hospitalization for mental health issues. These instances have occurred over a period that spans approximately 20 years. Happily, Pat’s mental health has been much improved since the last time she had a need for hospitalization.

An introduction to the personnel and their professions

As previously explained the identity of the people interviewed have been anonymized for the purpose of preserving their personal integrity, respecting the influence an interview could have upon the individual. At the same point respecting the agreements made with their employers. Following an introduction to the persons, a short explanation of the individual

profession’s competences is explained using the guidelines set out for the educations as stipulated under the appropriate Danish Law.

In all 13 professionals who were working, at their place of work, were interviewed. A Social Worker, 2 Nurses, and 10 Care Workers. The Social Worker interviewed has experience of working with people that have had problems concerning their social integration for a number of years, as well as having approximately 5 years’ experience of working in psychiatry. The Two Nurses interviewed, are young nurses. One of the nurses has approximately 8 years’ experience in different areas of Psychiatry, the other has under 2 years’ experience in psychiatry. Care Workers were the largest group of professionals interviewed, as a group they come with a broad pallet of life and work experiences. Their ages range from mid-20’s to mid-50’s, approximately 30 years between oldest and youngest. With regards to care workers experience with working in psychiatry så their work experience spans from having approximately 18 months to approximately 20 years’ experience.

Social Worker

- The professional competences of an educated social worker are described in ‘*Bekendtgørelse om uddannelse til professionsbachelor som socialrådgiver’* Retsinformation, (2011, bilag 1). Amongst others a Professional Social Worker should have the competences and skills to, analyse and validate social problems surrounding individuals, and within the community, and advise on these problems. Have the ability to work with different sectors and with professionals representing different professions, as well as coordinating contacts and meetings concerning an individual’s personal / social problems. A competent Social Worker can manage the alternative interests and views surrounding the individuals needs for help and social support, at a time when the individual is in contact with different (professional) groups or organisations that are involved in supporting the individual.

Nurse

- The professional competences of an educated nurse are described in *Bekendtgørelse om uddannelsen til professionsbachelor i sygeplej.* Retsinformation, (2016, bilag 1). There is, as would be expected that a Nurses education is heavily weighted in the understanding of a patient’s general health, and how the patient can overcome a physical or mental condition. A Nurses education does include aspects which includes educating them to understand

treatments that are preventative and have an understanding of rehabilitation processes and these mean to the individual patient. Nurses should be able to enter into interprofessional networks, cooperation's, and efforts that aim to support the patient in a positive manner. A nurse should be capable of forming a holistic understanding of a patient, which enables them to support the patient as an individual, contributing to the patient's ability to contribute to their own progress.

Care worker (Social- og sundhedsassistent)

- The professional competences of an educated care worker are described in '*Bekendtgørelse om erhvervsuddannelsen til social- og sundhedsassistent',* Retsinformation, (2019, §4) and they include elements that can be seen from both a social and healthcare perspective. A Care worker should have the competences that enable them to approach a patient needs and requirements to assist in a person's process of rehabilitation. A care worker should be able to aid a patient or citizen in their own home. Another part of the education trains a care worker to be competent in understanding and seeing changes in a person's physical and mental condition, at the same time being able to suggest appropriate ways to address changes in a person's physical or mental condition. The education also enables the care worker to be able work in a preventive manner to help a person avoid unnecessary risks to the person's wellbeing. As is the case with the educations for Social Workers and Nurses, so the education trains the Care Worker to work with professionals representing other professions to help increase the quality of service and care surrounding an individual person (Retsinformation, 2019, §4).

The pre -planned questions are described in the appropriate appendix – appendix 1 – questions to the discharged patient. Appendix 2 questions to professionals working in Psychiatric Hospitals

3.8. Collection and Recording of the empirical data

The collection of empirical data is qualitative, inspired and based on the guidance that is offered in The Focused Interview (Merton, Fiske, Kendall, 1990). To paraphrase Merton, the methods used in the Focused Interview are derived out of the fact that the interviewer is aware of the fact that the subject that they wish to interview, has experience of an event that interviewer would like to access. Retrospection allows for the prior understanding and

formulation of the interview questions as well as the researchers familiarity with the area of research, enables the interview to guide the interviewee in the interviewers desired direction. (Merton, Fiske, Kendall, 1990 p, 21-22).

The qualitative interviews, with structured questions enable the interviewer to amongst other things, focus upon the context and causes of how ‘events, actions, interactions’ are understood to have taken place (Maxwell, 2013, p.29-31).

Due to the restrictions caused by the earlier described Covid-19 virus, the ex-patient was interviewed over the telephone, and the telephone was recorded anonymously after obtaining the person's consent. The interview, although having strong elements of construction was free flowing to allow the person to express themselves as fully as possible. The questions asked in Danish can be read in appendix 1. This interview was conducted in Danish and recorded in Danish and lasted for 42 minutes.

A free flowing nature encourages the hope that after answering the initial planned questions, the ex-patient will answer in a manner that encourage the interviewers natural instincts and inquisitive nature to take over and enable an open discussion, in which the interviewee feels at ease to disclose as much information as they wish to, as the interviewer maintains a position of relative neutrality. (Merton, Fiske & Kendall, 1990, p.13-15). The interviewers position is relative neutral, because as Merton explains, the interviewer has already determined by analysis of existing facts that there is a need to investigate what is perceived to be a problem worthy of further investigation (Merton 1990, s.5) as does Giddens with his understanding of Double Hermeneutic (Tucker, 1998, p.54).

The empirical data that has been collected in the form of qualitative interviews, have been conducted with professionals working on psychiatric wards in the South of Denmark. All professional’s interviewed where all interviewed in situ. The interviews where short and precise, allowing only for small deviations from the previously constructed interview questions. se appendix nr. 2. Every person involved gave their aural consent to be interviewed, and for me to use their interview in the production of the thesis. At all times have I been very aware of ethical codes and procedures that ensure the integrity of those people, and the organisations that they represent (Brinkmann, 2009, p.81).

Out of respect for the organisations that allowed me to interview their employees, as well as both patient and employee confidentiality, I chose to record the answers I received, in written form, focusing on the key content of answers to the questions (Brinkmann, 2009, p.87-88). All of these interviews were conducted in Danish, with an allotted time of 15 minutes per interview. This time allowed for interviewing, was often the correct amount of time to interview a professional, occasionally the interviews were a little longer or a little shorter.

To note, all personal data that has been collected in the course of compiling, conducting and recording of these qualitative interviews will be destroyed as quickly as possible after the aural examination, in accordance with Aalborg University's rules and The current Danish personal data laws covering personal material (Aalborg Universitet, 2020).

3.9. Reflections over the Quality and validity of the project and it's research

From the point when research began, until the planning of the interviews had commenced, Denmark like so many lands was hit by the Covid-19 virus. The choice of informants, and the interviews that were conducted could well have been different, if Danish society had not been affected by the Covid-19 virus. Whether or not this has affected the quality of the project is open to question, although I believe not. However, it should be said that the opportunities available to interact with people in person, were reduced because of the Danish Government's attempts to manage the situation surrounding Covid-19 (Sundhedsstyrelsen, 2020).

Questions of quality and validity can be ambiguous, although relevant. In reflecting over the quality and validity of the project Maxwell's chapter on Validity in his book *Qualitative research design - an interactive approach'* Maxwell, (2013, p.122-124) explains that there has been a tendency for researchers who use qualitative methods to feel that the validity methods, and the methodology behind validity and quality are not relevant in Qualitative studies..

In acknowledgment of the scepticism surrounding validity and quality, when applying qualitative methods. This section uses Maxwell's validity checklist as a guide to understand the problems that can set question marks over research. In the case of *"Research Bias"*

(Maxwell, 2013, p.124). This has been previously explained in the section *Motivations and Prejudices.*

With regards to what Maxwell describes as "*Reactivity"* (Maxwell, 2013, p.124). This is relatively hard to dismiss, because anybody who reads the thesis, should be able to believe that myself as a student and researcher has always been loyal over for my research, and particularly the results and observations that I have reported. However, it is only the reader that can decide whether I as a researcher have been honest and true about my motivations and prejudices from the outset as well as throughout the research. Finally, they decide if I have achieved this or not (Maxwell, 2013, p.124-125).

Maxwell's use of Hammersley and Atkinsons concept of reflexivity (1995). Raises the point that however much the researcher chooses to try and limit bias and influence on their research, it just cannot be achieved. Very simply, it is the researcher's idea from start to finish. The interviewer / researcher participating in any interview or observation will always influence the collection of data, and the cause of events / interaction. (Maxwell, 2013, p.124-125). This point as author to the thesis, am I willing to concede, especially when the thesis primary focus involves interactions.

Although, the thesis cannot escape the questions raised about bias and reactivity, it can limit the effects of these influences and still achieve a high level of trustworthiness. In reference to Maxwell's checklist of eight specific strategies, three strategies are chosen to highlight this. *Intensive, Long Term Involvement … Respondent validation ... numbers.* (Maxwell, 2013 p.125-135). The choice of interview subjects as well as the personal experience of working in different psychiatric hospital wards meant that as a researcher there was enough prior experience to think and develop ideas relevant for the research and preparation of the research question. Giving validitet to the ideas surrounding the strategy of Intensive, Long-term involvement. Derived through my own experience and observations that have occurred through work experience (Maxwell, 2013, p.125-135).

Respondent validation, as described by Maxwell, "... *ruling out the possibility of misinterpreting the meaning of what participants say and do*" (Maxwell, 2013, p.126-127).

This strategy was thought of and accounted for in the planning of the interviews by using Merton's Focussed Interview guidelines. The ability of being able to communicate with the professionals on a mutual, peer level of understanding, eliminated many aspects of misinterpretation of meaning. If there was a certain element of doubt, the interviewer was always able to rephrase the question to obtain a greater clarity. With regards to the telephone interview of the ex-patient, so whilst every effort was made to ensure continuity, avoiding misinterpretation of meaning, so this took a greater time, because elements such as body language and eye contact where not apparent. Losing what Merton describes as the "*graphic representation of original situation*", (Merton, Fiske, & Kendall 1990, p.28-31).

In conducting 13 short interviews, the data collected for the analytic purposes of the thesis, using What Maxwell describes as the strategy of *"Numbers"* (Maxwell, 2013 p.128-19). This appeases to a lesser extent the way in which a quantitative understanding of results can be collected and analysed. This somewhat goes against the intentions and reasons for analysing the data that was collected, attempting to avoid a quantitative understanding. However, this is hard to avoid. It is hoped that the basic idea of Popper's understanding of *"Methodological individualism".* Giddens, A (1979, p.94-95), Popper, K (1966, p.98) can be maintained as was explained in the section called Double Hermeneutic.

In concluding the thesis it is very much intended that the individual person's understanding of the questions that I have asked them and the way they have answered them will show a true representation they themselves can identify with. It is at this point that the thesis can be judged to have an element of trustworthiness or to the contrary (Maxwell, 2013 p.125-135).

4. The Analytical strategy

In keeping with the hermeneutical ideals, and understandings of a person as a being free to think and adopt their own interpretation of what they see, and experience. The strategy is prepared is to achieve the best possible results for obtaining the information required for the purposes of answering the research question, whilst retaining a high level of integrity and trustworthiness. The research question has been constructed after the interpretation of existing knowledge, which is of interest to the researcher. Analysis's head focus is on the interaction between professionals, their peers, and not least the inpatients / previous patients.

4.1. Coding, Meaning Condensing, Specificity

In analysing the answers received from the professionals interviewed, a choice was made to first code the interviews and where relevant adopt an approach to condense the meaning (Brinkmann, 2009, p.223-230). Coding is applied in its simplest form, whilst analysing the answer's received with the intention of establishing a very basic idea of what the response to specific questions was. Coding is very simply explained as the researchers process of identifying, explicit words that the researcher believes can quickly summarize the answer received from the person interviewed. It can be seen as a first step of organising the answers received into data that can be processed (Brinkmann, 2009, p.223-230).

Meaning condensing is applied to the answers received, that require a more critical level of analysis. That would say that researcher begins to look at the answer received and understand the answer in a more systematic way, which in the case of the number of interviews that were conducted has a connection to the criteria stipulated by the questions that were asked. This is because the researcher is trying to find a continuity in the answers to the questions. (Brinkmann, 2009, p.223-230). The same process was repeated in the case of the recorded interview with the ex-patient. This is because as was described earlier, the ex-patient's interview was recorded to ensure that the information gleaned from the interview, was relevant and correct as well as enabling the possibility of transcription, if deemed necessary. (Brinkmann, 2009, p.200-202).

4.2. Understanding the analysis of the interviews

The analysis uses the coding principles, to provide an element of validitet associated with quantitative methods of research, however, maintains that the principle of finding a common ground between the interviewed subjects (Brinkmann, 2009, p.223-230). In preparing for the interviews, what Merton (1990, p.41-64) describes as *The Range* in The Focused Interview, was very helpful in deciding how coding, and meanings condensing should be carried out. It was decided that it would commence on a question by question basis. The interviewer, as designer of the questions, also at the time of writing the has an anticipation of what the response to the question could be As has been explained earlier in the understanding of *Reactivity* (Maxwell, 2013, p.124-125). The interviewer / researcher is integral to any

response received due to the nature of their interactions with the person they choose to interview. This can occur both consciously, and unconsciously (Maxwell p.124-125).

With focus on the questions asked to the professionals, several were relative direct and simple; How old are you ca? What is your profession? (Appendix 2) questions of importance, but not always of consequence to what would become the focus of the Analysis.

The question by question meanings condensing provided a very sound base to organise the collected data. (Brinkmann, 2009, p.227-230). With questions that require a more in-depth answer, there exists an expectation of what the answer will entail. For example - *Do you feel that you and your colleagues have a common approach and understanding when you interact with patients?* (Appendix 2). The reply expected here is yes, no, or I do not know. A closed answer to a closed question. However, when the follow up question is *Why do you feel this way?* (Appendix 2). Suddenly there exists an abundance possibility to answering the question. There is a reasonable expectation that the reply will include a reference that includes the person's views about interactions between themselves and other actors. The question by question analysis when compared with collection of data from other interviews enables the researcher to develop the themes and understanding of what the Analysis could or should contain. (Brinkmann, 2009, p.223-230).

Merton, Fiske, & Kendall, (1990, p.65-94) describes this in the *Specificity* of the Focused interview. Coding and applying techniques described in Specificity enables the interviewer to focus on what Merton calls the *"Significant Wholes"* (Merton, Fiske, & Kendall, 1990, p.66). Although Merton's explanations of processes in Specificity are largely related to the interview whilst it is in progress, it shows the thought process and way in which the ideas kan be linked to question by question analysis following or emphasising themes under interview, aiding analysis at a later point. This is done in keeping with the basic hermeneutic traditions of interpreting and reusing the newly accrued information to obtain a new understanding. (Merton, Fiske, & Kendall, 1990, p.65-94).

5. Conceptual Perspectives

This section is intended to provide an understanding to the thoughts that lie behind the choice of theoretical concepts and reference points, as well as provide a brief introduction to the concepts and reference points, used within the analysis and discussion.

Erving Goffman provides the inspiration for the analysis. A broad pallet of Goffman's studies concerning interactions and observations are referred to in the Thesis's analysis. Amongst others Goffman's own personal experiences and observations within locked institutions that he recounts in Asylums – *Essays on the social situation of mental patients and other inmates* (Goffman, 1991). However the main source of inspiration that is used in the analysis are derived from his book *The presentation of self in everyday life,* Goffman (1990b) explains how interactions impact upon the individual using *"…theatrical performance; the principles derived are dramaturgical ones."* (Goffman, 1990b, p.9). Primarily because of the way in which Goffman presents his observations and experiences, he is deemed for the purposes of this study the perfect foil to an analyse which focuses on interactions, and the relations between the relevant factors that are to be discussed. Goffman is often credited as being a central figure in the theoretical field of symbolic interactionism, a short explanation of symbolic interactionism is included in the Conceptual Perspectives.

The last point of reference derives from a previous semester that I studied at Aalborg University *Rehabiliterende indsatser i tid og rum'* roughly translated as Rehabilitation efforts in a context of time and place. Kjeld Høgsbro (2010), SIMREB (an acronym for) - towards a systematic inquiry into models for rehabilitation. SIMREB described as being "… *a Framework for designing evaluations of rehabilitation models … often entrusted to a professional assessment …"*, this as (Høgsbro, 2010, p.1). The case which Høgsbro uses can be adapted to help the reasoning and context of this thesis's analysis.

The short presentation of the theoretical concepts and reference points will be built upon and used in conjunction with the data that has been collected from the qualitative interviews. With this knowledge the reader can begin to see the researchers own understanding of the collected interviews. At the beginning of the analysis a cultural context is offered to explain were the theories developed, apart from SIMREB which originates from Denmark.

5.1. Cultural and Historical Context

Like many other theories, and terms, that have been used to identify, describe, and understand social phenomena, so are many of the theories used in the analysis of social problems based on observations and findings from other countries, independent of a Danish context. The earlier named Sociologists do not have strong affiliations to Denmark, if at all. Therefore, this must be remembered when using their theories and terminology, in connection with analysing a 'Danish Social Problem'. Goffman and Merton's, observations and their works are founded within the United States of America, although Goffman was originally from Canada. Giddens works are primarily founded on studies within and about the United Kingdom. The theories and terminology used in this thesis came to fruition many years ago, in some cases over 60 years ago.

5.2. Symbolic interactionism, interactions consequence

Giddens explains that symbolic interactionism is about microsociology, one to one communication within the normality of everyday interactions. The symbolic element represents a person's ability to recognise and describe an object without being able to see it. By naming an object, s/he instinctively knows what it is without seeing it. Whilst the interaction aspect often involves the understanding of two individuals' communications (Giddens, 1997, p.564-565). Meaning, people can interact with one another and speak about a certain object or event without seeing it, or indeed having been present at the time an event occurred. It can also be true of an interaction, that is perceived to be an interaction, whether it is unconsciously interpreted or deliberately interpreted to be an interaction. An illustration of this is provided by Merton as he uses Thomas theory to illustrate this as well as acknowledging the surroundings influence upon their *interaction* (Merton,1995, p.384). Thomas theory is extreme in its example "*He had killed several persons who had the unfortunate habit of talking to themselves on the street. From the movement of their lips he imagined that they were calling him vile names, and he behaved as if this were true*." (Thomas & Thomas, 1928; Merton, 1995, p.384). An extreme reaction however, Thomas & Thomas explanation does not measure the severity of the interaction but acknowledges that "*If men define situations as real, they are real in their consequences.*" (Merton, 1995 p.384) An observation that can have a relevance to both the observer and the observed within a psychiatric hospital.

Within the understanding of the spoken word and interactions exists the possibility to understand a person or misinterpret a person's communication. Over the last few years, the importance and symbolic importance of a handshake has taken a central stage in the Danish debate about Danish Citizenship. In short, a person who does not shake hands can be denied citizenship, because they choose not to interact or accept the symbolism that is communicated through this gesture. However, at the time this thesis was written in Denmark April 2020, due to the Covid-19 pandemic, this symbolic gesture is now understood to be dangerous, maybe even reckless in behaviour. (Udlændinge- og Integrationsministeriet, 2020). An example of how the rules surrounding symbols and interactions can be changed, and how misunderstanding can ensue

5.3. Goffman credentials

In 1955/56 Within the confines of St. Elizabeth's Hospital, Washington. DC, USA, Goffman, (1991) studied and interacted with both those patients confined to the hospital, and those charged with their rehabilitation. Goffman's recollection of the observations, and interactions are referred to within the analysis. One thing that is very noticeable about notable about his *Asylums - Essays on the Social Situation of Mental Patients and other Inmates* is his admittance of bias at times, bias slanted in favour of the patients, and an unfavourable opinion of psychiatry, or those who organise it (Goffman, 1991, p.8). A vivid contrast with what one would expect to encounter in a Danish Psychiatric Hospital, or any other Danish institution charged with the caring of people.

Goffman's concept of Stigma amongst other things explains the way in which a person interacts with another. Stigma builds upon the prior knowledge, experiences, and influences that a person has accumulated and uses them in context when they interact with another. In a group setting, this can be altered. A collective of people sharing the same values as those around them, is influenced when a stranger is introduced to the group. The dynamic can change by allowing the member to join or reject the person through a stigmatizing process (Goffman, 1990a, p.15).

The actors concerned with the interaction are not always conscious of the processes and influences that cause another person to discredit or treat a person differently from others. However, it can also be a conscious decision to treat a person differently. The interaction

between the professionals and inpatients take place in a setting that have a preordained character. In a manner similar to those Goffman described over 60 years ago (Goffman, 1990b, p.28-34). The professional is employed to help the inpatient within the confines of the psychiatric ward, this help is offered to re-establish the personal identity of the inpatient. Help is offered with the hope of rehabilitating the inpatient to a point where they no longer need to be treated and be seen differently from what is conceived as acceptable or normal, escaping special attention from members of established societies, through processes of categorising, and stigmatising (Goffman, 1990a, p.12). It could be said that the professionals meet the inpatient at the start of a destigmatizing process. Mental Hospitals at the time of Goffman's time of writing are described by him as being in the 2nd class of total institutions. "*... places established to care for persons felt to be both incapable of looking after themselves and a threat to the community, albeit an unintended one."* (Goffman, 1991, p.16).

Erving Goffman's understanding of interactions, and the symbolism present within these interactions, are important to the analysis of this thesis. As it is to contextualise his concepts. Explaining why his work *The Presentation of self in everyday life* (Goffman, 1990b) has been chosen as the primary analytic work to support the analysis of the qualitative interviews

5.4. The Presentation of self in everyday life Erving Goffman

Erving Goffman - *The Presentation of self in everyday life presents*, uses the idea of a theatre scene as the setting for the presentation of self in everyday life (Goffman, 1990b, p.28-82). The setting of a theatre stage, to anybody who has attended a theatre performance, or a dramatic performance increases the intensity of focus upon the performers, actor's communication, interactions, and the words they use. An author has an opportunity to appease the audience with symbolic gestures and understandings, often due to the limited space performers have to act in. The importance of the spoken words Symbolism, symbolic meaning grows because of these constrictions. This is evident in Robert Combs (2012, p.306-308) review of the dramatic performance of Eugene O'Neill's play The Iceman Cometh. A play set in a backstreet Saloon with rooms situated above the saloon, occupied by people living on the extremes of society in New York 1912 " *... the play's potential for intimacy in a small theatre. The warmth of human contact, envisioned without pretension or apology, gave comfort in the midst of a play that has sometimes seemed harsh in its depiction of modern existence."* (Combs, 2012, p.306)

Goffman's essence is captured in a scene that Combs chooses to reflect upon "*The dynamic between Larry and Parritt... defined by the pathos of people too frightened to be able to help each other, even if each saw something of the other's truth."*(Combs, 2012, p.307). Two men sat over from one other this could well symbolise a meeting of two people, within a Psychiatric Hospital. Both people have an expectation that the other treats them with the due respect that they think that they deserve. These two people present their own versions of the reality they represent, or indeed present representations of themselves that they choose to present. There always exists possibilities for the individual to manipulate the interaction between themselves and the other person if they are that way inclined. It could be to gain an advantage or maintain a facade that does not portray the full content, of a person. What Goffman describes as a *false front* (Goffman, 1990b, p.65-69).

The possibilities to manipulate, or present a facade on a larger scale, exist if a significant person wishes to visit an institution, and the persons controlling the institution are aware of this. Those people who receive the significant person will endeavour to present a positive facade to the person who is visiting the institution. In an analogy of Goffman's understanding of performances, preparing the stage to achieve the significant person and leave a favourable impression upon the visiting significant person (Goffman, 1990b p.29-30).

Goffman as previously described uses the theatre stage to explain his understanding of what he means by the individual's performances. The focus here is on what Goffman describes as Frontstage, he shortens it to Front. Goffman's description and definition of *front* is a key aspect in understanding how behaviour, interactions and observations occur within a given setting, in fact *"... all of the activity of an individual during a period marked by his continuous presence before a particular set of observers ..."*. (Goffman, 1990b, p.32). Front according to Goffman's definition is *"... that part of the individual's performance which regularly functions in a general and fixed fashion to define the situation for those who observe the performance.* (Goffman, 1990b, p.32). Actors involved in an inpatients treatment and understanding of the inpatient, themselves included are observed in situ. The scene may change, however the same 'actors' can meet one another at frequent intervals presenting the *Front* (Goffman, 1990b, p.32) that is specific to them. A person's front represents themselves at that specific time in that specific situation, culminating in a performance that convinces, or fails to convince the observer of the persons authenticity.

Another aspect to the person's identity is what Goffman refers to as '*personal front'*, this refers to amongst other things traits personal to the person, their identity as a man or woman, age sex, size or habits (Goffman, 1990b, p.34). The personal front can have positive connotations, and negative connotations. These connotations can shift over time, smoking as an example 60 years ago in the US, at the time of Goffman's writing was in many ways considered chic Hollywood stars such as Marilyn Monroe and Frank Sinatra epitomize this, contra today in Hollywood where smoking is positively frowned upon. In a Danish context smoking, has dramatically decreased in popularity and the general population's views of smoking most probably have similar view to those in Hollywood.

Whilst a person's Front is under observation, Goffman (1990b, p.40-41) explains the *'Dramatic realization'* of the person can go relatively unseen, however this can change for example by the flamboyant actions of an individual, *playing to the audience.* Alternatively, this can change through the observer's observations. Goffman (1990b, p.41) illustrates this with examples of somatic nursing, both medical and surgical nursing. Without going into detail, the actions of a surgical nurse seem more significant than those of a medical nurse, primarily because of the various procedures they perform in front of observers. Dramatic Realization opens up the opportunities of learning how observers understand and interpret the quality of the individual's *performance* as well as giving an insight as to what the observer chooses to base their assessment on. A performer in a workplace or in a social setting is quite often likely to adopt the socially accepted values or prevalent norms when they are front stage, presenting a Front that it is more homogenized and what others expect of themselves. Goffman refers to this as idealization. (Goffman, 1990b, p.44-59).

Goffman's concept of Misrepresentation can be understood as the way a person attempts to deceive observers and present a front that misrepresents their true self. This can be done for several reasons, to simplify it based on Goffman's examples. A trickster, spiv, conman can present a false front to gain a financial advantage by fraudulent means. Alternatively, something a person considers shameful, is wilfully not presented in the Front of a person, as to avoid any further ridicule or embarrassment (Goffman, 1990b p.65-69).

On a macro level Goffman uses an extract from The British Civil Service to illustrate that attempts, not to disclose information that could cause an inconvenience to the Civil Service or their paymasters, the British Government "*The rule here … Nothing may be said which is*

not true; but it is as unnecessary as it is sometimes undesirable, even in the public interest, to say everything relevant which is true …" (Goffman, 1990b, p.70). In many ways this quotation justifies the understanding of how individuals may choose to misrepresent information to observers. An observation of significance and relevance when analysing and reading official information that is specific to a study.

Goffman (1990b, p.28-82) dramaturgy, and presentation of key aspects of what are described within Performances these being *'Front, Personal Front, Dramatic Realization and Misrepresentation'.* are used to analyse and provide an understanding of the interactions within the collected data. In the analysis there exists no desire to question an individual's ideals concerning their own personal understanding of their realities, or identity. However, it does allow for an understanding of how a person's Front, and personal Front, can be observed from one performance to another (Goffman, 1990b, p.76-81).

5.5. SIMREB - Evaluation

Høgsbro (2010) SIMREB model – towards a systematic inquiry into models for rehabilitation offers this thesis an analytic reference point. The perspective that SIMREB offers, provides an analytic tool to help understand and contextualise the qualitative interviews used in the analysis of this thesis. SIMREB uses quantitative methods as well as qualitative interviews used in connection with an evaluation of the Kolonien Filadelfia Rehabilitation Centre (Høgsbro, 2010 p.1-18).

Although the actual process of Rehabilitation is not explicitly explained at any point in the thesis SIMREB understanding of Rehabilitation is relevant to the thesis research, because any period of hospitalization or a similar circumstance involves a process of rehabilitation or recuperation, which builds upon professional and patient contact and interaction. The qualitative interviews and references used in SIMREB enable the researcher to gain an insight into professionals understanding of interactions from a similar perspective. (Høgsbro, 2010, p.1-18). This is set in context along with Goffman's concepts *'Front, Personal Front, Dramatic Realization and Misrepresentation'* (Goffman, 1990b, p.28-82).

6. Analysis

The analysis seeks to address the purpose of providing new knowledge that can be used to support and answer the Research question. Knowledge of these interactions appear to be lacking in many existing publications that seek to explain the current state of psychiatry.

Qualitative interviews provide professionals with an opportunity to offer a credible account of their own views, on how they view the importance of their interactions with inpatients, as well as their peers. At the same time using their own professional judgement to contemplate, if they believe that they should be helping patients with the contributory causes that can persist in a hospitalized patient's life.

The analysis is of single form, where the research question is answered within the context of the four concepts that are taken from Goffman's *The Presentation of self in Everyday life* (Goffman, 1990b). After this is completed the analysis adopts a more critical tone in addressing the concerns of the patient, when they begin their life after hospitalization

The questions answered by the professionals are analysed, in relation to these concepts, and set against the responses from the lone ex-patient's responses to similar questions. It is conceded that a single qualitative interview cannot represent the entire target group, however it can give context to the analysis. Where this is not possible, Høgsbro (2010) SIMREB is referred to.

Again, due to the fact that it was only possible to obtain a sole ex-patient interview. The experiences of Morten Engell Thomsen recalling his first experience of psychiatry, are used to enrich the ex-patient perspective (Boss, 2020).

When citations or references are used referring to a particular professional's answer an appendix is referred to. The appendix does not disclose the full interview, merely the coding and the condensing of meaning to the answer received. Citations or references referring to Pat's interview are followed by the following: (taken from the interview dated 080420). This

is due to the specific instructions laid out in the semester instructions (Aalborg Universitet, 2020).

6.1. Front

As explained the stage is the symbolic scene for the performances of all individuals that interact with one another. With this analogy, it is possible to understand how interactions are performed and observed. In a psychiatric hospital, and on a psychiatric ward the scene and interactions can be constantly changing as can those observing the performance. The impact of actor's interactions with other actors on stage can have a profound impact upon the outcomes of others who are not on stage, when the performance is underway (Goffman, 1990b, p.28-34). Critically, Goffman's concept focuses intensely on the 'Fronts' on stage, to the detriment of other factors that could exist outside of the observers immediate focus.

There exists an infinite amount of possibilities in how to understand, what and how a stage should be considered, this is true of a person's hospitalization. The stage is a changing of ever shifting dynamic and determination. The questions asked to the professionals offer an understanding of their expectations before they were employed in the rolls they now occupy and as well as their understanding of their current place of work. The stage (s) of their performance (Goffman, 1990b, p.28-34). Unfortunately, although acknowledging the dynamic, shifting nature of the stage, in understanding the interactions at play, requires that the observer considers the interactions in a fixed location (Goffman, 1990b, p.33).

Questions relevant to understanding the professionals front were asked. *Why is it you chose to work in psychiatry?* (Appendix 2). By inference the question includes the premise that the person actively chose to work in psychiatry. The answers received show a collective positivity, and a desire to work in psychiatry, some of those had a prior understanding of what to expect within a psychiatric hospital *"it is what I was most taken by in my work practical"* Anon 2 (Appendix 3). *"I have a desire for it. It is what I want to do"* Anon 7 (Appendix 3). Both answers indicating an understanding of the field of Psychiatry before they entered it. Anon 8 answer was very specific, showing the level of excitement and intent in choosing Psychiatry, describing Psychiatry as exciting, with the possibilities of using their competences that they have learned in helping people cognitively. This answer offers an

insight into the persons pre-understanding of the environment they have chosen to work in (Appendix 3). The stage on which they will perform (Goffman, 1990b, p.28-34)

Other questions relating to the professional's place of work where asked, based on the professional's education, and the relevance of their education in the context of the Psychiatric hospital, they work in. Allowing for age, and how long ago some of the interviewed qualified to work in their profession, the answers received were very individualised.*" Yes - a good education with a four month work practical within a (bosted- sheltered housing complex) gave me good taste of psychiatry"* Care Worker Anon 10 (Appendix 3). This is echoed by Anon 8, although a little in doubt about the overall quality of the education, the four-month work practical was considered to be of great relevance (Appendix 3).

It should be said several people thought that their educations were not particularly relevant in forming their choice or expectations of a career in psychiatry. Anon 7 another care worker's recollection of their education as being very focussed upon the somatic understanding of problems affecting people, that the psychiatric aspect of the education was not really addressed in any great detail. This criticism is levelled at the educations received by the two nurses who answered questions, the practical experience offered at their respective times of education, had very little focus on psychiatry in comparison to other areas of nursing (Appendix 3). Lacking the dramaturgical insight others had before entering psychiatry (Goffman,1990b, p.28-82).

The expectations of walking out and performing Front stage requires an understanding that the person fulfils the criteria defined by Goffman *"front, then is the expressive equipment of a standard kind intentionally or unwittingly employed by the individual during his performance."* (Goffman, 1990b, p.32). The performer (professional) is expected to perform to a standard, that reflects their professions levels of expectations, amongst others. It should be reasonable to expect that a professional employed in a hospital setting is the esteemed party when addressing an inpatient. Allowing for the exception that a professional is new to their job, then a professional should be far more familiar with the scene where the interaction between themselves and the inpatient takes place. The majority of the professionals, especially those trained as health workers place an emphasis upon these meetings, and

interactions. When asked, *what do you prioritize in your working day?* Anon 4, together *with the patie*nt Anon 6, *patient firs*t Anon 7, *patient contact* replied the three care workers (Appendix 3). Answers indicating the importance, and by inference a personal awareness of their own role in their interactions, as well as how they should approach their performance when speaking to inpatients (Goffman, 1990b, p.32-33).

Goffman's describes this as the *setting,* this is the actual *'scene'* were the interactions occur and observed, normally a fixed setting adorned by the appropriate objects integral to the scene. (Goffman, 1990b, p.32-33). On a psychiatric hospital ward like many other places the symbolism of Goffman's (1990b, p.32-33) understanding of setting should be set in context. Goffman's symbolic '*setting'* was created over 60 years ago, although some things do not change so much over time. The setting of a professional sharing a cup of coffee over breakfast with an inpatient could very reasonably expect to have the familiar items associated with a drinking a cup of coffee, stools, table, cups etc. Interaction between two persons discussing an inpatients current mental health can be quite intimate in a setting, as described. This intimacy can be disrupted if there are other professionals performing the same act at the same time in the same place. The interaction loses its intimacy. This understanding requires that the knowledge of the professional is adaptable and has control over the setting to assure that the appropriate setting is chosen for the interaction between themselves and the inpatients.(Goffman, 1990b, p.32-34).

It could not be expected that an inpatient would be able to provide a Front that is as convincing as a professional who is used to stepping out onto the same stage at regular intervals in the process of carrying out their daily functions, as a person employed to provide professional healthcare. Pat the ex-patient, on all four occasions received a diagnosis of what is described as a *"Brief Psychotic Disorder"* (World Health Organisation, 2020, F23.0). Pat's diagnosis meant that when Pat entered 'the stage', the Front that Pat presented was very much influenced by the condition that Pat was affected by, remembering of course the diagnosis would have been afforded to Pat after several interactions with professional personal, until the time of diagnosis Pat was 'just' a woman acting out of character, without explanation (Goffman, 1990b, p.32-33).

Symptoms included with a Brief Psychotic Disorder include "*... delusions, hallucinations, disorganized speech, and/or grossly disorganized behaviour that resolve within a month."* (World Health Organisation, 2020, F23.0). The nature of the diagnosis that Pat received has an ability to distort the interactions between different actors involved in a course of treatment, because of the disorders individual nature. What would for most people be a simple act of drinking a cup of coffee, in the company of another individual would be a perfectly normally to most. For a person suffering from a Psychotic disorder, this would not necessarily be so.

In answering a question about w*hat they prioritize in patient contact?* (Appendix 3). It is not said explicitly, however in prioritizing the patient's needs, and choosing to play cards and have fun with inpatients, shows that Care Worker Anon 8 has an understanding of the their place of work, and where such activities should take place, whilst addressing the patient's needs (Appendix 3).

The stage and understanding of the relevance of the concept of Front, and the setting changes dramatically when the inpatient is not present as professionals interact with one another, discussing and planning a patient's course of treatment, or indeed observing the inpatient from a distance. (Goffman, 1990b, p.32-34).

This thesis acknowledges the fact that interprofessional cooperation is an important element in understanding the intricacies of the relations between different professionals and the professions that they represent. As well as being named in the explanation of a social worker, nurse, and care workers education profile in the section an *introduction to the personnel and their professions.* Interprofessional cooperation loosely translate to what Andy Højholdt describes as *Tværprofessionelt samarbejde* (Højholdt, 2016, s.67), whereby there is an expectation that the individual who is professionally educated interacts with other differently educated professionals with the purpose of solving a problem together in fellowship. The professional's identity and profession are preserved through the representation of the person in the cooperative work, on a level footing with all other represented professions to solve the problem. A problem solved in fellowship ideally creates new knowledge to the benefit of all participating professions. (Højholdt, 2016, p.68).

The professionals interviewed, with few exceptions believe that at least on a certain level, on the hospital wards in which they work, that there is a functioning level of interprofessional cooperation. Although it must be said as in the case of the social worker trained in the understanding and the concepts of interprofessional cooperation there was a belief that there is an overall tendency to work mono professionally (Appendix 3).This is constant with the findings in Høgsbro's SIMREB. In addressing the problems surrounding a patients rehabilitation, it was reported that a natural progression seems to adopt approaches akin to the established medical professions where Høgsbro notes a tendency that *"... leaves the social disciplines in a marginalized position ..."* (Høgsbro, 2010, p.10).

When asked *"How would you define the interactions between yourself and your colleagues when you work together to solve a problem connected to an inpatients treatment?"* (Appendix 3). The answers to this become more fragmented, Anon 1, a nurse believes that small groups of people can, but not large groups. Anon 3 believes that the differing professions fail to understand one another at times. Care assistants Anon 4 and Anon 12, believe that the way in which they interact to solve a problem connected to an inpatient's treatment, is purely about the fact of who you work with (Appendix 3). These observations that the professionals have chosen to speak about, draw parallels with the analysis carried out on the behalf of Region Midtjylland, where it questions how the information and knowledge used in a patient's course of treatment actually involves the correct professionals, and in the cases of some of the readmissions that occur in the Region that they are a contributory factor in the amount of psychiatric readmissions. (DEFACTUM, 2019, p.8).

In using the symbolic setting that Goffman adopts, of a living room, Goffman (1990b, p.32) as with colleagues in a familiar setting, so it appears that for some professionals working in a psychiatric hospital that that a solution to a patient's problem can be understood on the local individual level, or just with people who you naturally have a good connection with. The individual front of the professional can confuse interprofessional cooperation and interaction with colleagues, when addressing specific problems. This was a tendance that echoes some of the concerns reported in SIMREB, both Social Workers, and other professions *"It is not easy ... to communicate your neuropsychological investigations and paradigms into a*

physiotherapeutic setting" (Høgsbro, 2010, p.11). SIMREB being published 9 years earlier than the DEFACTUM report from 2019, noting similar tendencies

Pat's recollection of settings where interactions took place differ, they are predominantly positive. In acknowledging Pat's diagnosis that was on all four occasions*" Brief Psychotic Disorder"* (World Health Organisation, 2020, F23.0). and the distortions that could have affected Pat during Psychotic episodes. Pat recalls that personnel employed in the Hospitals were good. The description of the settings, as described by Pat were a little different. Two of the three hospitals where Pat has been hospitalised where described as clean, one of these hospitals was the scene of two of Pats courses of treatment. The third was described as dirty. (taken from the interview dated 080420). Pat's answers were made in response to the pre planned questions at the time of interview. Noticeably after a period of time the two things that Pat recalls are the people working in the hospitals, and the level of cleanliness within the hospitals. Showing the lasting influence and importance of the setting and the professional's approach to her.

6.2. Personal Front.

It should be said in a sweeping generalisation, that the professionals interviewed are representative of the tendency within the professions that they represent. All three professions have an overwhelming representation of woman. For purposes of anonymity this has not been named to now, however the 13 professionals interviewed for this study were very representative of the female bias in the three chosen professions. This should be considered when Goffman's concept of Personal front i referred to (Goffman, 1990b, p.34). The concept of personal front involves many parts that in many ways are integral parts of the person's being. From the way they stand, to the way they speak, or their age, gender, the permutations are infinite (Goffman, 1990b, p.34-45).

The questions were asked to predominantly woman. All of which were conducted in Danish and recorded in Danish. Some of the questions asked where very obviously questions that are integral to the defining of their *personal front* (Goffman, 1990b, p.34). *These where amongst others. How old are you? Which roll do you have and what is your education?* (Appendix 3). Although not conducting a quantitative study, when looking at the data collected it is easy to

see that person interviewed would likely to have been a woman, educated as a care worker, and she is in her mid-30's or approximately 50 years old. Some aspects of Pat's personal front during her periods of hospitalization would have been obvious Pat's age, occupation, her size, and shape in other ways far more complicated. Complications could easily have occurred with those observations concerning Pat (Goffman, 1990b p.34-45). In the attempt of trying to establish a picture of how Pat adapts to the stage she treads upon, reacting to persons or items in her proximity, within the psychiatric ward during a *"Brief Psychotic Disorder"* (World Health Organisation, 2020, F23.0).

When the professionals, answered not so obvious questions that eluded to the understanding of their own unique forms of communication and behaviour in relation to their own *personal front.* (Goffman, 1990b, p.34). The answers given where contemplated. Questions such as, *How well do you interact with the patients? What do you prioritise when you are in contact with a patient?* (Appendix 3). The answer received gave an insight into the person's psyche and their awareness over their own communication skills. These aspects of the personal front are what Goffman describes as *"appearance and manner"* (Goffman, 1990b, p.34-36).

The way in which a person's personal front adapts to information and how the observer has an expectation to how the person will be stimulated by the information caused through a given interaction. (Goffman, 1990b, p.34-40).

What becomes become apparent is that they are a number of the professionals that appear to reduce their own importance when meeting their patients. Their gestures, and speech and understanding of their own communication is evident in the way Care assistant Anon 4, prioritizes the patients by listening to them, ensuring their experience as an inpatient is a good one (Appendix 3). The response to the question, is consistent to Anon 4 everyday practises, forms an integral part of their personal front. One could term Anon 4 as a compassionate person, it would be reasonable to expect that they would react to all new information with compassion. In Goffman's understanding of status' influence, Anon 4 removes, or at least attempts to remove any professional or organisational barriers that exist between themself and inpatient (Goffman, 1990b, p.35-36). The same can be said of other professionals interviewed such as Care Workers Anon 6 & Anon 11 who chose to meet patients *i øjenhøjde*

(on a level footing), removing any ideas of status, surrounding their meeting with inpatients (Appendix 3).

Lup Psykiatri has a similar feel to it reporting that the majority of patients believe that they are well received in psychiatry, and during their time spent hospitalised the majority of patients believe that the staff gave them time to speak to them (Hansen, Holm, Dahl, Svendstrup & Witzel, 2019, p.33-34).

6.3. Dramatic Realization

The observations of the Dramatic performance that unfolds between the actors performing on stage is judged by those observing the performance, noticing the interactions between the persons involved in the interactions. In the case of the professional a continuity of performance through experience could be expected. Observing the patient's performance, places an onus on the observer to understand the patient's behaviour and communication to ascertain what type of performance can be expected from the patient, a process than can involve many observations in the same setting, for a period of time, to establish a familiarity in the expected responses of the inpatient. (Goffman, 1990b, p.40-44).

In understanding and adapting the symbolism behind *Playing to the audience,* Goffman (1990b, p.40-44) to the setting of a Psychiatric Ward, realises that a professional requires a dexterity in talent, overplaying their own individual performance, can have connotations towards the patients treatment and progress. It also requires an understanding of the individual's own strengths and weaknesses. A more reflective question was asked to understand the idea of the effect of playing to the audience influences the individual professional's performance. When asked "Is there anything you would change, in your own personal interaction with patients? (Appendix 3). To those who were willing to concede that there where things, that they themselves are aware of, often were personal traits that focused on their own frustrations at certain times. *"I am a little (curt) under pressure"* Anon 1, "... *more patience with the depressed* … Anon 6 (Appendix 3).

In asking questions, about Pat's individual psychotic episodes, the extent of the psychosis was not asked into because of the intimate nature of the episodes. All four of Pat's psychotic

episodes where provoked by incidents in Pats life. Pat's psychotic episodes where caused by reactions to events that unfolded in her life. When meeting the professional personal at the time of a psychotic episode, the expectation would be that Pats Dramatical presentation, would have been flawed, due to her psychosis and the nature of the individual psychotic episodes (Goffman, 1990b, p.40-41). The professionals that observed Pat, while she was in a state of psychosis appear to have understood Pat's performance, due to Pat's recollection of the staff involved in her treatment. *"Everybody was good to me … of course I had better connection to som as opposed to others."* (taken from the interview dated 080420). Comments that show that the professionals had an understanding, and by dint indicating an ability to navigate in the bounds of Pat's dramatic realization (Goffman, 1990b, p.40-41). Knowledge that is especially important to pass on to a person who has no experience of being hospitalized, appearing for the first time on stage as a character unable to present a true portrayal of themself. As in the case of Pat a person seeking help because she is not capable of acting in the way she herself wishes to.

These worries that can affect a person entering a Psychiatric ward, are explained by Morten Engell Thomsen recalling his first experience of psychiatry as s debutant on a ward. A young man, 35 years old at the time of interview, received a diagnosis of Schizoid personality disorder after a time of observation on a psychiatric ward (Boss, 2020). Schizoid personality disorder is a condition that is "*characterized by alienation, shyness, oversensitivity, reclusiveness, egocentricity, avoidance of intimate relationships, autistic thinking, and withdrawal from and lack of response to the environment."* (World Health Organisation, 2020, F60.1).

The experience, professionalism, and natural empathy to understand a performance from a debutant such as Morten should not be underestimated. From the symptoms that characterize Schizoid personality disorder and Mortens description of his thoughts on the way to hospital the professionals involved in assessing Morten through observation and interaction would have to be very adept in understanding Morten's Dramatic performance. Mortens description of his thoughts at the time of hospitalization describe a helpless man in fear, scared and nervous (Boss, S. 2020).

The professionals interviewed on their respective wards indicated an understanding on how Dramatic realization should be observed, as well as to judge when and how it was appropriate to speak about the patients' health. As is indicated by care assistant Anon 4 *"listen to them, ensure that they have a good experience, remember that should not always speak about their diagnosis… "(*Appendix 3). Care assistants Anon 7 & Anon 8 also indicated the importance of assessing the patients' needs and not just acting upon the patient.

6.4. Misrepresentation

Misrepresentation of oneself in the act of *'performing'* can be interpreted in many ways. A wilful act to deceive the observers could be to an actor's advantage. Goffman's understanding and presentation of *'White Lie"* (1990b, p.69) uses amongst other examples of doctors as people who tell white lies. These being roughly understood as an adaption of the truth to aid the doctor and appease the inpatient, or possibly satisfy the psychiatric system's needs. Just as *White lies* could be used by a patient wishing to remain in the hospital, or alternatively wanting to leave the hospital, before their course of treatment is completed.

The intricacies of the decisions that lead to the fact that people are discharged from hospital, after a shorter average stay in hospital are many and are indeed worthy of further investigation from different actor perspectives. Goffman's *White Lie"* (1990b, p.69), could indeed have relevance when psychiatrist's discharge patients from hospital before their treatment is completed. (Danske Regioner, 2018, p.6).

It should not be forgotten that misrepresentation does not require a deliberate act Anon 2, a nurse is very much aware of their own individual competences and trepidations. When asked about what they would change when interacting with patients very simply answered *"it will come with time"* (Appendix 3). Again, in reference to similar questions relating to patient contact *"it will get better with more life experience"* (Appendix 3). The observer in watching this performance of Anon 2 could because of Anon 2 trepidations, run the risk of misinterpreting the nurse's performance (Goffman, 1990b p.65).

Goffman (1990b p.65-73) concept of Misrepresentation allows for many influences, however the observer, or professional performing in good faith, presenting a genuine front, adhering to

all the rules so as not to deliberately deceive the patient or the observer can be susceptible to certain influences out of their control. If the person they are interacting with choices to present a false front, then there exists a chance that the professional will misinterpret in this case the inpatient. There also exists the possibility that the way in which the professional attempts to interact with the inpatient is flawed, due to amongst other things *a hole* in their education. Which is indeed a possibility according to Anon 1, Anon 2, Anon 6, Anon 7 and Anon 13 (Appendix 3).

Whether or not, Pat's experience of being an inpatient exposed her to staff that misrepresented facts, or deliberately presented a false front to Pat, is not known. However, Pat's recollection achieves an understanding that suggests she was always treated well and fairly, remembering individual acts of kindness, and care (from the interview dated 080420). Again, allowing for Pat's condition set in the light of Goffman (1990b, p.65-73) understanding of how misrepresentation can occur. During her four periods of hospitalization the professional personal involved in the treatment of Pat, where able to see through the facade of Pat, at the times when she was most affected by her condition. This understanding is not lost upon Care assistant Anon 10 when describing how important it is to be authentic, treating people as equals and as people, no matter what (Appendix 3). This awareness is shared by Anon 12 who recognises the importance of knowing yourself as an individual, your own qualities when helping people who are suffering from mental health problems, especially when they are in effect. Knowing when you are the right person to deal with the patient or not, offers the patient a better chance of being able to interact with the right professional, reducing the risk of misrepresentations (appendix 3).

An issue of significance regarding misrepresentations are the answers received by the respected professionals to the question "Do you believe that you can create an understanding of who the patient is, while they are hospitalized? Can you explain your answer? (Appendix 3). Whilst, Goffman (1990b p.65-73) explanations of the way's observers can be misled or deceived through misrepresentation, there is no suggestion that any of the professionals that were interviewed deliberately mislead through misrepresentation. The answers to the question from Anon 1, Anon 2, Anon 13 (Appendix 3). Due to the nature of their own

perceptions of what a patient's treatment should entail whilst they are hospitalized, believed it was not possible. Two of these are nurses.

The nature of their psychiatric wards they were working on are acute, therefore they believed only an acute understanding of the patient is relevant. The misrepresentation occurs here because of the professional's admittance that they do not expect to be able to form an understanding of who the patient is. By inference the replies received from the three professionals mean that interactions between professional and patient can only be superficial if the professional chooses to understand the inpatient solely on an acute basis.

The question relating to the readmission rate of 23% and the possible reasons for this rate of admission produced answers which have a relation to the previous question. (Sundhedsdatastyrelsen, 2017 p.7-10). In the planning of the questions, there was an expectation that some professionals would be challenged by questions concerning the idea of forming an holistic awareness of the inpatient, as the answers to the previous question from Anon 1, Anon 2, Anon 13 confirmed (Appendix 3). Therefore, the answers received from the same three people, where very interesting, and quite unanimous. All three citing different reasons for readmissions however they believed that many patients are discharged from hospital too quickly (Appendix 3).

Care assistant Anon 13, was quite damning in siting the opinion that patients have not completed their treatment before they are sent home, believing that patients are not included in the planning of their own course of treatment. These remarks are common to the answers from Anon 1, Anon 2, Anon 4 & Anon 10 (Appendix 3). Others like Anon 3 being far more direct in expressing their thoughts about perceived failings that surrounding interactions "*We (professionals) do not understand the patient ... we do not recognise the patient "(*Appendix 3). These are just a few of the individual professional's insight into their understanding of readmissions in Psychiatry. The theme of a lack of recognition and involvement of inpatients in their own treatment planning appears to be a theme that is constantly occurring. This is reflected in the most recent report concerning readmissions carried out by Defactum for Region Midtjylland reflects the interviewed professionals' observations and opinions (DEFACTUM, 2019, s.7).

6.5. Life after hospitalization

The longevity of a stay in hospital as a psychiatric patient is of a variable that has no fixed term. The World Health Organisations ICD-10 Classification of Mental and Behavioural Disorders lists many disorders, with explanations of symptoms and in some cases approximate expected length of illness. However ever every diagnosis, and every case of mental illness is unique to the individual, requiring an individual treatment plan, that should help support the person after hospital (World Health Organisation, 2020, p.8-23).

Pat's experiences of the help she received in planning life after her stays in the three hospitals, appears to be a little sparse. As a woman she was hospitalized for psychotic reactions to various events that had occurred in her life, prior to her hospitalization. When asked what help she had received to relieve these problems during the times she was hospitalized, she replied that she had not really received any help (taken from the interview dated 080420). Allowing for the changes in Danish Laws over the last twenty years, suggests that Pat is not aware that this could have formed a part of her treatment plan (Retsinformation, 2019). Again, echoing concerns raised in the LUP rapport, that many patients are not prepared for life after they are discharged (Hansen, Holm, Dahl, Svendstrup & Witzel, 2019, p.36). Pat's explanation for this, was that she was probably not hospitalized for a long enough period of time. Although, Pat did not recall being helped with her problems that led to Pat's hospitalization, she was referred to local (kommunal) psychiatry (taken from the interview dated 080420).

Recollections of her experiences of the services offered by local psychiatry are not particularly positive or encouraging. Recalling a group therapy session where people recovering from mental health disorders where expected to sit in a circle and wait for somebody to say something. Pat recalls on occasions that there could go 15 minutes before anybody said anything, causing herself to feel anxiety and provoking negative thoughts because of the group situation without interaction (taken from the interview dated 080420). The problematic experiences that Pat recalls within social psychiatry are acknowledged by both Anon 4 and Anon 1, both pointing to social psychiatry's problems. Anon 11 believes that social psychiatry is short on both quality and economy (appendix 3). Worryingly, mirroring the goals for the Ministry of Health's report from 2009, noting problems with

kommunal services for people needing support in the community for mental health issues, as they repeat in their report from 2018 (Sundhedsstyrelsen, 2018, p.6-13).

These recollections unfortunately share a resemblance to those findings presented in SIMREB. In which an overwhelming number of patients (where possible) and their relatives give the distinct impression that the preparations, and discussions surrounding the patients impending discharge where not optimal. (Høgsbro, 2010, p.12-13).

When confronted with the disconcerting number of readmissions that occur within 30 days of discharge from a psychiatric hospital (Sundhedsdatastyrelsen, 2017, p. 6-9) the response from the professionals was plentiful. Answers often pointed to problems or points of concern, often out of the control of regional psychiatry, these included "*they are discharged too early", "they are lost from the moment they leave here", "there is a lack of community programmes / sheltered housing", "loneliness", "no support in the community", "inadequacies in social psychiatry"* (Appendix 3). What these answers have in common are that they point to the contributory factors, social problems that can surround inpatients before and after they are discharged from hospital. Echoing many of Sophie Hæstorp Andersen, Chair of the Psychiatry and Social Committee in the Danish Regions critic (Jakobsen, R. (2018). At the same time being able to speculate that when Psychiatrists are coerced into discharging patients earlier than they feel is of benefit to the individual patient, there exists a risk that systemic and structural concerns become the Psychiatrists priority, downgrading the patient's importance. (Danske Regioner, 2018, p.6). In keeping with what the professionals are experiencing on the psychiatric wards.

In understanding the issues of interest, before planning the questions, it became obvious that there was a confusion within the systems of psychiatry. What social psychiatry consists of is open to interpretation (Sundheds- og Ældreministeriet, 2018, p.3-5). The professional's responses confirming this, indicating structural and organisational problems on a macro scale which a Goffman / Symbolic Interactionist analysis, cannot address in its entirety, although this form of analysis can pinpoint and explain why problems persist.

The final question asked to the professionals related to the extent that themselves and their colleagues should help the inpatient address their personal and social problems. The extent to which professionals thought it was a good idea and how far they should go in addressing inpatients social problems was mixed, although generally positive. Anon 13 answer, quite simply was *"We need to, in the extent that we can, they should be discharged to something."* (Appendix 3). Anon 6, sees it as an absolute necessity, because they believe that the reason for many patients need for hospitalization derives primarily from the social problems the patient has encountered and tries to cope with (Appendix 3). A view shared with Anon 3 the lone social worker. Anon 11, a care worker replied *"What should they leave to? ... Should they be discharged to nothing ... help should be started before they have left the ward"* (Appendix 3). A view which recognises the importance of a continuity within the single patient's treatment and the implications of not helping somebody within the society they will become a part of.

Technically, although not strictly psychiatry the 'third player' involved in the psychiatric treatment and care of people with mental illness is the General Practitioner. They prescribe vast numbers of psychotropic medicines in comparison to Regional and social psychiatry (Sundheds- og Ældreministeriet, 2018, p.5). At no point in any interview, was there a discussion, or indeed mention of General Practice. This could have been down to the line of inquiry, that deliberately avoided debating the 'third player', because the main focus was on the interactions between pre-determined factors, and actors. As interviews progressed the identity crisis and the many descriptions of social psychiatry in less than positive terms began to be of more importance, possibly to the detriment of other subjects, deserving of further attention. Especially in the light of the increased use of psychotropic medicines, and Danish Societies increasing dependence upon them (Sundheds- og Ældreministeriet, 2018, p.5).

A weakness could lie within, myself as the interviewer, being overly loyal to my chosen concepts that I used to analyse the answers received, steering the interviews in a way I thought was best to ultimately answer the research question (Brinkmann, 2009, p.189). Another critic of the approach to the answers received to the questions, was the very real time restrictions that I myself imposed upon the interviews, to reduce the intrusion of places of

work at time of national upheaval. The concept of time was not mine to control. In many ways going against the advice offered by Frederiksen (Frederiksen, (2018 p.83-106).

The professionals answers to direct questions that provoke an understanding of the person's that they treat or are involved in their course of rehabilitation, often acknowledge the need for a more holistic view of the problems surrounding the individual person, recognising contributory causes.

7. Discussion

Originally the ideas that stimulated the interest for this thesis where unfortunately scuppered by the COVID-19 Virus and the Danish Governments necessary reactions to the pan-endemic (Sundhedsstyrelsen, 2020). The hope of primarily approaching the thesis, and subsequent research from a user, patient perspective evaporated very quickly. Paradoxically, whilst writing this thesis, the fear for COVID-19, has meant that people have had to remain home, avoiding contact with as many people as possible, due to the Government's official policy. Occupied bed capacity in Danish Psychiatric Hospitals is normally close to being full. Ironically at the time of writing the thesis occupancy level fell dramatically, as did the possibilities to interview ex-patients. (Rahbek, 2020).
The focus shifted to conducting qualitative interviews of professionals employed on Psychiatric wards to research the interaction between themselves and inpatients. The qualitative aspect of the interviews was maintained after considering the issues of interest. A qualitative understanding to contrast the existing quantitative knowledge offering a more personalised perspective of the interactions between professionals, their peers as well as the inpatient was obtained.

The questions asked to all professionals as well as a single ex-patient where successful in creating new knowledge capable of answering the research question, and most importantly giving first-hand accounts of people's professional experiences of working on a psychiatric ward. Experiences that shed light upon the professional's thoughts and contemplations when interacting with their peers and inpatients.

Lengths of individual stays in psychiatric hospitals have fallen, although the number of readmissions is rising. The number of readmissions to psychiatric hospitals was the indicator and reason why the understanding of interactions between the professionals, their peers as well as the inpatient in situ was important. A realization means that the time spent as an acute inpatient could also be falling (Sundhedsdatastyrelsen, 2017, p.6-9).

The adopted approach to the analysis and the questions asked to both professionals and ex-patient provided answers that made it possible to answer the research question. The choice of approaching the study from a hermeneutic perspective, allowing for the double hermeneutic understanding of the creation of knowledge was very fruitful. Noticeably when set in context using The Focused Interview as stimulation, and a Goffman concept inspired analysis to relate the answers received to the research question. The intention was that the interactions between the actors involved in the care and treatment of inpatients could be understood. They were as where the peer interactions. The ex-patient was very good at describing how important the personal interactions that she experienced where, overwhelmingly positive.

Questions asked to the professionals often received mixed individual replies, especially when questions asked did not specifically refer to the contributory causes that could be associated to patients. Some of those understanding of their function and their wards purpose was to deal with people acutely. A hospital is a place where you deal with the immediate problem surrounding the patient’s mental condition. Thoughts, in line with existing quantitative accounts that acute, implies a short period of time.

When questions were asked to the individual professionals that specifically referred to readmissions. Answers received where not uniform, they echoed the same type of problems that have been reported by organisations that have presented a quantitative understanding of the problems that can follow a person who is in need of care or treatment for their mental condition. Unfortunately, these acknowledged that contributory causes are a factor, at the very least a trigger for the patient’s state of that are often not always dealt with. According to the interviewed professionals working within a hospital setting Social psychiatry, the more grass roots community care psychiatry, does not have the relevance it should have to many patients. Reasons cited are a lack of quality, echoing the critic often represented in reports

that social psychiatry is a place which suffers from a crisis of identity. (Sundheds- og Ældreministeriet, 2018, p.3-5).

A more solidaric understanding of meeting the patient's needs, a continuity of service, and at the very least an orienteering of the contributory causes that persist in a patient's life. These represent examples of the professional's individual reflections in answering the very simply formulated questions, that did not allow for any real depth to the answers. Establishing a basic consensus, that professionals should be seeking to address problems that are personal as well as those of a social nature. Offering an insight into the possibilities and understanding of the patient that professionals do have, when specifically questioned about the content of care and treatment

8. Conclusion

After analysing the questions asked to both professionals and the sole ex-patient, it was possible to answer the research question, with a degree of certainty.

How do professionals working in Danish psychiatric hospitals seek to interact with inpatients, that are hospitalized on a psychiatric ward, with the purpose of understanding and addressing the contributory causes that can persist and led to the individuals need for treatment.

As far as a single person can, the ex-patient was of the opinion that quality of after care, and continuity of service was not of the highest quality in social psychiatry. This being a person able to reflect upon four different periods of hospitalization,. The patient recalled that on all four occasions that they were treated well by the employees of the hospital, feeling that the staff wished her well, and did what they could for her as an inpatient. Unfortunately, only to confirm with that there was no real attempt to help her with the persisting contributory causes. This was accompanied by poor experiences in the social psychiatry.

The professional's working on the psychiatric wards are often positive, and work in the field of psychiatry because that is what is what they really want to do. Many of those interviewed, placing patient contact and the individual patient's need above other aspects of their work.

Education of the professional's plays a significant part in defining the role of the professional, within their place of work. In many cases though, the education does not provide an ideal understanding of the field of psychiatry. In some cases after a period of three and a half years, as a student it can be felt that the practical aspects of psychiatry have a low priority as compared to the somatic understanding of issues concerning the health and treatment of people. Allowing for this, the majority of the professionals, believe that they are good at establishing contact and communicating to patients on an individual level, allowing themselves the chance to understand the patient, doing their best to fulfil the patient's needs. Mirroring, the ex-patient Pat's experiences of hospital staff.

The focus of the individual professional's interactions with their patients on an individual basis appears to have a relative level of uniformity. This uniformity becomes very distorted when the professionals are questioned about their interactions with their peers, especially when it concerns an individual patient's care and treatment. Although it must be noted that a lack of agreement is not always a bad thing, according to some of the professionals interviewed. Interdisciplinary cooperation and interactions that occur between the professions, can suffer from the same lack of clarity and failure to reach a uniformed understanding of the patient. In conclusion, it must be considered that if fellow professionals cannot agree a course of care and treatment. Then the patient who is at the centre of discussion risks becoming secondary to disagreements and being misunderstood by some of the professionals involved in the patients care.

Explanations for this can be found in the answers received to questions about the implicit nature of their place of work, some professionals believing that it was not possible to understand who the patient is during their hospitalization on the wards they work on. For some professionals, an acute understanding has a time element to it. They feel that patients should not be hospitalized for no longer than necessary. Simply a stabilising process, whereby the individual is treated for the medically diagnosed condition and discharged.

When the parameters are changed and professional's working in psychiatry are confronted with the fact that close to a quarter of those discharged from hospital are in need of readmission shortly after their discharge, the response changes, although not totally in unison. Many professionals believed that at the very least that an inpatient should be discharged to something. It cannot be concluded in any great certainty, what something is. Something,

meaning at the very least that the discharged patient should not be lost from the moment they leave regional psychiatry, to begin their rehabilitation and life alone in the society to which they are a part of.

In conclusion to the research question and within the confines of the number of people interviewed during a time of upheaval in the whole of Danish Society it is possible to answer the research question. Professionals working in the hospital wards in varying degrees of enthusiasm, believe that private and social problems, that have been described as contributory causes, should form a part of the inpatients care and treatment at the very least to avoid losing the patient at the point of discharge.

Knowledge of the patients experience and the professional's experiences of working in psychiatry are often presented in a quantitative manner. Psychiatry by nature encourages debate. The debate and subsequent reports appear to overlook the individuals in need of treatment, as well as those who are providing it. For a brief moment, this thesis allows for these individuals voices to be heard, thus contributing to the knowledge available to others to help understand the relevance of persisting contributory factors to both the patient and professionals providing care for them.

To literate, *an observation to a premise*. After many reports, from many different organisations, and as this thesis concludes social problems are a factor that contribute to a large number of cases for hospitalization, and readmissions. Therefore, questions should be asked about why it is that the similar recommendations and causes for concern persist in the systems of Psychiatry? Those very similar to those named by the Danish Ministry for Health in 2009 are repeated constantly. After 11 years it is reasonable to expect that the views concerning psychiatry would have changed. Sadly, this thesis concludes that psychiatry on all levels in Denmark appears not to be functioning in a manner that is of benefit for all of those who are in need for it. The benefits of integrating a course of Social Work or social orientation into the inpatients planned treatment, appears to be a source of untapped potential, as does the immediate proximity of General Practice to the ex-patient requiring support in the community. These observations are of great interest and worthy of further study, which the author of this thesis intends to research when the opportunity arises.

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10. List of Appendix

Appendix 1 - Questions to discharged patients in Danish.

Appendix 2 - Questions to professionals working in Psychiatric Hospitals in Danish

Appendix 3 - Summary of the coding and exercise in condensing of the answers received from the professional’s interviews in Danish