# 'DIALOGUE ACROSS DISTANCE - BETWEEN USERS AND STAFF OF ACUTE ADULT PSYCHIATRIC HOSPITAL SERVICES'

Paper to the Ethnographic and Qualitative Research Methods Conference

- RECLAIMING VOICE

University of Southern California, Los Angeles
20 June- 22 June 1997

**Yoland Wadsworth**

Faculty of Arts
Victoria University of Technology
Werribee Campus, PO Box 14428, MCMC
Melbourne, Victoria 8001
and
the Action Research Issues Centre

Telephone: 61 (0)3 9216 8007, or 61 (0) 9650 6963
FAX: 61 (0)3 9216 8226
E-mail: YolandWadsworth@vut.edu.au

## ABSTRACT

Between 1989 and 1996 an Australian Statewide peak consumer group engaged in two cycles of dialogic research with staff working in a large public acute psychiatric service system. I was employed as a research consultant by the group. The larger purpose of the work was to 'build in' routine methods for staff to seek and receive consumers' evaluative feedback and collaborate with consumers on making valued changes to services as a result of this feedback. This paper reports on a small portion of this extensive project and particularly on those elements that involved (and confronted) consumers naturalistically experimenting with various methods to 'reclaim their own voice' and take part in dialogue with staff. I then explore the critical contradictions of staff's difficulty in 'hearing' consumers' voices in terms of their own suppressed, self-suppressed and repressing voices - within their own dominant discourse. There may be important implications for how people can speak to each other from one discourse to another (particularly when one discourse is dominant and the subordinate discourse is striving to replace or transform a dominant and damaging discourse), and yet-to-be-explored implications for what it might mean for those of us trying to facilitate such dialogue (including participants to the dialogue themselves) when needing to occupy each discourse (in order to understand and be trusted to have understood), but, when speaking in one discourse, no longer speaking in the other.

## Introduction

I want to introduce the story of this large-scale, emergent-design and whole-systems project in terms of its methodological journey.

From 'automatically' starting with the idea of a conventional questionnaire to people as they were being discharged from hospital (to collect evidence of poor quality practices), a small group of consumers at the Victorian Mental Illness Awareness Council (the VMIAC)[1] moved to wanting something which would do more justice to their own experience. They settled eventually on more of a story-telling approach. At the same time

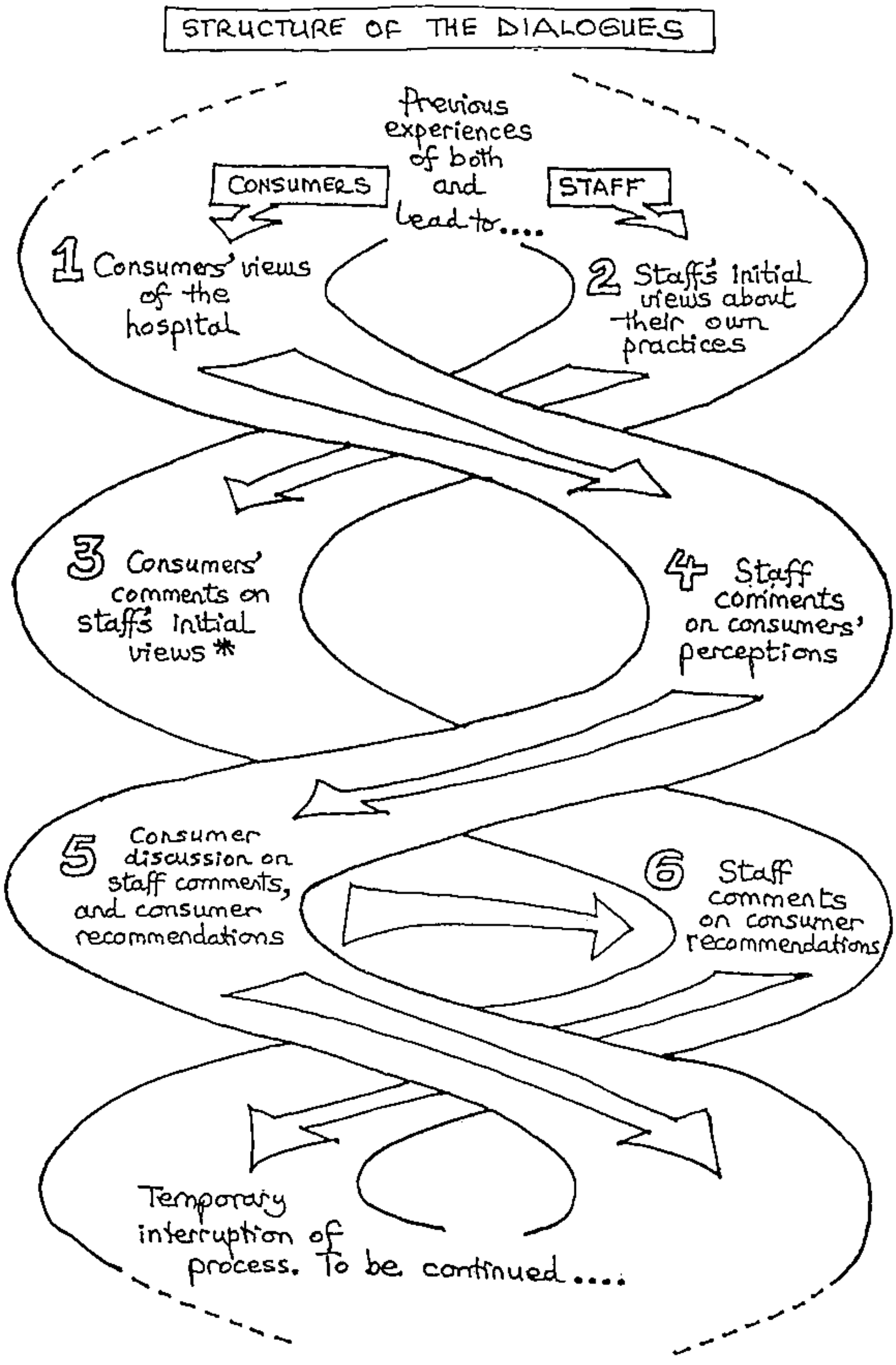
---

[1] Peak State-wide self help consumer organisation in Victoria, Australia.

DIAG 1

## THE STUDY DESIGN AND PROCESS

The basic design of the project allowed for the stages illustrated.



they decided they wanted change in ward practices and that yet more one-way speaking to staff was not going to be as effective as two-way dialogue with staff, and thus it was determined the project should involve staff speaking as well. In this way the first iteration of the research involved an elaborated exchange of views (see Diagram 1).

A series of informal interviews with a total population of all inpatients to one acute adult ward during a one-week period, was matched with a series of consumer-perspective questions to staff. The purpose of the consumer discussions was to hear people's experiences of coming to, being in and then leaving the ward, and a small number of very open questions were used in order to honour each person's own voice and self-told story. The staff were asked consumer-perspective questions (about what they were trying to achieve for consumers, what they were up against, how they knew if they achieved useful things for consumers), and then each of these two initial sets of views were swapped between the two groups for further comment. One further exchange followed this.

### Reflections on the initial dialogue

At the end of this series of exchanges, looking back over them, a simple characterisation of the dialogue might be that:

- Firstly, consumers told realistic tales of their admissions - sometimes uneventful, but still also notably painful.
- And staff told idealistic tales of their objectives, as well as stories of frustration.
- Then consumers were chuffed to hear staff were trying hard for them, but still felt indignant about damaging treatment, and made positive suggestions for change.
- Staff were divided over consumers' negative descriptions, with some urging attention and change while others felt defensive or complacent or sceptical or all three.
- Then consumers went through a further phase of sympathy but again became impatient for improvement and continued to press for change.
- Then staff continued to be pessimistic saying that either things had already been tried, that consumers' suggestions wouldn't or couldn't work or were too hard, or that consumers should do more things themselves rather than look to staff.

Some readers of this unfinished, contradictory and contingent set of voices, longed for us - as traditional evaluators - to simply tell staff the conclusions they should draw. On the other hand, many other staff readers responded with more or less appalled or offended feelings, even without our doing this.

Besides addressing the issue of dialogue between the two parties (consumers and staff) this small first study raised the question of how this kind of exchange might become 'built in' as a routine and ordinary element of practice, and also as part of a more comprehensive 'package' of feedback, communication and evaluative inquiry methods.

### The main study - 'building in' dialogue throughout acute psychiatric services

The second and largest iteration commenced with attempting to engage staff and consumers in small, voluntary, participative and action-oriented inquiry efforts at the ward level. We found a small but adequate 'space' for this in the hospital's QA (Quality Assurance) discourse. In responding to the difficulties of achieving this, the project's inquiry group drew on a wide range of methods in a prefigurative way to try naturalistically to test for various methods' capacities for both hearing from consumers and also for assisting communication and deeper dialogue between staff and consumers. Over the course of the four years of the project these methods included story-telling, dialogue, strategic questionnaires and surveys (for example to ask staff what questions they might like to ask of consumers), participant-observation, group discussions, discourse-analysis, suggestion boxes, consumers' case stories, and the use of an extensive inquiry network of more than 120 consumers, satff and policy-makers. We also documented staff's use of managerially-authorised methods and their effectiveness and ineffectiveness (such as representatives on committees, satisfaction surveys, complaints procedures, advocacy, etc.).

## Methodology

The project was based around negotiated agreement with ward staff and with management (primarily nursing) to use 'new paradigm' participative, action-oriented, 'practice research'. This developmental and emergent approach was subtlely contested on the grounds of not being objective science (primarily by psychiatry) - but this contestation was subdued and relatively isolated and did not render the project impossible (primarily because its small-scale inquiry approach had found its structural niche in QA, and the key personnel had the respect of the most senior staff.) However the methodology was later unsubtlely rejected by a new wave of management in the project's concluding months as the delicate and hard-won collaborative relationships began to diminish as the funds yet again ran out. At this time there was a reversion to a more objectivist demand by managers (with nursing and social work backgrounds) for a 'neutral' post-implementation evaluation in the form of their selection of a psychiatric nurse to take the place of the consumer-selected non mental health professional. Although many of the new 'structures' for consumer feedback and staff-consumer communication have remained in place both in the study hospital and elsewhere following the achievement of Government policy and a statewide funding program, they too are simultaneously both welcomed and contested and weakened by a new wave of managers and policy-makers for paradoxical reasons that were well-theorised by consumers and staff involved in the project.[2]

## Some findings

The project articulated key 'sites' that were needed in order for staff to successfully hear the voices of consumers and for consumers and staff to be supported to speak to and hear from each other. The sites were designed to assist staff enter into a consumer discourse and for consumers to work with staff on critically reflecting on their own discourse. These sites were:

(i) Firstly, all *organisational decision-making forums* (such as routine program and hospital management committees, staff meetings, handovers, policy committees, as well as via feedback methods, etc.);

(ii) Secondly, staff-consumer (non decision-making) *dialogue forums* in which deeper presumptions, beliefs, undiscussables and other thinking could be shared, surfaced and re-examined; and

(iii) Thirdly - if consumers (and staff) were going to have the strength and emotional support to engage in such dialogue - then *consumer-only forums*, (and staff-support forums) were identified as needed too.

Without all of these, feedback and communication methods suffered decay and distortion given the constellation of factors driving acute psychiatric hospital services from their 'health, healing and recovery' discourse, towards a 'control and coercion' one.

## Theory

The project contributed some new thinking by the consumer movement as to why it is so hard for staff to hear from consumers. It both moved beyond the 'mere' making of demands on staff, to hearing what staff say in response to these demands, and secondly to probing deeper into the contradictions in staff's practice between desire (to hear from and respond to consumers - to work *with*), and 'role' (to decide for and do *to* consumers - even against their will). This deep paradox of assisting consumers' own recovery to health, versus forcing return to 'health' (particularly by resort to administering compulsory medical drugs) appeared central to the issue at hand. The project speculated also on how and why humans respond with fear, dislike and control to 'difference' by those seen and experienced as different (in this case, in the ways the mind works) - rather than always with compassion, responsive and enabling strategies, and considered how these emotional defences become incorporated in organisations, roles and routines.

---

[2] For the theoretical findings of the project, see the final volume (Volume 3) of the monograph series (Wadsworth & Epstein, 1996b) on which this paper draws heavily.

## Issues

Profound issues arose from the relationships between emotions, organisational and cultural change and the mutual construction of power relations, especially in relation to the use of an iterative, emergent, responsive and non-coercive dialogic methodology. To give a single example, staff were dismayed by their own disempowerment within the services structure and appeared unable to hear consumers until they first themselves were heard. However, the things of which staff *most* wanted to speak (emotional responses of fear, anxiety, rage, frustration, and feelings of being badly-treated), appeared to be simultaneously the things they felt most forbidden to say (and most forbade themselves saying) for fear of dismantling the carefully-constructed 'difference' and 'othering' on which are based their authority and legalised powers as mental health professionals. That is, a line is drawn (reflecting the 'othering' constructed elsewhere in society) between 'them' (sick, emotional, irrational, out of control, incompetent) and 'us' (the healthy ones, rational, calm, in control and competent). Consumers continued not to be heard both because staff's own emotional responses block their hearing, and because the carefully-constructed objectifying professional mental health discourse has no place for active, sensible, valuable input from patients.

This is powerful 'closed loop' thinking (Argyris, 1993) which, while distancing and protecting staff from much of their anxiety (Menzies, 1970) and safeguarding the conditions for objectification and coercion at a possible future timepoint, also 'protects' staff from being able to make resonant connection with consumers that can be experienced as mutually affirming, healing and strengthening.

The three issues which will be presented for discussion on this occasion are regarding reclaiming the voice of consumers, reclaiming the voice of staff, and reclaiming the voice of the researcher(s)/facilitator(s).

## Consumers' voices

We made considerable headway in constructing a consumer-driven project which developed both consumer-run and consumer-only groups which more powerfully assisted the reclaiming - or claiming - of consumers' voices.[3]). The project was initiated by a consumer organisation and its topic and popular titles were selected and approved by consumers; the project was run by the consumer organisation which selected and employed a research team comprising a consumer research officer, two part time consumer consultants and a research consultant; and the project then employed a further 23 part time consumers as casual researchers and consultants over the four years. It operated out of its own project office (in a sympathetic nursing research and training centre) in which consumers felt safe and confident enough (even though it was on hospital grounds); and consumers shaped all phases of the project, including selection and asking of questions, analysing and synthesising results and deciding on the findings. These methods for nurturing consumer voices were all trialled as prefigurative for future 'building in' to the acute psychiatric services system. There was excellent evidence that consumers considered the project a great success throughout its active life, and their voice was 'reclaimed' (or found) by them to a gratifying extent.

Nevertheless consumers found the process enormously difficult, and, in attempting to reclaim their own discounted voices, consumers were in practice constructing together a new discourse in the face of a dominant existing mental health services professional one.

This is the kind of thing they said in answer to the question why is it so hard to be involved in giving evaluative feedback to acute psychiatric services?:

---

[3] In particular in the form of a group of around fifteen articulate users of acute psychiatric services which came together to give advice to the project hospital and then State system-wide, proactively 'giving voice' on their own terms (see their forthcoming book *Do You Mind?... The Ultimate Exit Survey - Survivors of Psychiatric Services Speak Out*, the Melbourne Consumer Consultants' Group, 1997).

It's too stressful, too confrontational
I want to make a good impression - otherwise who knows when I'll get out[4]
They're too busy - I don't want to be a bother
They know what they're doing - they're the professionals
Who am I to think I know better
I don't want to upset them - it's hard enough for them as it is
They could take it personally and I don't want to hurt their feelings
I might have to come back here and I don't want them to see me as a troublemaker
I don't want to upset them - some of them are my friends
I don't want to upset them - some of them I am afraid of
I don't want to upset them - they're really doing a good job under the circumstances
I don't want to feel worse
They're the ones who need looking after
Maybe I'm wrong
Maybe I only saw it as negative because I was depressed
If I say what really happened they'll say it's my illness
If I get really upset they'll put me back in the lock-up
I'm not sure that I have the right
I must have done something to deserve it
Things are not that bad
They have all the power - I can't buck it
Personally, I'm not political
They can't hear it anyway - they are so stressed-out themselves/they're more stressed out than I am
It's not really them, they're just doing their job under a whole lot of stresses - it's 'Their' fault ......government, politicians, the hospital, the drug companies, psychiatrists/nurses, the managers, the carers, the lawyers, the medical establishment....
They're doing the best they can
I couldn't do their job
Some consumers don't deserve to be listened to
I didn't deserve it - but I'll just keep quiet
I don't want more blood taken/ECT given/time in seclusion
It can't have happened - it's a hospital, how could they have done that in a hospital?
It was alright last time - maybe it was just my bad luck
Nothing ever changes
Nothing happened last time I wrote a complaint
I prefer to 'shut up and ship out'
It was just that one person, the others have been really good to me
I don't want to be here/I want to leave/I don't want to come back
Why should I have to try and improve the service? - I'm meant to be the patient
I'll be out of here soon
Last time I tried, they explained why it's all so impossible
Last time I tried, they wrote it in my file
I'm just in a bad mood/paranoid/anxious
It's all too hard and too big to change
Even if they wanted to do something they'd have to contend with their peers
It's OK
I just need to concentrate on getting better
I want to get on with my life

---

[4] And specifically for outpatients:
They'll think I'm still sick/getting sick again if I speak up
I just want to stay anonymous - you won't post me anything at home in an hospital envelope will you?

Consumers themselves required huge courage to 'come out' and speak up and co-create their voices. They faced constraint in the form of the difficulty staff experienced in meeting consumers on territory in which it was safe and enabling for consumers, and in engaging in discourse which was not (even if unwittingly) hurtful or offensive for consumers.

Staff's voices

All staff in the hospital who wanted to be were also involved in shaping the project - indeed in important ways the project focused more intently on working with staff than on working with consumers. However far fewer staff were actively involved and most found - despite sometimes strong convictions and commitments to so doing - engaging with consumers tremendously difficult. Here's the kind of things they said (and were more or less 'allowed' to say) about why it is so hard:

> *'We'd like to but we don't really need it'* -
> We already know what to do
> We already know what to do but are prevented from doing it by...... lack of time, 'Them' - funders, politicians, government, cutbacks, the hospital, the network, managers, carers, the influx of agency nurses, the pharmaceutical companies, the threat of litigation.... etc.
> We don't really need to be told how to do our jobs
> Managers and the department tell us what to do quite enough as it is - we don't need the patients doing it too
> Reforms are already in place, we have already worked out what to do and are getting it underway
> We read *'Understanding, Anytime'* when it came out
> If we are meant to be the professionals then we should already know what to do - what did we go to university for?
> We already observe, monitor and guess pretty accurately what consumers think and need
> Things seem to work fine without it
> We did all that in the 70s
> Nothing really matters except for waiting for the drugs to work
> There's no time for talking here - they'll get that in the community
> Consumer participation is just another management fad imposed on us
> We're not actually hearing about any problems, our patients don't seem to complain
> We're already looking into it
> We did ask but no-one had a problem
> There can't be any real problems, they'd tell us if there were
> They tell us the problems all the time, we don't need to hear more
> I'm sure we'd hear if there was something really big, like a rape or assault
> Patients are too ill/to confused/too paranoid to give accurate/sensible feedback
> We already know what the problems are...
> (Repeat)
> We already know what to do
> We already know what to do but are prevented from doing it by..... lack of time, by 'Them' - funders, government, the hospital, the network, nurses/psychiatrists, managers, carers, pharmaceutical companies, threat of litigation....etc....
>
> *'We'd like to but we can't* -
> We just haven't got the time
> This is not a very good time at present - perhaps in another year or two
> We haven't got anywhere near enough staff
> There are a lot of competing demands
> All we've got time for is processing people in and out
> Eight hour shifts don't give you enough time to speak to patients as well as everything else - review meetings, admissions, discharges, transfers, reports, arranging for patients to see everyone - doctors, consultants, the social worker, procedures, tests, it just goes on and on...
> Other things always seem to be more important, urgent, pressing
> We have to go really slowly with introducing this idea

We've had a lot of changes and need to let them settle a bit first
To be honest, things work more efficiently without it
There doesn't seem any point because there really aren't any solutions
It'll just be a Catch 22 - and it will raise patients' expectations
I'm worried it could turn bad if there is criticism
They're only going to want the impossible anyway
We can't give them what they want
I don't it either but I can't challenge it on my own
It'll only make staff defensive
I'd like to ask consumers but the other staff would talk about me behind my back/think I was breaking ranks
This is new, staff don't really understand it yet
They might find it a bit threatening
We can't force consumers to give their feedback if they don't want to
We have to maintain a secure environment
We haven't found consumers who are representative enough

*'It'd be alright if it was constructive, but criticism really is unwarranted'* -
We are already doing the best we can
We have to do 'certain things' to people
There are no other choices that anyone has been able to identify
It's what is expected by the job - by the managers, the institution, by my profession, by my job description, society at large - they don't know what else to do either
We do a good job already
We've tried everything else
This is the way it has to be - and when consumers get insight they usually accept it too
There have to be rules and procedures
Of course they'll be critical - it's an acute ward
They magnify things because of their illness
If we made it any nicer they wouldn't want to leave
Who made that criticism?
They'll be gone soon - we turn them round as fast as we can now
I'm just doing my job
We have to keep control, you can't be too soft - especially in a crisis
This is an acute ward, there are always crises

*'We'd like it but we just don't want criticism'* -
Morale is low enough here as it is
You think I like all aspects of my job? - get off my back-per-leeze
You think I think this is good nursing?
Staff aren't ready to hear it
It would only stir things up
I like to focus on the positive
It might clash with things we already believe/are committed to/from which we gain respect in team meetings/from which we gain status as a professional/ have to believe and say and do if we're to be listened to
I already feel bad enough as it is - I don't want to feel even worse
I don't deserve it, I've always stuck my neck out for consumers
I have a hard time too
I suspect consumers wouldn't want us if they had the choice
Consumers give us a hard time - I'm not allowed to talk about that
I get abused but I don't complain - it's part of being a professional, it's up to me to hold together/get it right/not wimp
Actually I'd prefer thanks rather than criticism
We never get much appreciation
No-one else wants to do this

We're the ones who've stayed in the public sector - the private send us their 'too hards'
I couldn't bear to think they never forgot some of the things that get said and done to them
I'm getting out of acute as soon as I can
You should criticise 'Them'.... funders, government, politicians, the hospital, the network, managers, carers, lawyers.... etc.
It's too hard and too big to change
I just need to survive

The system

It took us a long time to make these lists. They appeared overwhelming - and in a way they were. Because when all these individual trains of thought are put together you get something bigger than the sum of the individuals. You get a system. And in a system everyone can go on feeling more or less locked in and dissatisfied (and despite many obvious symmetries).

Peter Senge, in his book *The Fifth Discipline*, describes the system as ways of thinking which result in 'invisible fabrics of interrelated actions' (1990, p. 7):

> 'We just find ourselves feeling compelled to act in certain ways.' (ibid., p. 44)

Chris Argyris calls them 'routines' because they 'occur continually and independent of individual actors' personalities' and they are 'immediate', 'automatic', 'unconscious' and 'highly skilled' (1993, p. 20). They include also what he calls circular or 'self-sealing' and 'self-fulfilling' thinking. None of this might prove problematic unless it means a system is thus prevented from making needed change - or the 'how things are' is so taken-for-granted that the system remains impervious to realising there even is a need for change and that things could indeed be better. It is when the system in a sense goes into 'denial' or 'overdrive' that the effects of it being caught in its own compulsive routines become tragic if the end result is the displacement of its own highest and most desired goals, purposes, visions and mission.

Thus if a system's code remains uncracked, staff can go on feeling trapped, defensive, hurt, misunderstood or not heard, at the same time as sure they are already doing the best they can. And consumers can go on bottling up their experiences and feeling frustrated, cynical or angry and criticise 'chronic avoidance and self-justification' and, as Mary O'Hagan has put it, be defeated by the view of mental health services that 'the customer is always wrong'.

Up until now, the common response to this paradox in acute psychiatric services all round the world has largely been one of stalemate. But why are these patterns so powerful? Why have they proved so hard to overcome? What lies under them to make them so 'self-sealing' and circular?

Yet they are, in the first place, enormously important self-protective defences - maintained with great tenacity. We experienced the power of the system to self-protect in our own project. When we examined our own silences or self-editing, we got a clue to the power of the system to protect itself from disturbance. At times, for example, we were stopped in our tracks by the sense that the more staff only wanted to hear about the 'all good', the more consumers only wanted to tell about the 'all bad'. Even the paradox of staff's 'good intentions but no effective actions' was itself unable to be stated without numerous qualifications. We found ourselves allowing for all the difficulties and taking care not to imply that there were actually 'no actions', but just that these were at the moment unavoidably delayed or that we understood they were in the pipeline... and so on. We found ourselves becoming at times so contorted with the simplest descriptions of our project as to feel that even the smallest 'ask' was an imposition or alternatively that what we were asking *per se* implied a terrible insult to staff.

We were aware that we were often joining consumers and staff in their own self-muffling. We became experts in unspeak - referring to 'difficult times for consumers' or 'incidents', and at times not even referring to 'improvements' to services for fear of implying anything less than best practice was already in place. Alternatively, if there was some concession to the real situation, it would soon be followed by an effort to draw the conversation to a close. If we continued to press by asking 'Is there anything that could be done?', 'Could we just try asking a single consumer a single question just before discharge?' we would feel more and more uncomfortable for obviously not understanding/asking the impossible/harrassing well-meaning staff. And of course we felt for them - caught between their intentions and their situation. We edited carefully: both staff (so consumers could hear) and consumers (so staff could hear). We could not describe consumers' anger or descriptions of some of what had happened to them for fear of triggering anxieties or incredulity, for example- we could not use words like 'condescending', 'punitive' or 'savage' in relation to staff. These were 'unbearables' and seemed terribly unfair to staff. Sometimes we even edited staff so other staff would not be offended, for example taking out a reference to staff having to 'carry' other staff who needlessly upset consumers, making hard work for everyone trying to calm the consumer down again. At times, and looking back from a distance, some of our self-editing (of both staff and consumers' words) reached ludicrously-sensitised extents.

But when we faced the possibility of bringing some of it into the light of day we frequently could see no way to broach things, or, if we did, we'd suffer feelings of guilt and shame about hurting staff. We'd say 'We'll raise it later' or 'Put it in the file'. Some staff would *commence* discussions with us with assertions of how we saw them in a negative light leading either to our affirmations to the contrary but also to our feeling unable to raise any questions. Several times we only needed to use the word 'consumer' instead of 'patient' and there would be a reaction. Even to have used the term 'defensive' was enough to incur further hurt, offence and defence.

And these were in addition to staff's self-editing. At times we felt staff in meetings, or when speaking to each other were literally swallowing the words they wanted to say. We found they often either could not or did not want to speak about certain topics - even ones that seemed on the surface relatively unproblematic or obvious to us. They might gloss over something, move on quickly to something else, cut the conversation short, or otherwise indicate we'd strayed into uncertain, unpleasant or difficult waters. We learned that many staff dealt with stress and their emotional responses in private, at their own cost, and in tightly-knit and closed circles of trusted colleagues or friends. There are many instances recorded throughout the U&I monographs. The silence that fell in the nurses' meeting when the young nurse suggested that staff and consumers really had a lot in common. The silences in staff meeting rooms when we asked who would like to trial asking consumers some questions about their experiences of their inpatient stays - questions which many staff themselves had nominated as ones they wanted to ask.

What were all these patterns of thought and action protecting people from?

Silences

At some time in the life of the project, someone had pinned the following quote to the U&I project office noticeboard:

> 'What are the silences
> that you swallow day
> by day?
> If we wait until we
> are not afraid to speak,
> we shall be sending back
> messages from the grave.'
> (Audre Lorde)

To this we added the following:

> 'If you want to know how we are repressed,
> listen carefully to what we are not allowed to say.'
> (Source unknown)

In a sense, the lists of what staff and consumers say about 'why it is so hard' are what *can* be said. What could not be said (or was muffled or buried in these statements), however, became an increasing topic for our attention as we continued our detective work into the paradox of why it seemed to be so hard to hear directly from consumers about their experiences of the services, and work together on positive change. When we traced the threads behind these statements of 'why so hard' back to their underlying factors, we began to unearth a deeper analysis of what seemed to be going on on an acute public hospital psychiatric ward.

Eventually we named as 'cork-in-the-mouth' all those instances, across a range of different circumstances, where staff felt constrained to speak. These included:

> *Regarding their own stress, fears, and emotions.* Ironically in a mental health services system there appeared to be a taboo operating against appearing or speaking emotionally - particularly, for our purposes, regarding the system not hearing from or responding to consumers, or treating consumers in less than ideal ways. Even outside a therapeutic environment, staff seemed to feel constrained from expressing the range of emotions that they experienced (in working with inpatients) to ex-consumers involved in discussions around achieving structural change. There appeared also to be a taboo staff exercised against each other talking about these matters - even to the point of mutual shaming (e.g. with comments about not being capable if emotions were shown).
>
> *Regarding ordinary interpersonal contact.* Many staff seemed to have developed elaborate ways to avoid conversation with people - staff and consumers. There was the head-down-walk-fast strategy, the speak while standing side on and stepping away approach, the failure-to-get-eye contact method, the I-must-answer-my-phone-beeper emergency, and the no-time-to-answer-letters-or-return-phone-calls gold standard. 'Consumer Resistant Disorder' was initially a cheeky but empowering way for us to understand this when directed at us[5]. But when we realised that staff also treated each other and inpatients in these ways of avoidance, we realised it was a more general phenomenon.
>
> *Regarding asking questions per se.* Staff seemed to be required to have answers rather than questions, to already know what was best for the patient and be required to operate from a general sense of certainty and control rather than there being space for uncertainty, new ideas and creativity or alternative ways of seeing things. Staff professional culture and scientific discourse appeared to hold in place norms of 'knowing what to do' (without reference to consumers' self-knowledge) and defined this as 'care'.
>
> *Regarding bad practice, poor quality care, and patient 'incidents'.* Staff seemed so pained by direct reference to these we learned generally to speak in euphemisms, approximations, and abstractions. At times the split between consumers' steady stream of stories of these, and staff's denial of these was unbearable.[6] Staff's medical discourse allowed for 'case management' according to prescribed, pre-established criteria for all situations and incidents.

The following is an exchange at a staff-consumer Collaborative Committee meeting of the U&I project which goes to the heart of some of the silences, repressed voice and euphemism:

---

[5] While offering a comment on how the DSM (Diagnostic & Statistical Manual of the American Psychiatric Association) was using objectifying terminology experienced by many consumers as insulting or hurtful.

[6] Even the writing of these U&I research monographs was itself a microcosm of the paradox. When Yoland Wadsworth went to the files of material she found numerous stories which had never been able to be told, examples, observations and discussions we'd never been able to raise or put in the bulletins, and consumers' anecdotes that seemed so often to be in the negative, with so few in the positive. It was an exhausting process trying to write up under these conditions - yet it supplied a further insight into the 'undiscussables', and the undiscussability of the undiscussables' (Argyris, ibid. p. 97).

'I think it's difficult for staff because they come to - you know, it's not working in a rose garden and they have to face a lot of things and follow a lot of procedures that perhaps naturally they wouldn't choose. And so they go home at the end of the day and are not happy with it but cope and then they come to a consumer meeting and realise the hopelessness of it.' (*First consumer*)
Yes, and hear more of how it's awful. (*Consumer research facilitator*)
Yes. (*First consumer*)
And also don't have a chance to talk about what they did and things that have worked or whatever. (*Consumer research facilitator*)
Well, but most - didn't take the chances that were there....' (*Community person*)
....'____ (*inpatient*) you said what goes on here is about lies and deceit. And that's then how people start to feel it. Yes, isn't it? Can you elaborate on that...? (*Staff*)
... yesterday I had a nurse... I got my medication from her and (another nurse) grabbed it from me. She says, "Patients aren't allowed." And I thought, what the heck - can't we pour our own medication? She said, "...When you get home, you can do it without us because we won't be there." (*First consumer*)
Now, say you tell that story here... (*Consumer research facilitator*)
Yes. (*First consumer*)
And other staff hear that. (*Consumer research facilitator*)
Yes, I know. They'd be upset. (*First consumer*)
...yes, but... how can we get conditions under which the staff can say, "Oh, goodness, that's awful _____. Now why do we do that? How can we think about why we do that? Now what would it need to not do that?" _____, what would you prefer to have heard? (*Consumer research facilitator*)
"You can look after your own medication. You're very good. We know you can do it. You've got..." - they build up your confidence. (*First consumer*)
And also the reason we [staff] can't say that is because if people get their own medication because of different states of mind, we can't keep a tab on everyone and people will OD. (*Second consumer*)
And we've got to have a procedure... (*Consumer research facilitator*)
And so controlled medication has happened in hospitals historically all along, and that kind of history's very hard to... (*Second consumer*)
There are ways around it. I mean, they could perhaps... have just poured it and just put it down and you still have taken it. You still have power. You picked it up... (*Third consumer*)
Now... staff want to say, "We don't have power either," but they feel they can't say it. How do we arrange a forum where consumers can say that [what you just said] and then staff feel they can say, "You know, we haven't got power either.... And then together you go, "Well, what would have to change? How could we do it differently?" (*Consumer research facilitator*)
Or give the itsy bit of power I do have which is handing you the medication and why I want [not to even give that] to you. (*Second consumer*)

## Reclaiming voice

From these areas of difficulty, the project concluded there was a need to 'build in' the ability for homogeneous groups to meet, away from the dialogue, in order to self-empower people to be able to speak and 'surface the undiscussables'. We had some considerable success in consumers feeling free to speak their minds, and we had some, but significantly less success in freeing staff. The following describes the results of one joint consumer-staff meeting where staff went a long way down the track to hearing - and affirming - consumers' realities, and unpacking the dominant discourse embedded in language. However at the point when consumers need staff to 'come back' to analyse how they, with consumers, might break through to take the next step beyond the following kinds of expressions, we experienced some staff feeling unable to speak of their discomfort. In the example following - the second of the three columns on page five was the result of consumers' interpretations of staff's intentions based on their observations. If staff then had feelings (of anguish, indignation, etc.) and could have found ways to express them, then consumers might have responded by correcting their own speaking to 'this is what it *looks* like to us to really mean to staff', and then staff might say 'well we are much more caring than that', to which consumers could say 'well could you use the alternative language that would express that to us', and staff could say 'well we don't like it either' or 'we did not realise how it made you feel' and then stop and reflect and ask 'well why *do* we use that language?' and then speculate, 'well perhaps we use that language because...', and then - with consumers waiting more or less expectantly - staff might say 'well we'll have to change that. What could we do. Why don't we...', and consumers could say whether whatever strategies proposed would be good, and so on until the changes are made to practice, and consumers felt more healed and staff achieved a sense of well-being. Instead, staff may not be able to go past feeling wrongfully attacked, and either complain or feel unable to complain, and then withdraw.

That is, each 'side' needed to hold its perspective in tension with the reaction of 'the other' to it in order to most clearly grasp the underlying factors that were operating.

| Word/term used re. consumers | What it really means to staff | What consumers would prefer |
|---|---|---|
| High Dependency (HD) | Boring/fearful/drag | Intensive Care Unit |
| Personality Disorder | Pull yourself together | Psyche Distress |
| Treatment Plan | We fix you up | Recovery Plan |
| Attention-seeking | You're still bothering me | Seeking attention or assistance |
| Case Manager | You're a case, and we'll manage you | (We are not cases, and don't want to be managed)<br>Manager of services to individual |
| A schizophrenic | That's all we see you as | A whole person who happens to be medically diagnosed as having schizophrenia |
| Disturbed | Disturbing me/us | Frustrated; signalling 'I need help' |
| Disruptive | Disrupting my group/ my ward/etc. | Seeking attention |
| Hostile/aggressive | Having a go at me | Angry/angry and asserting (whatever form of physical) strength in reaction to something that has happened |
| Absconded | Left against staff's wishes | Left with the continuing support of community-based staff |
| Treatment-resistant | The doctors don't know what to do/to do yet | (Same) |
| For no apparent reason | We couldn't work it out | (Ask us why) |
| Was observed to... | We thought he/she was.. | (Same) |
| Confidentiality | Secret from no-one but the consumer | Secret from all except at the discretion of the consumer |
| Compliant | Takes the drugs | Choosing, collaborating |
| Challenging behaviour | We haven't worked out what to do yet | They haven't yet understood us |
| Coping | Not a problem | Holding it together, often at a great cost |
| I'll talk to you later | I hope I might get time to talk to you later (or I hope you might not need to) | Let's talk now |
| Lacks insight | Does not yet see it our way | Our own hard-won insights |
| Argumentative | Does not agree with me/us | Has their own opinion which does not correspond to ours |
| Difficult | Asks too many questions | Answer our questions |
| Psychiatric art | Amazingly good or obvious further evidence of diagnosis/ disorder | Art |

| | | |
|---|---|---|
| Seclusion | Alone in a room, locked in by others | A safe personal space, able to be locked by self |
| Settled | Taking the tablets, the injection is taking effect | Many of us would like to feel naturally settled |
| Specialled | Keeping an eye on them, having to stay with them all the time | (Someone knitting or reading nearby) prefer:<br>Being treated as special; sympathetic company of staff |
| Unco-operative | Won't do as we say | Needs to be listened to more and responded to better |
| Ventilating | Harmless expression of minimised emotion | Expressing what we really feel and having it heard and acted on |
| You'll be fine | Keep taking the tablets | Ask us, What do you need to be OK? |
| Back into the community | Out of the hospital | We wish that there was a community |

To have supported staff staying with such an interchange we realised staff needed strengthening staff-only sites. Yet these did not form. While a successful Consumer Consultants' Group was catalysed, no success was had in developing staff-only groups. Not only was there no impetus from staff to form a group to deal with their 'end' of the process, the consumer project was reluctant to facilitate this for fear staff would resort to the same damaging discourse (even if unconscious 'othering') that consumers experienced even in mixed groups where consumers were present. Thus an unresolved issue was how to form symmetrical homogeneous mutual support groups (to assist the heterogenous dialogue group) without the 'problem of incommensurable discourses'. While there was a tradition and neophyte culture of consumer self-help groups, only a demoralised industrial union culture existed for staff (which, at the time, positioned consumers as a danger to occupational health and safety).

There were many other issues to consider about staff's culture in order to understand this, and we achieved only preliminary thinking about how to address this. Our preliminary thinking drew on the analogue of racism support groups and some of the thinking in the men's movement. For example, these latter had, by analogy, incorporated a consumer or two consumers acting as trusted witnesses/critical friends to staff-only groups, and vice versa for consumer-only groups; or by working with critical masses of staff or consumers whose personal values make this less or unlikely). That is, while we initially thought of homogeneous groups being both a prelude to heterogeneous groups and being superseded by the latter (a la Guba and Lincoln, 1989), we finally concluded it might be more useful to conceptualise permanently-operating homogenous and heterogeneous opportunities - but with each retaining somewhat self-consciously, elements of 'the other' within the homogeneous groups. Ironically in our project, staff and consumers had to first learn about and hold consciously their real differences before they could join to find the commonalities. Dissolving or denying these differences generally resulted in the predominance of the existing power relations (or disempowering relations).

## Going deeper

A senior nurse commented on how nurses who are compelled to nurse in poor quality ways may not want to hear ex-consumers tell their excruciating stories of how they felt. Another senior nurse responded:

*Second nurse:* 'They don't want to, ... they don't want to hear... I think that one of the sad things that we do as nurses, and I think from years of observing nurses they do it because they think that they're doing it in the patient's best interests...

*First nurse:* 'That's right. That's right.'

*Second nurse:* '... [we say] 'we're carers'. And they disempower people, they strip them of their responsibility and [say] "You will tow the line"... we beat people into submission basically: "You will do and say what we want, and it's the only way you'll get out"...

*Consumer:* 'That's right. And when you lock that door on them, then the fear and all the negative - and you can't...'

*Second nurse:* 'That's right.'

*Consumer:* 'You can't fight it...'

Here then is illumination of the sometimes more and sometimes less gap between consumers' ways of seeing and staff's ways of seeing. Language here is forming the discourse of power relations. Thus what may have been experienced by some consumers as 'abuse, humiliation or neglect, emotional blackmail and atrocity' may instead for some staff have been 'limit-setting, standard treatment, individual service-planning and an incident'. What might be for some staff 'safe seclusion, necessary medication, a successful treatment option in x% of cases, unavoidable duty of care and behavioural modification' can be for some consumers 'being locked up, forcibly injected, electrically shocked till you lost your memory, being assaulted and treated like an animal'. What can be for some consumers 'frightening powerlessness and terror', can be for some staff 'therapeutic restraint and temporary ideation'.

From 18 months' reflection on this matter of paradox, silence and difficulty, and on the basis of some illuminating exchanges between a small number of staff and consumers who worked on 'cracking' this deeper puzzle, plus a unit manager and a consumer research facilitator gaining access to a small literature on systems' dynamics and change,[7] we developed a theory which tries to take into account the paradoxical, even contradictory tendencies of the system that we were observing.

We came to see the basic operating dynamic as being one which builds a services system both reactively and proactively in relation to two sets of human responses and desires - *responses of fear and desires to ensure control*, and at the same time, *responses of concern and desires to ensure healing and recovery*. The latter tendency is a more or less 'admissible' one, while the former one is the area in which there is more systems' silence (compelling consumers repeatedly to try to raise it to attention).

We have concluded that, while understandable, the system's tendency to 'fear and control' must be 'surfaced' as a regular act of self-awareness if it is to strengthen its desired tendency towards being for health, healing and recovery. Alternatively, if fear and dislike is routinely responded to with control, a system can come into being which routinely will carry out goal-displacing routines, and systemic resort to over-control and coercion. Everything we saw around us - from the neo-rationalist funding cutbacks to mental health services and their effects on depleted service access, the reliance on 'scientific' diagnostic distinctions, the use of the medical/health metaphor, the resort to police, special powers to override civil rights under mental health legislation, the locating of services in 'the community', through to the burgeoning involvement of the pharmaceuticals industry, could be read as manifestations of one or other element of these dual system's tendencies.

## Surfacing 'the undiscussables'

In moving to dialogue, two responses of the past appeared to us to need to be left behind. One was to not understand - and blame. And the other was to understand - and excuse. The future seemed to lie with understanding - and neither blaming nor excusing - but instead staff and consumers setting to work to surface and address the fears, seek to apply the least possible control and under conditions only where fear and loathing are absent, and strengthen with renewed vigor the positive practices of health, healing and recovery. Our 'model' for getting consumer feedback and engaging in communication and dialogue about it - including the employment of consumers as consultants on acute wards, and reflective practice dialogue groups, etc. - was our contribution to this.

Risking 'surfacing of the undiscussables' therefore, we concluded, precedes doing something about ensuring that fear-and-control responses are contained and do not get out of hand, that they get wound down to a minimum, and their effects are healed properly. In the first place this requires courage, confidence and pride. But a system which continuously ensures attention to its own fears and the level and kind of control exerted as a result - rather than denying them or projecting them, is more likely to be a safe system for consumers and staff. If it carefully organises the resources it needs to enable it to recover from its own anxieties and impetus to control, and to nurture its own levels of warm 'fellow-feeling', it will also be in a better position to provide

---

[7] Notably Isabel Menzies' 1970 classic which one of us went to Tavistock in London to obtain, while the other of us found an abridged version at Swinburne University and had it waiting on the desk of the London traveller, for her return!

a therapeutic and healing experience. Deep dialogue forums were one critical element in such a range of resources to address the silences and stand-offs between consumers and staff, and contribute to de-fusing fear and control reactions. As one of the consumer research team put it, after having worked in a number of different hospital areas as a consultant, 'Deep dialogue forums effectively break these standoffs when staff and consumers realise that when we talk, we are all winners, and a non-decision making forum is a non-threatening one, thus encouraging dialogue.'

Some guidelines we drew out for iterative dialogue that might journey through the barriers to voice were:

> Listen intently to each other, with respect, even with reverence.
> Hear the person out, even when you want to jump on something they said.
> Sit with it a while. When there is disagreement, take off the pressure to decide. Go away, and come back later. Let there be more talk away, where people feel more safe. We had a 'Permanent draft' idea - things were always provisional and open to change.
> Listen carefully - especially to silences. Ask why people can't speak rather than force too-painful speaking about the 'undiscussables'.
> Come into them sideways. Repetition is not bad - it's a sign something is not yet properly resolved. People can come back to an issue later in the conversation. This is not only tolerated but encouraged. We don't say 'we've already discussed that'. Agreements will only stick in practice if real.
> People agree to keep going - until glass walls of undiscussables are cracked and broken through. Keep remembering why we like and respect each other - and verbalising it.
> Sit with silences. When all is black and there is no light apparent from the bottom of the deep hole - sit and let your eyes acclimatise to the new reality. Suddenly someone sees a rope ladder in the gloom. Ask questions. What are our worst fears? How else can we see this? Why do we think like this? How else could we think? What else could we do? Who else could we ask?

If the Tavistock tradition was to see the organisation or society as sick and needing diagnosis and treatment, the new metaphor may be to see the organisation or society - and all who make it up - as losing the 'good story' and needing to be able to speak and to hear until together people find the new preferred story. As a survivor said recently, 'There will be no healing until all the stories are told'.

## The voice of the researcher(s)/facilitator(s)

Traditionally - and even in much new paradigm research - the voice of the researcher has not been heard or has been suppressed: sent underground by beliefs about bias, contamination and objectivity. Yet if groups of people are co-constructing realities, the researcher or facilitator cannot be 'outside' this joint discourse (or indeed the separate ones which are 'coming to the table'). Indeed, in order to understand, the researcher or facilitator enters each of the differing discourses to grasp their structure, content and consequences. Even a 'going back and forth' between them may more be a witnessing of and engagement in a speaking back and forth from them - or an enabling of the 'native language speakers' to speak directly to one another. Yet in doing this, any facilitator will need to occupy (and be trusted to enter) the world of either or both consumers or staff. Thus the facilitator (and depending on their own prior positioning) encounters exactly the same processes of dialogue as are being proposed between the groups. At the moment of occupying (or entering) the domain of the 'other' group, they will (and will be observed by the first group) to have left the first group's world (and become both knowledgeable and possibly seen as untrustworthy to the exact extent as exists for the broader conditions of dialogue).

The search for the unitary 'neutral' facilitator may be fruitless. It may be more useful to see the 'facilitator role' as one occupied more or less by a number of people, with each different person moving to close gaps and construct overlaps of understanding between those operating within the relevant discourses.

As well as pointing up the inappropriateness of the concept of 'neutral' facilitation, this may also implicate a far more active role - entering one or the other, holding up questioning mirrors between the two, assisting dialogue that illuminates the different forms of speaking, and being comfortable with sitting with silences that may be the moments of deeper communication and achievement of the 'aha' insights. Indeed the 'neutral' facilitator may fail to enter and grasp any of the relevant discourses, and instead be only mildly trusted or mildly mistrusted from all sides. The researcher(s)/facilitator(s) may actually not be able to make use of the driving discourse at all - in this case that orienting to consumers' ways of seeing - and staff's in relation to these.

This paper ends at the point of our beginning a new inquiry into the ways that researcher/facilitators need to work in order for one group to be able to contemplate the others' ways of seeing and to inquire into their own ways of seeing and the grounds for these when the two (or more) parties are neither equal in status or power. In human services, if an effort is directed towards enhancing user-responsiveness, then the 'direction of the gaze' of the inquiry group is towards narrowing the gap between the two ways of seeing in the direction of strengthening the impact on staff practice of consumers' perceptions and experiences. This implies a new kind of symmetry if the concept of collaborative inquiry is to remain meaningful - a symmetry which may fundamentally call into question the exact 'othering' on which the current situation rests.

## REFERENCES

ARGYRIS, C. (1993), *Knowledge for Action - A Guide to Overcoming Barriers to Organisational Change*, Jossey-Bass, San Francisco

BOHM, D., FACTOR, D., & GARRETT, P. (1991), 'Dialogue: A Proposal', Hawthorn Cottage, Broad Marston Lane, Mickelton, Glos., England

EPSTEIN, M. & WADSWORTH, Y. (1994), *'Understanding and Involvement (U&I) Volume 1 - A Project's Beginnings...'*, VMIAC, Melbourne

GARRETT, P. & PARSONS, D. (1994), 'Group Dialogue in Prisons', *Paper* to Fourth European Groupwork Symposium, Leicester, UK: July

GUBA, E. & LINCOLN, Y. (1989), *Fourth Generation Evaluation*, Sage, Newbury Park, California

MCGUINESS, M. & WADSWORTH, Y. (1991), *'Understanding, Anytime'*, VMIAC, Melbourne

PEAVEY, F. (1994), 'Strategic Questioning' in *By Life's Grace*, New Society Publishers, Philadelphia, pp. 86-111

SENGE, P. (1990), *The Fifth Discipline - the Art and Practice of the Learning Organisation*, Doubleday-Currency, New York

WADSWORTH, Y. & EPSTEIN, M. (1996a), *'Understanding and Involvement (U&I) Volume 2 - ...A Project Unfolds...'*, VMIAC, Melbourne

WADSWORTH, Y. & EPSTEIN, M. (1996b), *'Understanding and Involvement (U&I) Volume 3 - ...A Project Concludes'*, VMIAC, Melbourne

WADSWORTH, Y. & EPSTEIN, M. (1996c), *'Orientation and Job Manual for Staff-Consumer Consultants in Mental Health Services'*, VMIAC, Melbourne