Section 1

Background and Stance on the Problem of Knowledge in the Field





Chapter 1

Introduction

Stephen Tilley and Desmond Ryan

This book is a study in (and of) the field of knowledge of psychiatric and mental health nursing (PMHNing)[1]. It documents, and is a document of, a collaborative inquiry into the institutionalisation of knowledge in the field, with particular reference to UK higher education. In this Introduction we have three aims: to set out the purpose, topic and focus of the book; to explain what the authors were invited to do, and how they responded to that invitation; and to describe the sociology of knowledge model which informed Ryan's development of a framework for later analysis. The key to understanding the interconnection of these aims is to see them all as making clear how the book was originally conceived and theorised.

The idea for a book on the field of knowledge developed from work on *The Mental Health Nurse: Views of Practice and Education* (Tilley 1997). There, Tilley asked various contributors to convey their views of PMHNing practice and education. The paradigm in the earlier book was knowledge as plurivocal conversation, situated metaphorically in the contemporary agora; in short, as rhetorical, with each contributor seeking to persuade the audience to see the good of (and perhaps follow) his or her practice. While some of the contributors set their versions of practice and knowledge in an institutional context, e.g. admission ward or therapeutic community, there was no remit for self-conscious reference to the institution and institutionalisation of knowledge. By contrast, contributors to the present volume were asked to exercise precisely such institutional reflexivity. Why? We will outline three reasons.

First, by the mid/late 1990s the image of the field had shifted from site of conversation to contested territory. The field had become a site of challenge and counter-challenge over knowledge claims. As the politics of knowledge became

[1] 'Psychiatric and mental health nursing' is the term encompassing what are sometimes distinct identities, that of the mental health nurse and the psychiatric nurse (the latter formerly known as 'mental nurse'). See Altschul (1997) on use of these terms. I did not prescribe to authors which term to use, and authors have used whichever term(s) they saw fit. In various places authors remark on the significance of the term they or others have used. In this text PMHN is used as an abbreviation for psychiatric and mental health nurse. In places PMHNing is used as an abbreviation for psychiatric and mental health nursing.

more explicit, the institutional positions from which those writing about the field spoke became more important. This was set in the context of changing institutionalisation of nursing knowledge following the wholesale move of British nursing into higher education in 1992[2]. With this mass move into the academy, issues of knowledge production and dissemination became more important, and individuals' career prospects more closely tied to those of their academic departments and universities (and the Research Assessment Exercise, see below).

Second, along with the new audiences of academic teachers and researchers, and undergraduate and postgraduate PMHNing students, new journals appeared. In particular, the *Journal of Psychiatric and Mental Health Nursing* provided a forum for 'hot' debate on questions such as: Is PMHNing fundamentally concerned with care, with control, or with the tension between these? Is care to be construed as science-based? According to what knowledge paradigm – nomothetic or idiographic, quantitative or qualitative, RCT gold standard or narrative? Is there something unique about knowledge and practice of care in PMHNing? So hot were the debates about knowledge, so polarised and polarising the positions adopted, that Tilley characterised them as 'care wars' (Tilley 1997). The potential for dialogic or plurivocal knowledge development was clear but (Tilley thought) not fully realised.

A notable aspect of both potential and limitation was the personalisation of the debates and arguments. In particular, two figures were seen as articulating contrasting and (apparently) conflicting versions of PMHNing: Kevin Gournay (Section of Psychiatric Nursing, Institute of Psychiatry) and Phil Barker (University of Newcastle-upon-Tyne). These men appeared as 'champions' locked in battle, their moves in argument watched, cheered or challenged by respective 'camps' of supporting academics and practitioners. We will not try to characterise their arguments – some of the texts in this book give a sense of that – but instead note that in the field at that time arguments were addressed and heard as disputes between persons in institutional contexts. Institutional contexts were made relevant, by those in both 'camps', in making and in challenging claims (Gournay 1995, 1997; Barker & Reynolds 1996; Rolfe 1996; Lego 1997; Parsons 1997; Rolfe 1997).

The third aspect relevant to institutional reflexivity is the appeals made, in the course of arguments, to benefit (or cost) to service users: Gournay asserting that users want the most effective interventions appropriately delivered; Barker that the professional has to 'get personal' (Barker 1991) in working with users. These (textually-constructed) positions should be seen in the context of three policy imperatives of that period, all central to the 'modernisation' of the National Health Service. The first was the drive towards evidence-based health care (and

[2] Until then, most nurses were trained in 'Colleges of Nursing' linked to hospitals. They followed courses of study interspersed with periods of rostered, paid service, leading to registration. With 'Project 2000', nurse teachers and their students were brought into higher education institutions, the students mostly pursuing pre-graduate diploma courses in nursing with linked registration. Since the 1960s a minority of students have taken undergraduate degree courses in universities, with linked registration. The number of degree courses leading to registration is increasing.

evidence-based practice, services, education . . .); the second was the drive to make the patient the central focus of health service planning and delivery. Both were relevant to debates about the requisite knowledge base for practice, e.g. about whether that knowledge base was uni-disciplinary or multi-disciplinary, and the value and place of professional and patient (user, consumer) knowledges.[3]

These three aspects were closely interrelated, as two examples indicate. Consider first the attention given to the 'Thorn Initiative' programme of courses (initially at the Institute of Psychiatry and at the University of Manchester) providing multi-disciplinary training in psychosocial interventions (PSI). These university-based courses were promoted on the basis of appeals to the evidence base for the effectiveness both of PSIs and of the training itself. These claims for legitimation were articulated in the context of challenges and counter-challenges about their appropriate place in PMHNing practice and education (Gournay 1997; Rolfe 1997). These were, in effect, challenges about the institutionalisation of knowledge. They were critiqued, by Thorn Project proponents, of nurse educational courses purportedly endorsing 'nursing theories' lacking empirical validation.

The challenge was fundamentally about what is to 'count as knowledge' (Berger & Luckmann 1971; Doyle McCarthy 1996). This challenge was even clearer in a second example: the Research Assessment Exercise (RAE) of 2001.[4] Questions of whether and how mental health nursing research would be considered, who would 'count' the knowledge and what would 'count' as knowledge were more vigorously debated as the Exercise approached (Gournay & Ritter 1998; Rolfe 1998; Collectively 2001). Given the role of the RAE in determining a significant element of funding to institutions, for future knowledge production, linkages among the three issues noted above were more evident and more evidently significant. What persons, from which higher education institutions, would evaluate knowledge claims, and on what basis; the power of peer-reviewed journals in mediating research output; and the role of service users in different paradigms of knowledge production: these were all key themes in the politics of knowledge from 1996–2001.

Thus, drawing again on the metaphor of nurse-writers as rhetoricians, we can contrast their position from the mid/late 1990s with that before. They were speaking and writing in a new 'agora'. We can see the traditional elements of the rhetorician's art – *ethos* (the speaker/writer's character), *pathos* (relationship to the audience) and *logos* (the form and content of arguments) (Weaver, cited in Szasz 1979; Tilley 1997) – all changed, in ways difficult to read, in the changing field/'agora'. Essaying a view of this changed context required a different methodology from that in *The Mental Health Nurse*; collective/collaborative argument

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[3] All these imperatives are expressed in the key document *The New NHS* (Department of Health 1997).

[4] The Research Assessment Exercise is a UK-wide occasional (originally quadrennial) peer-review exercise intended to assess the quality of research done in higher education institutions. Institutions submit research to peer panels based on disciplines or subjects. Nursing research has been submitted mainly to nursing panels but has sometimes been submitted as part of multi-disciplinary entries (see Chapter 2). This is a key issue in the construction of knowledge in the field.

about the field of knowledge of PMHNing, conducted through an appropriately designed text. We turn now to discuss the methodology.

Methodology of the book – architecture of the text

The premiss of this book is that the field in which psychiatric/mental health nurses work lies at the intersection of a set of institutional forces which are as powerful as they are opaque. These forces shape what PMHNs do, write, read, learn, think, perceive, value. Tilley aimed to organise an account of the field that would reveal how it is situated in its academic and professional contexts, and how these contexts condition mental health nursing work. The book would show how those within the field, including users, professionals and policy makers, constitute interest groups, each of which tries to shape the field to its own advantage and contests with others in trying to direct work, education and policy.

The metaphors that informed planning and development of the book (and provided a reference point to which Tilley returns in drawing conclusions) are devices for imagining and writing towards something not clearly known or formulated, 'think withs', to borrow Hodgkin's (1997) phrase. The duo-metaphor guiding development of the book is that of UK psychiatric and mental health nursing as a *field* in which various figures, each in a *tower*, survey the field about them and each other in the field. The towers are the institutions in which these scholars work, in which they represent, in their teaching and their research, the knowledge needed for practice as PMHNs. Each appears as one working to create and sustain his or her variety of knowledge, each variety as distinctive as a medieval ducal crest or flag. While the features of some 'flags' are well known, others are not.

The UK authors of Chapters 2–8 were seen as working in towers, from which they could survey the field. They were asked to write from within their institutions, about how knowledge was institutionalised therein: to turn their gaze inwards in order to see and then convey the field of mental health nursing as that was the subject of knowledge production and communication in their particular institutional contexts. *How* they were to do that Tilley did not specify closely, wanting each to find the form as well as content best suited to that task – as they saw it. (Tilley will return in the Conclusion to consider whether this approach was the best to have taken.)

The use of these metaphors, and the relatively free rein regarding form and content, shaped the process of this collaborative inquiry into British psychiatric/mental health nursing, informed by a sociology of knowledge perspective. The collaborative inquiry proceeded in three 'rounds', of concentrically expanding reflexivity.

Chapters 2–8 (Section 2) constitute the '*first round*'. Each of Chapters 2–8 should be read as addressed in the first instance to the writers of other chapters in that section and then to a set of international commentators. This is because the writers knew that in the 'second round', when Chapters 2–8 were finished, they

would read the chapters written by other authors in that section, and comment on the field as they now saw it, in the light of others' views. For this reason, Chapters 2–8 can be read both as stand-alone views of the field as a bit of social reality 'produced and communicated' in and by the authors and colleagues in their settings, and as first moves in further communication about the field.

The remit given to the authors of those chapters was to give reflexive accounts of their own institutions (as teachers, scholars, researchers, or user variant of these). Five of the chapters were written on the basis of the authors' work in various academic institutions: some 'older' (pre-1992) and some newer (post-1992) universities; some in universities that had offered courses and research degrees for 40 years, others in former (training) Schools of Nursing now incorporated into universities; some with international reputations, others less well known. The authors of Chapters 2–6 thus were asked to consider how PMHNing knowledge was institutionalised in their academic settings, to indicate distinguishing aspects of knowledge of PMHNing in their settings, and the role they saw their institution playing in the field of knowledge. They were also asked to consider themselves in relation to their own institution – how they as knowledge producers were situated. Chapter 2 by Prof Kevin Gournay gives a clear picture of the Section of Psychiatric Nursing's contribution to multi-disciplinary research in the Institute of Psychiatry. The Institute is one of the main UK centres of postgraduate education and research for various disciplines involved in mental health work. Chapter 3, by Tilley, provides an account of what he calls the 'fragile' tradition of psychiatric and mental health nursing research and education at the University of Edinburgh, which pioneered development of academic nursing in the UK. In Chapter 4, Peter Griffiths and Vicky Franks convey in rich detail the practice-base and knowledge-base of psychodynamic and systemic psychotherapies at the Cassel Hospital and the Tavistock Institute in London, and nurses' roles in bridging those institutions and the Middlesex University. In Chapter 5, Alex Carson, a general nurse academic at the North East Wales Institute (part of the University of Wales), uses the method of self-reflection to consider critically the principled basis of the curriculum devised and taught by his mental health colleagues. In Chapter 6, Susanne Forrest and Hugh Masters, of Napier University, Edinburgh, describe their research on what users and carers valued in mental health nurses, and the process by which the authors then involved users in teaching and evaluation of students. The co-authors of Chapter 7 (Mary Chambers, David Glenister, Carol Kelly and Tessa Parkes) constructed their account on the basis of their experience of the boundaries of experiential knowledge of mental illness and formal knowledge in academic institutions. Ian Norman, the author of Chapter 8, was asked to contribute reflections on a study funded by the English National Board of Nursing, Midwifery and Health Visiting, in which he and co-researchers developed 'models' of mental health nursing, 'ideal types' of working knowledges in the field.

Emerson's maxim (Emerson 1841) that 'the field cannot well be seen from within the field' informed the 'second round' of the book's construction. The field as a social field could better be seen or imagined if all saw the field from

each other's perspective. Chapter 9 contains the products of the second 'round'. Here, the authors of Chapters 2–8 were asked to read all the other chapters from that set, and write reflective commentaries conveying their perceptions of the field in the light of that reading. This chapter is doubly reflexive: each sees the field from within the field in the light of the others' views; each is asked to see perspectively.

Chapter 10 comprises the third 'round', providing international perspectives on the state of knowledge of PMHNing in Britain. Here, scholars from a range of countries, knowledgeable about the field of PMHNing, comment on Chapters 2–9, reflexively constructing their responses by reference to the knowledge and practice base in their own national, cultural and institutional contexts. They are Ruth Gallop (University of Toronto), Mike Hazelton (University of Newcastle and Hunter Mental Health, Australia), Anthony O'Brien and Madeleine Heron (University of Auckland), Susanne Schoppmann (University of Witten-Herdige) and Shirley Smoyak (Rutgers University). Kathryn Church (Ryerson University, Toronto), a sociologist, contributed on the basis of her experience of work at the boundaries of academic and service users/survivors' knowledge, as a community researcher ally of the Toronto's psychiatric survivors community.

Desmond Ryan, a sociologist familiar with UK mental health nursing literature, conveys in Chapter 11 his view of the field based on reading Chapters 2–10. Chapter 12, the Conclusion, returns to the metaphors that guided construction of the book, and to the sociology of knowledge matrix.

The whole field, and nothing but the field?

Tilley's intentions in designing the book in this way were two-fold. On the one hand, writers were conceived of as people committed to versions of psychiatric and mental health nursing, looking over the ramparts of their institutions at the other figures and institutions in the field. The book was intended to give them scope to convey their views in forms and tones that would allow the battle for the soul of the profession to come alive. On the other hand, the book was intended to provide a space for a more distanced, less over-committed view of the field, by the above figures, by scholars from other countries and cultures and by more sociologically-situated perceivers.

Those involved in building professional identities are personally and professionally involved in their work, and bring these commitments into their academic work. The book was intended to provide a lesson in how the professional field conducts its business in academic terms, reflecting major tensions and commitments in the field as construed by participants, and constituting a vehicle for development and expression, through the text as a *whole*, of the academic virtues of reflective, principled argument.

The aim is clearly to give *a* picture of the field, not *the* picture of the field. In different chapters the reader will find some authors questioning the adequacy of the book's scope, and even whether a field is clearly identified. Even granting

that the focus is on academic institutions, one can ask why the particular institutions and authors were chosen for inclusion. The selection was based on Tilley's perception that the authors chosen were well placed and able to articulate a view from their respective institutions, and that the institutions were sufficiently varied in size, history and profile to reflect at least in part the variety of the field.

It is appropriate to note those who were asked to contribute but did not. Phil Barker, then Professor of Psychiatric Nursing Practice at the University of Newcastle-upon-Tyne, considered doing a chapter but declined as he thought this might perpetuate the personalised debate which had gone on too long, and as he and colleagues were prioritising work for the Research Assessment Exercise. Len Bowers, then Reader, now Professor of Mental Health Nursing at City University, was asked to contribute, partly in light of his role in setting up and moderating the internet-based Psychiatric Nursing List, an important site of debate at that time; but also declined due to pressure of other work. I asked Professor Charles Brooker, then at the University of Manchester, to do a chapter with colleagues as that institution was a prominent centre of research and training, but he declined when he moved to another institution.

The sociology of knowledge model adopted in this book

'The field of knowledge' might suggest a two- or three-dimensional, static construct. The guiding metaphor, described above, should highlight to the reader that this is not the case here. The field of PMHNing is better understood diachronically, as changing and developing over time.

Ryan devised a framework which we thought might be helpful to the contributors in writing their chapters, and to ourselves in interpreting the various authors' contributions. Let there be[5] two dimensions (see Fig. 1.1). Crossing them produces a four-cell table, with the following as occupant of each cell (see Fig. 1.2): institution, discipline, school/tradition, influence. The competitive dynamic of professional knowledge in the liberal democracies is to move round the circle from bottom left to bottom right. The ambitious holder of powerful

Personal ——————————— Political

and

Theoretical ——————————— Practical

Fig. 1.1 The dimensions of academic-professional knowledge.

[5] 'Let there be' is a version of what Burke calls 'entitlement' – bestowing a name and, in doing so, bringing something into being. Any term thus brought into being directs attention to one thing rather than another, and generates a 'terministic screen' (Blankenship 1989).

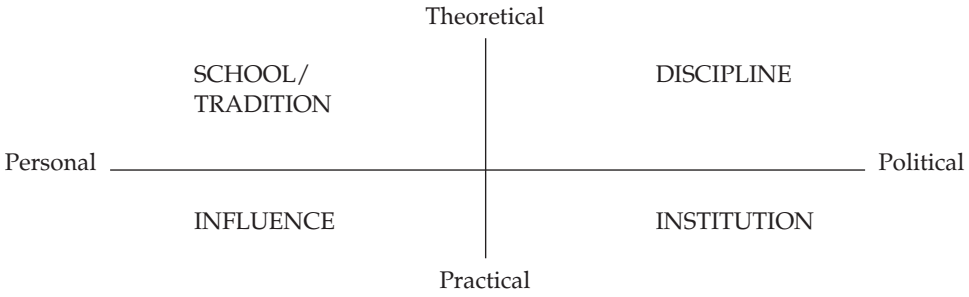

Fig. 1.2 Academic-professional knowledge as a process of power.

knowledge (knowledge that has social consequences) is a powerful knower in each cell, but the form taken by that powerful knowledge is different.

The circle is a series of transitions: on impersonality, on scale and on power. At each transition the personal influence of an individual gets harder to discern, although those centrally involved in the process of the field's knowledge-system are able to map it in detail. Outsiders and low-level insiders may see the workings of *institutions* as impersonal and ideal; insiders and participants experience them as personalised and politicised (Burns 1969). They also appreciate that they are the topmost level of an articulated system of knowledge which stretches from the individual scholar in his/her garret to policies that determine mental health outcomes for thousands.

What were our working definitions of institution, discipline, tradition, and influence?

Institution

Institutions are politico-economic structures which publicly hold knowledge which is interest-bearing, consensually validated, usable. This knowledge is taken from disciplines and traditions, though filtered through a mesh of political judgements as to practicability, congruence with political interests, etc. Modal institutions of this knowledge-bearing kind are:

- The 'professional body'
- The national standards agency
- Departments/courses in higher education
- The clinical system of the healthcare delivery service/agencies.

As political-practical, the institutions control practice, allocate resources (including non-material, e.g. recognition), seal legitimacy, promote leaders, reward teams and launch agendas for change. All of these aspects variably impact on/derive from the discipline sector. When the political system changes, knowledge in institutions becomes an open frontier, an openness that can also affect the disciplinary field.

The history of knowledge in institutions is a succession of authoritative holdings of knowledge-for-use (syllabuses, Schemes of Training, research paradigms and paradigmatic texts, letters of guidance).

Discipline

A discipline is a virtual structure of knowledge in public and competitive (through criticism, whether public or hidden, e.g. 'peer review') process. A discipline is visible in:

- books, journals and professional magazines
- research in progress
- conferences and meetings
- teaching and supervision.

All disciplines are subject to the ideological and values authority of the ideal-typical university, which has overall power to shape what is accepted as disciplinary knowledge.

Disciplinary knowledge is:

- universal
- public (i.e. published)
- textual
- conventional
- open to critique.

The history of a discipline is the history of claims for findings and critiques of claims, of knowledge in good or less good standing with disciplinary members, of guiding questions and controlling paradigms, of the moving frontier of interest and discovery, of argument and debate.

Tradition

A professional tradition is people-knowing-together, in real or virtual personal relationship, synchronically or historically. Knowledge in a tradition or school (a school is a tradition without an ancestor generation) is handled with explicit reference to its provenance from respected individuals with whom the handlers seek to identify. Traditions can evolve in a historical way or be constructed with a degree of artificiality (e.g. 'new' nursing cultures tracing their links to Florence Nightingale).

Unlike the universal, textual and criticisable knowledge of the discipline, the knowledge of the tradition is often esoteric, narrational and related to membership of values-based social groups. Traditions may well handle disciplinary knowledge in the appropriate way, while giving it a values spin or emphasising an

aspect of concern to the group. A tradition may be strongly positioned within the discipline by the practice orientation or research findings of the founding generation of leaders. Being values-based and genealogical, traditions can endure over many generations: this endurance often is expressed in political action in pursuit of values shared by the members.

A tradition is visible in:

- a boundedness of the group
- shared values, vocabulary, orientations to practice, research and teaching
- an explicit genealogy of personalised knowledge (teacher/student histories, collegial working, textual citation and oral references, research paradigms)
- honorific occasions, publications, ancestor-worship, folklore.

Influence

This seemed fairly obvious when we set out. We will, however, reflect further on 'influence' in Chapter 11 and in the Conclusion. According to this interpretative framework for *The Field of Knowledge*, we anticipated the field as a competitive influence field (like Darwin's Galapagos Islands, where different forms of life compete and some survive).

The influence–school/tradition–discipline–institution matrix is not a grid but a spiral, widening as it rises from influence → institution. Thus the higher up the spiral, the more control one has over bringing one's own professional knowledge into the field (though the more impersonal that knowledge has to be). The theoretical–practical/personal–political matrix provides the framework within which the dynamics of knowledge are made visible. What has to be thought of in relation to all these is knowledge.

With regard to influence, the mode of knowledge/form of influence is conversation/al, rhetoric (as the intellectual tool and form). It is like a Jackson Pollock painting: lots of little splashes of individuals influencing others, whether patients or other nurses. There is mutuality: at this level everybody can bid to make his/her knowledge accepted. Here nurses are continually interacting with non-discipline-specific knowledge (of patients, of common sense). The mode is persuasion, personal persuasion.

The membrane between influence and school/tradition is semi-permeable. Here one finds models, and the influence of some individuals becomes more discernable. Knowledge is communicated by, e.g. the public lecture. However, it is not just a question of communicating knowledge when you are building a school, but also of sharing values, celebrating the group, being publicly thankful for leadership and acknowledging intellectual and professional indebtedness, confirming that some are in and some are definitely out. To the cognitive is added the affective, but it is all more public than the process at the influence level. It is an exercise in building critical mass, giving people something to join. In Mary Douglas's terms (Douglas 1973: 77–92), it is group rather than grid (which is

much more the habitat of the discipline). Still, rhetoric and persuasion are modes of knowledge transmission/forms of influence.

Regarding discipline, the communication is by books, texts. The mode/form of influence (perhaps, rather, the sign of disciplinary success from a sociology of knowledge point of view) is the paradigm. The paradigm is built by competition, and in principle there should be only one dominant paradigm in each area of knowledge. This can also include, e.g., the one-to-one relationship (as in Peplau's widely seen and influential film *Nurse–Patient Relationship*) or the group meeting – both forms of practice-embedded knowledge. This is also the point where the knowledge of users and 'sad people' comes in from outside the field – tubes, as it were, run from the field to outside it and vice versa.

Regarding institution, the mode is laws, codes, protocols, objectivity, truth, incontestable knowledge, the canon. The institution may be seen as seeking to impose a practice – based on 'science' – which competes with practice knowledge which is more *ad hoc*, occasioned, circumstantial, 'art'. The influence of institutions over individuals is complex, as it is more than knowledge that mediates this dominance: it is also legal orders, social control systems, custodial technology.

Tilley circulated this framework to the UK authors, saying that they could use it in considering how to write their chapters, but that they need not do so, and were free to write in the form they thought appropriate. In the Conclusion Tilley will consider both the extent to which we used it in our own contributions to the book, and also how other authors did or did not use it.

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