What counts, who counts? Standardization and emotional labour in psychiatric care.

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WORK IN PROGRESS – DO NOT CITE

Introduction

Work in the public health sector in Denmark (as well as in other European countries) has in the last 15-20 years been undergoing great changes due to on-going rationalization under headings such as New Public Management, LEAN and Evidence Based Medicine. In this paper we focus on standardization as the heart of this process, and we scrutinize the complex ways that different forms of standardization affect work in a specific field, psychiatry, asking questions such as: What counts as work? How do social relations and hierarchies change? What are the implications for emotional work?

Psychiatric services comprise a special context for standardization. Psychiatry has a long history as a kind of stepchild of medicine, one of the reasons being the insistence on maintaining a humanistic focus, perceiving human beings as unique, and not whole-heartedly embracing the rational medical approach that categorize humans based on diagnoses. Subsequently, work in psychiatric care in Denmark is often organised in interdisciplinary teams comprising social workers, care workers, nurses, psychologists and psychiatrists, all involved in work concerning diagnostics and treatment. Emotional labour is an on-going part of the working process which takes place in interaction with the patients and their network. We perceive emotional labour as a highly skilled activity, which may both be rewarding and stress-full, and which comprises many different types of activity. It may for example be the very core of work, or it may be involved ‘in getting the job done’.

This paper explores how work in psychiatry is transformed through standardization. It is based on a case study of an ambulant unit within child psychiatry ‘producing’ diagnoses and treatment/education of children (and their families), using ethnographic field studies and semi-structured individual and group-based interviews. The paper illustrates how the social relations in the interdisciplinary team are strained, how the conception of work is subject to negotiation and struggle, and how emotional work is affected.

The paper first introduces the specific context – psychiatry- and the perceptions of psychiatric work developed by professional institutions that forms the background for the current organization of work. Next, the NPM inspired reforms are presented and we develop different ideas of how they may affect work. These ideas are further developed in the theoretical section. Here we situate ourselves and the study within the current theoretical discussions on standardization, professional identity and emotional work. Moreover we present our qualitative methodology. The analysis is presented in three headings: illustrating
the professionals’ perception of emotional work, the straining social relations, and the ambiguities of managing emotions in relation with clients. The paper ends up in a concluding discussion. This section is still very sketchy.

Psychiatric – historical development of the sector

Modernizing psychiatry

The present day psychiatric system, and psychiatric work has roots in the 1960ies where a new scientific psychiatric medicine, as well as a new institutional criticism was born. The development of medicine was a result of societal demands for new technologies to avoid force and violation of patients, expensive life-long “confinement”, as well as degrading working conditions of professionals, who were exceedingly unwilling to work in psychiatry, when the labour markets opened up for many other forms of public jobs.

Psychiatry changed from a treatment-centred institutionalized system with hospitalized patients, to a system which valued many different types of interventions with the patients based in homes or home-like settings. This was the start of a social psychiatry that acknowledged the defeat of hospital-institutionalization as cure or recovery, when patients most often remained ill all their life. Psychiatric work became organized in districts, much more local and in small scale institutions, on an outpatient basis with out-reach interventions, where professionals had to focus more on the everyday lives and life skills of patients than on treating patients (Høgsbro 2004). Work became less predictable, more ambulant and more personalized, as citizens gained more initiative and influence on services, and the meetings between citizens and professionals in the surroundings of the citizen were at the core of this psychiatry.

Professional groups had to experiment and patch-work and a new openness between professional groups, also across hierarchies, overtook former rigid boundaries between doctors and nurses. In the 1970’ies and 80’ies inter-professionalism was developed bottom-up through the efforts to deinstitutionalize the psychiatric system, and to break medical monopolies of knowledge and professionalism. New forms of legitimate professionals and knowledge arose, such as caring-, pedagogical-, psychological- , and social workers with other and more humanistic and social knowledge bases. This new interprofessionalism focused more on approaches and theoretical ontological presumptions about human beings in relation to the social world, than on specific disciplinary tools and regimes, that had reigned the hospitals. Psychiatric patients had their temperature taken by nurses, were diagnosed by doctors and kept active in the gardens and paint studios by more practical professionals in the institutionalized psychiatry. But now nurses, social workers, doctors, pedagogues and therapists worked in teams and shared work.

In the 1980ies the number of “beds” and hospital days decreased dramatically and the district- based psychiatry became the basis for admission, prevention and follow up in psychiatric intervention. From a New Public Management approach this called for centrally managed coordination and effectiveness and so the two systems were linked together in one organization in the 1990’ies. (KORA 2012) Through this process, focus became more and more on ambulant treatment and contact, also from the hospital institutions, and new hybrid organisations were born, such as ambulant units working with a range of
services from social- psychiatry such as psycho-education, therapy, life skills, but also with medical treatment and diagnoses. The field work we have conducted took place in such a hybrid organization.

**Concepts of illness and models of work**

Two approaches to therapy, the systemic and the psycho-analytical, have been especially influential since the family therapy movement began in the 50’ies- 60’ies.(Donovan, 2002). In Denmark the systemic approach to work has by far been the most influential in child- and youth psychiatry, and in the case we analyses this approach has been the dominant profile of the whole work place, and the approach of almost all employees until recently. The family as entity was therefore at the centre of work when a child was assessed for admission to psychiatric treatment. In the systemic approach work is focused on the interpersonal level as representation of the social dimensions of personal sufferings and difficulties. The professionals are trained in this approach to achieve a number of skills with which to engage with people who may not be motivated primarily by interest in intra-psychic insight or personal development and change from this perspective (Donovan, 2002).

Today the official reference point in psychiatry is the “bio-psycho-social” model of illness (abbreviated "BPS") is a general model or approach that posits that biological, psychological (which entails thoughts, emotions, and behaviors), and social factors, all play a significant role in human functioning in the context of disease or illness. Indeed, health is best understood in terms of a combination of biological, psychological, and social factors rather than purely in biological terms, but the concept is criticized for enforcing the traditional Cartesian body-mind slip, and confusing therapeutic practice (McLaren,Tavakoli) Recent research in Denmark suggests, not withstanding, that practice is becoming gradually more medical, as treatment is transferred to social and “local” psychiatry. Hospitals no longer have sufficient capacity to do much more than stabilize patients in severe situations (Madsen, Hvenegaard og Fredslund, 2011), while treatment is placed outside.

With leaning and standardization of ambulant and social psychiatry, medical solutions become the obvious solutions, instead of employing a wider reservoir of interventions, such as pedagogical, social and family oriented interventions. This is closely linked to new forms of management and the effects of leaning and standardization through planned and manualised treatment lines, or shared care etc. as presented above. But these new practices have consequences for understandings of and professional practice around mental illness. These practices become supported and legitimized by the “bio-psycho-social” model of illness, which offers medical solutions to mental problems, not from a pure bio-medical perspective, but also from a social perspective of how to maintain a labour-active and home-based life without stigmatization and exclusion.

**Late-modernisation of psychiatry**

With the growth of a locally based social- psychiatry came the growth in the contact between citizens and psychiatry, where a rising number of the Danish population could see how psychiatry could help them although they did not consider themselves as belonging to a category of mentally ill. In the years 2000-2008
there was a 40% augmentation of people in contact with the social- psychiatric system, and these included a rising amount of individuals in non-psychotic states and suffering from more diffuse mental states of depression, stress etc. (Madsen et. al.2012) However the further fall in hospital beds has also had an influence on this development, as the number of hospital days in psychiatric hospitals decreased by 20% in the same period. (Madsen, Hvenegaard and Fredslund, 2011).

The national health system and the medical profession are today trying to establish social psychiatry as a medical specialization, while at the same time creating closer links between hospitals and district and social- psychiatry. However the picture is that these two strands of psychiatry are moving further away from each other, and that this is based partly on the leading role social psychiatry plays in treatment of patients, and due to differences in professional approaches, concepts of illness etc., concludes a recent review of Danish psychiatric practice. (Madsen et. al., 2012)

However the social psychiatric system is largely under great pressure, because of this development in combination with a detected rise in mental illness and in popular attitudes towards mental illness, which create a higher pressure on access to social psychiatry. This is also true when speaking of child and youth psychiatry, which is a quickly expanding service and professional specialization. Approximately 1,4 % of all children and youth in Denmark are in treatment in psychiatry, and this is expected to rise (Thomsen 2011, Danske Regioner 2008).

Theoretical and methodological approach

In order to explore the way the specific changes induced by NPM affects identity and meaning of work and more specifically, emotional labour, we draw on different – but related - strands of sociology: On standardization, professions and emotional labour. We conceive NPM as a specific concept of transformation, where some of the most powerful elements are technologies of standardization, which affect the professions, their identities and their interrelations.

Here we take inspiration from the stream of research on ‘the sociology of standardization’ (Timmermanns & Epstein 2010). Their first achievement is to broaden the view on standardization, pointing out, how we may have terminological standards that attempt to create an exhaustive description of a field, performance standards that set outcome specifications, and procedural standards that specify how processes are to be performed. This distinction seems of high relevance in our case, where conceptions of psychiatry based on the medical paradigms diffuse into the field through standardized systems of categorization, used for documentation of work activities, through performance standards that are commonplace and seen as essential for securing good quality. Processual standards are implemented through the Learning of psychiatry, but will play a more crucial role in the transformation of the field with the future introduction of the treatment packages.

Accordingly, it becomes clear how standardization not only imply fragmentation and uniformity or even monotony in work, but may also more profoundly challenge the norms and ethics of a profession, on the core task, the sense of good quality and how should it be achieved. Thus, standardization might lead to erosion of a profession; like many critical readers have discussed (e.g. Kamp & Hvid 2012, Liff & Andersson...
But the consequences may be more complex, and we should look for transformation of professions and reconfigurations of the social relations. Several studies sustain this point. In a seminal study of the medical sector Timmermanns and Berg (2003) take our attention to how technologies of standardization may require skill-full activity and give new legitimacy to (certain) groups by positioning them as experts, thereby transforming the hierarchy of the organization. Likewise Halford et al. (2010) illustrate in their case study of electronic patient records, how the technology establish special spaces for the contribution of each occupational/professional group, and also imply a change in the hierarchical relation between them.

Another important point made, is that standardization in terms of systems of categorization implies that some parts of the work is made visible and valued, while others are rendered invisible or less valued (Suchman 1995). So, this implies that we should also focus on how emotional labour moves between zones of visibility and invisibility.

In our analysis of the implications these the changes have for work in psychiatry, we explore the fruitfulness of applying the concepts of emotional labour and professional identity.

Originally launched by Arlie Hochschild in her seminal work: The managed heart, the concept of emotional labour has received growing interest in academia; much in accordance with the growing interest in service work. Furthermore the changes in work and organization in late modern societies imply that workers increasingly have to navigate alone in a multitude of social encounters. Hochschild’s achievement was to draw the attention to how management under capitalism not only tried to use ‘hands and minds, but also hearts’ as it was framed. She focused on how management of the employees’ emotions was increasingly used in order to sustain profits; pointing out the detrimental effects on the emotional life of employees, suppressing their authentic emotions.

The simple dichotomy between authentic/inauthentic emotions has later been challenged. As fx Wouters (1989) discuss, expression of emotions are basically always culturalized; making this dichotomy implausible. Moreover Hochschild draws a very gloomy picture of working life and social relations in the service sector, which overlooks that workers also draw on their emotional work in creating meaning and professional identity at work (Field and Malcolm, 2008). Several authors (e.g. Fineman 2003) point out how interaction with the customers and clients may also be a source of pleasure and offers chances for exchanging ‘unmanaged’ humour and smiles.

In this paper we take inspiration from Sharon Bolton (Bolton 2005), who distinguishes between different forms of emotional management. Acknowledging that all emotions are managed, she points at different regimes of management; the organizational or managerial which aims at ensuring maximum profitability; the professional regime which forms part of establishing professional identities; and the emotions which are guided from the more general socialized conceptions of human interaction in specific contexts. As (Lewis 2005) underlines these should be understood as abstract archetypes, and in praxis we will observe how different regimes are applied depending on context.

Obviously, professional regimes play a dominant role in care work; and so indeed in psychiatry. Work in Psychiatry implies modulating clients’ feelings about themselves and their world. Teaching them and their families and networks to reorganize their way of thinking has played a role in social psychiatry with families
ever since the beginning in the 1950ies. Professional skills in modulating the feelings involved is today becoming even more present in the social encounters in work as we will illuminate in the following analyses.

The professionals in child- and youth psychiatry are strongly committed and engaged in their work, and it seems hardly possible to work in this field without a strong identification with interpretations of meaning of psychiatric intervention and support for children and young people. We take inspiration from a conceptualization of professional identity that critically discerns between an external and internal view on professions (Olesen 2001). Seen from an internal perspective professions are functionally linked to modernization processes in society and professions maintain legitimacy and identity by “doing the job” on the basis of a specialized knowledge base, and according to ethical standards of their profession. Furthermore they do this inside hierarchies of power where they seek to maintain their space and monopoly through practicing “social closure” towards other professionals (Neo-Weberian concept). The critical perspective here is that this is a logic that sets itself through without being included in narratives of the professions or being recognized by the professionals themselves.

From this inspiration comes the effort to look at professions more from the “outside” of the official narratives about the profession, and look at professions in relation to meaning making, linked to subjectivity and the contents, forms and organizations of work, and see this also as creation of meaning by professionals.

Analytically we can open up the concept of professional identity by recognizing the dynamic relation between work (tasks, clients, organization), knowledge and subjectivity of professionals. Professional identity expresses skills and is related to education and tasks, but is also formed and appears through the dynamics of the transference of thoughts, wishes, fantasies, and senses of the self and others in the workplace. Emotions here are an aspect of the creation of professional identity and meaning (Olesen 2011). Emotions can be seen as cultural mediations between inner reality of professionals, in addition to the outer present social reality they are relating to (Chodorow, 1999). Inter-subjectivity, represented through emotions in interaction, is also part of forming work and the work identity. Professionals who work together share professionalism and meaning, and this is partly mediated as emotions.

Methodology

The analysis that we present here is developed on the background of two years of investigation into work in Danish Psychiatry. We have especially focused on meaning and identity of professionals, relations in work, and the well-being of the professionals. The contextualisation perspective is taken from our former research where we have developed a critical understanding of New Public Management and the neo-liberal developments of this in later years (Andersen and Dybbroe 2011, Dybbroe 2011, Dybbroe 2012, Kamp and Hvid 2012, Kamp 2012). The central method of the investigation has been ethnographic fieldwork, adapting a multisited approach (Marcus 1995, Shore et al 2011). Work and the perspective of the professionals are studied through many sites, organized around the principle: 1. Follow the employee, 2. Follow projects or tasks, 3. follow a team. The choices vary in relation to the context and also practical possibilities. But we have had the chance to be in sites where we follow the work in the unit, comprising approximately 25 professionals, the work of three teams, and 5 cases. As a supplement to the ethnographic investigation we have also conducted documentary studies, in order to establish a critical ethnographic position, which sees...
work from the outside in relation to societal factors. Moreover we carried out 6 semi-structured qualitative interviews with employees belonging to different professions illuminating the professional trajectories and their interpretation of work, meaning and identity, in order to explore how the changes in psychiatric work are experienced and affect well-being and meaning of work for the professionals.

**Setting the scene. A regional child- and youth psychiatry unit in transformation.**

Our case – work at the ambulant unit of child-psychiatry – has during the latest 5-6 years been subject to different forms of standardization.

As part NPM a provider-purchaser model has been developed. In consequence, an IKT based catalogue of services delivered forms the basis for the unit’s economy. The catalogue is built upon the logic that the client is the child and the main product received is a diagnosis. This has two important implications. First, only services that involve the child (the client) are counted, not services that only involve e.g. the parents. Secondly, it is only possible to work in the system if the child is attributed a diagnosis. Thirdly time may be divided in productive time – time that counts in the system - and unproductive time. Also performance standards have been implemented. The quality of the performance is primarily assessed by annual measurements of customer satisfaction.

In order to further rationalize process of the diagnostics, and first and foremost bringing down the waiting-list, the unit has been Leaned. The main implication has been a reorganisation of work – a processual standardization - in order to enforce the norm of each team producing three diagnosis pr. month. Before the time used for establishing the diagnosis varied very much depending on the complexity of the case, and each team worked with several cases simultaneously.

The Diagnosis Related Grouping has since the 90ies formed the backbone of work the unit as in the whole psychiatry. It is the central frame of reference in this type of work. This is obviously a form of standardization; a standardized catalogue, but this is developed by central international professional bodies, disconnected from the NPM process. The role this terminology play in the process may however be object for change.

The work is organized in teams. Two-three colleagues will work together in this way. Management appreciate that the professionals challenge each other’s professional skills and approaches, and that they also perform some degree of out-put control of the work they do, and also mutually of their contributions. Management is very dependent on this, because the professionals work in inter-relational spaces with patients and other institutions and professionals, which management has no access to. Inside the teams the professionals may work horizontally, where each professional carry out different tasks in different spaces according to time schedules, and coordinate and reflect on these together. Or they organize their work vertically so specific tasks are taken by specific professionals according to an estimation of expertise or interpretation of how standards are best met. In these cases the tests that are to be performed can be the line of division of work, because only the psychiatrists and the psychologist can make the tests, while visit e.g. to the kindergarten of the child, might be made by anyone.
What counts, who counts – work and professional hierarchies in transition

The dystopia – the Psychiatry as a diagnosis industry.

The strong emphasis on producing diagnoses and producing them effectively that the management technologies convey is clearly not in accordance with the ideals of their work that different professional groups hold. One of psychologists, Simon, who have worked on the private side for a couple of years and have experienced this market logic fully realised, is particularly clear in his views:

“It is about the diagnosis rather than about the child. [caricated]: How many diagnoses did we do last week? .. And this is nearly where we are now. I mean, we talk a lot about how many services we made because it counts. Tests and investigations lead to diagnosis and diagnosis lead to money. So I fear that we begin to lose the humanistic perspective, the child and the family becomes just a number in the row. ...In our profession it is more appropriate to tell a coherent story about a child. And to point out that there are very many factors which can lead to that a child appears agitated and unfocused. Many other factors than ADHD”.

The different groups the social pedagogues, the social workers, the nurses and the psychologists phrase their ideals differently, but all distances themselves from ‘the diagnosis industry’. The diagnosis is acknowledged as the formal aim of work, but the meaning of it is negotiated in different ways.

Janice, a psychiatric nurse says: “In reality I don’t think it is so important what it is called [the diagnosis]. It is more about how the child can get some help after words. This is my opinion. So, I do not care if it is called the one thing or the other. But, for the sake of the parents, in order to secure them more help in the future, they have to have a diagnosis. Or else nothing will happen. That is the way it is in our society”.

So in her view the diagnosis is a means, not the aim, and moreover the thorough distinction between different diagnoses and subcategories is from her point of view futile. What she also highlights is however that the diagnosis is the only legitimate way claim that a problem that needs to be attended. The diagnosis is the access point in order to receiving resources.

Here she is much in line with Leo, a social pedagogue: His focus is at the families, and underlines the importance of meeting them in a proper way and of supporting them.

“You have to treat them respectfully, and understand that they do their very best; show it to them – even if they are late for the meetings and do not respect all agreements. They are in a difficult situation. They start up being normal parents and end up being parents with a handicapped child. They are shaken”.

He does not find that shortening the time allotted to establish the diagnosis – one of the results of Lean - is that problematic. He would rather use the energy to give the parents something else, something that makes sense in order to become better qualified for their new life as parents.

Here he points out that the important thing they do, is in fact emotional work. This implies a particular way of relating to the parents and also a pedagogical process of learning them new skills; new ways of dealing with their parenthood.
Another Psychologist, Birgit, underlines her and her colleague psychologists’ diagnostic skills, their long experience in working with the Diagnostic Grouping. She adds to this that she understands the establishment of a diagnosis as a process, a process that should prepare the parents for their future situation. So the skills of organizing this process are very important. And she and others still work on develop their skills further in order to manage the different kinds of complex and unpredictable situations face to face with clients and/or their network. However, she highlights the problem of the time. While it might be seen as a blessing that the families can receive a diagnosis within 14 days from they start at the child psychiatric unit, it is indeed a mixed blessing. The process is too short, and sometimes they have to leave the parents in deep crisis.

In summary, the analysis illustrates the different views on the increasing focus on producing diagnosis as a formal aim of their work. Focus in work is to support the families in the process they are going through, so highly skilled emotional work is highlighted as important for professional identity. However, in the rationalization of psychiatry emotional work is not acknowledged. The IKT system for registration of services actually makes this work invisible.

**Negotiating diagnosis and identities**

The weekly conference where the teams present their cases for an audience consisting of colleagues and management is an important institution. Here decisions upon, how to close the case and what diagnosis to give a child, are made. In this forum the professionals present their arguments and also their doubts or questions.

An important issue on how the diagnosis should be reached; what counts in developing the diagnosis? Formally – taking departure in the system-theoretic paradigm of psychiatry - observations in home and institutions plus the interviews with the parents all count on par with the psychological and medical tests. But obviously the renewed focus on delivering diagnoses challenges this parity. In this forum, different lines of arguments and pieces of ‘evidence’ are tested against each other.

At the same time this is the place where relations and identities are continually negotiated. As discussed in our theoretical section professional identities are constructed reflecting their education but also to their skills and the tasks they perform I specific contexts. So, the tools and methods the professionals apply do also affect how they are identified and their place in the hierarchy. In child psychiatry work is often divided so that the tests are performed by psychologists and medical doctors, whereas the other tasks could be made by everyone and should preferably be made in teams. But as time schedules are tight, the tendency is that these tasks are undertaken by one belonging to the other professional groups.

As Leo, pedagogue, remarks: “When you are a blacksmith, you may have a poor hammer; but when you are a pedagogue, then you do not have a poor method; you are a poor pedagogue. So, it means if you have a conflict on a professional issue, then it quickly becomes a personal matter”

While some conferences run smoothly and seem uncontroversial there are also dramas.
As one of the psychologists explains: “There are easy cases. The team agree that he suffers from ADHD – tests and observations point in the same direction - and now we go to the conference and present our evidence. There are seldom objections, and we feel released. It was a good performance and everyone is happy and smile and say: How clever you are; we have solved another case. And then we go on to the next case”.

The more difficult cases create more discussions and reveal the conflicts and lines of division.

In one case presented by Lena, newly educated doctor, and Jane, nurse, the tests fail to support any diagnosis. Janice, the nurse then delivers a very complex history. She describes the child as an anxious child, having problems with sleep and food. There have been tragic events in the family. The mother’s behaviour towards her daughter does not seem adequate etc.

A long discussion results. The colleagues show sign of impatience. “What do you think, in terms of a diagnosis” one of the psychologists remarks rather sharply. Another colleague follows up: “What do you want to obtain by taking this case to the conference. Obviously you haven’t finished your job”

Lena and Jane comes up with a proposal for a diagnosis, unconvincingly though.

Some of the more experienced colleagues comes to rescue, and proposes that a very competent psychologist should assist the team in further investigation, and management agrees that the (tight) timetable must be suspended. (field notes).

Clearly the tests are much easier to present. The test results can easily be aggregated to clear answers. And they often play a dominant role in the decision-making. Tests are always presented by the psychologists or the psychiatrists. The form of this presentation emphasizes hard data and facts. The observations, which are presented by the other team member, e.g. a pedagogue or a nurse, are often quite descriptive; focusing for example on the child’s behaviour in school, her interaction with other children etc.

After the conference Janice feels attacked and demeaned. She reflects: “Sometimes, it is quite difficult, when you have a case quite close on you. You and you teammate know every detail in it. To present it on a conference! You cannot include all the details. You are not able to communicate all those small sensations and peculiarities you experience, when you spend time with this particular family. And what do you do? Because, sometimes these sensations and peculiarities are exactly, what sustain your descriptions and judgements”.

But the incident support management’s reservations in relation to the ‘old paradigm’.

Sue: “We decided that there should be more clear criteria for how to present a case. We have an old legacy from when we worked in the ZY department, implying that they [the professionals] are very engaged in family matters. Sometimes, the result is too much talk about how dad and mum are; their history and so on. And OK, this is also important for how the child thrives. But if you have to diagnose, then it is not that important ... if we standardize the presentation, I think it will be easier to put questions and raise a discussion that is experienced as professional”.
As there are lacks of experienced doctors in the unit, the psychologists have a leading role. Birgit, one of them, explains that the psychologist are sharpest on DRG, they know this system very intimately. And when observing the conference, it is clear that this competence plays an important role.

Often, when a case is presented and a diagnosis is proposed, questions like: “What do you think about using 83.2 instead of 83.1, have you exempted xx [a specific diagnosis]?” are raised. Apparently this excludes a large part of the audience. The doctors and the psychologists – and few others - always bring the DRG booklet to the conference. It lies in front of them and are used several times, where all those having this book scroll the pages.

In summary, the focus on diagnostics and the intrusion of medical vocabularies and ways of thinking, and the new focus on flow and time saving, tend to undermine the position of the professional groups such as pedagogues, social workers and nurses. Their contributions - which are crucial for maintaining the social-psychology approach - are devalued, and this is clearly displayed when they perform on the conferences, as they are left troubling positions.

Professional Meaning and emotion management in the meeting with vulnerable families

The following analysis probes into work in relation to the clients/patients, as practice and materiality: What is work about? What is the position of the patients in this work under standardization? And how does this create meaning and is being bestowed with meaning by professionals? We have followed a sequence of intersubjective spaces, where most work takes place. Managing emotional labour, and the representation of professional identity through emotionality is in focus and discussed. The case is a typical case of a child that has been admitted for assessment, and during a 3-4 week period the two professionals, Simon, psychologist, and Carl, social worker, work with observations in settings of the clients, discuss these in team meetings, perform tests, present their analysis with the parents and eventually establish a meeting of the professional and familial network around the child.

In the standardized sequence of work the ultimate goal is to produce a diagnosis- but in the following scenes we see that for the two professionals the ultimate goal is somewhat different The criteria for this work is that the diagnosis has to be completed and decided, not necessarily when the professionals have done a professionally satisfactory investigation and analysis, but when the time schedule tells the professionals that standards may become at stake. The standards have since 2010 included a long list of forms of consumer satisfaction that have to be taken into consideration for the professionals, as they are followed statistically by top management, and bad satisfaction could create political problems for the unit as a whole. The professional performances are measured through consumer satisfaction on specific standards such as waiting time. Two months is the limit they can work in, from the off-set where a child is admitted for assessment, and until a plan for treatment and intervention has been described (Sundhedsplanen, 2010). Internally in the sector we have studied the decision is to try to reach the completion of three cases a month.

Another challenge is the registration system which has been geared in 2011, to only count direct work with the client in focus, the child, so that all parts of the investigation without the child, i.e. meetings with
parents, cannot be registered and financed. Meetings where solutions are to be discussed with parents are possible to register, but not the effort to get more information about the child and the family.

An inherent challenge in this work is how to gain access to more knowledge in order to do what the psychologist, Simon, calls ‘completing the jigsaw puzzle of what we are looking into, and doing this together between professionals’. A challenge in working with children and families is that smaller children are difficult to test, and small children as informants are a dubious practice. Simon refers that he can do more tests and call in the child and have this registered as a service and ‘counts as work’, but that more observations and dialogues with the families and in day care institutions, which could be helpful, are difficult to do, as they are potentially ‘overtime’ work for the professionals.

We followed the case of Charles, a 5 year old boy, who was detected as having ADHD by the municipal psychologist and transferred to child- and youth psychiatry. In the process from the visit in the home of the child, in the kindergarten and later in an anamnestic dialogue with mother, Simon and Carl all along reflect on what the case contains, and very quickly realize that mother of the boy is very vulnerable, and that the life of the child has been dramatic with family break ups, depressive parents. They do not have much time, and following them in the car between visits we learn how they use this as a reflective space, where the method seems to be: for how long time can we keep the thinking space open without a diagnosis? As a sort of counter effort to what is to be their task.

In the end they have to decide on something, and this diagnostic imperative places them a bit differently according to their distinct professional identities. The dialogue between the two professionals in the team meeting, preparing for the ultimate “net-work conference around the child”, and after the first presentation to the parents, greatly concerns itself with the reactions of the parents:

Simon: “mother wasn’t very keen on Charles (the child) not having an ADHD diagnosis, she would have wanted it…”

Carl: “the only one who was happy was Peter, step-father, who said:” wheeowh,” because it wasn’t an ADHD diagnosis, he was relieved…”

Simon: “I think they had expected an ADHD diagnosis, mother would have preferred it, it’s more difficult to have to do something yourself, and therefore we are often tempted as therapists to use diagnoses, or how to put it: it’s easier to say to grandma when she calls, that it’s ADHD than something in the upbringing and about mother’s own situation. And it’s simpler, that when they leave the meeting, well, what did they actually say, the people from child psychiatry ? One really wants to say it clearly and explain what is going to happen…”

Carl: “And then when you look into mother’s background, then she could have an ADHD diagnosis, her sister has an addiction, her father had an addiction for a period of time, grandfather had an addiction- it could be something in the ADHD spectrum, but now we’ll have to see what a pedagogical support can give, they have half a year to do intervention before entry into school, and they can come back with him if it doesn’t work.”

Both Simon and Carl are concerned with the outcome for the parents, and at the same time their own role in this, as professionals, as they attach a lot of meaning to the work process they have been through: did we see what was to be seen? Do we have enough understanding of the case? And not least: can we avoid
disasters for this child and the family? Both professionals are concerned with the process and how to monitor it in the next meeting/conference, and observe their own work in relation to outer standards (will the family be dissatisfied?) Carl explicitly safeguards their common work by stating ‘that they can come back’ if the work they have done didn’t give results. As psychologist and social worker they here seem positioned equally as the performers of a monitored practice, that could go wrong at the practical level, due to their work, as well as due to a lot of dimensions that they cannot work with, first of all the distress and situation of the parents. But it is also displayed that subjective professional meaning is at stake.

For Simon it is the analytical process and the methodical practice that gives professional meaning. It is about being true to what he can observe and how he understands the problem, in spite of other interests, and the diagnostic imperative. For Carl it is meaningful to be able to visualize and facilitate a positive social process in the future life of the child, and somehow Carl is close to taking social responsibility for this child’s recovery. Carl goes on to criticize the way the parents and the day care institutions pedagogically and socially address the child, and Carl displays a clear interest in being able to monitor the future process.

The situation of these two professionals can be seen as caught up in a double bind situation (Bateson) where two paradoxical rationalities are present: a bureaucratic and political which is standardised: They must come up with a solution that can satisfy consumers/clients. Fulfilling both rationalities seems in the case to be nearly impossible. Either they hand out the diagnosis the mother wants, and they renounce on professional meaningfulness, or they stick to their analysis and risk that the case bounces back to them in half a year. Carl is already suggesting a differentiated position, by referring to the ADHD diagnosis as a possible solution, and suggesting that they “will have to see..”, and not reassure the parents that an ADHD diagnosis would be wrong. Simon on the other hand tells in the following interview about the professional meaning in letting analyses of children remain open ended under the perspective that they are in development, and many things may change with new social and pedagogical support seen from a psycho-social perspective. This is what is most important for Simon, which he represents in the following network meeting with family, day care institution and the municipal psychologist responsible for coordinating social intervention.

In relation to their professional rationality they must present a professional work that is ethically and collectively identifiable for them both as a team, and at the same time as two distinct subjective professionals, psychologist and social worker. Their position in the professional hierarchies is something we have seen when the whole unit is united at the professional conference, but here they seem to stick to the model of inter-professional work and solutions. Their solution is to decide on the diagnosis ‘relational disturbance’, which is seen as a soft diagnosis, but which never the less can be accepted.

Managing emotions and creating an invisible diagnosis

The high point of professional competence for Carl and Simon is the final network meeting, where their concern is with the future for child and family. The meeting starts with Simon quite bluntly having stated that this is a sensitive boy who is not chronically ill or even belongs to a specific category of diseases, he invites Carl in to inform about his observations in the social contexts of the child, and these thorough and emphatic observations create recognition with the parents and the day care worker. This leads on to Simon concluding that everybody around the child has to be very attentive to his situation and how he can get into a socially better state. Then Carl and Simon go on to invite the institution into a dialogue, and slowly
the meeting is changed from a court room atmosphere where professionals are to deliver judgements, into a setting where all participants have to reflect on their own role, understanding of the situation and what solutions the professionals as experts of the child’s life, can come up with. The diagnosis about the relational disturbance is shortly mentioned as a characteristic, not as a diagnosis, and medicine is never mentioned. The space for cooperation and mutual understanding seems to slowly appear through the invisibility of the diagnosis, which Simon and Carl never said would be hidden, but their practical sense seems to guide them in the moment of action.

The dialogue between Simon and the institutional representatives becomes very emotional as they are more and more confused, because they have not been prepared to present ideas about the future and their own role in this. Eventually Simon and Carl start talking about the familial support, and the biological father, who is becoming more and more upset by the reaction of the pedagogues take an active part:

Father: “He goes to school for his own sake and not because M and P and I want him to become something big, but because he wants to, and we have to find him a school that is good for him.”

Simon: “What are your reflections on this?” he looks at mother

Mother: “I am so quiet”

Carl: “what do you think?” looks at both mother and Peter

Mother and Peter: “help as fast as possible, I have talked with my friend about it, if he is sent to a special class it can easily go the wrong way, but if he is in a normal class maybe it can also go in the wrong way”

This sparks off a heated discussion about schools, and the focus is no longer on the psychiatric system, and the initiative is put on the parents who become exceedingly upset

Carl and Simon close the discussion by saying that now there must be action, and following this Carl starts to line up what could be done and how it could be done if the municipality took the initiative. The municipality say that they have no money, and now the emotions of mother and biological father are roused. Simon and Carl let it get a space, they stay emotionally with the parents for some time and this at last lights a spark in the manager of the day care institution who promises to start making a plan and raising money for special support for Charles. Managing the emotional scene seems to have been able to illuminate the resources and the possibilities of the setting

An interesting afterthought is that on the one hand the meeting can be seen as displaying resistance towards the diagnostic imperative, and that it is possible to work with diagnoses as instrumental descriptions alongside a more emphatic social and psychological description of the problems. Another factor is that the outcome depends on professional skills of emotion management. Carl and Simon do not seem to fear chaos erupting at the meeting. They seem to have the experience of being experts of emotion work.

The practice of Simon and Carl is effective in relation to the standardization they are under, because they succeed in handing the responsibility over to the implied partners from the context of the child, and relieving psychiatry of responsibility. The meeting started with the initiative in the psychiatric unit and ended with the initiative in the most resourceful part of the context of the child.
Concluding discussion.

The paper illustrates how the introduction of NPM reforms and powerful elements: the technologies of standardization contributes to transform the professional paradigms that form the basis for work. This implies that the highly skilled emotional work in psychiatry is increasingly made invisible. The increasing focus on the diagnosis as the product implies that the social relations in the interdisciplinary team are strained, and some of the groups are marginalised. Moreover we show emotional work in relation to clients and network is affected.

To be able to manage time and to standardize work are demands on the professionals as we have seen in the analysis. This has the effect of making all not registered services, such as the telephone call to the municipality, the meeting with the mother when the child comes in to be tested etc. invisible and often secondary. This gives professionals the experience of not having time, not being able to “take the time it takes”. The unregistered work is often placed in spaces that are not created for this work: in the taxi between visits with clients, in the corridor discussing with a colleague, on the telephone while filling out forms in the registration system at the same time. Efficacy seems to be growing when you study psychiatry from inside the workplace, looking the workers over the shoulder, while at the same time theoretically reflecting on how practice can be understood from the outside.

But mental illness and people seeking help, are growing. In the beginning of 2010 a “right of treatment” bill was passed in parliament for people suffering from psychic illness, and this was followed by the introduction of “treatment packages” similar to the system of “shared care”, which had been the practice in Britain already for many years. (Sundhedsstyrelsen, 2012) Treatment packages are standardized services organized around specific diagnoses and evidence based treatment programmes for these diagnoses. (Virksomhedsplanen, 2012) The professionals compromise to work with these packages in cooperation across institutional and professional boundaries, and using methods proscribed in the standardized packages. Nearly all parts of psychiatry have now implemented this system, and patients will be admitted in the same way, will be presented with the same form of treatment and working methods of the professionals (i.e. group methods or individual treatment, cognitive or psychodynamic methods), specification of which professions that they will meet, and the information they will receive. (Psykiatriplanen, reg. sj. 2011) The psychiatric units and organisations are financed pr. Package and have target goals of how many patients they must treat or rather how many packages they must produce.

The experiences with packages from other, somatic, parts of the health system, are that it is easier managed and more transparent and controllable financially as well as qualitatively for the higher levels in the institutional hierarchies. At the same time this system is politically seen as more democratic and “user-friendly”, which has always played a significant role in Danish Public Management. But packages, or shared care has by recent research been criticized to create production lines, where patients become objects, and many of the services that formerly were included: educating, caring for, social work etc. with patients are squeezed out and become invisible (Sandholm, 2010.)

The basis of these packages are quantitative studies of effects of treatment and they privilege randomized investigations, (Det hele sundhedsvæsen, 2011). The critique raised internationally towards this new
paradigmatic approach in psychiatry is that in randomized studies using control-groups the idea is to maximize internal validity in the investigation, by controlling length of treatment and variability in treatment, and to disregard external validity in relation to social, cultural, economic etc. variations of treatment practice, facilities, and not least- in the way illness represents itself (Borkovec and Castonguy, 2006). A specific research population is constructed through strict criteria that omit many variations of real life settings, such as having more than one diagnosis, which is increasingly important (Stirman 2005) or not accurately fitting any diagnosis, or having been in treatment before etc. Neither the populations, the duration of treatment, nor methods and experiences of professionals may be representable of variations in clinical practices. Therefore it is argued amongst professionals that they are impelled to make a choice between standards and practice, and to often disregard their experiences and clinical estimation and to follow the treatment “manuals” instead, with large consequences (Westen 2006, Goldfried and Eubanks-Carter, 2004)).

When the success rates of treatment are moderate, and patients’ relapses frequent, the trust of professionals in these practices of standardization are continuously challenged, and working with them present daily dilemmas of whether to follow the manual, or listen to the patient and professional experience. Evidence based packages in theory do not take individual factors in patients trajectories, social and cultural factors, nor professional skills, approaches, experiences etc. into account. Potentially both the patient and the professional as psycho-social beings and at the same time unique, are made invisible, and the professional critique is also that several methods and clinical practices are being squeezed out of this model for work in psychiatry (Trojaborg 2012).

Mental illness is about suffering of unique human beings, and is represented as the way the sufferers’ inner worlds meet the outer world in unique ways in meetings with professionals of the psychiatric system. Here they can be recognized as suffering and experiencing a unique reality- and at the same time as belonging to a category which the professional has practical and not only theoretical knowledge of. The paradigmatic change that evidence based share care systems imply for psychiatric work is that the professionals must devaluate these meetings and the dialogue and negotiations with patients about their situation presently, their past and possible future, as life- historical trajectories. The standards, i.e. as packages, have already proscribed the time it can take, the amount of knowledge from real life that can be involved, the scope of action possible. Both theoretical and practical clinical knowledge of professionals can facilitate recovery, coping and bettering of the lives of patients, interpreted and implemented in practice in meetings with specific others. The question is,. is there time for this, and what is valued, i.e. financed and documentable, and what is not, in this new paradigmatic approach? And what could this imply for professional development of practice?

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