Who knows best?

An analysis of discourses in the protocol for the Early Recognition Method

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"When one speaks of psychiatry, or of medicine, or of grammar, or of biology, or of economics, what is one speaking of? What are these curious entities which one believes he can recognize at first glance, but whose limits one would be at a loss to define?"(Foucault, 1972)

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Abstract

This master study focuses on a strategy for violence risk management called the Early Recognition Method (ERM). Previous studies of ERM, and risk management in general, have often been conducted using quantitative methods. I suggest that a discourse analytic approach offers a different perspective and a useful addition to the existing knowledge about ERM. The aim of this study was therefore to critically explore discursive patterns connected to the ERM strategy. More specifically, the ERM protocol has been the subject of an analysis drawing on foucauldian theories about discourses, knowledge and power relations. From the analysis of the written text in the ERM protocol, three discourses have emerged: a psychiatric discourse, a scientific discourse and an empowerment discourse. The discourses carry with them traces of discourses and epistemes also to be found elsewhere in modern Western society. Based on the analysis, it can be argued that the discourses stand in contradictory relationships to each other. There is a battle going on about what is considered true knowledge and about who possesses it. The patient is offered a position of being a subject of illness and risk, as lacking ability to make the right decisions about what is best for himself, but, at the same time, he is urged to become an empowered subject with unique knowledge about his own illness and how it can be managed. The personnel are offered a subject position of being the professionals having a more qualified ability to know what is best for the patient, partly because of their scientific knowledge about ERM. Simultaneously the professionals are assigned a position in which they must be the asking, passive subjects, waiting for the patient's invitation to share the unique knowledge that he possesses. Furthermore, this study elucidates how power relations connected to the discourses are in alignment with shifts in modern society, changing how power is exercised on the citizens. I suggest that the ERM strategy is representative of governmentality and what Foucault calls technologies of the self, when it urges the patient to engage in self-monitoring for the purpose of self-improvement.

Sammendrag

Denne masterstudien omhandler en metode for risikohåndtering kalt Early Recognition Method (ERM). Tidligere forskning om ERM, og om risikohåndtering generelt, har ofte vært basert på kvantitative metoder. Jeg argumenterer for at en diskursanalytisk tilnærming kan gi et annet perspektiv og være et nyttig tilskudd til den eksisterende kunnskapen om ERM, Formålet med denne studien har vært å kritisk undersøke diskursive mønstre i tilknytning til ERM som metode. Mer spesifikt har protokollen for praktisk anvendelse av ERM vært gjenstand for en analyse som trekker på Michel Foucaults teorier om diskurs, kunnskap/viten og maktrelasjoner. Gjennom en analyse av teksten i ERM-protokollen, har tre diskurser trådt frem: en psykiatrisk diskurs, en vitenskapelig diskurs og en empowerment-diskurs. Disse diskursene bærer med seg spor av diskurser og epistemer som også er tilstede andre steder i det moderne vestlige samfunn. Basert på analysen kan det hevdes at diskursene står i et motsetningsforhold til hverandre. Det pågår en kamp om hva som ansees som sann viten og om hvem som innehar den. Pasienten tilordnes en posisjon som et subjekt kjennetegnet av sykdom og risiko, uten evne til å gjøre kloke valg om hva som er best for ham, og på samme tid oppfordres han til å innta en subjektposisjon der han med sin unike kunnskap om egen sykdom og hvordan denne håndteres, tar makten over sitt eget liv. Personalet tilbys en subjektposisjon som fagpersoner med en mer kvalifisert evne til å vite hva som er best for pasienten, delvis basert på sin vitenskapelige kunnskap om ERM. Samtidig presenteres de for en subjektposisjon der de må være et spørrende, passive subjekter som venter på en invitasjon fra pasienten til å få ta del i den unike kunnskapen som han innehar. Videre belyser min studie hvordan maktrelasjonene som kommer til syne gjennom diskursene samsvarer med endringer i det moderne samfunn, i det henseende at maktutøvelsen over borgerne har forandret seg. Jeg hevder at metodikken i ERM er representativ for maktrelasjoner basert på styringsmentalitet og det Foucault kaller selvets teknologier, idet pasienten anmodes om å ta del i å overvåke seg selv, med det formål å bli et bedre fungerende menneske.

Preface

Finally I have reached the end of this academic journey. The process of conducting my master study has been both developing and rewarding, and it is with mixed feelings I am now putting the final touches to it. I am happy and proud to be finished, and at the same time it is a bit strange that it is over.

There are many people who deserve a thank you. First of all, I would like to mention my supervisors, Truls Juritzen and Frans Flutter. Your engagement, your insights, and how you have shared your comprehensive knowledge with me have been immensely valuable throughout this project.

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Finally, to my dear children, Eirik and Silja: When I have been tired of studies and frustrated because my project has encountered some obstacles, you have created the space for me to focus on something completely different – thank you for that!

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Marion Cecilie Bakke

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1 Introduction

1.1 Background

Violence is a phenomenon with numerous harmful consequences for society. It has implications for public health, crime prevention, human rights, democracy - the list of challenges caused by violence seems like it is never ending. One of the issues connected to violence is how to deal with those who commit it. Are they to be punished or treated, and how can the population be protected from such individuals? In Western societies, when a person commits a violent crime and is not held accountable for his actions, forensic psychiatry is given the responsibility for treatment and services offered, along with the task of protecting the public. However, this poses new challenges regarding how to deal with the risk of reoccurring violent episodes, both during treatment and after.

There are numerous studies examining how to decrease the risk of forensic patients committing acts of violence. Many of these studies are directed towards research on risk assessment instruments which aim to predict the probability of violence, such as the Historical-Clinical Risk Management-20, version 3 (HCR-20 V-3) (Douglas et al., 2014) and the V-RISK 10 (Bjørkly, Hartvig, Heggen, Brauer, & Moger, 2009) or risk management tools, which are meant to manage and reduce an identified risk, such as the Brøseth Violence Checklist (BVC) (Woods & Almvik, 2002) and the Dynamic Appraisal of Situational Aggression (DASA) (Vojt, Marshall, & Thomson, 2010).

The focus of this study is a risk management strategy called Early Recognition Method (ERM). ERM is a management strategy that focuses on identifying early warning signs of violence. It was developed in Holland and the first clinical testing took place at the Dr. S. Van Mesdag Forensic Psychiatry Hospital (Fluttert, Van Meijel, Nijman, Bjørkly, & Grypdonck, 2010a). Fluttert et al. (2010a; 2008) conducted an intervention study introducing ERM as part of the inpatient treatment at the hospital, which resulted in a significant decrease in the number of episodes in which personnel had to intervene and use seclusion due to violent inpatient behavior. The study also showed a significantly decreased level of severity in the violent episodes that occurred after implementing ERM. The level of severity was measured using the Staff Observation Aggression Scale – Revised (SOAS-R).

Most studies on risk assessment or risk management tools focus on how to accurately assess and prevent violence. The insights gleaned have provided valuable knowledge on how the challenges of inpatient violence can be met, and how the consequences of violence to people and property can be reduced. However, research perspectives that take into account the social, cultural, and discursive context of inpatient violence are scarce. This in spite of research showing that interactions with staff can be one of the triggers/causes for violent patient behavior, thus indicating that improvement in interactions between forensic mental health nurses and patients may lead to a reduction of inpatient violence (Fluttert, Van Meijel, Nijman, Bjørkly, & Grypdonck, 2010b; Meehan, McIntosh, & Bergen, 2006). My suggestion is that the foucauldian concepts of discourse, power and more specifically governmentality, can be useful perspectives adding to the existing research.

At the beginning of this project I did a preliminary literature search, using different data bases such as Medline, PsychInfo, Oria and PubMed, with different combinations of the search terms: "forensic", "violence", "qualitative", "journal", "discourse analysis", "psychiatry", "risk assessment", "risk management", "Foucault" and "governmentality". I did not find any studies that had analyzed documents used for risk assessment or risk management within a sociocultural perspective.

What I did find was a study by Berring, Pedersen and Buus (2015) addressing discourse in connection with patient aggression. They conducted a critical discourse analysis of forensic nurses' practices of recording aggressive incidents. Their analysis indicates that nurses narrate these incidents in a quite stereotyped form in which the patients are seen as the aggressors and the ones causing the violence, while the nurses are depicted as the objects of aggression and the problem solvers. I also found a study by Oute, Huniche, Nielsen and Petersen (2015), who used a discourse theoretical perspective to analyze how two Danish political campaigns about mental illness articulate opposing subjects of normality or deviance, thus constituting a hegemonic discourse in which persons suffering from mental illness were depicted as weak, irresponsible and ineffective citizens. There is also an Australian study by Hamilton and Manias (2006) who critically analyze nurses' oral and written language in an acute inpatient setting. Their findings suggest that multiple discourses are at play in such settings, exercising power intrinsic to the nurses' language.

1.2 Aim of the study

It has long been suggested that discourse analytic approaches offer a welcomed addition to the traditional positivistic approaches and the traditional qualitative research built on phenomenological perspectives (Bratberg, 2014, pp. 9-10, 12-13; Crowe, 2005, p. 56). Discourse analysis and its place in the health and social sciences have been advocated by several writers (Cheek, 2000; Crowe, 2005; Lupton, 1992). Discourse analysis emphasizes the social and cultural context, and how language is part of constructing knowledge, elucidating the power of social relations (Bergström & Boréus, 2012, p. 354; Lupton, 1992, p. 149; Powers, 2007, p. 18; Tjora, 2017, p. 183).

I believe that the three studies mentioned under 1.1 Background (Berring et al., 2015; Hamilton & Manias, 2006; Oute et al., 2015) show how discursive patterns carry with them implications that we often fail to recognize, and that studies like these are needed to elucidate how the way we talk, write, and think might affect the treatment and care for persons suffering from mental illness.

The purpose of this study is to add to the preexisting knowledge on ERM by critically exploring discursive patterns connected to the ERM strategy drawing on the foucauldian tradition of discourse analysis. The specific aim is to critically explore discourses in the Norwegian version of the ERM protocol, which is a sort of manual developed for applying ERM clinically in a Norwegian context (Fluttert, Eidhammer, Knutzen, & Bjørkly, 2013a), and when writing about *the ERM protocol* in the following, it is the Norwegian version I am referring to. However, I wish to emphasize that being critical in this sense is not to direct critique towards the ERM strategy itself, but to provide a critical perspective on our ways of thinking and frameworks of understanding that we often take for granted. To analyze and elucidate discourses is important because discourses make certain actions possible, while excluding others, which I will elaborate more on in Chapter 3.3 and 3.4.

1.3 Research questions

As already mentioned the aim of this study is to critically explore discourses in the ERM protocol by drawing on foucauldian concepts and terms. To be able to achieve this aim I have formulated my main research question:

Which discourses are embedded in the ERM protocol?

This research question addresses the disclosing of discourses embedded within the text, which is necessary in order to critically explore them. Beyond just disclosing them, however, I wish to elucidate how these discourses are given power, and how their power is exercised over the persons applying the ERM strategy, both the patients and the nursing staff, thus potentially having real life effects. In order to point the analysis in this direction I will additionally try to answer the following sub questions:

1. *Which subject positions are being constituted within the discourses in the ERM protocol?*
2. *What kind of power relations are being constituted within the discourses in the ERM protocol?*

1.4 Data material

The text I have analyzed in this study is the ERM protocol NO version (Fluttert et al., 2013a). The protocol describes all of the steps of the ERM strategy and as stated in the protocol it is "intended for personnel trained in working with Early Recognition Method (ERM) who have acquired knowledge about ERM" (Fluttert et al., 2013a, p. 5, my translation). I would claim that the protocol is an important document in the clinical practice of ERM. Crowe (2005, pp. 56-57) argues that texts that are central to nursing practices are suitable for analysis of discourses, for example nursing reports, health policies, patient education material or texts describing treatment approaches. The ERM protocol is well known to all the institutions which apply the strategy, it gathers a lot of information about the practical use, it includes a template of the ERM plan used in collaboration with the patient, and it was also easily accessible to me - all of which are characteristics making it a suitable choice, thus also directing my research question, as sometimes is the case when conducting a document study (Lynggaard, 2015, p. 156).

1.5 Definitions and clarifications

ERM is a method that was developed in a hospital setting. Later on, the method has been applied in settings other than hospitals, for example sheltered housing facilities and private care institutions. When individuals are no longer hospitalized, we usually stop calling them patients. In Norway, the common phrase to use for a person living in sheltered housing is *beboer*, which can be translated to *resident*. Another word often used is *tjenestemottaker*, in English: *service recipient*. I will be sticking to the word *patient*, since this is also the word applied in the ERM protocol NO version.

A similar challenge is how to describe the personnel working in mental health care services. In the hospital setting, they are often referred to as nursing personnel, even though they are not all nurses by profession. Another word sometimes applied is care giver. I will mostly be using the word *personnel*, or sometimes *nursing personnel/nursing staff* when describing those who work in the health care services, regardless of which profession they have.

Aggression and *violence* are words with a strong interrelation, and they are often applied in regard to very similar phenomena (Fluttert, 2010, pp. 8-9; Rippon, 2000, pp. 454-456). Douglas et al. (2014) define violence as "an act or omission with some degree of willfulness that caused or had the potential to cause physical or serious psychological harm to another person or persons" (p. 100). It has been argued that though aggression and violence are nearly synonymous, violence is "reserved for those acts of aggression that are particularly intense, and are more heinous, infamous or reprehensible" (Rippon, 2000, p. 456). Another suggestion regarding the difference, is that while violence is perceived to be a conscious, controlled act, aggression is seen as emotionally based, less controllable behavior (Hopkins, Taylor, Bowen, & Wood, 2013, p. 688). However, though many professionals and researchers have tried to define the concepts, there seems to be no conclusive definition that everyone can agree on. It is all a matter of perspective and to what purpose they are being applied, which in my view makes it important to recognize that aggression and violence are complex concepts and that the discourse they are placed within is highly significant for our understanding of the terms. In the ERM protocol both words are used, but the possible difference between the two expressions is not addressed. In this thesis I mainly apply the term *violence*, but when quoting others, *aggression* is sometimes also used.

1.6 The structure of the thesis

In the previous sections I have delineated what the main focus and aim of my study is, including describing my data material briefly and making some clarifications. In Chapter 2 I will focus on the historical context of forensic mental health care, how ERM is placed within it and the influence of empowerment ideals on health care in general. In Chapter 3 I will describe my ontological and epistemological viewpoints that form the basis for my analytical and methodological approach, which I will describe further in Chapter 4. Chapter 5 will be an account of the findings I have arrived at, while Chapter 6 will include a discussion of these, based on the theories I have presented in Chapter 3. Finally, in Chapter 7, I will sum up my study with some short final remarks about how it has importance for the application of ERM as a clinical practice.

2 Mental health care and violence

The title of this chapter does not intend to suggest that there is a causal relationship between mental illness and violence. There are people with mental illness who are not violent and there are people who are violent who do not have a mental illness. However, mental illness is considered a risk factor for violence (NOU 2010:3, 2010, pp. 42-43). This chapter aims to describe the connection between violence and mental illness, looking at the historical development of forensic mental health care, empowerment as an ideal for health policies, including forensic psychiatry and how ERM is placed in this context.

2.1 Historical context

The institutionalization of care for the insane in Norway dates back to the second half of the 19th century. Previous to that, care for the insane was practically the same as care for the poor (Kringlen, 2007, p. 19). The first Norwegian psychiatrist was Herman Wedel Major who played an essential role in creating the first law on mental health care (Sinnsykeloven av 1848) and the building of Gaustad Asylum, which opened in 1855 (Kringlen, 2007, pp. 49-56, 58, 70). The development of psychiatry as a new medical specialty was not peculiar to Norway; it was a development taking place all over Europe at the time (Kringlen, 2007, pp. 33, 65-68).

The first written account of a Norwegian case regarding the management of persons with mental illness who are also violent and dangerous dates back to 1735, before psychiatric institutions existed. The servant Birthe Jonsdatter killed the child of her master in 1735 (Kringlen, 2007, p. 28). She was first given the death penalty, but then received a pardon because of being in a state of "rage" (Norwegian: *raseri*)[1], and she was ordered to be placed at a hospital or a workhouse. However, she was difficult to handle and lived the rest of her life being sent back and forth between hospitals and prison until she died in 1743 (Kringlen, 2007, pp. 28-29). When the asylums were built a century later, the patients were divided into groups of "calm" (Norwegian: *rolige*) and "violent" (Norwegian: *voldsomme*) (Kringlen, 2007, p. 70). The first institution assigned for the purpose of treating mentally insane who were also

[1] The Norwegian word *raseri* is in our time used as an equivalent to strong expressions of anger, equivalent to the English *rage*. When used almost as a diagnosis in the case of Birthe Jonsdatter, it might be that the word *furor*, which Foucault (Foucault, Faubion, & Rabinow, 2002, p. 189) uses when addressing the question about irresponsibility of crimes committed by persons regarded as mad, is a more fitting one.

violent, was the Criminal Asylum in Trondheim, with responsibility for 53 male insane criminals from 1895 (Kringlen, 2007, p. 355). In 1919 it was decided to make the former leprosy hospital Reitgjerdet into a hospital for male patients who because of violent behavior or inclinations for escape and criminal actions had proven difficult to care for in the ordinary asylums (Kringlen, 2007, p. 355).

Reitgjerdet hospital continued and expanded its function of caring for insane criminals until the late 1970s when a scandal revealed extensive use of coercion, physical punishment methods and illegal incarceration (Blom, 1980). Following these revelations the matter of care for this group of patients was much debated, and the Norwegian parliament decided in 1982 to close Reitgjerdet (Kringlen, 2007, p. 357). As a consequence, a committee was assigned to assess the need for care, treatment and management of patients with mental illness and a high risk of severe violent behavior. The committee concluded that these kinds of patients were a marginal group who needed specialized psychiatric treatment and care (Robak, 1983, p. 314).

In the aftermath of the Reitgjerdet scandal, the Norwegian forensic psychiatric departments as they exist today where founded. As of today, there are regional high security forensic psychiatric units in Oslo, Trondheim and Bergen, and several medium security forensic psychiatric units all over Norway (Kringlen, 2007, pp. 412-415; Sigurjónsdóttir, 2009). Patients admitted to these hospital units have committed a crime and been sentenced to psychiatric treatment, or they have displayed serious acts of violence in addition to having severe mental illness and have proven difficult to handle within ordinary psychiatric units (Kringlen, 2007, p. 413). Kringlen (2007, pp. 414-415) claims that an unrealistic fear of dangerous patients has led to the development of forensic psychiatric units, thus stigmatizing numerous patients in the process.

The field of psychiatric practice has gone through major changes over time regarding the views on what is the best clinical care and treatment. Since ERM is a strategy mainly aimed at being applied by nursing personnel, I will focus on this part of mental health care. Nevertheless, it is presumed that the ideals that have influenced nursing practice are to a large degree views shared by all professions working in mental health care. According to Kringlen (2007, p. 403), the first assistant personnel employed at the asylums were guards (Norwegian: *voktere*), and mainly male. He explains how their main task was to maintain order and

discipline. They were the largest group of workers in mental health care until after World War II, but, little by little, nursing personnel made their way into the institutions. The nursing staff was commonly dominated by females. Nowadays, most of the employees in mental health care are educated nursing personnel. The views on treatment are presently characterized by an emphasis on therapeutic relations, autonomy, respect of the patient's individual needs, patient participation, validation and empowerment (Hummelvoll & Granerud, 2010, pp. 40-41; Vatne, 2006, pp. 15-17).

In psychiatry there has been a gap between clinical and scientific activity, according to Kringlen (2007, p. 315). The prevailing views on treatment, symptomatology and prognosis, was traditionally based on the clinical experiences of psychiatrists. Larger scientific studies were scarce until the 1960s. The number of Ph.D. theses increased through the following decades, and since the millennium there has been an explosive growth in scientific dissertations (Kringlen, 2007, p. 415). The number of empirical studies has grown, and there is also an increasing demand that clinical treatment should be evidence based (Kringlen, 2007, pp. 421-424).

In addition to presenting the historical facts of European and Norwegian forensic psychiatry, I also want to take a look at the discursive context which it is placed in. Foucault used both psychiatry and the penal system as fields for his studies (Foucault, 1967, 1979). He also wrote an essay "about the concept of the 'dangerous individual' in nineteenth-century legal psychiatry"(Foucault et al., 2002), wherein both the legal system and psychiatry, as well as the connection between them, are subjects of discussion. In the essay about the dangerous individual, he explains his views on how these two disciplines, psychiatry and law, came to be connected. He advocates that psychiatrists justified their role as specialists within the legal field due to the question of accountability regarding serious crimes committed without any obvious motive by persons considered to be mentally insane (Foucault et al., 2002, pp. 179-182). Another thing that made it possible for psychiatrists to enter the field of law was that the penal system had gone through a change from punishment for the purpose of vengeance and retribution, with the objective of controlling individuals, to a system of procedures meant to reform and rehabilitate criminals, in addition to protecting society from danger (Foucault et al., 2002, pp. 187, 192; Skålevåg, 2014, p. 82). Psychiatric treatment met with both of these demands, as it carried with it both the promise of rehabilitating the mentally insane into well-

functioning citizens (Foucault et al., 2002, pp. 187, 189), and the seclusion and confinement that the treatment brought with it (Castel, 1991, pp. 291-292).

Foucault also talks about risk assessment in the abovementioned essay. In his view, risk assessment stems from civil law and insurance (Foucault et al., 2002, p. 196). He remarks on the similarities of identifying causes of accidents and using this knowledge to reduce risk, with locating dangerous individuals through knowledge of their characteristics (Foucault et al., 2002, p. 197). He claims that this also calls for expert opinions, giving power to those who possess the knowledge of who the dangerous individual is and what is the right action to take towards him (Foucault et al., 2002, pp. 197-199). An important conclusion Foucault (2002) draws from risk assessment entering the psychiatric-legal field is that "the right to punish was applied and varied on the basis not only of what men do, but also of what they are, or of what it is supposed that they are" (page 199).

2.2 Empowerment and citizenship

Norwegian psychiatry, including the treatment and care of patients regarded as dangerous, has gone through a lot of changes in the more than 160 years that it has existed. One of the more recent adjustments is the downsizing of psychiatric institutions and increased funding to community services in accordance with the Health Service Coordination Reform (Norwegian: *Samhandlingsreformen*) (Helse- og omsorgsdepartementet, 2008-2009). However, this shift in the view on how to arrange the treatment of mentally ill, started already in the 1960s and -70s. Both in the United States and in Europe, research had indicated that it was difficult to provide good therapeutic care in the large institutions. The resistance towards a coercive psychiatry grew and the demand for reform gained ground in Norway as well (Kringlen, 2007, pp. 408-409).

In 1997 the Norwegian parliament approved a recommendation from the Social and Health Department called "Transparency and Complete Service: Mental Illness and the Services Provided" (Norwegian: *Åpenhet og helhet. Om psykiske lidelser og tjenestetilbudene*) (Sosial- og helsedepartementet, 1996-1997). In this document it is stated:

> Institutional services cover only a small part of the need for services for those with long lasting and severe disorders who need substantial public help and support over a long period of time. As a principle institutional care should only be given as a temporary effort, and nobody should have a specialist institution as a permanent residence. Institutional stay will seclude the patient for a short period when needed, provide for correct diagnostics, map problems, and start treatment and rehabilitation – a process which usually will acquire follow-up after discharge from care. Stays in institutions should increasingly be regarded as part of a more comprehensive process including a number of services and extending over time. (Sosial- og helsedepartementet, 1996-1997, p. 15, my translation)

As a part of the reformative trend stemming back to the 1960s and 70s, the emphasis on civil rights and citizenship has become more prominent (Perron, Rudge, & Holmes, 2010, pp. 100-101). Citizenship has been referred to as "belonging to a socio-political community vested with specific rights and responsibility that shapes one's life within a broader social, economic and political system" (Perron et al., 2010, p. 100). In Western countries, including Norway, it has commonly been a goal for the health services to increase the influence of the patients and better enforce their rights (Juritzen, Engebretsen, & Heggen, 2013, p. 443). As a result of the wish for an improvement in patient participation, the law on patient and user rights (Pasient- og brukerrettighetsloven, 1999) was passed in 1999, along with three other important laws on health services passed the same year, all of which emphasize citizen rights and are known as the Health Law Reform of 1999 (Hofmann, 2007, p. 33). Another example of the same trend is how the Norwegian National Guidelines for Assessment, Treatment and Follow-up of Persons with Psychotic Disorders (Norwegian: *Nasjonal faglig retningslinje for utredning, behandling og oppfølging av personer med psykoselidelser*) states that:

> All good mental health care puts the patients/users and their close relations in focus to enable the patients/users to take responsibility for themselves and their own development. One must therefore facilitate the patients/users having a large influence on their own treatment and follow-up, and that their close relations get the help and support they need. Participation has its own value as a therapeutic agent, as it may provide increased autonomy and contribute to making the patients/users

> experience hope and more control over their own lives. (Helsedirektoratet, 2013, p. 22, my translation)

Connected to citizenship is empowerment, as both concepts concern civil rights and responsibilities (Juritzen et al., 2013, p. 444; Perron et al., 2010, p. 101). When empowerment is defined as part of health care, it has been defined as "the processes of health education, health promotion, and community development as well as the outcomes of these interventions" (Powers, 2003, p. 229). However, to understand the concept of empowerment, it is wise to take a look at the origin of the term. Many believe empowerment was popularized in the 1970s by Paulo Freire, a Brazilian Marxist-based educator, even though he did not use the word in his writings. According to the Marxist understanding, empowerment is social liberation of the education of the oppressed (Juritzen et al., 2013, p. 444; Powers, 2003, p. 228). Later, in the 1990s, consumer culture and market-oriented theories have applied the term *empowerment* to a context where individual civil rights have been compared to market choice (Juritzen et al., 2013, p. 444; Powers, 2003, p. 228). In Norway empowerment is often used either as a synonym or at least as strongly connected to user participation (Norwegian: *brukermedvirkning*) (Juritzen et al., 2013, p. 444).

It has been argued that the terms *citizenship* and *empowerment* used in health policies have a discursive effect on health practices, as they affect the way health care professionals intervene with the patients (Perron et al., 2010, p. 101; Powers, 2003, p. 229). The deinstitutionalization of mental health care mentioned at the beginning of this section provides a concrete example of the effect on health services. Another example is the revised Norwegian law on psychiatric health care, enforcing the patients' rights in making decisions about their own treatment (Psykisk helsevernloven, 2017). In March earlier this year, the health minister of Norway, Bent Høie, published a newspaper article with the title "I'd rather listen to the patients", in which he argues in favor of empowerment for patients receiving psychiatric health care (Høie, 2019). My examples are taken from health care, but the empowerment and citizenship trend is not peculiar to these services; empowerment and citizenship are present in multiple fields, such as law, education, ethics, and social services (Perron et al., 2010, p. 101).

Empowerment is usually viewed as a strengthening process, enabling people to take charge of their lives and make informed decisions (Grealish, Tai, Hunter, & Morrison, 2013, p. 136;

Juritzen et al., 2013, p. 444). However, some writers and researchers have questioned this predominant positive perspective and urged that the discourse of empowerment be investigated in a more critical manner, taking into consideration the new practices that it opens up for (Petrakaki, Hilberg, & Waring, 2018; Powers, 2003; Solvang & Juritzen, 2018). One aspect that has especially been pointed out is how taking charge of one's own life is followed by the responsibility for the decisions that are made and the actions that come with them. Some have argued that by empowering patients there is a possibility of trying to make vulnerable people live up to demands that they are not able to meet (Oute et al., 2015, pp. 282-283; Petrakaki et al., 2018, p. 147). It has also been claimed that the concepts of empowerment and citizenship do provide a form of social control, though it may be more subtle (Powers, 2003, pp. 232, 235; Solvang & Juritzen, 2018, p. 7).

2.3 Early Recognition Method (ERM)

2.3.1 Origin and development of ERM

As mentioned in the introduction, ERM was developed in Holland and initially tested at the Dr. S. Van Mesdag Forensic Psychiatry Hospital in Holland by Frans Fluttert and colleagues (Fluttert, 2010; Fluttert et al., 2010a; Fluttert et al., 2008). Fluttert (2010) states that the reason for the development of ERM was that he saw a need to address the lack of effort made to learn from previous events of aggression occurring at forensic psychiatric units:

> The core message is that aggression is not allowed, but generally not much effort is made to learn from previous events of aggression. However, this learning process is of utmost importance to enhance a better self-management of aggression by forensic patients. When patients are able to recognize and control the precursors of aggression, this could help them to carry out stabilizing actions in order to gain control over their behaviours and thus prevent aggressive incidents to occur. (p. 10)

Fluttert also emphasized the need to involve patients in identifying the precursors of aggression, instead of relying on clinically observable warning signs alone, which traditionally has been the case in risk assessment (Fluttert, 2010, p. 11). The desire for

increased patient involvement is part of the reason why ERM is a strategy that encourages user participation.

ERM draws on the work of Birchwood (Birchwood, McGorry, & Jackson, 1997; Birchwood, Todd, & Jackson, 1998) who was concerned about early intervention regarding signs of psychosis. The main idea that Birchwood proposed and ERM adopted is that relapse back to psychosis (or violence) is a very individual trajectory and that there is a need to identify the personalized early warning signs of this relapse process to be able to intervene at an early stage, thus making it possible to prevent relapse (Fluttert, 2010, pp. 12-13).

The first studies on ERM were conducted in a forensic hospital setting, but there is now promising research being conducted, suggesting that the strategy is applicable to other mental health care services (Johansen, Fluttert, Hansen, & Hounsgaard, October 2017).

2.3.2 ERM in Norway

The first documented use of ERM in Norway dates back to 2008, when the medium secure forensic psychiatric unit at Buskerud Hospital conducted a pilot study on the use of the ERM strategy. The project was funded and supported by the Centre for Research and Education in Forensic Psychiatry for Southeastern Norway (Eidhammer, Knutzen, & Fluttert, 2010, p. 4). Since then, several institutions have implemented the strategy as part of their treatment program. Amongst these are medium secure forensic psychiatric units at Oslo University Hospital, Vestre Viken Hospital and Akershus University Hospital. Additionally, there are also some private health care facilities and two Norwegian prisons that use ERM (Gunnar Eidhammer, personal communication, 03.04.2018).

To apply ERM clinically, a certain amount of theoretical knowledge and practical training is required. In Norway, this is offered at the Regional Centre for Research and Education in Forensic Psychiatry, Oslo (SIFER), where Frans Fluttert has a part-time position. Employees at SIFER have made a Norwegian translated version of the ERM protocol (Fluttert et al., 2013a), which is my data material, described in Chapter 1.4.

3 Theoretical perspectives

How one understands the concepts of reality and knowledge has significance to how research is conducted (Malterud, 2017, pp. 26-28). Regarding research methodology the terms *ontology* and *epistemology* are highly relevant. *Ontology* is the study of reality and refers to how we perceive the very nature of being, while *epistemology* is the theory of how knowledge emerges and is concerned with what is regarded as true (Holloway & Galvin, 2017, p. 21). In this chapter I wish to explain and account for the ontological and epistemological views that are the basis for my study and the theories I have applied when developing my analytical design.

3.1 Social constructivism

In the social constructivist tradition reality is regarded as socially constructed by society (Alvesson & Sköldberg, 2008, p. 81; Berger & Luckmann, 1966, p. 13). Social constructivists do not necessarily reject the idea that things exist on their own, that there are representations of phenomena in the world that are present independent of society. What this theoretical viewpoint claims is that we only have access to phenomena through our social connections and that the phenomena themselves can never be detached from that context. Thus, knowledge is also a construction determined by our place in the cultural context we live in and cannot be regarded as something universal and objective (Thomassen, 2006, p. 117). If knowledge about reality is assumed to be socially constructed, then it is also implied that language plays a major role in that construction, since language is what we use to describe reality (Bergström & Boréus, 2012, pp. 28-29; Justesen & Mik-Meyer, 2012, p. 28).

3.2 Poststructuralism and postmodernism

Social constructivism is linked to poststructuralism and postmodernism, although both of these terms are much disputed (Alvesson & Sköldberg, 2008, p. 98; Jørgensen & Phillips, 1999, p. 15). Cheek (2000, pp. 3-4) claims that it is difficult to both define and separate them and that much of the confusion is derived from the different ways they are applied and articulated by writers. According to Cheek (2000, p. 5), what characterizes postmodern approaches is the emphasis on how reality can be perceived in multiple ways - making postmodern views challenge the idea of a universal understanding of truth and reality. As for

poststructural approaches, Cheek (2000, p. 6) states that the focus is on the analysis of texts as representations of reality, with texts in this context referring to a wide definition of how phenomena are represented, spoken, acted or written. Another way to put it is that poststructural approaches emphasize the significance of language (Bergström & Boréus, 2012, p. 29).

> Poststructural perspectives challenge the notion that language is a neutral, objective, value-free conveyer of aspects of reality. Rather, they expose and interrogate language itself as being both constituted by, and constitutive of, the social reality that it seeks to represent. (Cheek, 2000, p. 40)

Jørgensen and Phillips (2002, p. 10) describe the following four focal points that poststructuralist approaches to discourse analysis have in common:

- Language is not a reflection of a pre-existing reality.
- Language is structured in patterns or discourses - there is not just one general system of meaning (…) but a series of systems or discourses, whereby meanings change from discourse to discourse.
- These discursive patterns are maintained and transformed in discursive practices.
- The maintenance and transformation of the patterns should therefore be explored through analysis of the specific contexts in which language is in action.

These points are highly concerned with language and discourse, which brings me to the next section where discourse and discourse analysis will be in focus.

3.3 Discourse analysis

Discourse analysis has its origin in the social constructivist tradition. It shares the view of reality as being socially constructed and emphasizes the importance of studying language as a method of understanding more about the human world (Jørgensen & Phillips, 1999, pp. 11-12). Within the field of discourse analysis, there are several theoretical and methodological approaches, and I am aware that when I use the term *discourse analysis*, this usage is not without its problems (Bergström & Boréus, 2012, p. 353; Horsbøl & Raudaskoski, 2016, p. 9; Jørgensen & Phillips, 1999, p. 9). Different writers refer to the topic in different terms: as *discourse theory* (Jørgensen & Phillips, 1999, pp. 36-40; Wetherell, 2001, p. 1), *discourse*

traditions (Wetherell, 2001, p. 6) and *discourse analysis* (Alvesson & Sköldberg, 2008, p. 459; Bergström & Boréus, 2012, p. 353; Jørgensen & Phillips, 1999). As the references show, some of these writers also use more than one of the terms. Nevertheless, like Bergström and Boreus (2008, p. 353), I find that *discourse analysis* serves me best, as I wish to account for both the theoretical views and the methodological implications that come with it. The discourse analytic approach that I have drawn upon in my study is linked to the poststructural tradition, and I will elaborate more on this in the following section. However, initially I wish to clarify some basic concepts about discourse and discourse analysis.

First, I would like to take a closer look at the concept of discourse. The term *discourse* might seem a bit abstract and illusive, and it is defined differently by theoreticians (Bergström & Boréus, 2012, p. 355; Lupton, 1992, p. 145). Jørgensen and Phillips (1999, p. 9) refer to discourse as a way of understanding and talking about the world. If we break their definition into two parts, *the understanding* and *the talking*, it might become clearer what discourse is. When they refer to *the understanding*, I believe what they mean is the collective frame of how we see the world, the social context in which speech occurs (Eliassen, 2016, p. 53; Johannessen, Rafoss, & Rasmussen, 2018, p. 58). And then there is *the talking*, the repeated patterns in the use of language that are expressed through speech and writing originating from the frame of understanding (Bratberg, 2014, p. 29; Johannessen et al., 2018, p. 59). The definition implies that when someone speaks, he is already placed within a discourse, and his utterings are formed by the discourse; what he says and how he says it is not arbitrary (Villadsen, 2017, p. 298). For example, when a teacher enters a class, there are already some expectations as to what he can say and how he can say it. It is expected that he will stick to the subject he is assigned to teach and will use the terms connected to the subject, and his students would be very surprised if he, for instance, started swearing and speaking slang in the middle of class. As this example shows, the teacher is placed within a discourse, and the students must also play their role according to it. They are all part of the discursive structure of teacher-class.

Second, I wish to address the purpose of discourse analysis. What the example above also shows is how discourses have "real" consequences in regard to actions. In the abovementioned example, the consequences are regarded as good for society; the teacher does his job and his students hopefully learn something new. However, the point still is that

discourses legitimize some actions while excluding others (Johannessen et al., 2018, pp. 60-64). Sometimes the discourses are so incorporated into our culture and our way of thinking that the effect they have is not even noticeable to us (Cheek, 2000, p. 23). Discourse analysis is a way of revealing this, but the purpose of discourse analysis is not to determine if something is good or bad. Discourse analysis is not meant to be normative. The aim is merely to point out that discourses are there, and they can affect us if we let them (Johannessen et al., 2018, p. 51).

3.4 Discourse, knowledge and power: The foucauldian perspective

The French philosopher, Michel Foucault, has been one of the most influential theorists in discourse analysis (Bergström & Boréus, 2012, p. 358; Cheek, 2000, p. 22; Jørgensen & Phillips, 1999, p. 21). He did not appreciate labels, but many claim that he has a strong link to poststructuralism and postmodernism (Alvesson & Sköldberg, 2008, p. 367; Bergström & Boréus, 2012, p. 358; Cheek, 2000, pp. 18,22). Foucault's view on discourse is that it is strongly connected to knowledge and power. According to him, these terms are inseparable, and it is not possible to speak of one without the others. Foucault (1984) says that "it is in discourse that power and knowledge are joined together" (p. 100). He believed that knowledge and power are closely connected and that the link between them is expressed through discourse (Cheek, 2000, p. 22). In this section, I will do my best to outline my understanding of his theories and describe how these terms relate and depend on each other.

Much of Foucault's work was focused on the concept of knowledge. He wanted to challenge the ideas we take for granted and question fundamental "truths" about how knowledge emerges (Cheek, 2000, p. 22; Villadsen, 2017, p. 297). Inextricably linked to knowledge, is discourse, says Foucault, and discourse is the order that forms and regulates the articulation of knowledge (Eliassen, 2016, p. 53). Foucault does not talk about discourse solely as patterns of speaking and writing. His understanding of the concept is wider than that (Bergström & Boréus, 2012, pp. 358-359). Foucault belongs to those who claim that discourse already is in play before the speaker opens his mouth to utter something, a view on discourse which aligns with the definition I gave in the previous section. The speaker is already placed within the discourse, and speaks according to it, shutting out what does not belong (Villadsen, 2017, p.

302). Foucault talks about this in his famous inaugural lecture, "Order of discourse", at the College de France in December 1970:

> I would really like to have slipped imperceptibly into this lecture, as into all the others I shall be delivering, perhaps over the years ahead.[2] I would have preferred to be enveloped in words, borne way beyond all possible beginnings. At the moment of speaking I would like to have perceived a nameless voice, long preceding me. Leaving me merely to enmesh myself in it, taking up its cadence, and to lodge myself, when no one was looking, in its interstices as if it had paused in an instant, in suspense, to beckon me. (Foucault, 1971, p. 7)

There are a lot of things regulating speech, such as context, culture, genre and much more. When reading the texts of Foucault, one can see that over the years, he expanded his understanding of what discourse is (Alvesson & Sköldberg, 2008, pp. 367-369; Bergström & Boréus, 2012, p. 357; Villadsen, 2017, p. 306). In his later works, he not only sees discourse as being linked to the practice of speech, but also to other social practices. He became more concerned about how knowledge was effectuated through discourse regulating the conduct of people, especially in institutions (Hall, 2001, p. 75).

It can be argued that Foucault's main project was to make the ways of thinking and acting that we take for granted a little less obvious (Gordon, 1991, p. 48; Villadsen, 2017, p. 297). What he, and other poststructuralists would want us to see, is that there could always have been other discourses, other ways of talking about things, based on different kinds of knowledge (Cheek, 2000, pp. 24, 41). He describes this critical project of his, this way:

> A critique does not consist in saying that things aren't good the way they are. It consists in seeing on what type of assumptions, of familiar notions, of established, unexamined ways of thinking the accepted practices are based. (…) Criticism consists in uncovering that thought and trying to change it: showing that things are not as obvious as people believe, making it so that what is taken for granted is no

[2] Foucault held this lecture in French, using the expression *tenir un discours*, which means to give a speech/hold a lecture, thus playing with the word *discours*, which can mean both speech/lecture and discourse (Foucault, 1999, p. 7). In the English translation this double (or triple) meaning is lost.

> longer taken for granted. To do criticism is to make harder those acts which are now too easy. (Foucault et al., 2002, p. 456)

Another important aspect of Foucault's views on discourse is the discontinuity and constant battle between discourses (Hall, 2001, p. 75; Jørgensen & Phillips, 1999, pp. 146-149). *Discursive battle* refers to the notion there is a constant conflict going on between different discourses. They all struggle to become the one right way of thinking and push the others aside (Cheek, 2000, p. 23; Johannessen et al., 2018, p. 71). This is part of the *discontinuity* of discourses and shows that discourses are never set, they will always change and adapt, new discourses will arise, and some discourses will disappear over time (Foucault, 1972, pp. 226-227; Hall, 2001, p. 74). Another aspect of what Foucault refers to as *discontinuity* is that discourses do not solely exist side by side, never being in contact with each other. On the contrary, they are intertwined, and it is not easy - or maybe not possible at all – to determine where one discourse ends and another one begins (Foucault, 1972, p. 226; Jørgensen & Phillips, 1999, pp. 148-150).

As explained earlier, Foucault claims that there is a connection between discourse, knowledge, and power (Cheek, 2000, p. 22; Foucault, 1984, p. 100). The assumption is that knowledge is socially constructed, and the tool for the production of knowledge is discourse. What we believe to be true has power over the way we conduct our behavior and also on how we try to regulate the behavior of others, and this is the power Foucault wished to elucidate (Alvesson & Sköldberg, 2008, pp. 373-374; Cheek, 2000, pp. 22-25; Hall, 2001, p. 75).

The traditional view is that power is a force flowing in one direction, going downwards from the ones who possess the power to the ones power is exerted upon. It is a term that often is connected to political, formalized structures; for example, someone is given power by democratic election or someone takes power by force. However, Foucault challenges these common assumptions and concerns himself with a different kind of power, what he calls the microphysics of power (Eliassen, 2016, pp. 117-119), bio-power (Alvesson & Sköldberg, 2008, pp. 374-375) or the capillary network of power (Cheek, 2000, p. 27). He claims that power is present in all human relations (Foucault et al., 2002, pp. 343, 345), and that it is a complex phenomenon, flowing in multiple directions, always changing (Dreyfus & Rabinow, 1982, p. 185; Foucault, 1984, pp. 92-93).

The relationship between knowledge, power, and discourse is not easily explained. Knowledge makes it possible to exercise power, but when power is exercised, it also creates knowledge. This dynamic process is strongly connected to the reproducing and adjustment of discourses (Alvesson & Sköldberg, 2008, pp. 373-374; Hall, 2001, p. 75). As I have pointed out earlier, there are few things - if any - that are settled and defined once and for all in Foucault's theories. This quotation illustrates the complexity of the power-discourse relation:

> Discourses are not once and for all subservient to power or raised up by it, any more than silences are. We must make allowance for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power, it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. (Foucault, 1984, pp. 100-101)

Analyses of power should, according to Foucault, be focused on *how* power is exercised. He concerns himself with power relations, rather than trying to describe *what* power is or *who* possesses the power (Alvesson & Sköldberg, 2008, pp. 370-372; Foucault et al., 2002, pp. 336-339). Dean (1996) suggests that we should use Foucault to "inaugurate a critical engagement with our present and to diagnose its practical potential and constraints" (p.210). It is important to recognize that Foucault's view on power is not a normative perspective. He does not talk about power in terms of "good or bad" (Gordon, 1991, p. 6). His concern is that power relations are omnipresent, multidirectional, and always changing, and that we should use the analysis of discourse to understand how they affect us (Cheek, 2000, p. 32; Foucault, 1972, pp. 241-246). The reason why this is important lies in the assumption that discourses regulate our conduct. Foucault (1972) says:

> I am trying to define in what way, to what extent, to what level the discourse, and particularly the scientific discourses, can be objects of a political practice, and in what system of dependency they can be in relation to it. (p. 245)

The link between discourses, politics, and practices, can be illustrated by the example of how the discourse of evidence-based practice (EBP) has gained terrain in Norwegian nursing

educational institutions. Egede-Nissen and Knutsen (2017, pp. 49-50) did a study examining Bachelor's theses written by nursing students, and their findings suggest that EBP-discourse influences both the structure and the content of the theses at the expense of other discursive frameworks. Their study serves as an example of how institutions, as Foucault (2002, p. 342) claims, are privileged points of observation, since power relations are put to work and carried out very efficiently through institutions. However, he says, because power relations are present in all social networks, analyses should not be limited to the study of institutions (Foucault et al., 2002, p. 345).

Foucault's theories on power have been criticized for being deterministic and leaving little room for resistance (Foucault, 1972, p. 225; Rose, O'Malley, & Valverde, 2006, p. 100). Foucault dismisses this criticism and argues that power, the way he sees it, cannot exist without resistance (Foucault, 1984, p. 95). He argues that "freedom must exist for power to be exerted" (Foucault et al., 2002, p. 342). In his view, power can only be exerted on individuals that are free to make their own choices (Gordon, 1991, p. 5). Power is also productive, in the sense that it is not only repressing and controlling, it is also productive (Hall, 2001, p. 77). For instance it produces knowledge and discourses, thus confirming the triangular relationship that I have referred to earlier.

3.5 Governmentality

To show how European societies through the past four centuries have become more effective at governing, Foucault describes three regimes of power relations which have been present from the Enlightenment to the present (Lundgren, Juritzen, Engebretsen, & Heggen, 2012, pp. 20-23). In the 17th century the dominant power regime was what he called *sovereignty*. This kind of power regime was personified by the European monarchs of that time. The objective of sovereignty was to enable the monarch to maintain power over his territory and its inhabitants (Foucault et al., 2002, pp. 204-205). The method of protecting the monarch's power was to exercise strong control - often violently - over the citizens.

Then, in the late 18th century and early 19th century, a new power regime arose: *disciplinary power*. Violent methods of punishment were used less and less, and the objective of power was to establish continuity and assure the common good by controlling and regulating the

behavior of individuals (Foucault et al., 2002, pp. 206-211). This disciplining power was exercised through the techniques of normalization, examination and surveillance.

Normalization refers to the process of classifying some things as normal and others as abnormal. The constitution of knowledge and truth plays an essential role in this process, because it has to be established whether something falls in to one category or the other. In the transition period between the 18th and 19th centuries, modern sciences about humans, for example medicine and psychology, emerged, and with their advent, came the accumulation of knowledge about humans (Lundgren et al., 2012, p. 21). This knowledge had to come from somewhere and that is where examination and surveillance comes in. *Examination* is a central technique of disciplinary power with hierarchical observation as a key element (Dreyfus & Rabinow, 1982, p. 156). Citizens are examined so scientists can use the gleaned information to categorize traits and behaviors into groups of normal or abnormal, good or bad, thus allowing for *surveillance* to be an integrated part of society (Dreyfus & Rabinow, 1982, pp. 156-160). An important aspect of surveillance is that the citizens can be monitored at any time and that this is something they are very well aware of (Lundgren et al., 2012, p. 22).

The disciplinary power techniques laid the foundation for yet another regime of power, the one Foucault claims to be characteristic of Western societies of our time: *governmentality* (Dean, 2006, p. 55; Rose et al., 2006, p. 86). The term Foucault introduces us to is derived from *govern* and *mentality* and refers to this power regime as a mentality of governing from within. The key characteristics of governmentality are not sanctions and force, but support, encouragement and praise (Lundgren et al., 2012, p. 22). Governmentality builds on the techniques of disciplinary power, but citizens are now expected to perform the techniques of normalization, examination and surveillance on themselves; they are both the objects and subjects of government (Cheek, 2000, p. 27). The essence of governmentality is what Foucault calls the conduct of conduct; making citizens regulate and control their own behavior (Dean, 2006, p. 44; Gjersøe, Engebretsen, & Heggen, 2012, p. 49; Gordon, 1991, p. 2). The final objective is to provide security for the population (Gordon, 1991, p. 20).

As an opposite of the security that governmentality seeks to provide, is the presence of danger and risk. Foucault advocated that danger is always present, meaning that things can always go wrong, but the possibility of doing something to reduce the risk is also present at all times

(Gordon, 1991, pp. 46-47). A consequence of making government a shared responsibility with the population is that new technologies of risk assessment and risk management have been made possible (Lundgren et al., 2012, p. 23). An example of this, which is also linked to the risk of violence, is a relatively new addition in the Norwegian legislation on the work environment. In 2017 a new regulation was added about work that entails risk of being exposed to violence. The regulation demands that employers are obligated to do a risk analysis assessing the need for preventive measures (Forskrift om utførelse av arbeid, 2017). This is only one example among many, on how risk assessment and risk management have become part of the governmental structures of our society.

Finally, I wish to emphasize at that even though Foucault placed the three power regimes along a historical continuum, he also argued that they did not replace each other in succession, they continue to co-exist:

> Accordingly, we need to see things not in the terms of the replacement of a society of sovereignty by a disciplinary society and the subsequent replacement of a disciplinary society by a society of government; in reality one has a triangle, sovereignty-discipline-government, which has as its primary target the population and as its essential mechanism the apparatus of security. (Foucault et al., 2002, p. 219)

3.5.1 Technologies of the self and confessional technology

A particular characteristic of governmentality is that it introduces new technologies of government, technologies in this context meaning something other than the literal understanding of technology as engineering and machinery. When Foucault uses the word *technology* it refers to the machinery of society, the practices which operate to control and regulate the population (Eliassen, 2016, pp. 232-236).

Foucault draws two historical lines that lead to the development of governmentality (Juritzen, 2017, p. 108). The first one goes back to ancient Greek philosophy, where an ideal was to ennoble one's personality; the individual's duty to become a better self. He called it *technologies of the self* (Juritzen, 2017, p. 108). The second aspect he delineates was what he called *pastoral power*, which is connected to Christianity. This is a form of power that is

salvation oriented, individualizing, lasting throughout a life span, and last but not least, is linked to the production of truth about the individual (Foucault et al., 2002, p. 333).

Rose et al.(2006) defines *technologies of the self* as "ways in which human beings come to understand and act upon themselves within certain regimes of authority and knowledge" (page 95). Dean (2006, p. 47) further describes these technologies as the practices we use to govern our own self, our character and our personality, thus being a sub category of the "conduct of conduct"-concept I explained in Chapter 3.5. Perron et al. (2010, p. 108) emphasize that technologies of the self also contain the element of comparison to others, to what is regarded as normal. The technologies of the self are dependent on the cultural context in which the individual subject is placed; the actions taken upon the self are triggered by demands and circumstances (Eliassen, 2016, p. 230). An example is dieting and exercising to live up to the Western ideal of slim individuals as beautiful, healthy and in control of their bodies. Foucault's suggestion is that governmentality, through technologies of the self, activate and engage individuals in taking responsibility for governing themselves (Lundgren et al., 2012, pp. 22-23). Perron et al. (2010, p. 108) argue that the deinstitutionalization of mental health care over the last decades serves as an example of how the responsibility of regulating one's own conduct is transferred to the individual, in this case the patient.

An important aspect of pastoral power is, as I have already mentioned, how it is connected to the production of truth about an individual. Essential to this truth-making, is the confession, which implies that the individual should reveal his deepest secrets and hidden practices to someone of authority, with the presumed goal of getting to know himself better (Dreyfus & Rabinow, 1982, pp. 173-174; Eliassen, 2016, pp. 237-238; Juritzen, 2017, p. 108). The technology of the confession has spread, and its effects can be seen in the legal system, medicine and other sciences, educational institutions and so forth. I believe that this *confessional technology*, as Dreyfus and Rabinow (1982, p. 173) call it, is what Foucault speaks of in a lecture at Berkeley in 1980, where he says:

> I mean the fact that, one of the main moral obligations for any subject, is to know oneself, to explore oneself, to tell the truth about oneself and to constitute oneself as an object of knowledge, both for other people and for oneself.

What is worth noticing is that while these technologies of the self might seem limiting, responsibility and demands are not all that is given through them - autonomy and freedom are also being offered (Rose et al., 2006, p. 91). As I have explained earlier, Foucault sees power as present only when there is an actual possibility of choice. Rose et al. (2006) says that "freedom is not to be defined as the absence of constraint, but as a rather diverse array of invented technologies of the self" (p. 100). This is also supported by Gordon (1991) who claims that "disrespect of liberty is not simply an illegitimate violation of rights, but an ignorance of how to govern" (p. 20).

4 Method

When conducting analyses of discourse, theory and method are linked together (Jørgensen & Phillips, 1999, p. 12). In the previous chapter I have described the philosophical and theoretical models which frame my study. In this chapter I will focus on the methodological techniques that I have used to analyze the text. I will also address the question of quality criteria for my study and describe my data material in more detail.

4.1 Quality of research

The concept of validity in qualitative studies is somewhat problematic, given that the findings are interpretative (Green & Thorogood, 2014, p. 227; Tjora, 2017, p. 232). In quantitative studies the aim is to obtain objective, neutral and value-free results, and it is assumed that this ideal can be achieved through reliability and validity in the research (Holloway & Galvin, 2017, pp. 303-305) In the social constructivist tradition, which I have described in Chapter 3.1, the view is that there is no universal truth which can be revealed through research (Berger & Luckmann, 1966, p. 13; Thomassen, 2006, p. 117). Nevertheless, this does not mean that the qualitative researcher should disregard the question of validity (Jørgensen & Phillips, 1999, p. 120). There are definitely some quality criteria that should be addressed to explain why a qualitative study is credible (Green & Thorogood, 2014, p. 227). However, these are not the same as for quantitative studies, and some even argue that qualitative researchers should abandon the concepts of validity and reliability altogether and use other names for the quality criteria which are important in this kind of research (Holloway & Galvin, 2017, pp. 303-308).

Given the assumption that knowledge can never be objective and neutral, research will never be flawless. The question of validity in qualitative studies is therefore not about eliminating problems, but about making them visible and actively relating to them (Malterud, 2017, p. 25). In the following sections, I will describe the principles of reflexivity, transparency and integrity, and how these can be used as quality criteria for my study.

4.1.1 Reflexivity

Jørgensen and Phillips (1999, p. 121) explain the concept of reflexivity as how researchers should contemplate on their role in regard to their own research and be open about why they have made the choices related to their research. This principle is also described by Tjora (2017, p. 235) who says that to account for your own position means to explain how personal engagement, knowledge, and experience can affect, but also be applied, in the analysis. Also, it is not only in the analysis that our dispositions affect us. Throughout the entire research process, we should be aware of their impact. What do we aim to study; which questions do we ask, and what are the things we dismiss and ignore (Cheek, 2000, pp. 20-21)? Green and Thorogood (2014, p. 230) also emphasize that researchers must be recognized as an essential part in the process of producing their own research data.

I believe that there is no possible way for me as a researcher to detach myself from the discourses I study (Jørgensen & Phillips, 1999, pp. 32-33). Language is the tool I use to describe my findings, as well as the ideas I derive from them, and as I have pointed out earlier, the use of language is never neutral. By conducting this study I am discursively producing knowledge about the world. According to the principle of reflexivity I wish to strengthen the validity of my study by describing my position in relation to my material and discuss openly what effects my contribution to the discursive production might have.

I have worked in mental health care for a long time, the last six years in forensic psychiatry. My closeness to the research field is something that needs to be addressed. Obviously, being part of the culture and the discourses that I wish to study must influence me in some way. However, this might also be an advantage. Tjora (2017, pp. 235-238) argues that such closeness can be an asset. He states that special knowledge, engagement and interest can strengthen a qualitative study, as long as the researcher accounts for it and explains his or her predispositions. Nevertheless, my closeness to the topic of this study and the research field is something that I have kept in mind and reflected upon throughout the duration of the project, to make myself aware of how it may affect the research process.

Another aspect that I believe needs mentioning is my interest in language and the power of language. Since I was a child, one of my major interests has been books and reading, and language and the written word has been important to me for as long as I can remember. This

has also had an impact on my professional life where I have used a lot of my time as a social educational nurse (Norwegian: *vernepleier*) to work with patient journals and nursing documentation. I have been involved in several projects regarding this, and I teach classes about it. Because of this, I have experienced first-hand how the things nursing personnel write about patients have an impact – on both the personnel and the patients. There is no doubt in my mind that this has been significant as to why I have chosen both the topic and the method for this project.

The ERM protocol was already well known to me, but up until the project started, I had read it only for the purpose that it was intended for, as a tool to apply ERM clinically. I remember the first time I was presented with the text, when I had recently been introduced to the ERM strategy and was excited about this new instrument which I had great hopes would improve the treatment we gave our patients. I found the protocol to be a useful tool as it gathered much of the knowledge about ERM and seemed practical to apply in clinical work. I had no objections or critical views on it at that time.

When I picked up the protocol again, this time to conduct my analysis, it was kind of like reading it for the first time. Of course, that is a statement with some modifications; my prior knowledge of the text and of the method could not be erased. However, this prior knowledge might also be seen as an advantage, as it enabled me to read and understand the text in a way that a person with no knowledge of the instrument wouldn't be able to.

4.1.2 Transparency

There is a demand for transparency in qualitative studies (Green & Thorogood, 2014, p. 227; Malterud, 2017, p. 36; Tjora, 2017, pp. 248-250). This means that as a qualitative researcher it is necessary for me to provide both honesty and clarity regarding method and procedures throughout my entire research process. Transparency is particularly linked to how the research and the findings are presented (Tjora, 2017, p. 248).The way I see it, transparency for my study can be provided by describing the analytical process in such a manner that the readers can understand how the analysis was done. I have tried my best to do so in Chapter 4.4 Analytical process.

4.1.3 Integrity

Integrity in research refers to the independence of the research, that the research should be detached from any forces wanting a specific result (Tjora, 2017, p. 253). This can be especially problematic when you have been employed or engaged to do a specific study. In my case the study itself is independent and not an assignment from anyone. Nevertheless, it is not independent of me and my professional standpoint, and I would like to address this by describing any potential problems in regard to this.

It is no secret that I have a positive attitude towards ERM, as I have been the leader in a project for implementing the method at my workplace. I am also a part of the ERM network in Norway and have colleagues that apply the method as part of the treatment at their respective institutions. However, it has not been my agenda to use this research project to promote ERM. On the contrary, my aim has been to look at the method with a critical eye in order to elucidate power relations that the users of ERM might not be aware of. It is my sincere impression that this knowledge will be welcomed by colleagues, as it is not meant to dismiss ERM as a beneficial method, but to provide insight that can be used when applying it.

I have had two supervisors on this project: Truls Juritzen, (Associate Professor) and Frans Fluttert (Associate Professor and Senior Researcher). Juritzen had no knowledge of ERM or of me prior to my engaging him to be my main supervisor. Fluttert, on the other hand, is the creator of ERM, and I can see how this might seem problematic. I wish to stress that he has not been involved in the analytic process and has not tried to influence the results in any way, nor made any changes to the ERM protocol while the study has lasted. His role has been to advise me on the matters regarding existing knowledge of ERM, while Juritzen has been the one who has supervised the analytical process and advised me on that. It should also be mentioned that Fluttert has been supportive of the project and of the critical approach that I have applied, appreciating any knowledge that contributes to what we already know about ERM.

4.2 Description of the data material

The original ERM protocol was written in Dutch. It has then been translated into English and later into Norwegian. Consensus groups and back-translating it to the original language was

used to assure the quality of the translations (Frans Fluttert, personal communication, 19.02.2019). The version I have applied to conduct this analysis is the Norwegian translation (Fluttert et al., 2013a). The intention of this section is to give a summary of the contents of the protocol, thus also describing the steps of the strategy, enabling the reader to become familiar with both the protocol and the strategy.

The protocol is a 22-page brochure, with a purple front page and a spiral lining, printed in A5 format. The title is *ERM - Early Recognition Method: "From Black box to Brain box" – Risk management in psychiatric health care*. There is also an appendix containing the ERM plan template. The protocol is partly illustrated with small images, but mostly it consists of text, including some flow sheets and textboxes.

The protocol starts with an overview of the strategy. The reader is introduced to the research on ERM, how it was developed and what the purpose of the strategy is. References to the research are listed. The next two pages are used to illustrate the phases of the strategy in a flow sheet called "Tree of decision making" (my translation). It shows the different directions that the strategy might take, that is, dependent on whether a patient is willing and/or able to participate. Then there is some information about the different phases, giving a rough overview of these.

The next parts of the protocol follow the phases of the strategy: *Preparation* (Phase 1), *Listing early warning signs* (Phase 2), *Monitoring* (Phase 3), and *Action plan* (Phase 4). First, there is a chapter on Phase 1: *Preparation*. It describes how a patient can be introduced to the strategy and explains how to talk to a patient about ERM. There are also descriptions of characteristics regarding the patient and his network that might affect the work with the ERM strategy.

The following chapter deals with Phase 2: *Listing early warning signs*. It explains how these signs can be identified through conversations with the patient, his network and the nursing staff. Some emphasis is put on the patients' individuality, both in regard to early warning signs and possible vulnerabilities. It is also made clear how to describe early warning signs according to levels of severity and an example of how this can be done is provided.

The chapter on Phase 3: *Monitoring* is not very long (shorter than one page). It explains the goal of monitoring and suggests how often and in what manner the monitoring should take place. The last chapter, which describes Phase 4: *Action plan* is a bit longer than the previous one. It suggests possible interventions if a patient should display any of the listed early warning signs in a moderate or severe level. The chapter starts by explaining the goals of this phase and then goes on to describe the different types of interventions, depending on who suggests them and who is supposed to perform them.

The last part of the main document is more like an appendix, even though it is a part of the 22 numbered pages. It is a list called FESAI-NO (short for Forensic Early Signs of Aggression Inventory, Norwegian version), which is a list of a variety of early warning signs. The FESAI can be used to assist nursing personnel in the identification of early warning signs in an individual patient. FESAI was developed based on data collection from 3768 descriptions of registered early warning signs (Fluttert, Van Meijel, Bjørkly, Van Leeuwen, & Grypdonck, 2013b; Fluttert et al., 2011).

At the end of the document there is an actual appendix, consisting of the ERM plan template. This is a template of the document for writing in when working with the ERM strategy clinically. It can be used throughout all the phases. The template mostly uses first person pronouns about the patient, whereas the main document speaks of the patient in the third person.

4.3 Methodological approach to analysis

In this study, I have drawn on the theories of Foucault to conduct the analysis. Foucault resisted giving a specific method for doing an analysis of discourses based on his theories, and it is not easy extracting any methodological principles directly from Foucault himself (Alvesson & Sköldberg, 2008, p. 375; Cheek, 2000, p. 31; Villadsen, 2017, p. 304). However, he left behind an extensive production of texts about discourse and discourse analysis, and in addition to reading some of his works, I have also looked to other theoreticians who interpret Foucault's works to get a grasp of his theories and understand his research. Foucault sought to identify discourses outside the obvious ones, like the ones connected to a profession or a scientific discipline. He assumed that there were more basic discourses at work across

separate fields of knowledge (Foucault, 1972, pp. 239-240; Villadsen, 2017, p. 303). As for my study, I suspected before starting the analysis that I would find traces of a medical or psychiatric discourse, but I have tried to keep an open mind and also look for other, more unexpected and less visible discourses.

Foucault's research consisted of some large studies including a variety of texts from different historical eras, that is, *Madness and Civilization* on the history of how madness has been perceived and treated (Foucault, 1967), *The Birth of the Clinic* dealing with the development of the medical discipline and hospitals (Foucault, 1973), and *Discipline and Punish* about the correctional system (Foucault, 1979). Some of the researchers who draw on the theories of Foucault conduct their analysis in a similar way as him, by exploring a vast amount of text material and looking for patterns across different discursive groups (Villadsen, 2017, p. 310).

My study is a Master's degree project and not as large as a Ph.D., and the ambition level therefore had to be adjusted accordingly. I have conducted the study within quite a small time frame, and I did not have the possibility of examining several texts and to choose from them. Instead I have chosen just one text to study closely, and some might argue that my study cannot claim to have been conducted in a "true" foucauldian manner, given that Foucault argued that a discourse does not consist of only one text, one statement, one action or one source (Hall, 2001, p. 72). The way I see it, my text must be considered to contain discourses that also exist elsewhere. I base my analysis on this text, but I also have had to look to other sources, such as other studies and government documents, to arrive at my findings. I believe I can use Foucault's theories as tools to disclose traces of discourses in the ERM protocol, but it is unlikely that those discourses have emerged from this text alone and are exclusive to it.

One of those who has made an effort to interpret how Foucault studied discourses, is Stuart Hall (2001, pp. 72-74). He summarizes his understanding of Foucault's analytic strategy into six elements which he considers necessary to address, when one does a discourse analysis on a representation of a phenomenon, like for example, madness or sexuality. The first element Hall draws to attention is *statements*. What knowledge of about the phenomenon in question do these statements offer? The next element is *rules*. Which rules apply within the discourses? What is possible to say and what is not? The third element is *subjects*. A subject in this context is someone that personifies the topic. How is this subject described; what are its

attributes? The fourth element to look for, according to Hall, is *authority of knowledge*. How does the discourse acquire authority? How does it embody the truth? The fifth of Hall's elements is *practices*. What practices does the discourse make possible and legitimate? How is conduct being regulated and disciplined through the discourses? How do the discourses inflict their power on those involved? Finally, the last element Hall describes is acknowledging the arising of new and different discourses or *epistemes* at a later time. Discourses are never set, he says, but change as history moves forward.

In my study I have drawn on these elements that Hall (2001, pp. 73-74) outlines and applied them in my analysis, at least to a certain extent. I have adapted them to fit an analytical strategy usable for answering my research questions. I believe that these elements were useful when I started reading the text with a researching eye. They helped me in my analysis, by breaking into parts the ingredients that makes a discourse, and they made the discourses visible to me. I would argue that these elements collectively have been essential for answering my main research question about which discourses are embedded within the ERM protocol. The elements have also contributed to answering the sub questions.

In the next sections I will elaborate more on each of the different elements, how I understand the terms and how each of them has made it possible to answer my research questions. I have studied different sources in addition to Hall, both Foucault's own works and other foucauldian theoreticians as well, in order to understand each term's meaning. The following sections on the elements are listed in the order that used them when I conducted my analysis.

4.3.1 Statements

Foucault claimed that in order to analyze discourse, one should focus on what is actually being said, not what the meaning behind it is (Foucault, 1972, pp. 233-235; Villadsen, 2017, pp. 299-300). In other words; pay attention to *what* is being said, rather than *why* it is being said.

> I do not question the discourses concerning what silently they mean, but on the fact and the conditions of their manifest appearance; not on the contents which they may conceal, but on the transformations which they have effectuated; not on

> the meaning which is maintained in them like a perpetual origin, but on the field where they coexist, remain and disappear. (Foucault, 1972, p. 235)

According to my understanding, searching for statements is a methodological approach which meets with this demand. I have tried to refrain from attempting to see the meaning behind the text, and instead directed my attention to the words being used and the actual statements being made. However, it should also be taken into account that a statement is not synonymous with a sentence, an assertion, an allegation or with speech. A statement is always placed within a context that gives it a certain meaning, and can be interpreted very differently due to the context (Eliassen, 2016, pp. 63-65).

Statements have different characteristics: they can for instance be strong and obvious or more weak and subtle. One way to disclose whether it is the former or the latter is to look at the argumentation. Does the text argue in favor of its statements? Does it feel the need to justify what is being said? If so, that could imply a need to convince the reader that it speaks the truth and reveal that the statements are not strong enough to stand alone (Johannessen et al., 2018, pp. 78-80).

Searching for and investigating statements in the ERM protocol has contributed to disclosing the contradictions between different discourses in the text. It was easier to see how the various statements argue against each other when I looked at them separately. Also, by examining what is being said, it has also been made clearer to me what is not being said; what is taken for granted and what it is not possible to speak about, thus revealing some aspects of the power relations.

4.3.2 Subjects

The word *subject* is an interesting one. When used as a verb it means to bring something under control, often by force. You can "subject yourself" to the power of others. On the other hand, when used as an adjective, the word *subjective* means to base something on your own opinion or ideas (Wehmeier, 2000). Foucault often liked to play with the different meanings of words, and in his essay "The Subject and Power" he draws attention to the double-meaning of the word *subject* (Foucault et al., 2002, p. 331). He suggests that this double-meaning illustrates how the subject is constructed within discourse; the subject must *subject to the*

discourse, but is at the same time part of the process of *constituting itself subjectively within the discourse* (Foucault et al., 2002, p. 331; Hall, 2001, pp. 79-80).

The assumption Foucault lays out is that the discourse is determining how a subject is allowed to behave (Villadsen, 2017, p. 311). The traditional view on human individuals, or subjects, is that we are autonomous, self-dependent, in control of ourselves, and the producers of knowledge (Bergström & Boréus, 2012, p. 361). Foucault, on the other hand, claims that it is the other way around: Discourse is what produces knowledge and the subject is also produced within the limits of the discourse. The subject may produce texts and be the bearer of knowledge, but it is always operating within a discursive context and is limited and regulated by it (Hall, 2001, p. 79). Because of this, I argue, an analysis directing the attention to the subjects in a text can be helpful in exposing the discourses.

There seems to be two components that Foucault includes in the production of the subject (Hall, 2001, p. 80). The subject is produced by the discourse and serves as a personification of the particular knowledge that the discourse produces. This means that the subject must have certain attributes defined by the discourse. However, the subject only acquires meaning when the individual places himself within the discourse, when he takes his position as this particular kind of subject. This could at first glance be regarded as a very limiting way of seeing things, but upon closer inspection Foucault focuses on the power that lies within the possibility of making oneself a subject. Even though there are limits, there is also space for maneuvering within the discourse and being able to form yourself as a subject. Like the case is with so many of Foucault's terms and definitions, reciprocity is essential also to the matter of the subject; discourse produces subjects, but subjects also produce discourse (Eliassen, 2016, pp. 186-188).

The placement of subjects within a discourse is often referred to as *subject positions* (Hall, 2001, p. 80). To be more precise, the subject is located in a position from which the discourse makes most sense, meaning that the individual can have all the right characteristics, but the subject has no meaning until the individual identifies with the position that the discourse constructs. However, an individual can take several subject positions, as there are different discourses at play at the same time, and the subject positions thus contradict each other, the same way as discourses do (Jørgensen & Phillips, 1999, p. 53).

Looking for subjects in the ERM protocol has enabled me to see how knowledge about the subjects is produced and constituted. It is also useful to look at what kind of role the subjects are being assigned (Johannessen et al., 2018, pp. 81-82). Are they playing an active part? Are they regarded as responsible, and are they the cause of anything? Examining how the subjects are constituted in the ERM protocol, investigating the relationship between them and how they relate to each other is a methodological approach that also has helped make the power relations visible to me.

4.3.3 Practices

As mentioned earlier, in Chapter 3.4, Foucault's definition of discourse includes not only the practice of language, but also the practices which are made possible and legitimized through discourse (Bergström & Boréus, 2012, pp. 358-359; Villadsen, 2017, pp. 298, 302). Thus, when Hall writes about practices, I understand the term in light of the foucauldian definition; that discursive practices refer to how the subjects' conduct is being regulated and controlled. This includes of course the use of language, but is not limited to it. Other practices are also linked to the discourse.

There is a reciprocal relationship between practices and discourse. A discourse makes certain practices possible, and these practices, in their turn, confirm the discourse (Johannessen et al., 2018, p. 63). I wish to use the concept of madness to explain this. No one would object that there have always been people with somewhat deviant behavior, those whom we now refer to as *the mentally ill*. However, these people have not always been referred to as *mad* or as *ill* or as *suffering from mental disorders*. Before the Enlightenment, they were looked upon as different, but their behavior was not considered to be an illness. It was when we started to talk about madness as an illness that practices of treating it were made possible. Without this way of talking about madness as a disease of the mind, it would not be meaningful to treat it. Thus, the discourse of madness as illness created the practices of psychiatry (Perron et al., 2010, pp. 106-107). Then, as the psychiatric discourse gained ground, these practices in their turn contributed to sustaining the discourse, but also to changing it substantially over the years. What is being talked about as best practice now is not the same as it was a hundred years ago, or even a few decades back (Bratberg, 2014, p. 47; Johannessen et al., 2018, pp. 60-65).

In my study, the element of practices has contributed to revealing the power relations, given the assumption that discourse makes some practices possible and others impossible. However,

I wish to point out that there is no causal relationship between the two: Discourse *affects* practices, but it does not automatically *cause* them (Johannessen et al., 2018, p. 65).

4.3.4 Authority

Hall (2001) describes this element as how "knowledge about the topic acquires authority, a sense of embodying the 'truth' about it; constituting the 'truth of the matter' " (p.73). The way I see it, this element represents how a discourse claims its importance, its right to be placed on the map. It is not necessarily just the words that are being used, but also other contextual means of making itself true. So, what gives the discourse the power to make itself true? The answer to that, Foucault might say, is knowledge. Power and knowledge cannot be separated - they are totally dependent on each other. Knowledge is always a form of power, and by putting knowledge to work by regulating the conduct of others, knowledge acquires "real" power (Dreyfus & Rabinow, 1982, pp. 114-115). For example, health care is organized based on certain views that constitute the way health care should be practiced, thus giving legitimacy to some perspectives and dismissing other viewpoints based on that authority (Cheek, 2000, p. 41).

I have entitled this section "Authority," but one might argue that this element might as well have been called knowledge, which Foucault in French refers to as *savoir*[3], (Eliassen, 2016, pp. 61-62), or I could have called it power, for that matter. According to my understanding, this element embodies the triangular connection between discourse, power, and knowledge that I have addressed in Chapter 3.4. However, I find that the word *authority* has helped me focus on which means the text uses to constitute that it speaks the truth and, hence, elucidated the knowledge/power relation.

4.3.5 Rules

Hall (2001, p. 73) explains this element as how certain ways of talking about a topic are regarded as "sayable" and "thinkable," while others are excluded. In the lection "Order of Discourse", Foucault explains the procedures he believes to be the mechanisms that organize and control the production of discourses. He says:

[3] The English word *knowledge* is not directly translatable from the French *savoir*, or the Norwegian word *viten*. *Savoir/viten* is not just *the theoretical concept of knowledge*; what we know. It is also *the articulated knowledge* which is regulated by discourse (Eliassen, 2016, p. 53).

> I am supposing that in every society the production of discourse is at once controlled, selected, organised and redistributed according to a certain number of procedures, whose role is to avert its powers and its dangers, to cope with chance events, to evade its ponderous, awesome materiality. (Foucault, 1971, p. 8)

According to my understanding, these procedures that Foucault speaks about are what Hall has named *rules*. Foucault divides these procedures, or rules, into three groups: the principles of exclusion, the principles of rarefaction, and the rules of subjection (Foucault, 1971, pp. 8-20). These three groups are then divided into different kinds of procedures belonging to each group. As mentioned before, Foucault studied vast materials spanning multiple centuries, which is, in many ways, very far from what I am aiming to accomplish with my project. Nevertheless, I find that these procedures he speaks about, are relevant in my analysis, but not in the detail that he describes in this lecture. Because of this, I have chosen to describe and apply the following primary classification of the three groups of procedures that regulate and control discourse.

The principles of exclusion are aimed at the exterior of the discourse: Where are its borders and what cannot be said within the discourse? These procedures limit the discourse and regulate what is allowed to be said; they determine the division between what is false or true, what is prohibited or allowed, and what is reason or folly (Eliassen, 2016, p. 69; Foucault, 1971, pp. 8-12).

While the principles of exclusion are aimed at the exterior, the next group of procedures that Foucault mentions are internal rules, where the discourse exercises control over itself. He calls these *the principles of rarefaction* (Foucault, 1971, pp. 12-17). These procedures equip the discourse with an internal order of how it can be expressed, what frames of understanding it is placed within, and where it can emerge from (Eliassen, 2016, p. 69).

Foucault (1971, pp. 17-20) calls the third group of procedures *the rules of subjection*. These are the rules determining under which conditions a discourse may be employed, imposing rules upon those who employ it, and denying access to those not belonging to it. These procedures determine who are allowed to be the speaking subjects of the discourse, the ones who have access to the discourse, and the premises for their speech (Eliassen, 2016, p. 70).

I find that the element of rules has guided me to see more clearly how the discourses open up to some things, while they close off to others. Like practices and subjects, this has been helpful in revealing power relations embedded in the text.

4.3.6 Epistemes

Hall (2001) describes this element this way:

> (…) acknowledgement that a different discourse or episteme will arise at a later historical moment, supplanting the existing one, opening up a new discursive formation, and producing, in its turn, new conceptions of 'madness' or 'punishment' or 'sexuality', new discourses with the power and authority, the 'truth' to regulate social practices in a new way. (p.74)

As mentioned before, Foucault claimed that behind any present discourses, there were more basic underlying *regimes of truth* which work across the other, more visible discourses (Alvesson & Sköldberg, 2008, p. 369; Hall, 2001, p. 76; Villadsen, 2017, p. 303). Murray, Holmes and Rail (2008) describes an episteme as "the implicit ground of our knowledge, the condition of possibility for something to appear as true or false, good or evil"(p. 274). Additionally, Eliassen (2016, p. 57) explains the episteme as the superior system of the interrelationship between different fields of knowledge in any given era. This means, as I understand it, that the discourses in the text do not exist in a void, detached from everything else. They are part of larger discursive formations – epistemes. Thus, this element might help in uncovering how the ERM protocol is part of a larger structure.

The discontinuity of both discourses and epistemes is essential to Foucault. Even though his works outlines some of the epistemes he thinks has been, and are, in play, he wanted us to see that there are no distinctive divisions where one episteme ends and another begins. He explains it this way: "The epistemic is not a slice of history common to all the sciences: it is a simultaneous play of specific remanences" (Foucault, 1972, p. 228). This is an aspect that I have had to take into account when conducting my analysis.

4.4 Analytical process

The purpose of this section is to provide transparency by leading the reader through the process of my analysis. I wish to provide the information necessary for the reader to understand how my analysis has been conducted.

As I have already mentioned, the text was well known to me before this project started. It would have been impossible for me to detach myself from my prior knowledge of the text and the research field. The important thing for me, when I first approached the text as a researcher, was to investigate it with a different and more critical gaze. I have striven to never lose sight of my research questions, so I printed them out and put them up on my office wall, to literally keep them in plain sight at all times.

The first step of the analytical process was to read the text with my researcher's glasses on and get to know it in a different way. I took notes, writing down everything that came to mind and was noticeable to me. I was aiming at familiarizing myself with the text in a new and different way. During this reading, I did not focus on the elements, though I knew they were going to be important later in the process. Nevertheless, they were present in the back of my head, and even though I tried keeping them there, it isn't possible to disregard the fact that they may have directed my focus.

The next part of the analytical process was to look for the six elements described in Chapters 4.2.1 to 4.2.6. I started out by searching for the *statements* in the text, using a color marker to underline sentences and words that formed statements which seemed essential. I then repeated this, searching for *subjects* and *practices*, marking out excerpts about these elements with different colors. I also made notes, writing down my observations and the deliberations that came with them.

When I had gone through the text and searched out these three elements (statements, subjects and practices), I found myself a little at a loss. So far it had been, if not easy, at least quite possible to find what I was looking for without too much struggle. But now, as I faced the elements of *authority*, *rules* and *epistemes*, the terms kind of escaped my understanding and I was not able to grasp their full meaning. Because of this, I had to return to my literary studies in order to see if that could help me move forward with the analysis. I delved into the works

of Foucault and of others who had pursued understanding his theories, and, little by little, the contents of the last three elements became clearer to me.

After having immersed myself in foucauldian theories, I went back to the text, reading it with my newfound insight. What now seemed obvious to me was that I could not use the technique of color marking the text in pursuit of *authority*, *rules*, or *epistemes*. These elements are, according to my understanding, laying the foundations for the text and operating in the background, without necessarily being put into words. I therefore read the text once more and tried to notice how the elements of authority and rules manifested themselves in the text, not only by words, but also by noting what was not being said, what was taken for granted, signifiers of how the text acquired authority, and how rules were put to work. The epistemes were put on hold for a while, and I will get back to why that was in a little while.

The next thing I did was to gather my notes and try to see the wholeness of what I had found noticeable so far. I had the building blocks, but could they be put together and become a construction? My aim, as stated in my main research question, was to disclose discourses in the ERM protocol. To be able to make the discourses visible to me, it was necessary to take a step back and look at the bigger picture. It is important to emphasize that I do not claim to have discovered discourses as naturally existing entities of language production. According to my epistemological perspective, the discourses do not exist independently outside of context. They aren't preexisting entities, waiting for me to come find them. I am indeed a part of their construction and constitution. Nevertheless, I still argue that the discourses I will describe in Chapter 5, where I account for my findings, are present in this text and also many other texts, and that the names I have given them are not as important as the way they affect our actions.

As for the epistemes, I have mentioned earlier how they are the contextual frame in which the discourse is placed, the larger discursive formations of our time and culture (Alvesson & Sköldberg, 2008, p. 396; Eliassen, 2016, p. 57; Hall, 2001, p. 76; Villadsen, 2017, p. 303). When I decided to use the elements that Hall describes as an analytical approach, I was a bit hesitant about whether I should include epistemes in my analysis or not. I first thought that it would not be possible for me to comment on which epistemes lay the foundations for this particular text, from just this text alone. My view on this changed a bit as I proceeded with the project, and I would argue that to exclude this element would be to disregard the significance of the context the text is placed within. However, the ERM protocol alone is not sufficient as

a basis for commenting on the epistemes of our time, and I have had to look to other sources to be able to reflect on this element in connection with my findings.

As for my research questions, from the beginning I wanted to focus on the discourses in the ERM protocol. What has changed many times along the process is the specific formulation of my main research question. I have discussed this with my supervisor numerous times, until we finally arrived at the formulation it has today. We have discussed how different uses of words and phrasing can be interpreted in multiple ways. For example, should I use the phrasing *discourses found in* the ERM protocol? That could give the impression that the discourses are just lying there, existing on their own, waiting for me to come dig them up, which would disregard the aspect of my being part of their creation. I found *embedded* to be a more suitable word, because it makes me think of something that is part of a larger framework. I can pick of traces of a discourse, but it has no meaning unless you put it into a larger context.

The sub questions have changed more substantially during the research process. I started out with four, and ended up with two. The power/knowledge relation was something I wanted to investigate, but I struggled to arrive at a specific question that was meaningful for the analysis. The subject positions, however, came into focus during the analysis, when I discovered how important the element of subjects was when describing the different discourses. Towards the end of the analysis all research questions where formulated as they are now and used throughout the discussion of the findings to keep a focus on my aim.

4.5 Language and translations

I would like to address the issue of how my study is caught between several languages and the possibility that meaning and content of words might get lost in translation. I believe it is important for the transparency of my study that I provide insight into how I have dealt with the language challenges.

I have conducted an analysis of the ERM protocol NO version, a document originally written in Dutch. In the analytical work, I used my native language, which is Norwegian. However, much of the literature I have applied to arrive at my methodological approach was written in English. Now that I am writing this thesis, I have chosen to do so in English. In addition, I am drawing on the theories of the Frenchman Foucault, who wrote most of his original works

in French. Because of all these aspects my project is under the influence of many different languages.

As I have already mentioned, the analysis was conducted in Norwegian. In addition to using the Norwegian version of the protocol as my text material, conducting the analysis in Norwegian also means that when I read the text my thoughts about it were Norwegian, and the notes I made during the analysis were made in Norwegian. However, I continued to use the English words for Hall's elements, to avoid minor shifts in the meaning of the terms that could occur if I translated them.

In the following chapter I will be describing my findings and the use of quotations from the analyzed text will be necessary. At first, I intended to use the English version of the protocol for the quotations, but then I discovered that the Norwegian version was not quite identical, because it has had additions and revisions made to it after the translation. Given the resources and expectations of a master study, I have not been able to use a professional translator. I have translated the Norwegian quotations myself and to further add to the accuracy of these translations, I have had a colleague with bilingual background read my translations and give advice on them. On the occasions where a word or an expression has not been directly translatable, I have used footnotes to further provide an explanation.

5 Findings

As mentioned in Chapter 4.3.1, Foucault advocated the view that discourse analysis should be based on the actual text in question, without trying to finding a hidden meaning behind it. In my analysis of the ERM protocol, I have tried to stay true to this ideal. The findings have emerged to me through my analysis of the protocol, but the paradox of social constructivism is that I am both the creator of the findings and the interpreter of them. I cannot separate my research as an entity existing independent of myself. However, to show the reader where the findings originate from, I will present the excerpts from the text which have made me able to say that I have disclosed the contours of three discourses, thus answering my main research question: *Which discourses are embedded in the ERM protocol?* The quoted material which is used in this chapter is taken from the ERM protocol and translated by me, if not otherwise referred. The page number refer to the pages of the Norwegian protocol (Fluttert et al., 2013a).

I also wish to emphasize that discourses are not separate compartments with watertight shields between them, as I have already explained in Chapter 3.4. The discourses I aim to describe are intertwined, and not detached from each other, and sometimes they even meet in the same text excerpt. Nevertheless, I have divided them into separate categories for the purpose of describing the analytical results. Jørgensen and Phillips (1999, pp. 148-149) claim that categorizing discourses can be useful for analysis, especially to elucidate contradictions and discursive battle.

Furthermore, this chapter about findings will address the sub question of *what kind of subject positions are being constituted within these discourses*. I will be using the elements Hall (2001, pp. 73-74) outlines to describe how the discourses emerge from the text and into my view, but the different elements don't have the same significance for each discourse, as the findings originate from the text and not from what I wish to find. As for sub question number two - *What kind of power relations are being constituted within the discourses in the ERM protocol?* – I will get back to that in Chapter 6.

5.1 Mental illness and the treatment and care of professionals

As explained in Chapter 4.3.3, the constitution of mental deviance as an illness is deeply embedded in our society as a discourse legitimizing the treatment of individuals suffering from mental illness. The labeling of these persons as *patients*, a word which the ERM protocol also consistently applies, is in itself a reproduction of such a discourse. The ERM protocol upholds the notion that violence can be seen as a symptom of mental illness and that aggressive symptoms, like all other symptoms of illness, can be treated. Early signs of aggression are described as caused by either "psychotic symptoms/delusions" or "mental instability or need for inner and outer control" (Fluttert et al., 2013a, p. 8). The discourse of mental deviance as an illness can be seen in these excerpts from the protocol:

> The purpose of ERM is to help prevent the patient from having a relapse in his main problem areas (violence, drug addiction, psychosis, unwanted behavior, self-injury etc.). (p. 5)

> Symptoms that could affect the possibility for cooperation on the ERM plan. Describe to what extent the patient displays these symptoms:

	Not/hardly evident	Moderately evident	Highly evident
confusion, incoherent thinking			
depressiveness			
fear			
inactivity			
taciturnity			
social isolation			
concentration disorders			
poor registration of information			
over-sensitive to stimuli			
impulsiveness			
aggressiveness			
craving for alcohol or drugs			

(p.11)

Words like *relapse*, *symptoms* and *disorders* are linked to illness, and by using such words, the protocol is writing itself into a discourse based on a medical understanding of mental deviance. It is something that is possible to diagnose by identifying symptoms, like the ones listed in the table above, and relapse back to illness can be prevented by treatment, for example by applying the ERM strategy.

The patient is depicted as a subject suffering from mental illness. To assume this subject position, the patient must subject himself to the discourse by at least being willing to accept the fact that he is a patient and that he needs treatment. Thus, the patient can subject himself to the discourse, but there is also the possibility of his resisting it by refusing to be labeled as a mentally ill person in need of treatment.

Contrasting the subject position of the patient, the discourse additionally creates a subject position for the personnel. The personnel are described as subjects of professional knowledge and the ones offering treatment. The contrast between the subject positions of the patient and the personnel can be seen in the following quotations from the ERM protocol:

> The patient's limitations make him dependent on others in recognizing early signs and intervening on his behalf. (p. 12)

> If an agreement can't be achieved regarding one or more of the early warning signs, a decision can be made to not include (or delay including) them in the ERM plan. The personnel can write down these early warning signs under 'Additional warning signs'. Even if the patient does not agree, the personnel will continue to apply the additional early warning signs based on their professional assessment. (p. 14)

Noticeable here is how the patient is described with words such as *limitations* and *dependent* and the one in need of others *intervening on behalf of him,* while the personnel are the ones able to make a *decision*, *apply* the method and use their *professional assessment*.

Through this discourse, the ERM protocol constitutes subject positions in which the personnel are given power because of their professional knowledge and allows for the practice of making decisions on behalf of the patient, thus carrying with it associations of paternalism:

> If the patient does not wish to cooperate on the ERM strategy, while ERM nonetheless is considered clinically relevant, the decision about moving forward in making an ERM plan will be made by the treatment team. (p. 9)

All of the last three abovementioned quotations show that in this discourse the personnel are the ones who possess the true knowledge. It is tacit what this clinical or professional knowledge really is, and it is thus taken for granted that the readers are in agreement about what it consists of. A need to explain it and argue in favor of it is not considered necessary. The text carries enough authority of its own to allow refraining from doing so. This can be considered an example of the power/knowledge relation which Foucault writes about (Hall, 2001, p. 75). The two are deeply intertwined: The power lies in the knowledge, and the knowledge must have the power to make itself true. In this case, the professional knowledge that the personnel possess gives them power to make decisions and to intervene on behalf of the patient, making use of the discourse to constitute their professional knowledge as true. A mechanism the discourse uses to constitute itself as true is how the abovementioned quotations apply the principle of exclusion. Foucault (1971, pp. 8-10) pointed out how statements like these could be seen as a technology of separating the true from the false, the madman's speech from the voice of reason, applying the rule of separation. Thus, the patient, representing what he called the madman, cannot be trusted to have true knowledge because of his symptoms of illness, while the personnel represent the voice of reason.

The intervention plan template in the ERM protocol has an interesting feature which adds to contrasting the professionals with the patient and also the patient's network. The interventions are divided into three groups of possible actions to be taken should the patient display any early warning signs: There are interventions that can be initiated by the patient himself, the personnel, or the patient's network.

> When I [the patient] notice that early warning signs occur, I can take actions that make me feel more stable and calm. These actions are: (appendix)

> When I [the patient] notice that early warning signs occur, I must make sure not to get into situations which I know will increase my stress and tension level. These are

> situations which I know from earlier experiences, have increased my stress and tension level. (appendix)
>
> When early warning signs occur, the personnel can initiate actions which contribute to regaining stability, in addition to support and secure other persons in my immediate vicinity. (appendix)
>
> When early warning signs occur, persons close to me/in my network can support me by taking the following actions: (appendix)
>
> When early warning signs occur, it is best that persons close to me/in my network avoid particular actions/approaches. These actions/approaches make me more stressed. (appendix)

It is worth noticing, that in the case of both patients and network, there are suggestions of what they should *not* do in addition to what they should do, while no such category of suggestions is provided for the personnel, which might give the impression that the personnel have no need for them. This raises the question of why this is omitted for the personnel.

Additionally, it is interesting to look at the active versus passive dimension of the subject positions, as Johannessen et al. (2018, pp. 81-82) suggest. An image of the patient as the one in need of help and the personnel as the ones with the means to help is created within this discourse. This can be illustrated by the following quotation from the ERM plan template, urging the patient to reach out to the personnel when the early warning signs appear:

> In that way, I [the patient] can have a dialogue about what is the best thing for me to do. (appendix)

The helper versus the helped dimension is also present in this excerpt from the text:

> In the cases which this can be discussed with the patient, it will help him understand how the process of relapse occurs and the probability of insight will increase. (p. 14)

These two quotations draw attention to how it is suggested that the patient needs the personnel to be able to help himself. Thus, the patient is constituted as a more passive subject, the one that is acted upon by the personnel. He needs them to *have a dialogue about what is the best*, and they can *help him understand*; he is not able to do this completely on his own, he is *dependent* and has *limitations*, as some of the previous quotations described. However, the patient is not completely passive; he has to step into his subject position by actively reaching out to the personnel, or at least by participating in conversations with them, in order to give the discourse the power it seeks.

Nevertheless, though the patient is not completely passive, the personnel are the ones with the most initiative in this discourse. They introduce the patient to the method, they make contact with the network, and they make sure to schedule times for conversations about ERM:

> In the first phase you [the personnel] focus on explaining to the patient what ERM is. (p. 6)
>
> This means that the patient's possible resistance, doubt or mood swings should be observed and validated by the personnel. (p. 8)
>
> Establish a positive relation [with the patient] for cooperation on ERM. (p. 8)
>
> Ask the patient if he would be willing to cooperate on ERM. (p. 8)
>
> Discuss with the team and with the patient, which members of the family or network can be invited to conversations about identifying early warning signs. (p.13)
>
> Examine the patient's condition by regular assessment and ERM conversations. (p. 17)

Through such statements as these the personnel are constituted as subjects with multiple possibilities of actions to be taken. They can *explain*, *observe*, *validate*, *establish relations* and *examine*. However, the personnel are dependent on the patient to accommodate their

requests and invitations to some degree, and the possible resistance of the patient is always present. The personnel must *ask, discuss* and *invite* and are therefore not independent of how the patient chooses to respond to their invitations. The personnel are encouraged to respect the patient's resistance, but at the same time the quotations could also be seen as quite paternalistic. The discourse allows for the personnel to accept that the patient has his own viewpoint, but there is not much openness to changing their own.

As mentioned by Johannessen (2018, p. 63), discourses set boundaries for practices, allowing for some practices, while excluding others. The ERM protocol argues in favor of certain practices for the personnel, while diminishing others:

> The personnel's attitude is supportive, positive and encouraging. (p. 5)
>
> The frequency and/or intensity of the ERM conversations should be adapted according to the patient's current mental condition. (p. 8)
>
> If it is difficult or impossible to discuss the patient's view on his own illness, the subject is laid to rest. (p. 10)
>
> Try to understand this development with an open mind, without judging. (p. 14)

The legitimized practices for the personnel are *support, encouragement, adaptation, understanding* and being *open-minded,* while *judging* is a practice that is excluded. The personnel should also avoid provocation by laying a subject *to rest* if it is difficult for the patient to discuss. Thus, the discourse constitutes the personnel as a supporting and understanding subject who refrains from judgment, which is in alignment with the prevailing view on what is considered to be appropriate mental health care, as described it in Chapter 2.1.

In the ERM protocol, it is taken for granted and not articulated explicitly that ERM is a treatment strategy that is beneficial, and as bearers of the knowledge of the strategy's benefits, it is important that the personnel manage to motivate the patient to see the advantages of

involving himself in ERM. There can be obstacles on the way to making an ERM plan, but they are possible to overcome using the right techniques and means:

> Experiences with the use of ERM suggest that point 5 and 6 are relative and dynamic. This means that the patient could increase his motivation or insight, which in turn could lead to a wish or an ability to cooperate on ERM. It is therefore important to check this out regularly! (p. 9)
>
> **Motivation**
> Is the patient willing to cooperate on ERM?
>
> | | The patient's opinion | The social networks opinion | The personnel's opinion |
> |---|---|---|---|
> | Very motivated | | | |
> | Motivated | | | |
> | A little motivated | | | |
> | Quite reluctant | | | |
> | Very reluctant | | | |
> | Impossible | | | |
>
> Possible reasons for low motivation or resistance:……
> (p.10)
>
> There are two crucial questions here:
> Is this the right time to begin working with ERM?
> If not, which steps can be taken to reduce or remove any possible obstacles? (p. 12)

The discourse thus constitutes the personnel as a motivating subject with legitimized practices aimed at making the patient motivated to cooperate. They are supposed to assess to what degree the patient is *motivated*, *reluctant*, or has *the ability to cooperate*, and they must act accordingly. If the patient is reluctant or there are *obstacles*, they should try to take steps to *reduce or remove* these obstacles and *check out regularly* if the situation has changed in some way. There does not seem to be an option to just move on and dismiss the method altogether. By excluding that possibility, the discourse constitutes the truth that ERM should be applied

and that the personnel should take all necessary steps to facilitate the patient's motivation and cooperation.

Which practices are excluded and which ones are allowed for the patient subject could be perceived as somewhat more difficult to get a grasp of. There are, of course, actions that the text articulates as desired and others that are described as unwanted, either by stating it explicitly or as tacit opposites of other actions. Examples of desired actions described in the text are:

> The patient cooperates actively in the ERM work and is not very dependent on others. (p.12)

> Describe interventions together with the patient, which he can initiate himself, in order to obtain stability and avoid risk behavior. (p. 18)

These wanted behaviors are quite different from most of the other descriptions of the patient. In these quotations the patient is described as *cooperating actively* and *not very dependent on others*, he can *initiate interventions*, *obtain stability* and *avoid risk behavior*. It could seem that these statements constitute the patient as well, rather than having an illness; they are describing practices of normality rather than deviance.

However, the protocol also describes actions that are more in alignment with the subject position of a mentally ill and deviant patient. Examples are:

> Does the patient feel he has a mental illness that has any bearing on for example the occurrence of risk behavior or decreased function? (p. 10)

> Periods in which the patient in general is feeling bad or unstable. (p. 17)

> Periods in which the patient, for different reasons, is not taking his medicines regularly. (p.17)

In these quotations the text articulates the notion of mental illness as a disease with symptoms that cause the patient to feel *bad or unstable*, engage in *risk behavior*, or show *decreased functioning*. He has need for *medicine* to become better, but he might not be *taking them regularly*.

It could, however, be questioned whether these characteristics, even though described as unwanted, are equal to excluding practices, given that behaviors such as lack of compliance, violence, or inability to communicate are expected, due to the discourse constituting them as symptoms of illness. Without these symptoms, unwanted as they may be, a person could no longer be placed in the patient subject position. He would no longer have any deviant characteristics, no signs of illness, and would have to assume another kind of subject position. It might therefore be argued that the behaviors described as unwanted are actually the practices that this discourse allows for, while the desirable characteristics can only be legitimized as long as there is something left of the illness, some deviation from normality present. This can be seen by the quotation stating that the patient is *not very dependent*, but dependent nonetheless, and that the risk of violent behavior is present, even if the aim is to avoid it. The patient needs his medicine, so he is not completely free of illness.

By drawing on the theories of Foucault and Hall as tools, the analysis has disclosed that the ERM protocol has embedded a discourse based on the notion of mental illness as a disease of the mind, an illness in need of professional treatment. In the following sections this discourse will be called *the psychiatric discourse*. This label must not be understood as a discourse representing psychiatry as a medical specialty, but as a label describing the dominant discourse of mental health care, influenced not only by psychiatrists, but also by nurses and other care givers working in the clinical mental health field. The psychiatric discourse constitutes two main subject positions. One subject position is assigned to the personnel, who are the normal, active, motivating, inviting subjects, who also possess true knowledge about mental illness and the best way to treat it. As their opposite the discourse constitutes the patient in a subject position of being ill, dependent on the professionals, but with the opportunity to take the invitation given by the personnel and thus obtain a more active position as long as he is willing to subject himself to the discourse.

5.2 Scientific knowledge as truth

As described in Kringlen (2007, p. 315), psychiatry has gone through major changes, and the emphasis on scientific research has increased over the last decades. It is no longer acceptable for psychiatrists to determine treatment for a patient based only on their own individual clinical experience, and there is also a demand that the treatment and care should be evidence based (Kringlen, 2007, pp. 421-424). The ERM protocol writes itself into this point of view by embedding a discourse advocating science as the producer of true knowledge. The introduction of the ERM protocol focuses on how the strategy has been developed and tested in a scientific manner by conducting an intervention study:

> The research on ERM is described in Flutter's Ph.D. and has generated multiple international publications. The first intervention study on ERM was conducted at the FPC Dr. S Van Mesdag in Holland showing that the use of seclusion as a coercive measure and the level of aggression were significantly reduced after implementing ERM. (p.1)

Though it is not said explicitly, this quotation implies that scientific research produces valid and reliable knowledge and that science has proven that ERM works. It is possible to reduce violence by applying the strategy. These statements are confirmed by listing references to research articles:

> Preventing Aggressive incidents and seclusions in forensic care by means of the 'Early Recognition Method'
> Development of the Forensic Early Signs of Aggression Inventory (FESAI): Preliminary Findings. Towards a better management of inpatient aggression.
> The investigation of early warning signs of aggression in forensic patients by means of the 'forensic early Signs of aggression Inventory' (p. 2, only titles included)

Furthermore, closer inspection of the research articles the protocol refers to suggest that it is not just any kind of research referred to. The title formulations appear to be similar to those of natural sciences and positivistic traditions in which observation, quantification and categorization are the ideals. Words that can be recognized as belonging to these traditions are *preventing*, *by means of*, *preliminary findings*, *better management* and *investigation*. The text

seeks to acquire authority by referring to research that is consistent with the ideals of the natural scientific traditions.

Though both the patient subject and the personnel subject are positioned within this discourse, descriptions of the former are the most articulated. It can be argued that the lack of descriptions of the personnel subject aligns with the natural sciences and positivism. Within the positivistic tradition, true knowledge is objective and neutral, not influenced by the researchers who produced it, thus there is no need to describe the researchers. In this case the researchers are replaced with the personnel, but the same premise applies. The personnel are just the objective and neutral tools, and therefore not important or relevant. They are kept in the background, observing and documenting, while the patient is the object of observation, or treatment, and his characteristics must be described in detail.

When this discourse constitutes the subject position of the patient, scientific research is used to create knowledge about patient characteristics. Especially the FESAI can be seen as an example of how this is done. The FESAI is based on multiple descriptions collected from a large number of patients. The protocol states:

> The Forensic Early Signs of Aggression Inventory (FESAI) was developed by researching descriptions of 3768 early warning signs. These were categorized into 15 main groups with sub categories. The FESAI consists of 44 early warning signs and an open category called “other early warning signs”. The FESAI is meant to be an aid for nursing personnel and patients in the process of identifying individual early warning signs. (p. 1)

This quotation mentions numbers several times, and the high number of descriptions (3768) gives the statement authority, based on the notion that high numbers of incidents provide better validation of study results, which is regarded as a quality criterion for quantitative studies.

The FESAI categorizes early warning signs, thus describing common characteristics of a patient with risk of violence. The following is an example of one of the 15 main categories, with its sub categories:

2. Social isolation, decreased social contact

a) Increasingly superficial contact

b) Avoidance of eye contact

c) Increasing isolation, withdrawal

d) Walks away from conversation or other activities

(p.20)

In this excerpt from the FESAI, categorization is clearly an important feature. Dividing phenomena into systematic categories is also typical of the natural sciences, along with observation, documentation, generalization and quantification, all of which are present in the FESAI. Foucault called this the dividing practices of scientific knowledge (Juritzen et al., 2017, p. 52).

What is less visible within this discourse is the individual patient. The patient is given a subject position where he is a member of a larger group who share the same characteristics. However, it is recognized that there could be individual signs that do not fit into any of the fixed categories, therefore a fifteenth category called *other early warning signs* has been included, but not explained further. Also noticeable in the excerpt from the FESAI is that the patient is not presented with pronouns at all, which is the same throughout the entire inventory list. This adds to the impression of detachment from the individual.

The FESAI is one example of making use of dividing practices, but there are several other examples in the protocol where this is articulated:

> Information/observation from the personnel can be relevant to substantiate the patient's own reports, as a supplement or in the cases where the patient can't or won't say anything about his early warnings signs. (p.6)

> The table shows examples of conditions and forms of expression in patients with psychotic disorders and personality disorders. (p.8)

> Write down the early warning signs recognized by the nursing staff based on observations made. (p.13)

Examine and document the occurrence or absence of early warning signs. (p. 17)

Words that stand out as examples representing natural scientific ideals are *observation*, *relevant, examine, document* and *occurrence*. Also, the use of tables, forms or lists structuring information, which is a large part of the ERM strategy as it is described in the protocol, can be considered as quite typical of the natural scientific and positivistic traditions.

When the protocol is explored looking for the techniques it uses to acquire authority, the rules of subjection emerge as an example. As I described in Chapter 4.3.5, the rules of subjection deal with who is allowed to speak and under what conditions they may do so. In addition to Frans Fluttert, the creator of the ERM strategy, the authors of the ERM protocol are names that are known within Norwegian (and to some degree European) forensic psychiatry as accomplished researchers and published writers. Thus, the ones who are given a voice are members of the discipline relevant to the discursive context the ERM protocol writes itself into. They are representatives of discourses belonging to the forensic psychiatric research field. The rules of subjection are also applied by using research terminology, such as "intervention study", "significantly reduced", and "international publications," and not explaining the terms further. These are terms that acquire meaning to people inside the discourse, which makes the discourse quite exclusive, shutting out persons who do not have the prerequisites to understand the expressions.

The discourse described in this section has emerged through the abovementioned excerpts from the ERM protocol, drawing on the theories of Foucault and Hall as analytical goggles. This is a discourse advocating the ideals of natural sciences and positivism which carry with them a demand for empirical evidence as the basis of true knowledge. The discourse builds on what Foucault calls the dividing practices, and there is little emphasis on the individual patient and the personnel subject. It will be referred to as *the scientific discourse* in the discussion to come. The label refers to the natural scientific traditions where true scientific knowledge is considered to be objective, neutral and value free.

5.3 User participation and empowerment

As explained in Chapter 2.2, the prevailing view in Western societies is that empowerment and user participation is an ideal, affecting multiple fields such as law, education, social work and health services (Perron et al., 2010, p. 101). Because of this, it is reasonable to assume that since one of the cornerstones of ERM is user involvement, traces of this political and ideological current could be found in the protocol. The following excerpt from the introduction of the protocol provides an example of such ideals being advocated:

> It is essential that the patient himself is able to identify his early warning signs and to initiate stabilizing actions. Thus, user participation and interaction between the personnel and the patient (and possibly his family/network) become of great significance. (p. 1)

This quotation has characteristics similar to Norwegian government documents addressing the same issue, like the ones I have quoted from in Chapter 2.2, thus confirming the presence of an empowerment discourse in the protocol. The words *user participation* (Norwegian: *brukermedvirkning*) and *interaction* (Norwegian: *samhandling*)[4] are associated with the ideal of empowerment and are commonly regarded as opposites of paternalism, coercion and force (Juritzen et al., 2013, p. 443). The discourse acquires authority by articulating the ideals of our time, thus making use of the rules of subjection.

The discourse argues in favor of the patient being the one with the best knowledge about himself, and the following quotations show how this view is advocated:

> It is preferred that the primary source of information about the early warning signs is the patient himself. (p. 6)

> An important point is what the patient himself thinks about his own behavior and condition. (p. 14)

[4] Here I have translated the Norwegian word *samhandling* to *interaction*, because it in this quote refers to the joint effort between the personnel and the patient to identify early warning signs and initiate interventions. At other times the word *samhandling* can be used in connection with different parts of the health service system *cooperating and coordinating* their effort to help a patient or client, as is the case for *Samhandlingsreformen* (The Health Service Coordination Reform).

> The starting point [for successful application of ERM] is the patient's experiences[5]. (p. 5)

What can be seen in these quotations is how the patient is put first, he is *the primary source* of knowledge about himself and *the starting point* of the ERM strategy. Such statements constitute the patient subject as unique and valuable. He is regarded as the owner of this knowledge, which is shown by the use of genitive - *the patient's experiences* – it is his experience, not anyone else's. The phrase *the patient himself* is used multiple times, underlining who is the focus of attention. It is also stated literally that the patient's thoughts are *important*.

Within this discourse, the patient is given the subject position as the one possessing exclusive knowledge about his individual early warning signs, the one able to pass knowledge on to the personnel and his network:

> Interventions defined by the patient. (p.6)

> What explanations does the patient give for his disorder, behavior or deterioration? (p.10)

> Ask the patient if he has a clear recollection of a particular incident in which he recognized being in crisis (violence, self-harm, intoxication, depression, mania etc.). Ask him to describe in as much detail as possible, his feelings, thoughts and actions in the time before the incident. (p.13)

> Discuss how the patient himself interprets the relapse process. (p. 14)

It can be observed that in these quotations the patient is given the opportunity to *define*, to *explain*, to *recognize*, to *describe* and to *interpret*. The patient has the answers, and the personnel must ask, or at least be willing to discuss, in order to be able to obtain the knowledge that the patient possesses. They are the ones knocking on the door, asking to be invited in to share his knowledge. They may ask, but then they must take a step back and wait for the door to be opened.

[5] In Norwegian there are two different words that both translate to the English *experience*: *opplevelse* and *erfaring*. Both of these have been used in the Norwegian version of this quotation. *Opplevelse* refers to the contents of a subjective experience and is connected to perceptions, emotions, motivations and so on, while *erfaring* is the knowledge derived from *opplevelser*.

However, the patient is not only a subject of knowledge. He is also made responsible for his actions and expected to contribute in the effort to decrease the risk of violence, thus positioning him as an obligated subject:

> [The patient should] avoid stress and learn coping skills. (p.6)
>
> [The patient should] develop acceptable behaviors. (p.6)
>
> [The personnel should] together with the patient, describe actions which he can initiate himself, in order to obtain stability and avoid risk behavior. (p.18)
>
> When I [the patient] notice one or several early warning signs, I can get in touch with one of my contacts. (appendix)

These quotations, when seen together with those mentioned previously, show the two sides of empowerment. The patient is given the opportunity of taking charge, by *defining interventions,* and *describing and initiating actions,* but doing so will also include taking responsibility, making an obligation to better himself - he must *develop acceptable behaviors* and *learn coping skills*.

Another interesting aspect of this discourse is how it articulates that the practice of making decisions without the patient's involvement or consent is not accepted:

> If the patient is not comfortable using words and expressions related to his mental illness or the name of his diagnosed condition, find an alternative description in collaboration with the patient. (p. 8)
>
> Imperative to a successful use of ERM is (…) that the goals are defined in cooperation with the patient, use of language and terms that the patient understands. (p. 5)
>
> Discussing early warning signs with the patient's network could be relevant and can be done with the patient's consent. (p. 6)

The patient's feelings and opinions are highly important in these quotations. The personnel are only allowed actions that show consideration towards the patient's individual needs. They must *find alternative descriptions*, *use language that the patient understands* and they must

seek his *consent*. The patient's *cooperation* is considered to be *imperative to a successful use of ERM*, and practices that do not strive to make the patient *comfortable* with the ERM work are excluded.

Noticeable in this discourse is the emphasis on individuality. The text urges the personnel to adapt their way of approaching the patient to his individual needs; it is his knowledge of himself that is important, not as a member of a group sharing specific characteristics, but as a unique individual:

> The goal is to reach an agreement on which early warning signs are the most individual. (p.14)

The emphasis on individuality is also supported by how the ERM plan template is designed. The template, printed as an appendix to the protocol, is the document that the personnel bring with them to have conversations with the patient about ERM, and it consequently applies first person pronouns, thus adding to the image that the patient is the owner of the plan.

By drawing on the theories of Foucault and Hall, the analysis has disclosed a third discourse embedded in the ERM protocol. This third discourse advocates empowerment and user participation as an ideal, and therefore it will be labeled *the empowerment discourse*. The discourse uses words as *ask*, *together*, *cooperation*, *collaboration*, *consent*, and *wish*, which support the image of choice and free will. It constitutes a subject position for the patient in which he is the one in charge; the one able to make choices and take responsibility for his own recovery process. The personnel can be the subjects asking the patient to empower himself, but it is up to the patient whether or not he seizes the opportunity to subject to the discourse, take part in creating true knowledge about himself, and, at the same time, obligate himself to certain responsibilities.

5.4 Epistemes

As the attentive reader might have noticed, I have pointed to several of Hall's (2001, pp. 73-74) elements throughout the description of my findings. I have written about statements, subjects, practices, authority and rules. However, there is one element left that I have yet not described, and that is epistemes. Due to the fact that my analysis is based on one singular text, it is difficult to say anything conclusively about the underlying regimes of truth, or epistemes,

that this text is placed within. Nevertheless, I believe it is possible to suggest that the discourses in the ERM protocol write themselves into two epistemes typical of our time, and I will describe and discuss these briefly in this section.

First, there is the regime of truth that Murray et al. (2008, p. 272) describe as an evidence-based paradigm which promotes an ideal of true knowledge free from bias. They claim that this episteme constitutes a view that scientific "evidence is presumed to be visual, immediate and incontestable" (Murray et al., 2008, p. 273). I suggest that the psychiatric discourse and the scientific discourse are both placed within this episteme. The way quantitative research is being promoted, the categorization of symptoms and illnesses, and a trust in observation as the road to true knowledge, can be seen as characteristic of this episteme.

Secondly, I wish to suggest that the empowerment discourse is placed within another regime of truth. I believe it can be argued that an episteme of identity and individualism is present in our time. Elliott (2012, p. 351) describes how within several theoretical perspectives, there is consensus that there is an increasing call upon individuals to become the architects of their own lives. In this lies the notion that one should continuously reinvent one's own identity and create individualized solutions to more systemic social issues. This requires self-monitoring and self-reflection, as is the case with the ERM strategy. I suggest that the way that the ERM protocol calls upon the patient to take charge of this process of self-monitoring and self-reflection, and thus reinvent his identity, might be regarded as representative of an episteme of individualism.

6 Discussion

Before I enter into the discussion of my findings, I initially wish to repeat what my research questions are, in order to remind the reader of the aim of my study. I have aimed to critically explore discourses embedded within the ERM protocol. I have drawn on the foucauldian tradition, and used the elements outlined by Stuart Hall to conduct my analysis. My main research question was*: Which discourses are embedded in the ERM protocol?* Furthermore I have also asked *which subject positions and what kind of power relations are being constituted in the protocol*? By applying these analytical tools and questions, three discourses have emerged from the text. I have accounted for these discourses and the subject positions they constitute in the previous chapter about findings. In the discussion to follow, I will address the discourses one by one with an emphasis on power relations and subject positions. Then I will try to explain how the discourses are related to each other, sometimes all pulling in the same direction and other times contradicting one another. Finally, I will also discuss the possible limitations of my study.

At this point it seems appropriate to have a quick look back at the foucauldian view on power and the analysis of it. Within this tradition one asks not *what* power is, but rather *how* power works (Alvesson & Sköldberg, 2008, pp. 370-372; Foucault et al., 2002, pp. 336-339). It is the relational aspect of power that is the focus of interest (Foucault et al., 2002, pp. 343, 345). Power is not owned by anyone in particular, it is at play in the relations between subjects and discourses, and it is present in the practices that are legitimized through our talking and writing. When I discuss my findings it is my aim to show how theories about power relations can be a useful way of understanding and interpreting the text. Another thing to keep in mind is the connection between power, knowledge and discourse as inseparable concepts (Foucault, 1984, p. 100). When drawing on Foucault, I cannot discuss one and leave the others out, and I will try to stay true to this.

6.1 The psychiatric discourse

The ERM protocol embeds traces of a discourse constituting psychiatric disorders as illnesses which require treatment and care for the persons suffering from such disorders. The *psychiatric discourse*, as I have chosen to call it, carries with it the history of mental health care stemming back to the 19th century. This discourse has changed substantially over time, becoming the discourse that it is today. One thing which is constant though, is the division between "reason and folly" (Foucault, 1971, p. 9), a discursive procedure supporting the disciplinary process of normalization. The psychiatric discourse is built on the notion of a division between what is considered normal and what is considered to be an illness or an abnormality. This process of categorizing mental illness as abnormal has been seen in multiple studies (Barrett, 1996; Oeye, Bjelland, Skorpen, & Anderssen, 2009; Oute et al., 2015).

To segregate mentally ill from normal is not only a way of talking and thinking, it also has practical consequences for people's lives. Persons with mental disorders have commonly been placed in institutions, both for the purpose of treatment and care, and to protect society from their deviant behavior (Castel, 1991, p. 290; Perron et al., 2010, p. 103), thus literally segregating the mentally ill from the normal. Though the recent mental health policy in Norway has been to downsize large psychiatric institutions, it could be argued that this has not affected the possibly violent patients to the same degree as others. The law still allows for coercive treatment of individuals regarded as dangerous to themselves or others (Psykisk helsevernloven, 2017). This kind of legislation would not be possible if our society did not take for granted that these patients are ill and in need of treatment, even if they may not understand it themselves. The psychiatric discourse embedded in the ERM protocol plays a part in maintaining these views by constituting a subject position for the patient in which he is a deviant person in need of treatment.

Besides being ill and in need of treatment, the patient represents danger; he is also a risk subject. Castel (1991, p. 283) argues that when psychiatrists define someone as a risk patient, it supports the hypothesis that there is a relationship between symptoms and an act to come. Could it be that through the psychiatric discourse in the ERM protocol, the risk subject that is constituted is judged not only by what he does, but also by who he is, or what it is supposed that he is – to paraphrase Foucault (2002, p. 199)? Norwegians, like other Western societies,

like to think of our country as a state of law and justice where everyone is presumed innocent until proven guilty, and where you cannot be punished for an action that has not yet taken place. Nevertheless, psychiatrists are given the power to judge whether or not someone should be held against their will in a psychiatric hospital, and the decisions can be based on what they are likely to do as well as what they have actually done. The patients are submitted to coercive measures because of what they are, because of the risk of violence that they represent. This aspect of the psychiatric discourse border lines with discourses connected to law and order.

The division of subjects into opposite positions of normal and deviant have also been discussed by Oute et al. (2015, p. 277) who studied discourses in Danish mental health campaigns. They argue that such a framework legitimizes practices of control, setting up an order where the deviant can be ruled by the normal (Oute et al., 2015, p. 280), as is the case when the psychiatrist has the power to admit patients involuntarily based on risk criteria (Psykisk helsevernloven, 2017). In the ERM protocol the subject position of the personnel represents normality, while the patient subject is the deviant. The psychiatric discourse legitimizes practices where the personnel can overrule the patient's opinion, as, for example, in the following quotation form the ERM protocol cited previously: "Even if the patient does not agree, the personnel will continue to apply the additional early warning signs based on their professional assessment" (Fluttert et al., 2013a, p. 14).

I have also pointed to another distinct difference between the personnel and the patient in the ERM intervention plan template. While the patient is asked to list suggestions of what he should *not* do in addition to what he should do, the personnel are only asked to list the interventions they should apply. This could be interpreted as a tacit way of implying that the possibility of the personnel doing anything wrong is non-existent. When looking at it this way, it might be suggested that it is another way of emphasizing that the personnel are the ones possessing true knowledge.

I argue that the aspects of the psychiatric discourse which I have explored through my analysis show how the psychiatric discourse applies discursive procedures associated with disciplinary power relations. By constituting subject positions for the patient and personnel based on the division between normal and deviant, reason and folly, the discourse is making use of normalization. Furthermore, the procedures of examination and surveillance are applied

when the discourse legitimizes practices of examining early warning signs and then monitoring them regularly. I have also shown how the discourse even show signs of sovereign power relations, for example paternalism, control, and coercion. The protocol advocates how a lot of effort should be put into convincing the patient that he ought to cooperate, and if he still does not agree, the patient's opinion can be overruled if the personnel believe it is the right thing to do. All of this adds up to the notion that the personnel are the ones possessing true knowledge, and the prospect of them being wrong is not articulated through this discourse, thus shutting it out as a possibility . To put it short: *The personnel know best.*

However, though a lot of the aspects of the psychiatric discourse which I have elucidated revolve around the power and knowledge of the personnel, the picture is more complex than that. As Foucault (1984, p. 95) said, power cannot exist without resistance. The patient always has the choice of resisting the discourse or subjecting to it. The subject position of the personnel depends on the patient as their counterpart. Their position has no meaning without a patient to treat and care for, without the contrast of his illness to their normality. Thus, there is not power floating in one direction, with the personnel as the ones with the power and the patients as the ones over whom power is exercised. The subject positions are co-dependent, and both parts have the choice of subjecting to the discourse and assuming their positions. If one of them does not do so, the discourse loses much of its power.

6.2 The scientific discourse

It has been claimed that modern health discourses are driven by scientific research (Murray et al., 2008, p. 273; Powers, 2003, p. 227). The previously mentioned study conducted by Egede-Nissen and Knutsen (2017) supports this argument by suggesting that the demand for scientific foundation has changed the way Norwegian nursing students write their bachelor theses. Kringlen (2007, p. 415) also describes a massive increase in scientific dissertations in the Norwegian psychiatric field over the last decades. The ERM protocol adds to this trend by embedding a discourse advocating that true knowledge is based on scientific evidence, which I have labeled *the scientific discourse*, which refers to natural scientific ideals and traditions. The whole idea behind the ERM strategy is that by knowing the early warning signs, it is possible to decrease the risk of aggression and violent behavior. This assumption is based on intervention studies, which means that science has shown it to be possible.

In the chapter about findings I have demonstrated how the scientific discourse in the ERM protocol is substantially based on dividing practices of scientific knowledge: categorization, observation, documentation, quantification and generalization. The FESAI stands out as a very clear example of a dividing practice. In the FESAI, early warning signs are categorized based on a quantitative study of commonly occurring signs, and the personnel are supposed to observe and document the early warning signs of the patients using the FESAI. There are few signs of individuality, as the FESAI list is based on a generalization about early warning signs of aggression, and all of the possible individual signs are grouped together in the last category: Other early warning signs. This category is not explained further, which might give the impression that it is not very important - it is just put there for those early warning signs that do not fit anywhere else.

The subject positions of the scientific discourse also leave little room for individuality. The use of personal pronouns within this discourse is marginal; in the FESAI there are none of this kind. The patient subject is part of a larger group, his individuality is not important within this discourse. The personnel subject is almost invisible; their position is only as the observer and the collector of data about the patient. The lack of emphasis on individuality seems typical of the scientific discourse. Scientific knowledge is based on the disciplinary technology of normalization. Data are collected about large numbers of people and incidents to acquire knowledge about standards and averages, to be able to describe what is normal and what is deviant, thus categorizing individuals into groups.

Scientific categorization is also the basis for diagnostics, which is present in all kinds of health care, not only in psychiatry. Based on the notion that mental deviations are illnesses, the scientific discourse legitimizes a practice of categorizing symptoms into diagnoses. Diagnosing mental illnesses is done by the use of scientifically based manuals like the DSM-5 (American Psychiatric Association, 2013) and ICD-11 (WHO, 2019). Labeling symptoms as illness can be understood as a procedure the scientific discourse uses to acquire authority and power. Oute et al. (2015) claim that “psychiatric classifications frame the legitimization of the subtle forms of social control that have come to be an inherent part of the development of contemporary psychiatry” (page 281). This view is also supported by Powers (2003) who argues that psychiatric diagnoses are “discursively constructed technologies of social control” (p.230). In my understanding, this implies that when a subject is classified as deviant or ill, it

allows for certain practices, like treatment, having a real and practical impact in people's lives. The use of diagnostics is relevant to the ERM protocol because this text also applies the practice of categorization of symptoms and illnesses. For example, the labeling of someone as a "psychiatric patient with violent and aggressive problems" (Fluttert et al., 2013a, p. 1) is used as a premise in the argument in favor of using the ERM strategy along with the scientific research conducted on the use ERM. Thus, the categorization legitimizes the practice of using the ERM strategy.

I suggest that the scientific discourse embedded in the ERM protocol represents disciplinary power. I have elucidated how it applies technologies of normalization and dividing practices to acquire power and authority. I would argue that the scientific discourse gives little room for individuality, as can be seen by the constitution of subject positions. The personnel are merely the observers and the individual patient is lost within the larger group he is supposed to fit into. The scientific discourse advocates scientific knowledge as describing indisputable facts, proven by empirical research that is neutral and objective. The knowledge presented is never questioned, leaving out the possibility of anything being wrong. Scientific knowledge is truth, and *those who apply scientific methods know best*.

6.3 The empowerment discourse

The ERM protocol additionally has embedded a third discourse, a discourse advocating autonomy, citizenship and empowerment. This is a relatively new and modern ideal, representing a shift in Western society, where the emphasis on the individual right to be in control of one's own life has become more prominent. It has been suggested that similar discourses of empowerment and citizenship represent a governmentality based power relation (Juritzen et al., 2013; Perron et al., 2010; Powers, 2003). I would agree that practices constituted by an empowerment discourse could serve as technologies making individuals govern themselves. In the case of ERM, the empowerment discourse urges the patient to take the subject position of a self-governing subject, and also of a subject who is the creator of knowledge about himself.

However, it is not arbitrary what choices the patient is allowed to make within the empowerment discourse. Powers (2003) claims that "patients are considered empowered by

health professionals only if they make the correct choices as defined by the health care provider" (p. 227). For example the empowerment discourse in the ERM protocol legitimizes that the patient does not want to call his illness or his symptoms by the medical and diagnostic names, but, nevertheless, he must at least subject himself to the discourse by admitting that he has certain problems and being willing to cooperate with the personnel. He must make the correct choice and cooperate about the ERM strategy, and if he does so, he is called empowered. He has taken charge of his own life in the way the personnel want him to.

Thus, the empowerment discourse in the ERM protocol creates room for an obligated and responsible subject, a subject who is able to make the correct choices. The empowerment discourse articulates expectations of practices like cooperation, striving to make oneself better, loyalty to the action plan and so forth. Several writers have drawn attention to how governmentality constitutes individual responsibility of taking care of one's health (Oute et al., 2015, p. 281; Perron et al., 2010, p. 108; Petrakaki et al., 2018, p. 149; Powers, 2003, pp. 229-230). Some of these writers have also raised the question of the ethical implications of responsibilizing mentally ill persons (Oute et al., 2015, p. 282; Perron et al., 2010, p. 108). Oute et al.(2015, p. 282) argue that a lack of ability to meet with the demand of self-management, could cause a negative attitude towards those who do not position themselves as responsible subjects.

One of the aspects of empowering the patient is the invitation for him to be a producer of knowledge about himself. This brings to mind Foucault's (1980) words about how the "moral obligations for any subject, is to know oneself, to explore oneself, to tell the truth about oneself and to constitute oneself as an object of knowledge". I would suggest that the ERM strategy is substantially based on this confessional technology. It invites the patient to actively take part in revealing who he is, telling the truth and sharing knowledge about himself with the personnel, thus constituting himself in a subject position where he is the creator of knowledge. In contrast to the patient, the subject position of the personnel is to be the passive, awaiting subject, asking for the patient to give them the opportunity to share his knowledge. By constituting these subject positions, the discourse grants value to the individual knowledge which the patient possesses as something special, unique and wanted. When subjecting to the discourse, the personnel are given the opportunity ask the patient to share his valuable

knowledge, but therein also lies the possibility that he may refuse to do so. As the personnel place themselves in this subject position they must accept the possibility of refusal.

One important characteristic of the empowerment discourse in the ERM protocol is that it encourages the patient himself to describe his early warning signs and participate in monitoring these signs on a regular basis. Several writers have described how our modern society is surrounded by a self-monitoring or self-tracking culture, which produces countless technologies and instruments made for the purpose of us monitoring ourselves. For example you can find apps that collect data on everything imaginable in our lives, like food intake, physical fitness and mental health status (Kappelgaard, 2016, pp. 37-38; Lupton, 2014, December, p. 77; Petrakaki et al., 2018, p. 146). The focus on user participation and self-monitoring which ERM offers, places the strategy within the idea that citizens should be encouraged to take more responsibility for their own health (Lupton, 2014 p.79, Perron et.al, 2010, p.102). However, though the instruments for self-monitoring are modern, the idea is not new. As mentioned in Chapter 3.5.1, to strive to better oneself is an ideal going all the way back to ancient Greek philosophy, and it is one of the two historical lines that Foucault describes as a basis for governmentality (Juritzen, 2017, p. 108).

I believe it is meaningful to use Foucault's ideas of technologies of the self and confessional technology in connection with these aspects of the ERM strategy. Powers (2003, p. 231) claims that technologies of the self are present in health care services and are used to observe, measure and treat deviant behavior. She mentions examples like taking a medical history or nursing assessments, and argues that these technologies are built on a scientific model based on statistics and normalization. I suggest that the ERM strategy can be perceived as a self-monitoring technology and a confessional technology. My analysis shows how the ERM protocol possesses many of the characteristics of such a technology. The ERM strategy aims to responsibilize patients, offering them the possibility to govern themselves. It also has elements of confessional technology, asking them to reveal their inner secrets. Thus, they create knowledge about themselves, and this knowledge can exercise its power on the patient himself, persons close to him, and the nursing staff. For example, it is worth considering what consequences it has for the patient if he confesses his inner secrets. If he is part of constituting himself as a danger subject - a subject of risk, and will this affect how he is viewed and treated?

Furthermore, there can be disadvantages connected to responsibilizing psychiatric patients, expecting them to make choices that are beneficial for themselves and for society. Lupton (2014, December, p. 83) has indicated that self-tracking discourses can be normative, because they build on the idea of individual responsibility for good health. The constitution of such discourses creates a danger of defining individuals who can't meet with the demand of responsibility as failing subjects, not being able to become productive, well-functioning citizens.

I argue that the empowerment discourse embedded in the ERM protocol is substantially based on the power relations of governmentality. As my analysis has shown, this discourse applies technologies of the self by allowing for practices of self-monitoring, confession, and taking responsibility for self-government. Though the empowerment discourse has its limitations, it could also be argued that it provides a substantial possibility for choice and creativity. The discourse constitutes a subject position for the patient in which he is to be in charge of making decisions about himself. He is invited to position himself within the discourse and share his knowledge. His knowledge is seen as unique and valuable, and he determines whether he will share it or not. This constitutes a powerful subject position for the patient. The paradox, however, is that his knowledge will acquire power only if it is shared and recognized as true knowledge by others. He is dependent on the personnel subjecting to the discourse as well, by recognizing the patient as the subject in possession of true knowledge. Furthermore, as the patient shares his knowledge, he is also becoming a co-creator of reproducing the discourse. In the empowerment discourse, the patient is taking an active position in constituting the relationship between discourse, knowledge and power. Knowledge is power, and the one with the true knowledge is the patient. *The patient knows best*.

6.4 Discursive relations and battles

Up until now I have divided the discourses of the ERM protocol into separate units and given them individual labels. However, this is a simplification of the relationship between them. Yes, they are different, and they all struggle to be the one telling the truth, the one possessing the knowledge and the power; however the picture is also more complex than that. Foucault (1972) writes:

> I have studied, one after another, whole sets of discourse; I have characterized them; I have defined their play of rules, of transformations, of thresholds, of remanences. I have compounded them. I have described clusters of relationships. Wherever I have deemed it necessary I have allowed the *systems* to proliferate. (p.229)

As I understand him, he is saying that though he has characterized and labeled certain discourses, they are all part of a larger system, sets of discourses. It is impossible to tell where one discourse starts and another begins. There is a large web of discourses related to each other. Sometimes the discourses pull in the same direction and other times they are at battle (Foucault, 1984, pp. 100-101).

The discursive battle is present in the ERM protocol when the psychiatric discourse presents us with the truth that professional knowledge has a higher value than the opinion of the patient, while, at the same time, the empowerment discourse advocates that the most valuable knowledge is possessed by the patient and that he is the master of deciding who can obtain it. I would argue that these two different points of view stand as an example of the change that Perron et al. (2010, p. 109) have described as a shift in the history of psychiatry. They suggest that discourses built on citizenship serve as a counterpart to the effect of traditional psychiatric discourses and represent a change that is beneficial to the patients. I believe the Norwegian legislative adjustments that have occurred lately, like the Mental Health Care Bill (Norwegian: *psykisk helsevernloven*) referred to in Chapter 2.1, are also representative of this shift. It could seem like the psychiatric discourse connected to paternalism and coercion is losing ground to a more empowerment based discourse, and that the ERM protocol has embedded the new ideals to some extent.

Another observable difference between the discourses in the ERM protocol is how the subject positions of the empowerment discourse and the scientific discourse are profoundly different when it comes to the patient's individuality. Whereas the empowerment discourse positions the patient as a unique individual with specific individual characteristics, the scientific discourse positions him as a member of a group sharing the same characteristics. I suggest that this discursive battle is also a battle between epistemes. The episteme of individualism is in conflict with the episteme of evidence-based science.

Though the discourses have their differences, they sometimes play on the same team, advocating ideas and assumptions that are similar. I argue that an example of the discourses teaming up can be found between the psychiatric discourse and the scientific discourse. They both focus on illness and symptoms, constituting the patients as subjects with certain characteristics in common. I suggest that it could be said that the psychiatric discourse borrows authority from the scientific discourse in order to categorize symptoms and claim the right to make decisions on behalf of the patient. In my opinion it is not probable that the personnel could argue in favor of the use of the ERM strategy had it not been the subject of scientific study, given the strong demand for psychiatric treatment to be evidence based (Kringlen, 2007, pp. 421-424).

There are also places in the protocol where all the discourses pull in the same direction. When using the lens of governmentality, all discourses support ERM as a technology of the self, a technology based on making all citizens to take responsibility for governing themselves and being the best possible members of society. The patient is *empowered* to tell the truth about himself and the *psychiatric* understanding of mental deviance as an illness is supported by categorizing and treating symptoms based on *scientific* research. I also argue that the division between normal and deviant is present in all discourses, even the one advocating empowerment. All discourses take for granted that people suffering from mental illness need help of some kind. They either need treatment by professionals, treatment based on scientific knowledge or they need to be empowered in order to enable them to help themselves. Thus, all the discourses implicitly segregate persons into an "us" and "them" dichotomy, similar to the one found by Oute et.al.(2015, p. 277).

When I have analyzed the power relations constituted in the ERM protocol, they paint a complex picture as well. I would like to repeat the words of Foucault on this matter:

> Accordingly, we need to see things not in the terms of the replacement of a society of sovereignty by a disciplinary society and the subsequent replacement of a disciplinary society by a society of government; in reality one has a triangle, sovereignty-discipline-government, which has as its primary target the population and as its essential mechanism the apparatus of security. (Foucault et al., 2002, p. 219)

I suggest that what can be seen in the ERM protocol is an entanglement of all three kinds of power relations. There is the sovereign-like power relation being constituted when the psychiatric discourse allows for the practice of disregarding the patient's opinion, based on his illness and lack of ability to make qualified decisions. Disciplinary power relations are also very much present, for example through technologies of normalization, surveillance and examination. When all three discourses create subject positions of patient and personnel, they all take for granted that the persons in question are not representative of the normal. They are ill, or deviant, and they need to be looked after and treated for their illness. This assumption is so embedded in our way of thinking and talking about mentally ill, that it is never questioned at all, thus giving it significant power. Furthermore, I argue that governmentality is also substantially visible, as all of the discourses constitute practices of self-governing. The ERM strategy builds upon the governmentality-based aim of creating well-functioning, self-monitoring patients, willing to engage in confessional technologies and creation of knowledge.

Why is this question of who possesses the true knowledge so important – enough for me to be addressing it in the title of my thesis? As mentioned in Chapter 3.4, Foucault concerned himself with how discourses together with knowledge have power over the conduct of people, and he focused especially on institutions as, for example, hospitals and prisons (Hall, 2001, p. 75). I suggest that this is a perspective worth taking into consideration when applying the ERM strategy as part of the treatment. It is not a matter of indifference who we think knows best. It can for example affect the personnel's approach towards the patient. If the personnel subject themselves to the psychiatric discourse, they allow themselves to make decisions on behalf of the patient because they are believed to have the true knowledge of what is best. On the other hand, if they subject themselves to the empowerment discourse, the patient's knowledge is regarded as most true and without it, the use of the ERM strategy will have less value.

6.5 Strengths and limitations of the study

In my study I have concentrated on analyzing a singular text. This has given me the opportunity to read it very closely and focus on the details. For those who apply the ERM strategy in clinical practice, the protocol is an important text, because it provides instructions

on how to use the ERM strategy as a clinical treatment method for patients. However, the ERM protocol does not exist in a void. It is just a small contribution in a large network of texts, vocal statements and other utterings that are parts of discursive practices. It is influenced by a number of discourses and, in turn, it can also be a (re)producer of discourses. Because of this, even a quite small text like the ERM protocol is not without significance as a contributor to discourse and the practices that are legitimized through its discourses.

Though my study differs from those of Foucault who studied large amounts of textual materials, spanning centuries, and not just singular texts, I argue that I have been able to draw on his theories and use discourse analytical perspectives to disclose discourses embedded in the ERM protocol. I do not suggest that these are discourses that emerge through this text alone. It is my belief that what I have found are traces of discourses that can also be found in other sources. However, I would like to emphasize that I am the one who has categorized them, described them, and named them. This is the paradox of discourse analysis that I can never escape. I am myself part of the discursive creation of knowledge, not able to detach myself from the language I use to describe my findings and the social context I am placed in. My findings can never be neutral, objective and value-free. If someone else had conducted a study on the same text, there is a possibility that the findings would have been quite different.

Foucault's theories on governmentality have been criticized for being too abstract, not taking into account practical, real world implications (Rose et al., 2006, p. 99). In my study I have not had access to clinical practice. I have studied a text, so I am not able to draw any conclusions to how the text actually affects clinicians. Crowe (2005, p. 57) writes that texts are not regarded as facts, they are perceived to be cultural representations. They do not give access to experience, but can be seen as a constitution of ideas and values. Thus, my aim is not to describe how the ERM method works. Other researchers have focused and still are focusing on that. Rather, I would like to elucidate the socio-cultural context in which it is placed. I would like to point to the words of Rose et. al (2006), when they address the critiques of governmentality:

> If, on the other hand, it [governmentality] is regarded as part of an analytical toolbox, good for some purposes but not for others, and capable of being used in conjunction with other tools, then the problem appears more as a limitation

> of the critique than a critique of the limitations of governmental analyses. (p. 100)

I argue that my study has value for the purpose of disclosing how the discourses embedded in the ERM protocol might affect the practices of clinicians. After all, it is a protocol on how to apply the ERM strategy clinically. It is the protocol's intention to instruct on clinical practice and it is likely that it to some degree succeeds in doing so. Therefore it is not without concerns what the ERM protocol's influence consists of and how the protocol works it power on the persons involved.

An assumed flaw of governmentality studies is that they neglect resistance, but it might be argued that this criticism is based on a misconception (Rose et al., 2006, p. 100). As I have explained previously, in Chapter 3.4, Foucault emphasized that freedom and creativity is required for power to be exercised. He says:

> In itself, the exercise of power is not a violence that sometimes hides, or an implicitly renewed consent. It operates on the field of possibilities in which the behavior of active subjects is able to inscribe itself. It is a set of actions on possible actions; it incites, it induces, it seduces, it makes easier or more difficult; it releases or contrives, makes more probable or less; in the extreme it constraints or forbids absolutely, but it is always a way of acting upon one or more acting subjects by virtue of their acting or being capable of action. (Foucault et al., 2002, p. 341)

As I have shown through my analysis, the ERM protocol, looked at through the lens of governmentality, is full of struggles and conflicting articulations, thus countering this criticism. There are multiple power relations at play and governmentality is not the only kind of power relation I have found to be present in the discourses. Furthermore, though the protocol on many occasions urges patients to take the subject position of a self-governing individual, there is always the possibility of their resisting subjecting to the discourse.

As is the case in qualitative studies, there are limitations on the degree of being able to draw any definitive conclusions based on my study. I have striven to meet the quality criteria for qualitative studies which I described in Chapter 4.1 by being transparent and reflexive, and it is now up to the reader to judge whether I have succeeded or not. From the epistemological

viewpoint of social constructivism, I am both the creator and the interpreter of my data. The discourses I have found are thus influenced by me. If someone else had analyzed the same text, it is highly possible that he or she might have disclosed additional or other discourses. For example I am aware that traces of discourses connected to medicine and law are present in the protocol, but they have not emerged as clearly to me as the three discourses I have accounted for. When doing discourse analysis this is a problem one always will encounter because there are always a multitude of discourses at play when we talk and write, some more visible than others. However, it is very difficult, and maybe impossible, to see them all at once.

I would like to mention that in conducting my analysis from a critical perspective it has not been my agenda to diminish the positive effects of the ERM strategy. Nor have I wished to discredit the ambition of the ERM strategy to increase patient involvement. My critical approach aims at drawing attention to the established truths that we take for granted and show that there might be power relations hidden to us which nonetheless affect our clinical practice. I have wanted to stay true to Foucault's critical project by challenging assumptions and established ways of thinking, by trying to make what seems obvious a little less taken for granted (Foucault et al., 2002, p. 456). It is my hope that the new knowledge emerging from my study can be a contribution on how to further develop the ERM strategy, both its theoretical framing and its clinical practice. At least I know that conducting this analysis has given me some different perspectives, and I am sure that this will influence how I apply the strategy and how I talk about it in the future. I still think it is a good strategy for managing risk of violence, but I believe that I now am more aware of how power relations are at play in the relationship between the patient and the clinician.

7 Final remarks

In conducting this study, my aim was to add to the existing knowledge about ERM by critically exploring discursive patterns in the ERM protocol drawing on the foucauldian tradition of discourse analysis. More specifically I wanted to investigate discourses, subject positions, and power relations in the Norwegian version of the ERM protocol. Through the analysis, three discourses emerged: a psychiatric discourse, a scientific discourse and an empowerment discourse. I have described them and discussed how they constitute knowledge and power relations that could influence the practices of the persons involved. I have argued that there are traces of the central perspectives on power relations which Foucault outlines: sovereignty, disciplinary power and governmentality. In particular I have focused on how the ERM strategy is based on the ideal of empowerment, making use of self-monitoring technologies. Thus, the ERM strategy urges the patient to take both charge and responsibility for his own life. At the same time, the discourses in the ERM protocol present the patient as a subject of illness and risk, lacking abilities to make qualified decisions. I argue that this contradiction has ethical implications, because patients could be presented with demands that they are not able to meet. On the other hand there is also a risk that it might be taken for granted that the personnel, representing both science and psychiatry, are the ones who know what is best for the patient.

Though the discourses embedded in the ERM protocol are sometimes in a battling relationship with each other, representing different views on what the truth is and who knows best, they all constitute the notion that ERM is a beneficial treatment strategy to use for patients with mental illness and violence risk. As a health professional I believe it is important to remember that the use of the ERM strategy is a discursively constructed practice which has real implications for our clinical approaches and for the patients we aim to help. The use of ERM can have major consequences for a patient when used as a rationale for readmission, delay of discharge, choice of treatment, and clinical interventions. Health professionals should therefore seek to elucidate and make themselves aware of the discourses that surround us and how they exercise their power on us and our patients. It is my hope that I, by analyzing the ERM protocol drawing on a foucauldian discourse analytic perspective, have added to the

existing knowledge of the ERM strategy and that this knowledge can contribute to the further development of the strategy.

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