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Front-Line Care Providers' Professional Worlds: The Need for Qualitative Approaches to Cultural Interfaces

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Abstract: This paper re-conceives the professional worlds of health and mental health care providers from cultural perspectives and argues that individual providers live (professionally) at the interface between multiple personal, professional, and organizational cultures. It also argues that qualitative methods afford services researchers better opportunities to describe the cultures and characterize their interfaces. A conceptual discussion of psychiatric nurses' professional worlds in the interfaces among nursing and psychiatric medical cultures as well as organizational culture is presented. Qualitative analysis of 25 individual psychiatric nurses' written comments on their professional work and lives in public sector mental health service agencies are discussed.

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1. Introduction

Over the last ten years, voices from the U.S. health care community have called for effective health services which are appropriate for the increasingly diverse groups of service users (clients or consumers) in the nation. Both health care providers and services researchers have explored the needs of different sociocultural, ethnic, or racial groups and suggested a variety of service delivery improvements responsive to the needs (e.g., GAURNACCIA, GOOD, & KLEINMAN, 1990; MANSON & KLEINMAN, 1998; MANSON, SHORE, & BLOOM, 1985; OKAZAKI & SUE, 2000). With a few exceptions, on the whole, suggestions have been translated by policy makers and administrators into easily

implemented (e.g. through administrative mandates) "improvements" to structural or procedural components in the health care delivery system. [1]

Contemporary U.S. health and mental health policies, which are influenced by vogue sociopolitical slogans advocating elimination of health and mental health outcome disparities among diverse groups, have encouraged services research addressing cultural sensitivity and the appropriateness of services. In reality, achievement of health outcome equality will involve products of dynamic diverse cultural interactions at multiple levels of the health and mental health care delivery systems. The relevant cultural interactions, in the context of mental health service provision and receipt minimally entail interactions among four mental health care system cultures: (1) client cultures (e.g., poor adolescent single mothers in urban neighborhoods, recent South Asian immigrants, Hispanic deaf children, etc.), (2) provider's private cultures, (3) provider's professional cultures (e.g., nursing, psychiatry, social work, etc.), and (4) organizational cultures (e.g., general hospital, university-affiliated teaching hospital, private doctor's office, community health center, etc.). [2]

In research, however, the vast majority of studies that address cultural relevance have emphasized intercultural interactions between providers and clients at an interpersonal level. Existing suggestions and recommendations include race, ethnicity language matching (e.g., SNOWDEN, HU, & JERRELL, 1995), education for appreciation of culture-specific values and illness concepts (e.g., SHORT & JOHNSTON, 1994), and race and ethnicity-tailored service delivery (e.g., TAKEUCHI, SUE, & YEH, 1995). While these approaches represent an important start, they minimize the relevance of both professional culture and organizational culture as potentially significant intervention points in the attempt to improve the cultural sensitivity and relevance of existent service delivery systems. The existing mental health services research literature has already highlighted ways in which behavioral, psychological, and financial aspects of front-line care providers' jobs (e.g., job performance anxiety, patient volume quotas, job satisfaction, salary, etc.) can be obstacles to cost-effective service delivery, quality and continuity of care, and positive mental health outcomes. Services researchers have only rarely collected information on front-line care providers' personal and contextualized "lived [professional] experience[s]" (VAN MANEN, 1990). [3]

The present paper attempts to examine a specific group of front-line providers' professional worlds by positioning them in multicultural contexts broader than the intercultural interactions that occur at an interpersonal level. First, the paper will examine the concept and place of "culture" in services research. Second, it will explore two largely neglected cultures in services research—professional cultures and organizational cultures. Third, it will discuss psychiatric nurses' lived experiences within their professional worlds where interfaces between the two cultures constantly revolve and evolve. Last, it will consider the needs for qualitative approaches to understanding front-line care providers' professional worlds in interfaces between multiple service delivery system cultures. [4]

2. Culture in Services Research—So Far

Despite the rhetoric promoting sensitivity and cultural competence in managing culturally diverse clients, the concept of "culture" has been largely excluded from theoretical conceptions and research methodology in mental health services research. Only recently have a handful of researchers begun identifying and illustrating (mis)uses of the term, "culture," in mental health services research. Borrowing heavily from related disciplines such as medical anthropology, cultural psychiatry, cross-cultural psychology, or sociology, they have called the services research community's attention to the need for alternative conceptualizations of culture (FABREGA, 1990; GUARNACCIA & RODRIGUEZ, 1996; HELMAN, 1990; ROGLER, CORTES, & MALGADY, 1991; TAKEUCHI, UEHARA, & MARAMBA, 1999). [5]

A services researcher's alternative view of culture is heavily influenced by his/her professional background. JAHODA (1980), for example, distinguished two different ways of conceptualizing culture in cross-cultural psychology and anthropology. In cross-cultural psychology, culture is considered "... a category conceptualized much like 'social class,' i.e., a term summarizing a bundle of rather ill-defined antecedent variables that usually 'make a difference'" (p.115). Cross-cultural psychology holds a static, outcome-oriented, and decontextual view of culture as a set of values, beliefs, customs, social institutions and so on that individuals inherit simply by belonging to a distinct group (e.g. FAVAZZA & OMAN, 1977; HELMAN, 1990; SUE & SUE, 1990). Within this approach, notions of the individual's lived experiences, transformation of generally shared culture ("collective culture") into individualized ones ("personal culture"), or dynamic interactions between personal culture and collective culture have been completely omitted (VALSINER, 1999). The most frequently employed methodologies in cross-cultural psychology rely on controlled (quasi-) experimental designs with large sample sizes, data collection using "objective" measures, statistical data analyses, and significance test-based interpretation of results. [6]

In anthropology, on the other hand, culture is conceptualized as a *system*, or rather a set of closely related systems in such areas as kinship, political power, religion, and so on" (JAHODA, 1980, p.114). GEERTZ (1973), for example, views culture as a historically transmitted pattern of meanings embedded and expressed in symbols that are used to "communicate, perpetuate, and develop ... knowledge about and attitudes toward life" (p.89). Anthropological perspectives are, in general, open to more dynamic, process-oriented, contextual views of culture and individuals' (or groups') "felt experiences in their local contexts." (KLEINMAN & KLEINMAN, 1991; WARE & KLEINMAN, 1992). Common anthropological methodologies include non-experimental designs and observational data collection through a variety of media (e.g., hand-written recording, audio- and videotaping, drawing, photographing, etc.) and methods (e.g., ethnography, in-depth interviews, paper-and-pencil measures, etc.). Regardless of research methods and media, the ultimate goal and unit of analysis in anthropological research is limited to the "shared local world" (WARE & KLEINMAN, 1992, p.547). [7]

Within services research, notions of culture have been caught between policy, research, and practice, realizing a measure of vogue popularity. On the side of policy, culture has been used as a platform for advocating effective service delivery to culturally diverse groups of patients and spawning a host of professional catch-phrases (e.g., "culturally competent," "culturally sensitive," "culturally appropriate," "culturally relevant," "culturally-tailored," and so on). [8]

On the side of services research, "culture" is often initially included in services research grant proposals in response to a funding agency's stated policies. Yet, in research practice, culture-inclusiveness may be subverted by a variety of methodological shortcomings and logistic limitations. Omission of culture frequently occurs because of a dearth of well-articulated definitions of the concept, a lack of theoretical models for culture-laden phenomena, and a shortage of empirical research examples. Culture can be relegated to a background position due to logistic issues including researchers' lack of appreciation for cultural community concerns, miscommunication, and/or (un)professional attitudes toward the community members. Asymmetric power relationships and uninvested partnership between researchers and service users can precipitate differentially unsuccessful recruitment and poor retention rates among service users, as well as service user communities' lack of interest and support. The exclusion not only maintains the lack of knowledge about cultural community members as the status quo, but exacerbates the problem by the precedent it establishes. [9]

On the side of practice, the lack of easily accessible information and knowledge on cultural community members help neither the service providers nor the service consumers. Misunderstandings and frustrations that the parties experience during the course of service transactions often contribute to dissatisfaction on the part of one or both. In the extreme, dissatisfaction can degrade into discontinuity of care. Dissatisfaction also feeds health and mental health advocacy group agendas. They lobby policy makers who benefit from standing on a platform advocating effective service delivery to culturally diverse groups of patients and spouting "cultural" catch-phrases, but without actually delivering policies that practically benefit the intended. In contemporary U.S. service delivery arenas, "culture" has taken a conspicuous—although tokenistic sounding—appeal. [10]

The services research community has been paying insufficient attention to culture; although it clearly does recognize the need for developing, testing, and recommending culturally appropriate service programs. If the primary goal of services research is to provide useful and effective information for service providers, clients, and policy makers, it is not enough to simply examine the set of cultural values and beliefs shared by the majority of members of a racial, ethnic, or linguistic group. It is not sufficient to show whether racial, ethnic, or linguistic matching of providers and clients is better than non-matching. Services research needs to expand extant conceptions of culture by explicitly delineating whether and how the clients' personal cultures and their collective cultures differ (or are similar) in their perspectives on health, illness, and care. It also needs to elaborate on how service provision contexts—where multiple cultures and

multiple system levels intersect—impact the accessibility, affordability, continuity of care, treatment compliance, as well as treatment outcomes for both groups and individuals. [11]

In practice, service providers interact with clients one at a time, individual-by-individual. The services (s)he provides to each individual client are guided by a complex nexus of professional, intra- and inter-organizational relationships embedded in the context of a specific service delivery agency. The group-aggregate data provided by services research is seldom useful for the front-line professional as (s)he serves an individual client from a "different" cultural background—especially when the client's views of health, illness, and care are incongruent with the cultural group to which (s)he is assumed to belong. The yet unrealized promise and value of including alternative conceptions of culture in mental health services research is that it can bridge the gap between group-aggregate information and individual client's needs and problems—particularly for those individuals who idiosyncratically deviate from their nominal group peers. [12]

Local health and mental health service provision contexts can be better understood by examining and conceptualizing the contexts as multicultural interfaces between client, provider, professional, and organizational cultures. Each of the cultures derives from the individual and collective activities of constituent members, and are, therefore, distributed unevenly among the members. For each member, individual personal cultures consist of personal perspectives, values, and activities, combined with idiosyncratically transformed variations on manifestations of collective cultures. Local health and mental health service provision contexts can be considered interpersonal arenas where the cultures of multiple groups—as expressed by individual group members—and multiple individuals intersect. [13]

To date, the bulk of services research has addressed themes of culture in services delivery by focusing on client's and provider's cultures at personal and interpersonal levels. Only recently, has services research began to recognize the importance of professional and organizational cultures in health services delivery (e.g., RODRIGUEZ, LESSINGER, & GUARNACCIA, 1992; SCHLESINGER & GRAY, 1999), but questions about the interfaces remain unelaborated. [14]

3. Professional Culture and Organizational Culture

Pluralism enters the local health care system through three primary sets of stake-holders—clients (and their families), health care professionals, and service provid-ing organizations. In the U.S. case, all these stakeholders become parts of a health care system that entails constant negotiations among the stakeholders. [15]

Over the past two decades, health care communities have begun focusing increased (and much needed) attention on health and mental health care issues associated with consumers' increasing ethnic and cultural diversity. While attention to consumer plurality has increased, the effects of provider plurality in diverse professional and organizational cultures have remained minimalized and

ignored. Moreover, the impacts of provider plurality on attempts to eliminate health disparities among minority patients have likewise remained underexamined. Less than a handful of services research studies—and none including cultural approaches—have tried to examine (in)congruent intra- and inter-organizational coordination of services on consumer's mental health outcomes (e.g., GLISSON, 1996; GLISSON & HEMMELGARN, 1998; RIDGELY, LAMBERT, GOODMAN, CHICHESTER, & RALPH, 1998). Because the professional work of front-line care providers within their cultural contexts are inevitably linked to the quality of their client care; professional and organizational culture, as well as the interface between the two must be brought to the forefront in mental health services research. [16]

3.1 Professional culture

The concept of professional culture is not new, although it may be unfamiliar to many services researchers. Paraphrasing HARRE (1993, p.5), professional culture is defined as "a form of [professional] life" which is comprised of "a cluster of material and symbolic practices" organized around a body of specialized knowledge, shared by a group of qualified practitioners. Professional culture is comprised of explicitly prescribed materialistic practices such as job responsibilities, day-to-day service delivery, role differentiations, status hierarchies, communication channels, etc. It is important to emphasize that materialistic professional practices include both idealized syntheses of job duties and responsibilities as well as (and perhaps more importantly) what actually happens in day-to-day, moment-to-moment professional life. At the same time, it also encompasses the *meanings* attached to the material practices (e.g., positive and negative stereotypes, hierarchical domination/submission, and senses of being (un)needed, (dis)respected, (un)recognized, (under)appreciated, etc. [17]

Although the professional sector of the U.S. health care systems is comprised of a number of different professional groups such as doctors, nurses, medical technicians, therapists, social workers and so on, each group constructs its own professional culture. Once constructed, the boundaries and constituents of professional culture are actively maintained through relevant intracultural guidelines, regulations, and sanctions. Yet, like any culture, professional culture is an open system that continuously and semipermeably interacts with other neighboring (professional) cultures. Through repeated interactions, professional cultures becomes dynamically linked to one another through mutual influences—each professional culture simultaneously influences its partners and is influenced by them. [18]

The importance of professional culture for individual health, mental health, or social service providers' professional lives results from the interplay of two intimately connected professional socialization processes—enculturation and acculturation. Although the two processes are dynamically related, enculturation may be defined as a process by which individual professionals learn about and identify with their own professional culture. It is conceptually distinguished from acculturation, which refers to the process by which individual professionals, en-

culturated in one professional field, assimilate selected aspects of another professional culture through the experiences of professional interactions. [19]

3.1.1 Professional enculturation

Enculturation in general social settings refers to a developmental process of learning collective guidelines for valued forms of life through the assistance and guidance of more experienced members of a cultural group. The process leads and encourages the cultural novice to observe and experience the material and symbolic practices valued by the cultural group. The guidelines explicitly or implicitly push the neophyte toward collectively constructed and sanctioned perspectives: What to think and how to view the world, what to expect and how to experience it, as well as how to act in it in relation to other people and aspects of the environment. What a neophyte acquires through the enculturation process is a collective cultural "lens"—a way of seeing the world. During the course of enculturation, an individual personally positions him/herself relative to extant manifestations of collective culture, personally interprets, and eventually transforms collective cultural guidelines into personal ones that VALSINER (1999) calls "personal culture." Thus, personal culture and collective culture share commonality, but neither is isomorphic with or a completely nested subset of the other. [20]

Applied to professional contexts, professional enculturation is a career developmental process that links a trainee to a professional group that she/he wishes to join. A cultural neophyte (e.g., nursing student) with career aspirations of becoming a professional nurse must locate him/herself within an existing, but constantly changing professional culture (e.g., the world of professional nursing). The novice is charged with mastering collectively-valued aspects of professional nursing life including a set of substantive theories, technical skills, and/or interpersonal communication skills of professional nursing practice including both material procedures (e.g., competently administering medical procedures and providing medical treatment) as well as symbolic practices (e.g., considering patients as holistic beings living with illness experiences, understanding their problems, and caring for them through interpersonal relations). [21]

Members of the nursing community actively and intentionally channels and supports the enculturation of new members into their ranks through formal educational programs, certification requirements (i.e., culturally guided, valued material practices), and training experiences. At the same time, through the process of professional enculturation, a nursing student learns philosophical, epistemological, ideological, and ethical foundations and meanings of proper professional activities (i.e., culturally shared, valued symbolic practices). Critical features of the learning experience are purposefully constructed often through recommendations of prominent leaders in the field. Implementation of the enculturation experiences in specific programs is achieved with tailoring to local and regional contexts—through state and regional nursing organizations and local training institutions. [22]

3.1.2 Professional acculturation

Acculturation in general social settings is defined as "... phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (REDFIELD, LINTON, & HERSKOVITS, 1936, p.149). When individuals from one culture interact with members of a different cultural group within a particular context, changes occur at both collective and individual levels. While, in principle, the exchanges and influences could be equal between the groups, in practice one culture usually dominates, leading to a distinction between "dominant" and "nondominant" groups. Imbalances in power, influence, and perceived relative value have important practical and psychological changes for individual members of the interacting groups. Among dominant group members, it can foster attitudes of perceived superiority; while among nondominant group members it can yield perceptions of inferiority, prejudice, and discrimination. Individuals, too, can vary widely in their acceptance of cultural contact and its consequences. Overall, acculturation may be said to bring about mutual (although not necessarily symmetrical) influence, cultural diversification, and consequences both positive and negative. [23]

Applied to professional contexts, professional acculturation refers to a career development socialization process in which individuals already enculturated into one professional group interact and acquire elements of the professional cultures of members of other professional groups within particular practice settings. For example, on multidisciplinary community-based treatment teams, nurses learn about social service eligibility and availability, social workers learn to monitor medication side effects, physicians learn about treating patients as whole, multifaceted individuals. Each of the team members learn about the care activities performed by fellow team members, and how to provide that type of care as dictated by individual patient need and situational demand. [24]

While both the daily experiences of individuals from dominant and nondominant groups may vary and members of both groups may differ in their acceptance of acculturation changes, over time the changes are incorporated into individual providers' personal professional cultures. As the individual providers re-express aspects of their personal professional cultures along with the changes brought about through acculturation, they can alter the characteristics of their local group professional culture in such a way that the acculturated beliefs, values, knowledge, or activities are incorporated into their local professional cultures. As subsequent providers join the group, the new local version of professional culture would be transmitted to them through either enculturation (if the new provider was initially learning the profession) or acculturation (if the new provider came "pre-equipped" with professional culture of another local group). [25]

3.2 Organizational culture

The concept of organizational culture has long been considered important in business and management decision making, and anthropological conceptions of organizational culture have even been receiving increased attention in recent years (e.g., TRICE & BEYER, 1994). The concept of organizational culture, however, remains largely missing from services research. This omission overlooks linkages between (1) formal agency structures and procedures, and informal translations of the structures and procedures into clinical care decisions and actions, and (2) the qualities and outcomes resulting from agency services. Of the services research attention to organizational culture, most of it has been focused on relatively small clinical care units, such as hospital divisions or clinical care treatment teams. Consequently, services researchers may have seriously underestimated the influence of larger cultural units (e.g., the sponsoring organization or institution) on provider job-related attitudes and behavior, and ultimately, on the quality and effectiveness of health and mental health care services. [26]

Within the field of business and management, multiple conceptions of organizational culture have been developed out of differing theoretical traditions. For example, from an anthropological perspective, TRICE and BEYER (1984) define organizational culture as a system of publicly and collectively accepted 'meanings' that operate for a group at a particular time. Anthropological approaches to organizational culture, in general, consider "context" important and organizational factors irreducible to the sum of their constituents. Following LEWINian psychological tradition, SCHEIN (1990, p.111) views culture as "what a group learns over a period of time as that group solves its problems of survival in an external environment and its problems of internal integration." Any definable group with a shared history can have a culture, including organizations. Moreover, within an organization, many subcultures may exist. SCHEIN (1990, p.111) defines [organizational] culture as "(a) a pattern of basic assumptions, (b) invented, discovered, or developed by a given group, (c) as it learns to cope with its problems of external adaptation and internal integration, (d) that has worked well enough to be considered valid and, therefore, (e) is to be taught to new members as the (f) correct way to perceive, think, and feel in relation to those problems." [27]

Conceptualized this way, the notion of organizational culture differs from its cousin, the more popular notion of organizational climate. Organizational climate is a surface, external manifestation of organizational culture (SCHEIN, 1990). While it ostensibly allows services researchers to "directly" measure aspects of organizational atmosphere, it lacks the capacity to show or explain how the organization functions at deeper levels. A few mental health services research projects have examined the relationships between organizational climates and client outcomes. For example, MOOS and his colleagues (1997) showed that the organizational climate of psychiatric wards, therapeutic settings, community residential program polices, and treatment orientations influence patients' outcomes as measured by dropout rates, discharge rates, community tenure, and

treatment participation. While these studies provide important information on the impact of organization atmospheres on clients' outcomes, most of them limit their methodology to conventional research methods and base conclusions on group aggregate data and (implicitly) relatively static conceptions of organizational culture (e.g., GLISSON & HERMMELGARN, 1998). From this perspective, information on individual front-line service providers' professional life worlds and how they unfold, develop, and evolve within the context provided by particular service provision agencies is missing. [28]

When new providers join a service-delivery agency, they learn about their new organization's collective culture through enculturation and acculturation. First, they gradually become familiar with organizational expressions of culture such as agency mission statements, norms and rituals of inter-professional relationships, client availability expectations, reimbursement policies, department meetings, informal social gathering and so on. The novices' familiarity with the organizational culture establishes a reservoir of resources from which they draw in interpreting collective culture into personal ones. On the basis of their personally-filtered version of organizational culture, they construct, modify, and reconstruct their professional activities and career development paths. Through subsequent expressions of their "personal organizational cultures," they (in conjunction with their peers) can serve as catalysts for organizational culture change. [29]

Some indirect evidence for differential transformation of organizational culture are evident in a study by SILVERSTER and colleagues, who examined differential reactions of employees to organizational culture change at a large scale multinational organization (SILVESTER, ANDERSON, & PATTERSON, 1999). Specifically, the study indicated that managers, trainers, and trainee made different attributions of organizational changes. Unfortunately, it did not systematically examine individual differences in attributions or try to relate them to the personalized organizational cultures realized by individual employees. [30]

4. Psychiatric Nurses in Multicultural Interfaces

Within the U.S. professional nursing community, there is consensus that psychiatric nursing is challenged. Major concerns include the current climate of managed care which demands workforce restructuring and more efficient utilization of human resources (e.g., HAGERTY, BISSONNETTE, BOSTROM, LOVELL, & SIELOFF, 1995; MERWIN, 1996), a dearth of advanced practice positions in mental health service agencies (e.g., MALONE, 1993), a shortage of psychiatric nurses (e.g., McBRIDE, 1990; POTHIER, STUART, PUSKAR, & BABICH, 1990), and a professional nursing identity crisis (e.g., McCABE, 2000; OLSON, 1996). To date, improvement recommendations have called for work condition and service system changes designed to enhance the recruitment and retention of psychiatric nurses, but they have gone unheeded. Although, as OLSON (1996) noted, grim comments on nursing occupational situations are not at all unique to the nursing profession, the degree of accumulated perils at every corner of psychiatric nursing practice seems to be reaching an apex. The time is

ripe and the need is urgent for a re-examination of the professional circumstances and conditions under which psychiatric nurses labor—a re-examination that cannot ignore nurses' lived-experiences as seen through their own eyes. [31]

Psychiatric nurses occupy a unique professional niche at the juncture of two parallel professional cultures, nursing and psychiatry, which are hierarchically organized within larger sociocultural contexts. While each professional culture shares a focus on the mental health and well-being of individual patients, the cultures differ drastically in their beliefs, practices, and social structures deemed important by the health care provision system for meeting patient needs. Like the experiences of bicultural individuals living in a host culture, but maintaining their own cultural heritage and practices, psychiatric nurses negotiate a labyrinth of partially (non)congruent sets of professional roles, expectations, responsibilities, rewards, compensation, and interpersonal relationships within a local service providing context. [32]

While the professional disciplines of psychiatric nursing and psychiatric medicine share numerous commonalities in patient populations, conditions of concern, and care, the two fields are clearly distinguishable by their respective professional cultures. Table 1 summarizes major differences between the two professional cultures. In part, the distinct cultures have evolved out of different philosophical foundations, epistemological bases of knowledge, historical and sociocultural social contexts, and institutional traditions. In the case of nursing culture, the discipline grew out of humanistic and holistic traditions and developed into a health care profession (HORSFALL, 1997). [33]

In 1960s and 1970s in America, an active professional social movement transformed the nature of nursing from an occupation into a profession (PEPLAU, 1977). A profession differs from an occupation in that the former requires extensive training and is governed by a code of ethics (e.g., American Nurses Association, 1985) shared within the collective professional body. Professionals become powerful because organizations and clients depend on their knowledge and competence. They are able to claim authority because they are members of a professional group whose legitimacy is endorsed by society at large (STARR, 1982). During the process of professionalization, mental health nursing has rather uncritically adopted biomedical models of psychiatry with little regard for their congruence/dissonance with the historical values and practices deemed important by nursing. While the initial effort toward professionalizing nursing has largely been succeeded, the change has simultaneously produced an unintended consequence—internal dissonances within nursing professional culture. This internal dissonance sees to have arisen the imported medical model and its implications were not fully interpreted under the native holistic model of nursing and integrated with the host culture. Ironically, through the course of social and institutional changes in larger social contexts, the imported medical model seems to overturn the native nursing model through the dissonance that has accompanied it. Ultimately, it may fundamentally change nursing professional culture if it has not already done so. [34]

4.1 Psychiatric nurses in interfaces between professional and organizational cultures

The built-in power hierarchies of most U.S. mental health care organizations have legitimized the medical profession's treatment decision-making power and physicians' patient care dominance over psychiatric nurses. The culture of medicine, therefore, may be seen as dominant over the culture of nursing in most medical and mental health care settings. With the differences between nursing and medical cultures (Table 1), when members of the two cultures are brought into contact and medicine is considered the dominant culture, discrepancies between the practices valued by the dominant group (physicians) contrast with the practices valued by the other group (nurses), who are expected to accommodate them.

Cultural Dimensions		Nursing	Psychiatry
Symbolic Practices	Philosophical	• Humanism	• Materialism
	Epistemological	• Intersubjectivity • Mind-Body interaction	• Scientific objectivity • Mind-Body separation
	Ideological	• Caring for illness	• Curing disease
	Ethical	• Advocacy	• Fiduciary
	View of Professional	• Collaborator • Self-expertise	• Authority • Other-expertise
	View of Patient	• Holistic understanding • Agent experiencing illness • Self-expertise	• Materialistic understanding • Organic carrier of disease
Materialistic Practices	Etiological	• Psychosocial	• Biological/Physical
	Basic Treatment Model	• Holistic	• Biomedical
	Therapeutic Relation	• Interpersonally relating	• Interpersonally distancing
	Role Responsibility	• Nursing diagnosis • Medication • Conversation	• Medical diagnosis • Medication

Table 1: Comparison of Nursing and Psychiatry Professional Cultures [35]

The practical implications of conflicting values seem to be expressed among nurses as an array of negative feelings and thoughts. The existing literature well documents consequences for nurses in terms of job satisfaction, job stress and

coping, roles and job responsibilities, conflict, burnout, turnover, CARSON, FAGIN, BROWN, LEARY, & BARLETT, 1997; DAWKINS, DEPP, & SELZER, 1985; DECKER, 1997; KNOOP, 1995; SEYMOUR & BUSCHERHOF, 1991; STUART, WORLEY, MORRIS, & BEVILACQUA, 2000). While none of these studies have specifically focused on U.S. psychiatric nurses' professional lived experiences within the interface(s) between professional cultures and organizational cultures, their reports on patterns of negative and positive aspects of the nurses' professional work experiences can be reconceptualized as professional and organizational cultural interface issues. [36]

STUART and her colleagues (STUART, WORLEY, MORRIS, & BEVILACQUA, 2000), for example, examined psychiatric nurses' work-related activities and perceptions in public sector "inpatient" hospital settings and "community" mental health agency operated by the Department of Mental Health (DMH) in one state. They reported that psychiatric nurses in the two different work settings—(they did not examined multiple professional and organizational culture interfaces)—showed no statistically significant differences in years of work experience, job satisfaction, autonomy, organizational commitment, participation in DMH decisions, or likelihood of leaving DMH. The study also revealed several differences between the inpatient group and the community group, in areas including proportions of supervision provided by a senior nurse (97%, inpatient vs. 31%, community), average meetings with supervisor per month (6.5 meetings, inpatient vs. 4.3 meetings, community), and average days of missed work (5.3 days, inpatient vs. 2.7 days, community). In terms of four "normative" roles of nursing practice, the inpatient and community groups reported differences in percentage of actual involvement in direct care (28%, inpatient vs. 45%, community), management (26%, inpatient vs. 13%, community), and clerical tasks (24%, inpatient vs. 19%, community) except clinical communication (21% for both groups). Both groups showed preferences for increases in the first three roles. [37]

While group aggregate statistical results are informative and useful for profiling the collected perceptions, beliefs, attitudes, and behaviors of a group of individuals as STUART et al. showed, they are insufficient substitutes for culture-inclusive qualitative analyses. Aggregated characteristics of group members are neither equivalent to collective culture nor representative of personal culture. Although the literature on social influence has been burgeoning, only a few studies have detailed dynamic processes involved in small group formation, social reality construction, or leadership-mediated social change (e.g. SHERIF, HARVEY, WHITE, HOOD, & SHERIF, 1961). [38]

Service providers' workplace circumstances implicitly or explicitly direct shifts in their roles and responsibilities according to emergent professional tasks demanded by interfaces between professional and organizational cultures. These shifts and their differential psychosocial impacts on individual service providers' perceptions are difficult to accurately describe and examine using currently available quantitative research methods. It, then, becomes necessary to understand the front-line care professional's lived experiences through their daily

professional lives in way that extend beyond what the existing services research literature has offered. It is in this arena that qualitative research tools can be so helpful. They have a capacity of handle the complexity and subtlety embedded in and evolving out of multiple cultural interfaces in individual providers' professional worlds. [39]

A few services researchers have attempted to explore service providers' lived professional experiences using qualitative methods (e.g., THOMAS et al., 1999a, 1999b). In addition to conventional survey style questions, STUART et al. (2000) added an open-ended item to the end of their questionnaire and invited respondents to share anecdotes of experiences related to their survey responses. While only 25 out of a total of 330 participants documented their experiences, the comments were explicit and informatively descriptive. These individual nurses' comments do not comprehensively or systematically address many aspects of workplace multicultural interfaces. They present a tantalizing partial picture of problems and issues that arise. [40]

4.1.1 Public sector psychiatric nurses' professional lived experiences

The length of the individual nurses' comments varied ranging from 38 to 340 words. Analysis and coding of the passages was performed in three stages. (1) Each passage was initially read as a whole. Next, the passage was divided into a sequence of statements, each expressing single thoughts and, typically corresponding to sentences. Third, the meanings of each statement were re-read separately and compared to their meanings when embedded in the full passage. Annotations or additional text from the passage was added to a statement if the two meanings differed. (2) Each nurse's comments were reorganized based on referential temporality: past, present, future. The reorganized series of statements were then re-read to determine whether the reorganization of the statements changed their meanings compared to their meanings in the original passage. In the present case, reorganization did not change the meaning of any statements. (3) Within each temporal period, themes related to professional culture, organizational culture, the interface between them, and their impact on or interpretation by the nurse were coded. [41]

Table 2 presents thematically categorized examples from the "present" temporal period. They were selected to illustrate the personal lived experiences of psychiatric nurses within the interface between professional and organizational cultures. As seen in the table, even the ad hoc method of qualitative data collection employed in this survey revealed aspects of the lived experiences of psychiatric nurses that would not easily be obtained with conventional quantitative measures. Among the sample of comments included in the table, a number revealed aspects of organizational cultural transmission (005), perceived unfairness in hiring practices (007), and organizational characteristics such as "maneuverability" (012), which may be associated with job dissatisfaction and/or turnover.

Conceptual Themes	ID	Narrative Examples
Perceived Organizational Culture	005	”The values/policies of the central office of the DMH[1] are not always the same as those experienced at community mental health centers where center directors are autonomous and not accountable for upholding DMH philosophies and protocols.”
	007	”The department has a practice of hiring in new nurses at higher salary rates than nurses who have been with the department five or ten plus years ...This makes it hard to stay with an organization, no matter how much you like it.”
	012	”I enjoy working in DMH for the maneuverability–moving from facility to facility under the same ‘umbrella’.”
Interface of Professional Culture & Organizational Culture	004	”Prior to coming to ..., I was always supervised by a psychiatrist and my role was extended. Here...the only way nurses are mainly utilized is to do medication administration and medicine monitoring. My skills and knowledge have not been utilized and in the past 11 years I have mainly been supervised by a social worker which I resent ... ”Nurses are seldom advanced and the social workers get advancements rapidly.”
	004	”I love being psychiatric nurse but not under the current conditions. There is no future for nurses in our field when the center directors are so obviously negative about advancing the nurses in mental health centers across the state.”
	006	”DMH needs more nurses ... With more nurses, more time could be spent with patients...DMH needs more psychiatrists and LICENSED physicians, and those physicians need to be more concerned with stabilizing psychiatric symptoms than they are with assessing chronic physical illnesses and sending patients from one medical clinic and medical specialist to another.”
	020	”I would like to see the department recognize the importance of the nursing profession and validate the worth by hiring a nurse to participate in upper level management decision ...There is a strong bias against nursing ... Nursing jobs in the community...often require evenings, weekends and longer hours without adequate compensation.”
	023	”I have had 7 different supervisors since March 1993 ... we had psychiatrists writing policies and procedures for Nursing!!...If we speak out in behalf of a patient then we are ridiculed ...”

Table 2: Psychiatric Nurses' Personal Experiences in Multicultural Professional Worlds [42]

Several psychiatric nurses made explicit comments about their lived experiences within the interfaces of professional and organizational cultures. Participant (004),

1 DMH (Department of Mental Health)

for example, expressed negative affect ("resentment") when she was paired with social worker supervisors in her present work place, while she did not experience similar sentiments when she was teamed with psychiatrists in her previous employment setting. Several ad-hoc "key informants" on psychiatric nursing professional culture explained that psychiatric nurses, in general, perceive themselves as professionally better qualified than selected groups of front-line service providers including social workers. Whether and how different individual psychiatric nurses' perceptions and attitudes toward the specific individual social workers echo the collective perceptions require additional and more extensive qualitative cultural research. Another psychiatric nurse (006) expressed negative feelings toward the way physicians handled psychiatric clients, giving voice to nursing culture's traditional symbolic practice of "caring" rather than "curing." Other participants described frustration with the way that the Department of Mental Health treated nurses and nursing, in general, (020) as well as how it endorsed the built-in hierarchical power relationships between nurses and physicians (nursing and psychiatry) in the larger medical community (023). In summary, despite limitations in the way the present qualitative data was collected, qualitative analysis of the nurses' comments reveal important aspects of their lived experiences. It also illustrates the promise of qualitative methods combined with new cultural perspectives and conceptualizations for adding new information and unique insights into providers' professional worlds. [43]

5. Repositioning Culture in Services Research with Qualitative Approach

The field of services research has long borrowed cross-cultural psychological conceptualizations of "culture" as a static homogeneous group characteristic indicated by such surrogates as race, ethnicity, the country of origin, immigration status, and so on. Doing so, caters to quantitative biostatistical and epidemiological traditions in public health research; as well as provides an expedient response to sociopolitical demands for evidence-based, population-based scientific research designed to promote culturally competent service delivery and eliminates minority health/mental health disparities. From the community of providers' perspective (both agency and individual), population-based group information on sociocultural minority group clients is useful and a necessary starting point. However, in the day-to-day activities of providing services to individual clients with unique and personal sets of problems, group-level knowledge does not always translate well into optimal treatment or service delivery strategies for individual patients. Despite an obvious relationship, there is a discontinuity between the group-level knowledge and beneficial individual-level practice. The discontinuity arises because individual cultural group members are not passive sponges who gradually soak up the collective culture in which they are embedded. They are, rather, active participants in the process. They idiosyncratically perceive and comprehend aspects of the collective culture, personally transform it, selectively choose which elements to absorb, and actively decide which elements to reject. It is this gap between the collective and the personal that must be bridged if services research is to provide information relevant for care providers to know how to treat this individual client sitting in front

of them most appropriately. Only then, will real progress toward providing culturally appropriate services in a client-sensitive way make inroads toward the elimination of minority health disparities. [44]

Likewise, knowledge of health or mental health care professionals' professional or organizational affiliations are insufficient for understanding their beliefs, attitudes, and behavior about the care they provide. Within a service provision agency, not all professional groups share equally in the agency's organizational culture, nor do all providers equally share in either their collective professional cultures or the organizational culture of the institution or agency. Even if one hypothetically assumed that organizational or professional culture is equally shared by all individual providers, the providers still selectively perceive and interpret their collective cultures idiosyncratically. Through the socialization processes of enculturation and acculturation, which unfold through interactions in multiple cultural interfaces, individual providers construct and reconstruct their own personal versions of the collective cultures. It is against the backdrop of these multiple, interacting cultures and interfaces between them that individual provider-client service delivery interactions are framed. Existing services research, so far, has neither conceptually nor methodologically elaborated on the multiple cultural interactions that occur, their interfaces, or their ultimate implications for patient outcomes. [45]

Understanding the complex, dynamic nature of service provision and receipt in multicultural interfaces and generating useful information for all invested stakeholders—clients, providers, service provision agencies/institutions, and eventually policymakers—requires consideration of new research tools. Qualitative methods seem uniquely suited to the task. Not only can they allow for examination of collective cultural characteristics, but they can be used to examine individuals' personal transformations of collective cultural elements (KLEINMAN & KLEINMAN, 1991). Not only can they be used to describe cultural products, but also they can be used to explore and reify cultural processes. [46]

Qualitative methods alone, however, are not panaceas. Like quantitative methods, they can be misused (intentionally or not) and obscure rather than clarify. Although discussion of specific qualitative research methods and techniques are beyond the scope of this manuscript, a cautionary comment seem appropriate. The use of qualitative methods advocated in this manuscript are intended as tools for exploring particularly intractable problems of human experience where interacting cultures are realized, expressed, and interact on multiple levels (collective and individual). They are not intended as data reduction techniques for synthesizing qualitative characterizations into a few terse categories that are then aggregated and used in quantitative analyses. The latter strategy neither circumvents the fundamental problems that plague quantitative analyses (enumerated above) nor exploit the true strengths of qualitative methodologies. [47]

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