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ORIGINAL PAPER

Opening the Gift: Social Inclusion, Professional Codes and Gift-Giving in Long-Term Mental Healthcare

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Abstract Deinstitutionalisation has not only made the social inclusion of clients a key objective in long-term mental healthcare, it may also affect the role of the care professional. This article investigates whether the social inclusion objective clashes with other long-standing professional values, specifically when clients give gifts to care professionals. In making a typology of gifts, we compare the literature on gift-giving with professional codes for gifts and relate both to the objective of social inclusion of clients. Our typology draws on an analysis of ethnographic fieldwork carried out in 2007/2008 at a Dutch mental healthcare centre. We identify four types of gifts for professionals in long-term mental healthcare, each relating individually to professional codes and the objective of social inclusion of clients. Only the 'personal gift' directly supports social inclusion, by fostering personal relationships between professionals and clients. Acceptance of this type of gift is advocated only for long-term care professionals. We suggest that professional codes need to consider this typology of gifts, and we advocate promoting reflexivity as a means of accounting for professional behaviour in deinstitutionalised care settings.

Keywords Mental healthcare · Social inclusion · Professional codes · Gift-giving · Ethnography

The work for this article is original and unpublished.

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Introduction

Over the last decades, the social inclusion of clients[1] of long-term mental healthcare has become a primary objective of Dutch mental healthcare policy. It is widely agreed that clients should live in the community, among other citizens, rather than in institutions. Rehabilitation programs have been set up with the goal of trying to enable clients to participate in regular community life. In spite of all the effort geared towards enhancing social inclusion, research shows that actual social inclusion of clients is still a challenge (Leff and Warner 2006; Michon and Van Weeghel 2008). Clients may be living *in* the community, but they are not perceived to be members *of* the community, since they have few social relationships (Ware et al. 2007). Clients thus need to be supported in fostering these.

One way of building and maintaining relationships is through giving gifts. Marcel Mauss (2002), one of the founding fathers of the anthropology of the gift, describes gift-giving as an act that can create and strengthen social bonds. This power of gift-giving has been investigated in studies on social inclusion and exclusion in contemporary Western societies. A study by Komter (1996a), for instance, reports that social exclusion of marginalised people in the Netherlands partly results from a failure to partake in gift-giving practices. She maintains that gift-giving practices are a main constituent of regular community life. Supporting clients of long-term mental healthcare in gift-giving practices is an example of a concrete way of supporting clients in building and maintaining relationships and enhances their social inclusion.

In the professional–client relationship, however, gift-giving is explicitly discouraged. Guidelines laid down in professional codes for Dutch mental healthcare workers state that professionals should—where possible—be cautious about accepting gifts from clients (Table 1). Accepting a gift from a client could lead to a transgression of the boundaries of the professional relationship (Nadelson and Notman 2002). The current ideal of social inclusion may, however, require a revision of the professional role in the guidelines. In providing community care outside of the institutions, professionals may themselves have to become members of that community. They may function as important enduring contacts in the networks that clients do happen to have and whom gifts might be given to. In that case, professional codes that advise caution in accepting clients' gifts are in conflict with the objective of enhancing the social inclusion of clients.

How do professionals currently deal with gifts from clients? The literature suggests that care professionals are unsure of their role with regard to gifts from their clients (Levene and Sireling 1980). Brendel et al. (2007) have, therefore, developed a pragmatic framework for dealing with gifts. In answering six basic questions, they run through the possible practical consequences of accepting or declining a gift from a client. These questions ask whether giving the gift could

[1] The terms employed to refer to people using mental healthcare services are contested and politically laden with ideas about the practice of mental healthcare (McLean 1995). In the mental healthcare centre involved in this study, actors primarily use the term 'client' to refer to this group of people. Our use of 'client' in this article does not imply our personal stance in the debate, merely that we wish to stay close to the empirical material.

Table 1 Professional codes on gifts from clients in the Netherlands

Guideline document	Code on gifts from clients (our translations)
National professional code for nurses and caregivers (V&VN/NU'91, 2007)	Article 2. 12 As a nurse/carer I shall consider the professional boundaries of my relationship with the client. This means that:[…] As an independent worker, I shall accept no loans from the client or accept gifts in kind, or money, or presents when these represent more than symbolic tokens of gratitude
Professional code for psychotherapists (NVP, 2007)	Article II. 4.1: Prohibition on acceptance of gifts During the course of treatment and afterwards, the psychotherapist shall not accept any gifts from the client that surpass a relatively small value. With regard to acceptance, the meaning of the gift should be considered
Professional code for psychiatrists (NVvP 2003)	Article II. 26 When a patient has drafted a will while under psychiatric care for an illness, the psychiatrist shall not accept legacies from the patient (Civil Code, book 4, art. 953, par. 1). A psychiatrist shall not accept gifts from living patients that are disproportionate to usual recompense

harm the client, whether the gift has great monetary value, whether the gift is desirable to the professional, whether accepting runs counter to professional norms, whether declining could be hurtful or counter-therapeutic for the client and if the decision to accept or decline is in the best interest of the client. The problem with this framework is that it presupposes unequivocality of professional norms. What if, as we argue here, a contradiction in these professional norms arises? In this article, we study the contradiction between the objective of social inclusion and the professional norm of being cautious with accepting gifts, as advocated by professional codes. We examine examples from practice, of gifts presented to care professionals, to shed light on the role gift-giving may play in the social inclusion of clients of long-term mental healthcare. We ask the following general research question: what types of gifts do clients of mental healthcare give to their care professionals, and how do these gifts relate to professional codes and the objective of social inclusion?

Background: Gift-Giving

The nature of gifts is a disputed issue (Komter 1996b; Osteen 2002). In Marcel Mauss' (2002) version, a gift is inseparably tied to the identity of the giver. This presence of the giver in the gift causes the receiver to reciprocate and creates a continuous cycle, including three basic elements: giving, receiving, and giving in return. It is by repetition of this cycle that social bonds are made and maintained.

Thus, one interpretation of Mauss is to say that gifts are social trading objects in a continuous cycle of gift-giving, ruled by the imperative to reciprocate. Some,

however, claim that the imperative to reciprocate is a Lévi-Strauss invention that was later attributed to Mauss; Lévi-Strauss turns the empirical fact of gift-giving into the underlying principle of (obligatory) reciprocation (Sigaud 2002). Lévi-Strauss is thereby able to give one and the same explanation for social facts as varied as sharing wine and the taboo on incest, as he interprets both wine and daughters as goods that can and sometimes should be given to others (Lévi-Strauss 1976). He turns multiple, empirical *total social facts*[2] into one underlying, abstract social phenomenon: the principle of reciprocity.

The emphasis that Lévi-Strauss puts on reciprocation is disputed by a perspective that sees gift-giving as an act of altruism, inspired by the motive to construct intimacy or build personal networks. David Cheal, for instance, describes forms of gift-giving as means of communicating intimacy with others (1996). One way of creating intimacy through gift-giving is by singularizing the gift, making it uniquely suited to one particular recipient (Miczo 2008). In this perspective, both giving and receiving (accepting) say something about the personal investment of the giver and receiver in a relationship (Fennell 2002). The time interval between gift and counter gift permits agents socialised in the gift economy to 'forget' that gift exchange rituals can be analysed as arranged according to the principle of reciprocity (Bourdieu 1998).

In our analysis, we have borne these two general perspectives in mind, which view gift giving as either impersonal relationships of obligatory exchange or personal gift relationships between friends or other intimates. Yet even this dichotomy is contested. Komter, for example, criticises it by emphasising that the role of gifts in human relationships is more varied than can be contained by either of these two perspectives (2001). Komter also writes that giver and receiver may hold different views of their relationship, a suggestion that even further complicates the interpretation of gifts we saw given.

In healthcare research, the role of the gift in the professional–client relationship has received marginal attention. We found two quantitative studies on gift giving in healthcare. One investigated the incidence of gift-giving in a range of medical specialties in a British hospital and showed that medical specialists were mostly grateful, but sometimes embarrassed by gifts from patients (Levene and Sireling 1980). The other compared differences in gift-giving between medical and psychiatric inpatients and shows how the stigmatization of mental healthcare clients negatively affects gift-giving practices (Wiener et al. 1999). A small body of literature discusses gift giving from a psychotherapeutic perspective, where analysing clients' gifts is a primary objective (Hahn 1998; Hundert 1998; Smolar 2002). Closest to our own objectives is the qualitative research article by Drew and colleagues that studied the nature of gifts to professionals in general healthcare (1983). However, as these authors conducted their research at a department of internal medicine, their analysis cannot comment on aspects of gift giving that are specific to long-term mental healthcare. In addition, they interpret all gifts in terms of reciprocity. They leave no room for alternate, altruistic views on gift giving. By

[2] That is, events that have simultaneous social, religious, magical, economic, utilitarian, sentimental, legal and moral significance (Lévi-Strauss 1976).

leaving the question of reciprocity versus altruism open in our study, we not only contribute to the ongoing discussion on the social inclusion of clients of long-term mental healthcare, but also achieve results that step outside of this dualism.

Setting and Data Collection

This article was established within the context of a larger research project on the 'relational citizenship' (Pols 2006a) of clients of long-term mental healthcare. Continuing on previous research, ethnographic fieldwork was conducted in two rounds of 2 and 3 months, respectively, at a mental healthcare centre in the south of the Netherlands. This centre offers clinical care, ambulatory care, day care, part-time treatment, home care, and a day activity centre, and is located in the outskirts of a semi-large city. The mental health centre has been a frontrunner in developments in rehabilitation and social psychiatry in the past. Corresponding to national policy goals, this centre currently understands rehabilitation and social inclusion mostly in terms of independence and self-management. We, however, studied a care team that held a different view; they considered relationships to be the cornerstone of social inclusion. This is also how we understand social inclusion in this research: establishing a network of meaningful relationships—irrespective of the geographic location of this network.

Via this multidisciplinary team of care professionals, access was gained to a variety of social settings in which long-term clients live. The care team consisted of a group of professionals working as case-managers to clients of a certain area of the city and the adjoining countryside. Irrespective of their disciplinary training and in regular consultation with the other team members, these professionals worked with all types of long-term clients (excepting clients from the separate care department for addiction problems). Thanks to their long track record at the mental health centre, this team was also able to provide introductions to other long-term care settings, outside of the geographic area that was appointed to them.

Given on-site permission for participant observation, SO studied all types of long-term care settings receiving support from the centre's professionals. Studied settings include both long and short-stay departments at the centre, the day activity centre, a rehabilitation home where a group of clients learn how to live on their own, and the homes of clients who are living independently again, after having resided in one or more of the other settings. This kind of research allowed the fieldworker to have many informal conversations about the research topic with the actors involved. To gain insight in the perspectives of participants and as a form of triangulation key informants (care professionals, clients, and members of the social networks of clients) were also interviewed in-depth. As part of the large project on 'relational citizenship,' we interviewed six clients, one experiential expert (twice), the manager of a buddy project for mental health clients, eight buddies and friends of clients, ten family members (eight of which in a 'double interview') and seven care professionals. Interviews were conducted in private at locations that suited participants best: mostly in participants' own homes or in interview rooms at the mental health centre. This resulted in 32 audio-taped semi-structured interviews in Dutch. All participants gave informed consent for the interviews.

Irrespective of commitments to either reciprocal or altruistic conceptions of the gift, gift giving is regularly defined by its demarcation from a market exchange. In studying gift giving in the context of professional (mental health) service provision, it thus becomes important to discuss the economic context of mental health service provision in the Netherlands. At the time of study, the mental health sector was in the middle of a transition from a welfare state-oriented organisation of care towards a market-oriented structure. Professionals delivered services to clients in a configuration of actors defined by the Medical Treatment Contracts Act (WGBO), the Health Insurance Act (Zorgverzekeringswet) and the Social Support Act (WMO). This resulted in a situation in which, in general, no direct payment of professional services took place; payment of professionals was handled by healthcare institutions and financed by social insurance provisions and insurance companies. The arrangement of third-party payment can in principle leave clients in doubt over if and how payment of their professionals occurs. We come back to this point in our analysis.

Data Analysis

In our research project, we explored social inclusion of long-term clients 'on site' as it was performed by the actors involved (Latour 1987; Law and Hassard 1999). By conducting participant observation, social inclusion could be studied as it was enacted (Mol 2002) in contact with the concrete, physical surroundings. 'Following the actors' (Latour 1987) on controversial issues regarding social inclusion led us to subordinate themes to be further investigated. In this article, we identify gift-giving as one such theme; gift-giving is both controversial in relation to professional codes and promising in relation to social inclusion, since it creates social bonds. We have taken a material semiotic approach (Mol and Mesman 1996) to studying the kinds of gifts given and the types of relationships they enact between professional and client. We have not asked either professional or client why they gave, accepted or refused certain gifts, but studied what kinds of relationships specific gifts enacted between them.

By starting our analysis from the premise that the meaning of gifts is not fixed, we took an inductive approach to analysing our material. Through open coding, we selected fragments of field notes and interviews in which things were offered, received, or otherwise transferred from clients to professionals or in which participants spoke of giving and receiving. The interpretation of these coded segments gained a deductive aspect, since we analysed them with secondary research questions drawn partly from the literature on gift-giving. Pivotal questions were: Which element of the gift giving cycle is most important—giving, receiving or giving in return? How long does the gift relationship last? Where does the gift place the professional in the client's network? We analysed these data following the thematic framework approach described by Ritchie et al. (2003); we sorted and synthesised data by charting them and constructed a typology across this chart. The process of charting and working towards a typology was cyclical; during the analysis new questions emerged from the data that were inserted as new categories in the chart.

Four types of gifts being given in long-term mental healthcare were found: a symptom gift, a compensation gift, a courtesy gift, and a personal gift. We describe these types in turn below, relating them to both literature on professional practice and literature on gift-giving. In the discussion, we answer our general research question by describing how these gifts relate to professional codes and to the objective of social inclusion.

The Symptom Gift: Professional and Client as Therapist and Patient

The first type of gift that clients may give is emblematic for mental healthcare. The beliefs of the giver are the central value of the symptom gift. Brian, a social worker, illustrates this kind of gift-giving. Explaining why he receives so many gifts from a particular client Brian said:

> Well, and this is a very personal hypothesis, I think it's her way of linking people to her. […] She's creating something around her, so that people will continue to like her, and then she hopes that people won't abandon her when she needs them in the future. I think that's at the heart of it all. In a very basic way she's feeling insecure, because she's been abandoned by lots of people in the past.

As this quote shows, Brian thinks the gift is a sign that refers to the belief of the giver. In this case—as might be the case elsewhere in mental healthcare—the belief is easily interpreted as having to do with the client's mental health problems: the client's feelings of insecurity. The gift is seen as a symptom of these problems.

Considering the beliefs of the giver is pivotal in a kind of interaction between giver and receiver modelled after the interaction between psychotherapist and patient. Robert Castel describes the Western world to be permeated by what he calls a 'psy-culture' (Abma 1996). According to Castel, a psychoanalytic style of reasoning and understanding variations in behaviour is not only reserved for psychotherapists, but common to us all. This explains why a social worker would reason according to psychoanalytic fashion.

In the interaction between therapist and client, it is the task of the therapist to understand the client—better than clients understand themselves—so that the client can learn from the analysis. Interaction with the therapist is, therefore, put under scrutiny, which makes exploration of the meaning of gifts an essential part of the therapeutic intervention (Hahn 1998; Smolar 2002). The professional code for Dutch psychotherapists therefore dictates:

> With regard to accepting [a gift], the meaning of the gift should be considered […] (NVP 2007, p. 17, our translation).

Whether or not therapists accept a gift depends on how they interpret the meaning of this gift to the giver. This professional code thus indicates: accepting or declining a symptom gift is secondary—the symptom gift must first be analysed. When a gift is a symptom of problems, considering these problems and acting upon them is the principal course of action the professional must undertake.

In this manner of reacting to gifts, the emphasis is placed on the first element of the gift-giving cycle: the giving. Receiving and reciprocation are only relevant to symptom gifts, insofar as they affect the beliefs of the giver. For instance, receiving or reciprocating her gift may work on the feelings of insecurity of the client discussed in the quote above. In other words, the recipient is hardly relevant as a person when symptom gifts are given. This makes giving symptom gifts a rather 'unsocial' type of gift-giving. Symptom gifts are not about relationships, they are about individual people. Thus they do not provide any direct means for enhancing social inclusion.

The Compensation Gift: Professional and Client as Provider and Customer

The second gift we identified in mental healthcare is offered as a means of compensation for services provided or to be provided. The essential value of this gift is its monetary worth, as a case manager in the care team explains in this field note fragment:

> I take Linda aside to ask her about gifts. She says that gifts are a touchy subject. Sometimes she gets something small, like a plant and she really likes that. But her motto on gifts is 'never too expensive and not too often'.

Expensive gifts and too many gifts put their monetary value centre stage. In compensation gifts, the monetary value is balanced against the cost of the services the professional provides. Compensation gifts thus lead to a professional–client relationship that resembles a provider–customer relationship, where the third element of the gift-giving cycle is pivotal: giving in return. With compensation gifts, reciprocation is, indeed, as Lévi-Strauss said of all gifts (1976), *the* underlying principle.

This emphasis on reciprocation by clients is problematic in mental healthcare. It is the main reason why professional codes advise against accepting large gifts, both in the Netherlands and abroad.[3] Compensation gifts can be problematic in two ways, depending on when the gift is given and who does the reciprocating. The first problem with compensation gifts is illustrated by the following quote from a care professional:

> I really think people shouldn't [give me things]! I'm really clear on money. No way, none whatsoever! [I often have to turn down one of my clients, who] comes up to me with money for really the simplest of things, like when I've arranged his tax forms or something. Yes. Or when I drive over to pick him up from his daughter's place. It's a strict deal we have: *you don't pay me, because my boss is already paying me*.

In this situation, a *client* tries to reciprocate *after* receiving a service from his care professional. The compensation gift is intended to pay the professional for a service

[3] The recommendations of the Ethics Committee of the American Psychiatric Association on the acceptance of large monetary gifts is a good example of such advice in the international context (APA 2001, p. 36–37).

that is already paid for in his salary from the mental healthcare centre. Whether clients are aware of this or not, this would amount to being paid twice. Being paid twice is not in line with professional integrity and as the code advises: professionals should refuse compensation gifts. The second problem with compensation gifts is illustrated by this quote:

> There are times when I say to people: "It's all very well that you're giving me this, but we should still to be able to have a row, too. We have to be able to disagree. That's what makes it hard for me, if each time you come round, you come bearing gifts."

In the situation described here, the client tries to give *before* receiving the service, obliging the *professional* to reciprocate. Accepting money or big gifts places the care professional in a position of indebtedness to the client. As a consequence, this could cloud their professional judgement, making it difficult for them to make decisions that go against the will of the client (which is at times deemed necessary in mental healthcare). It also creates the risk of giving preferential treatment. Both consequences are not in line with ideas on professionalism. As the code advises, professionals should refuse compensation gifts.

Although compensation gifts do not always take the form of money, monetary gifts are characteristic, since they strongly trace out the form relationships take between professional and client in compensation gifts. Although Viviana Zelizer described money as having a varied social life, functioning as either direct exchange, entitlement *or* gift (1996), professionals treat monetary gifts solely as means of direct exchange or as means of creating entitlements. Both direct exchange between professional and client and special entitlements for clients do not sit comfortably with notions of professionalism in mental healthcare. Since compensation gifts ought to be declined, they cannot function in any desirable way as a means of enhancing social inclusion.

The Courtesy Gift: Professional and Client as Acquaintances

The third gift that clients may give in mental healthcare is intended to thank the professional. Its essential value is to follow the conventions of common courtesy. A courtesy gift is not about 'care' in terms of professional services, but rather care in terms of concern. Or, to put it differently, at stake is not *what* care is provided, but *how* it is provided. The following story of a home visit to Mrs. Smit in the company of a dedicated care professional illustrates this:

> Mrs. Smit is getting us coffee, while her case manager Rudolf goes through her mail and sorts out her finances. Suddenly, Mrs. Smit appears with a bar of chocolate and gives it to Rudolf. "He does so much for me!" she explains to me. Rudolf smiles in appreciation, takes the chocolate bar, puts it to one side and continues filing Mrs. Smit's bank statements.

Rudolf does not get thanked for filing bank statements. The 'so much' Mrs. Smit refers to is a wide-ranging category: it comprises of all the care, authentic concern, and dedication Rudolf shows for her case.

Professional training stimulates students to build and maintain care relationships with clients, based on mutual understanding, empathy, and trust (NFU 2009, p. 30). Although showing concern is something all care professionals are trained to do, following the maxim of 'detached concern' the emphasis is placed more frequently on professional detachment (Halpern 2003). Professionals should remain detached from clients to prevent the professional–client relationship from becoming (overly) personal. Indeed, as nurse Gary says:

> However good the relationship is, clients can never become your friends. That is just not possible.

The air of detachment in clinical settings gives way to a technocratic understanding of care, where care is increasingly organised as if it were a commodity (Scheid 2000). Given these circumstances, clients can feel that authentic concern is something that is *given* to them on top of the (detached) care services they receive, and that this concern calls for a gift in return (Drew et al. 1983; Spence 2005). In terms of the basic elements of the gift-giving cycle—giving, receiving, and giving in return—in courtesy gifts the emphasis lies on reciprocation.

Courtesy gift-giving in a way resembles the logic of the classic gift economies in Polynesia, discussed by Mauss, Bourdieu, and many others. As Bourdieu (1998, p. 94) writes, in this kind of gift-giving, "the initial [gift] is an attack on the freedom of the one who receives it […], it is a way to possess, by creating people obliged to reciprocate". Yet the way in which people are socialised, creating a certain 'habitus' as Bourdieu calls it, allows them to enter the gift-giving ritual while ignoring or denying the principle of reciprocity underlying it. In analogy, we may conclude that clients' courtesy gifts are given 'as if' they are free gifts, as if there is no pressing need to give them. At the same time, clients giving courtesy gifts have been socialised into feeling the need to reciprocate: to thank their care professionals for the concern and dedication they have shown.

While there are similarities between courtesy gift-giving and the gift-giving described in classic gift economies, there are contrasts as well, as the element of honour is played out differently. We might say that clients retain their honour or social prestige by giving courtesy gifts: they restore a social balance. While restoring this balance, there is no need for clients to give beyond the effort of the 'initial gift': the care given by the professional. After giving a courtesy gift, professional and client reach quits and may go their separate ways. Yet in classic gift economies, giving more than one has received or even destroying wealth are important ways to gain prestige, which keep the gift-giving cycle going and giver and receiver perpetually bound to each other. Giving more (either by giving a more expensive gift or by putting more effort into choosing a personal gift) would change the professional–client relationship by removing the element of detachedness. More expensive gifts and more personalised gifts fall outside of the scope of the courtesy gift.

To sum up: the courtesy gift underscores a dimension of care that is sometimes overlooked. It points out that caring is not only a (medical) technical procedure, but also a social activity (Sevenhuijsen 2000). Courtesy gifts pay tribute to relationships, which acknowledge this social dimension; people relating to each other as social acquaintances. Although professional codes on gifts advise exercising

restraint, other guidelines take precedence here. Professional training stimulates care professionals to be attentive to the social nature of care relationships, and therefore to accept courtesy gifts in order to have a good relationship not turn sour. Not accepting courtesy gifts would simply be rude, since it would be disrespectful to the (honourable) social position of the client. However, social inclusion is not directly enhanced by giving courtesy gifts, since the social network of the client is not enlarged by this type of gift-giving. After giving and receiving a courtesy gift, professional and client do not remain socially bound to each other.

The Personal Gift: Professional and Client as Friends

A fourth kind of gift given in mental healthcare is chosen to relate personally with the receiver, either by choosing a very personal gift, or by giving some other personal favour. The essential value of the personal gift is to underscore the bond between giver and recipient. Personal gifts can do this because they emphasise the first two steps of the gift-giving cycle: giving and receiving.

Giving can be emphasised by singularizing the receiver: by making a gift uniquely appropriate for one particular person (Miczo 2008). This does not necessarily mean picking out for a gift an object the receiver greatly desires; it can also be accomplished by other means. Consider this fragment from field notes written on a visit to a rehabilitation home:

> During the shift handover, Jacob [client] stumbles in, hiding a bouquet behind his back. The home rule is that staff should not to be disturbed during shift handovers, so he is sent away. But Jacob is pushier than usual, saying he needs just a minute. It turns out it's his case manager Nancy's birthday and he wants to give her the flowers. Coincidentally, Becky [client] is also celebrating her birthday today, but Jacob hasn't bought Becky anything.

This gift singularizes Nancy. Jacob's determination to give Nancy flowers combined with the fact that Jacob did not get Becky anything gives the impression that more than anyone else in the rehabilitation home Nancy is a special person for Jacob. By remembering her birthday, he shows his personal investment in their relationship. Personal gifts are given between professional and client in relationships that reach a personal level: where the professional and client are (also) friends.

Receiving is also important in personal gifts, since it shows the receiver's investment in the relationship. It takes two to tango; if the receiver does not accept, there is no personal relationship. As the following quote from a discussion with a professional shows, care professionals dealing with personal gifts think receiving can be an important professional activity:

> I think it is important for people to be able to give back, to let them [the clients] take care of me every once in a while. […] Sometimes it's important to allow the tables to be turned. You shouldn't always leave [clients] out in the cold with your 'professional detachedness'. So, sometimes I let [clients] see a bit of me, of my personal life.

This care professional talks of allowing clients 'to give back'; sometimes he is not the only one giving care, sometimes clients care for him. This is only possible if he gets close to clients, by telling them about his personal life.

With a personal gift, it is not so much a question of how much one *has* invested in a relationship (the monetary value of a gift), but far more how much one *is* invested: how much one is personally committed to the relationship. This understanding of personal gift-giving is in line with Cheal's (1996) observation that gifts play a role in communicating intimacy between close ties. Indeed, Fennel (2002) writes that in gift and counter gift, the giving parties communicate to and fro about their respective investments. Gift-giving thus becomes a dialogue between giver and receiver about their mutual investment, about how close and personal the ties between giver and receiver are.

Still, telling clients about your personal life is at odds with the professional attitude of 'showing concern while remaining detached' and it contradicts professional codes. The professional code for psychotherapists, for instance, states that personal relationships can occur, but only after termination of the professional relationship (NVP 2007). Professionals should prevent relationships from becoming personal by not disclosing personal information and remaining emotionally detached from the client. But in the case of long-term clients, counter-expertise exists to the doctrine of professional detachedness, which promotes being friends with clients in order to maintain and rebuild the subjectivity of the client after crises and long-term admissions (Petry and Nuy 1997). By investing oneself personally in the care relationship, the professional helps clients re-find their life history and identity. Since being friends can help long-term clients, some professionals say it is the right course of action to accept personal gifts from clients and thereby become part of the client's personal network. In these cases, accepting personal gifts enhances the social inclusion of clients.

Discussion: Gift-Giving, Professional Codes and Social Inclusion

In the introduction, we stated that in the case of gifts from mental healthcare clients to their professional carers, professional codes can conflict with a key objective in mental healthcare: the social inclusion of clients. We sought to dispense this apparent conflict by looking at the diversity of gifts and gift-giving in practice. From this exercise, we draw several conclusions on gift-giving in general, professional codes and the social inclusion of clients of mental healthcare.

With regard to gift-giving: in the introduction we mentioned that the nature of gifts is a contested issue (Komter 1996b; Osteen 2002). Investigating gifts empirically has permitted us to set aside the question of the (essential) nature of gifts and allowed us to observe various types of gifts given in practice. Our observations contradict the doctrine of a unified nature of gifts that for instance Lévi-Strauss presents (1976). Indeed, others have already accused Lévi-Strauss of building his theories on gift-giving on a conspicuous lack of foundation in practice (Sigaud 2002). Our study shows that empirical research is essential for providing meaningful contributions to the understanding of gift-giving. Staying focussed on

the empirical material has enabled us to describe an unexpected type of gift: the symptom gift. This gift is surprising because where gift-giving is broadly considered as the quintessence of social interaction, the symptom gift is in fact an unsocial type of gift.

Our research also underlines the point that the dichotomy between impersonal relationships of obligatory exchange and personal gift relationships between intimates, friends, or relatives does not hold empirically. Indeed, in this study, we also traced these archetypical relationships. The compensation gift, for instance, can produce demanding clients who hold little regard for the professional as a person, whereas the personal gift occurs when professional and client have become friends, within the boundaries of the professional relationship. We also observed a gift that does not belong to either one of these categories. The courtesy gift is a hybrid in which the elements of reciprocity and intimacy come together. Hence, when a client gives a courtesy gift to the professional, their relationship is not as impersonal as an obligatory exchange or as intimate as a personal relationship.

Having made this typology of gifts, we can now come back to our general research question. Because giving gifts is an example of how social inclusion can be stimulated, we asked how specific gifts given by clients to their care professionals relate to professional codes and to the objective of social inclusion of clients. With regard to professional codes, we conclude that the codes advise professionals to *analyse* a symptom gift, to *decline* a compensation gift, to *accept* a courtesy gift and to *prevent* a personal gift from being given, by remaining detached as a professional. With regard to the relationship between gift-giving and social inclusion, we conclude that the symptom gift is an unsocial type of gift, the compensation gift could at best lead to undesired types of relationships, and the courtesy gift does not necessarily produce lasting relationships between professional and client. Therefore, the symptom gift, the compensation gift, and the courtesy gift do not directly support the social inclusion of clients.

Indirectly, symptom gifts may help clients understand their own behaviour and change social behaviour in the future, enabling contact with others. Courtesy gifts may also indirectly affect the social inclusion of clients, since practicing social conventions in the relationship with the care professional may improve clients' abilities to interact successfully with other people. Research on whether and how these indirect effects of clients' gift-giving occur could provide further leads for the social inclusion of clients.

Only one type of gift supports social inclusion of clients directly: the personal gift. Accepting personal gifts changes the position of the professional vis-à-vis their clients. They are no longer detached, but attached; invested in reciprocal enduring relationships with clients. This changes the professional's social position. Although most professionals working at the mental health centre we studied complied with the professional codes, some of the professionals that had worked longest with long-term clients chose a different, contested professional attitude. These professionals were not just mental healthcare representatives. At the same time, they were part of the social circle of long-term clients. In providing community care, the professionals themselves have become deinstitutionalised and have begun participating in community life as fellow citizens. They felt that maintaining personal relationships

could benefit clients and belongs to the right professional attitude towards long-term relationships with clients. Indeed, in general healthcare, long-term relationships between professional and client have been reported to change into more personal relationships as well (Wiles and Higgins 1996). Nevertheless, the professional codes advise preventing against the chance of receiving personal gifts by remaining emotionally detached from clients. We, therefore, conclude that in long-term relationships, professional codes do not fully describe how professional–client relationships should be fashioned.

Yet it is important to keep evaluating professional behaviour in long-term relationships, especially in mental healthcare where clients can be vulnerable. This study indicates that professionals could perhaps better account for their behaviour by referring not only to professional codes. Indeed, reflexivity may be more important (Pols 2006b). This involves reflecting on professional behaviour and how to improve it, either in care team discussions, or—even better—by bringing in outsiders with new perspectives. Pols shows that this way of accounting for care ties in well with relationships between professionals and clients that have become personal, because the set courses of action of professional codes are at odds with the flexibility needed to maintain personal relationships.

We advocate promoting reflexivity as a good course of action in relation to gifts. Professionals already encourage one another to consult supervisors or ask others for their opinion on specific gifts (Hundert 1998). Turning these informal moments of reflexivity into routine procedure may enable professionals to feel more confident about their courses of action in relation to personal gifts and will help protect clients from undesired relationships with professionals. Instead of underscoring the relevance of professional codes that foreclose personal professional–client relationships, building in contextual reflexivity procedures in professional practice seems preferable in long-term mental healthcare, where social inclusion of clients is a key objective. We, therefore, fully agree with the attendees of a short conference on professional codes in mental healthcare, who concluded that professional codes had better be used as a tool to kick-start ethical discussion than as a tool to make ethical discussion redundant (Anzion 1993).

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References

Ruud, Abma

1996 De Patiënt. De Opkomst van de Therapeutische Samenleving [The Patient. The rise of the Therapeutic Society]. *In* Met zachte hand. Jeroen Jansz and Peter Drunen, eds., pp. 115–134. Lemma, Amsterdam: Opkomst en verbreding van het psychologisch perspectief.

Anzion, PAM
1993 Beroepscodes in de GGZ [Professional Codes in Mental Healthcare]. Maandblad Geestelijke Volksgezondheid 51(1): 57–58.
APA American Psychiatric Association
2001 Opinions of the Ethics Committee on the Principles of Medical Ethics. Washington, DC: American Psychiatric Association.
Bourdieu, Pierre
1998 Practical Reason. Cambridge: Polity Press.
Brendel, DavidH, James Chu, Jennifer Radden, Howard Leeper, HarrisonG Pope, Jacqueline Samson, Gail Tsimprea, and J Alexander Bodkin
2007 The Price of a Gift: An Approach to Receiving Gifts from Patients in Psychiatric Practice. Harvard Review of Psychiatry 15(2): 43–51.
Cheal, David
1996 'Showing Them you Love Rhem' Gift Giving and the Dialectic of Intimacy. *In* The Gift: An Interdisciplinary Perspective. AafkeE Komter, ed. Amsterdam: Amsterdam University Press.
Drew, Jennifer, JohnD Stoeckle, and J Andrew Billings
1983 Tips, Status and Sacrifice: Gift Giving in the Doctor-Patient Relationship. Social Science & Medicine 17(7): 399–404.
Fennell, LeeAnne
2002 Illiquid Goods and Empathetic Dialogue. *In* Questions of the Gift: Essays Across Disciplines. Mark Osteen, ed. London: Routledge.
Hahn, WilliamK
1998 Gifts in Psychotherapy: An Intersubjective Approach to Patient Gifts. Psychotherapy 35(1): 78–86.
Halpern, Jodi
2003 What is Clinical Empathy? Journal of General Internal Medicine 18(8): 670–674.
Hundert, EdwardM
1998 Looking a Gift Horse in the Mouth: the Ethics of Gift-Giving in Psychiatry. Harvard Review of Psychiatry 6: 114–117.
Komter, AafkeE
1996a Reciprocity as a Principle of Exclusion: Gift Giving in the Netherlands. Sociology 30(2): 299–316.
1996b Introduction. *In* The Gift: An Interdisciplinary Perspective. AafkeE Komter, ed. Amsterdam: Amsterdam University Press.
2001 Heirlooms, Nikes and Bribes: Towards a Sociology of Things. Sociology 35(1): 59–75.
Latour, Bruno
1987 Science in Action: HOW to Follow Scientists and Engineers Through Society. Cambridge, Massachusetts: Harvard University Press.
Law, John, and John Hassard
1999 Actor Network Theory and After. Oxford: Blackwell Publishing.
Leff, Julian, and Richard Warner
2006 Social Inclusion of People with Mental Illness. Cambridge: Cambridge University Press.
Levene, MI, and L Sireling
1980 Gift Giving to Hospital Doctors—in the Mouth of the Gift Horse. British Medical Journal 281(6256): 1685.
Lévi-Strauss, Claude
1976 The Principle of Reciprocity. *In* Sociological Theory: A Book of READINGS, Lewis A Coser, and Bernard Rosenberg, eds., pp. 74–84. New York: The Macmillan Company.
Mauss, Marcel
2002 The Gift: The Form and Reason for Exchange in Archaic Societies. London: Routledge Classics.
McLean, Athena
1995 Empowerment and the Psychiatric Consumer/Ex-Patient Movement in the United States: Contradictions, Crisis and Change. Social Science & Medicine 40(8): 1053–1071.
Michon, Harry, and Jaap Van Weeghel
2008 Rehabilitatie-Onderzoek in Nederland; Overzicht van Onderzoek en Synthese van Bevindingen in de Periode 2000–2007 [Rehabilitation-Research in the Netherlands; Overview of Research

and Synthesis of Findings in the Period 2000–2007]. Utrecht: Trimbos Instituut, Kenniscentrum rehabilitatie and ZonMw.

Miczo, Nathan
2008 The Human Condition and the Gift: Towards a Theoretical Perspective on Close Relationships. Human Studies 31(2): 133–155.

Mol, Annemarie
2002 The Body Multiple; Ontology in Medical Practice. Durham: Duke University Press.

Mol, Annemarie, and Jessica Mesman
1996 Neonatal Food and the Politics of Theory: Some Questions of Method. Social Studies of Science 26(2): 419–444.

Nadelson, Carol, and MalkahT Notman
2002 Boundaries in the Doctor-Patient Relationship. Theoretical Medicine and Bioethics 23(3): 191–201.

NFU Nederlandse Federatie van Universitair Medische Centra
2009 Raamplan Artsopleiding 2009 [General Outline Medical Training 2009]. Houten: Drukkerij Badoux BV.

NVP Nederlandse Vereniging voor Psychotherapie
2007 Beroepscode Voor Psychotherapeuten [Professional Code for Psychotherapists]. Utrecht: Nederlandse Vereniging voor Psychotherapie.

NVvP Nederlandse Vereninging voor Psychiatrie
2003 Beroepscode voor psychiaters.

Osteen, Mark
2002 Introduction: Questions of the Gift. *In* Questions of the Gift: Essays Across Disciplines. Mark Osteen, ed. London: Routledge.

Petry, Detlef, and Marius Nuy
1997 De ontmaskering. Terugkeer van Het Eigen Gelaat van Mensen met Chronisch Psychische Beperkingen [Exposure. Return of the True Face of People with Chronic Psychic Limitations]. Utrecht: Uitgeverij SWP.

Pols, Jeannette
2006a Washing the Citizen: Washing, Cleanliness and Citizenship in Mental Health Care. Culture, Medicine and Psychiatry 30(1): 77–104.
2006b Accounting and Washing: Good Care in Long-Term Psychiatry. Science, Technology & Human Values 31(4): 409–430.

Ritchie, Jane, Liz Spencer, and William O'Conner
2003 Carrying out qualitative analysis. *In* Qualitative Research Practice, A Guide for Social Science Students and Researchers. Jane Ritchie and Jane Lewis, eds., pp. 219–262. London: Sage Publications.

Scheid, Teresa
2000 Rethinking Professional Prerogative: Managed Mental Health Care Providers. Sociology of Health & Illness 22(5): 700–719.

Sevenhuijsen, Selma
2000 Caring in the Third Way: The Relation Between Obligation, Responsibility and Care in Third Way Discourse. Critical Social Policy 20(1): 5–37.

Sigaud, Lygia
2002 The Vicissitudes of The Gift. Social Anthropology 10(3): 335–358.

Smolar, AndrewI
2002 Refelctions of Gifts in the Therapeutic Setting: the Gift from Patient to Therapist. American Journal of Psychotherapy 56(1): 27–45.

Spence, SeanA
2005 Patients Bearing Gifts: Are There Strings Attached? British Medical Journal 331(7531): 1527–1529.

V&VN/NU'91
2007 Nationale Beroepscode van Verpleegkundigen en Verzorgenden. Hilversum: Van der Weij Drukkerijen BV.

Ware, NormaC, Kim Hopper, Toni Tugenberg, Barbara Dickey, and Daniel Fisher
2007 Connectedness and Citizenship: Redefining Social Integration. Psychiatric Services 58(4): 469–474.

Wiener, A, S Wessely, and G Lewis
1999 You Don't Give me Flowers Anymore: An Analysis of Gift-Giving to Medical and Psychiatric Inpatients. Social Psychiatry and Psychiatric Epidemiology 34(3): 136–140.
Wiles, Rose, and Joan Higgins
1996 Doctor-Patient Relationships in the Private Sector: Patients' Perceptions. Sociology of Health & Illness 18(3): 341–356.
Zelizer, VivianaA
1996 Payments and Social Ties. Sociological Forum 11(3): 481–495.