The Nature of Mental Health Nurses' Knowledge

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CONTENTS

ABSTRACT

There is a need to develop a clear understanding of the knowledge used by mental health nurses in day to day practice. Knowledge relating to holistic/therapeutic activities form the basis of mental health nurse education, however various studies have consistently shown the majority of mental health nurses activity relates to administrative and routine tasks and containment. This disparity between the knowledge bases prescribed, those described and the inability of education reforms to resolve such inconsistencies suggests other influences are at work.

Concepts of power and knowledge figure largely in the evolution of nursing per se and mental health nursing in particular. Michel Foucault proposes that power forms knowledge and produces discourses. A body of knowledge is not formed by a 'subject who knows' but rather through the processes and struggles that transverse that subject. Thus mental health nurses do not produce a regime of knowledge but rather power relations inscribe on the nurse and sustain forms/domains of knowledge.

To gain access to these inscribed knowledges two approaches are adopted and integrated - Genealogy and Q-methodology. Genealogy provides a detailed account of the power relations surrounding mental health nursing and the knowledge bases programmed by these. These power relations are evident in the discourses concerning mental health nursing generated by psychiatrists, 'nursing in general', and society. The Q-methodology facilitates the identification of subjectivities in relation to the knowledges inscribed on mental health nurses.

The knowledges programmed by the power relations and evident within the subjectivities relate to mental health nurses' regimes of practice as 'doctors' assistants', 'controller of patients, environment and self', and 'therapeutic activities'. It is proposed that mental health nurses' knowledge is task orientated, related to 'knowing how' to do things rather than the 'knowing that' of evidence based practice.

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CHAPTER 1

INTRODUCTION

The need for a coherent knowledge base to guide nursing practice has been advocated since the days of Florence Nightingale. Nursing, historically viewed as firmly entrenched in medical views of illness and health, is proposed to have rejected its traditional knowledge bases in the 1950s and replaced these with humanistic models (Mullhall and Oiler, 1986). By developing a distinct knowledge base to support humanistic perspectives, nursing aspired to become a multifaceted activity addressing the health needs of individuals in a holistic manner. Salvage (1990) proposes that this 'new nursing' emphasised an ideology of nurse/patient partnerships with a concomitant accentuating of nursing's therapeutic aspects and potential. However mental health nursing's advancement towards this ideal has been somewhat slow. Whilst knowledge relating to therapeutic/interpersonal activities has been said to inform mental health nurse education initiatives since the 1960s, various studies (Altschul, 1974; Towell, 1975; Clinton, 1985; Porter, 1992; Whittington and McLaughlin, 2000) have consistently shown that the described practices of the mental health nurse are somewhat different. Here the mental health nurse is presented as rarely engaging in such activities, the vast majority of time being given over to administrative and routine tasks. Thus there would seem to be a disparity between the knowledge bases proposed to guide mental health nursing practice and the reality of care.

There is a need to develop a clear understanding of the knowledge used by mental health nurses in their day to day interactions with patients. Schon (1995) highlights the need for an "epistemology of practice" (pviii), an understanding of the relationship between the practitioner's knowing and that presented in its associated professional literature. Such an understanding would allow for the development of effective education programmes which build on the strengths of nurse practitioners, whilst facilitating the development of skills viewed as essential to the effective practice in mental health nursing.

Why study mental health nurses' knowledge?

As someone who entered nursing at the age of sixteen as a cadet, it seems strange that it wasn't until I moved to nurse education as a teacher that I became fully aware of what is generally termed the theory-practice gap. I had undertaken nursing education programmes, which provided me with the qualifications to practice in a variety of settings (both general and mental health environments) and had been only dimly aware that what I learnt in school was rarely translated into practice. It seemed a 'given' that the two were quite separate. I simply got on with the process of nursing and doing what I had to do to achieve registration.

When I moved from general nursing into mental health nursing I was struck by the differences in cultures and the simmering distrust between the two groups. General nurses were termed 'proper nurses' by my mental health colleagues - the title was by no means complimentary. Mental health nurses were often treated as little more than nursing assistants by general nurses, dismissed as having little knowledge or skill. Nevertheless I felt mental health was where I wanted to practice as a nurse and I stayed.

As my career progressed my belief in nursing as a profession and the need to generate a knowledge base on which to base practice grew, fuelled by the education courses I attended. I became a believer in what we now term evidence based practice and an advocate for nurses as autonomous practitioners. However it was apparent that most nurse education programmes available tended to be general nurse orientated. In higher education very few undergraduate programmes were available specifically for mental health nurses. In accessing education programmes I continually asked, "How does this relate to mental health?" "What is the relevance to my practice as a mental health nurse?" and ultimately, "What is mental health nursing knowledge?" Frequently the answers were ambiguous and less than satisfactory. Whilst the debate in the literature of the time revolved around "What is nursing?" I struggled with "What is mental health nursing?"

Having spent a number of years directly involved in nursing care I came to the cross-roads at which most nurses arrive at some point in their career, "If I am to advance any further where now?" At that time three options were generally available, stay at

sister level, move up the management hierarchy, move into nurse education. I chose the latter.

Moving into nurse education provided me with yet another perspective on the nature of nursing and more specifically mental health nursing. Entering the domain at the same time as the inception of the Project 2000 curriculum (United Kingdom Central Council for Nurses Midwives and health Visitors (U.K.C.C.), 1986) provided me with first hand insight into the difficulties of delineating not only what was appropriate nursing knowledge but how this related to the mental health students. The bringing together of mental health and what was now termed 'adult' nursing in a common foundation programme brought cries from the mental health students and teachers alike that the course was "adult" orientated. What also became clear through the introduction of reflective practice and the encouragement of students to talk and write about their experiences in clinical environments was that what they learnt in the school of nursing was often dismissed in/by practice. The students talked in terms of "What you teach us here is just theory, what we see out in practice is the real world". This related not only to the common foundation portion of the course but also to the programme specific to mental health. Whilst it was possible to blame the overwhelming numbers of adult students and teachers for the adult orientation of the common foundation, it was not possible to do the same for the programme designed to represent mental health practice needs.

At this point I registered for the Post-Graduate Diploma in Adult Education and for the first time in my career became a full time student (my registration courses were of the 'apprenticeship' model and my undergraduate studies in the form of a part time course). This allowed me the opportunity to 'step back' from nursing and reflect on my experiences. At the same time I was introduced to a world of theory-practice gaps, hidden curricula, learning theories and philosophy. It provided a different lens through which to view mental health nursing and issues related to the application of theory to practice. I increasingly questioned the education system advocated for nurses per se and its efficacy, particularly in relation to producing the mental health nurse envisaged in literature.

In my role as nurse educator I had become involved in the development and delivery of the social science aspects of the nursing curriculum. This, combined with my

experiences on the Post Graduate Diploma in Adult Education, created a burgeoning interest in post-modern approaches in relation to education and health care issues. These promised an opportunity to shed new light on old problems and provide an alternative understanding of issues relating to mental health nursing.

Mental health nursing has been termed the "other half of nursing" by Powell (1982, p85) and this is certainly the impression I have gained in my years both in practice and in education. The activities mental health nurses are often hidden, devalued or subsumed within the larger framework of nursing per se. Whilst the activities of mental health nurses are not random, equally practices do not appear to be based on the knowledge identified as underpinning mental health nursing or advocated by the education system. Thus the question to be answered is "What is the nature of mental health nurses' knowledge?" The literature available provides few answers either prescribing what mental health nursing should be or describing what it is. Some studies attempted to explain the yawning chasm apparent between these two perspectives but few were contemporary and most adopted traditional methods of investigation.

Thus I proposed a need to:

- Uncover the factors influencing which knowledges are used and which knowledges are presented as central to, but disregarded by mental health nurses.
- Identify the knowledges that underpin present mental health nursing practice.
- Offer a post-modern interpretation of the nature of mental health nursing, its knowledge bases and from this propose whether change is desirable and/or feasible.

Context of Mental Health Nursing and Its Education

Initially the control of mental health nursing lay firmly in the hands of psychiatrists and their representative body of the time, the Medico-Psychological Association (M.P.A.) who, commencing in 1890, devised, managed and assessed training programmes. The Nurses Registration Act of 1919 allowed for the setting up of a

General Nursing Council (G.N.C.) giving nursing responsibility for all nurse training syllabi, registration and examination. In 1922 the G.N.C. proposed, irrespective of speciality, that all nurses should undertake the same first year training and preliminary examination. This provoked concern amongst mental health nurses, who continued to access the programme organised by the MPA, even when, in 1925, the G.N.C. ceased to recognise the association as an examining body. The two training schemes ran in tandem until 1951 when the education of mental health nursing was placed firmly in the hands of the G.N.C.

The face of health care delivery began to change in the 1950s. The advent of the National Health Service (N.H.S.) brought about an alteration in the management of health facilities generally. In mental health the discovery of psychotropic drugs heralded the possibility of controlling aspects of mental illness, and with this came the possibility of care in the community. The growth of humanistic theories and approaches promoted a reconsideration of the way nurses should interact with patients. In response to these changes the World Health Organisation commissioned Expert Committees (1953; 1956; 1963) to consider the role of the mental health nurse in the care of the mentally ill and the form their education should take. Reports advocated a more therapeutic and holistic approach, hence elements of psychology and sociology were to be added to the training syllabi. Similarly the Central Health Services Council (1968) was to propose that the development of skills associated with therapeutic, interpersonal relationships should be central to mental health nurse training.

Yet the education programmes for mental health nurses continued to have a large emphasis on physical aspects of care and medical orientated approaches. It was not until 1982 that a curriculum embodying the earlier recommendations appeared. This programme was presented as a radical departure from traditional approaches and as the launch pad for the new, 'therapeutic' mental health nurse. However within seven years this was to be replaced by a total revision of all nurse education resulting in the introduction of 'Project 2000' (United Kingdom Central Council for Nursing Midwifery and health Visiting (U.K.C.C), 1986). This curriculum in many ways echoed earlier ventures, all specialities of nursing were to share a common foundation – initially of eighteen months, reduced to one year in 2000 – with a

branch specific programme (again initially of eighteen months and now two years). It is this approach which forms the basis of nurse education today.

Professionalisation

Rafferty (1996a) proposes that education is one of the means through which cultural values are transmitted and occupational socialisation is achieved. Equally Grant (1997) asserts that education is central to the formation of the type of individuals desired by its implementers. However the dichotomous images of 'nursing as a profession' and 'nursing as a vocation' has negated a clear articulation of the goal of nurse education. These issues are made clear in Florence Nightingale's comment "they call it a profession, but I say it is a calling" (Salvage, 1985, p90). Miss Nightingale saw nurse education as a moral process, the developing of appropriate characteristics and demeanour in those 'called' to nursing. However 'they', epitomised by a Mrs Bedford Fenwick an ardent proponent of registration, presented it as an academic undertaking (Baly, 1973; Rafferty, 1996a). Both these images are still evident within nursing and have led to friction as to the occupation's appropriate 'form' and thus its educational needs. However the pre-occupation with achieving professional status, Salvage (1985) and Rafferty (1996a) suggest, has gained momentum over the years and is more prevalent now than ever before. As such many of the reforms and educational initiatives undertaken within nursing are seen to reflect the desire to bring about the professionalisation of nursing.

Freidson (1986) asserts that originally the term 'profession' referred to university educated occupations such as law and medicine. Although presented as learned in character, these were activities of the 'well-born' and the status ascribed to them represented that of the individuals within them rather than their associated knowledge bases. However the new and refurbished middle-class occupations of the 19th century usurped the term in an effort to gain respectability and this quickly became the hallmark of successful occupations. Certainly this reflects nursing history and the beginnings of the professionalisation movement within it.

One of the aims of those working towards the Nurse Registration Act of 1919 was the professionalisation of nursing and a limiting of the usage of the term 'nurse' to those who had achieve a particular qualification (Abel-Smith, 1960; Baly, 1973).

Hence there was a need to bring all groups who used the title 'nurse' together under one umbrella, promoting the image of one united body. More recent initiatives such as Project 2000 (E.N.B. 1988) and the white paper 'Making a Difference' (Department of Health (D.O.H.), 1999a) have been attempts to further this project.

However this move towards professionalisation presupposes the unifying of a group of people who share the same aim, but as Dingwall (1979) and Clay (1987) identify, nursing is an assortment of groups each with its own specialist interests, history and characteristics. The drive by nursing to present a 'corporate image' has failed to acknowledge the knowledge demands of those within it, most specifically in relation to mental health nursing. The most recent review of mental health nursing (D.O.H.1994a) suggests that current education practices do not meet the needs of those entering mental health nursing. It is claimed that essential skills of mental health nurses remain undeveloped as those associated with general nursing are given greater precedence in the education process. It would seem that mental health nurse education has yet to meet the proposed needs of its students and thus the desired interventions with its clients.

Issues of Power and Knowledge

Knowledge plays a complex role in professions often being seen as a defining trait. Richman (1987) proposes the greater an occupation's claim to professionalisation, the more abstract and theory laden their proposed body of knowledge. The more abstract the knowledge, the greater the image of intellectual ability and trustworthiness. Nursing has vigorously pursued the establishment of a defined knowledge base and the transmission of this through its education system in an effort to emulate the traits associated with professional status.

Huntington and Gilmour (2001) consider nursing to have focused on traditional empirical approaches to knowledge generation to explain the nature of nursing practice and these inform nurse education. The vocational image of the nurse sacrificing her/his self to a calling to care for the sick has been replaced by the idea of 'evidence based practice' in which nursing science provides a body of empirical knowledge that underpins nursing action (Hugman, 1991; Berragan, 1998;

Bjornsdottir, 2001). Nursing's struggle to translate nursing care into a scientific undertaking with the appropriate knowledge base was hoped to result in a legitimisation of their position as equal to that of the medical profession (Hiraki, 1992; Crawford, Nolan and Brown, 1995). However, the knowledge generated is frequently designated as a simpler, dilute version of medicine and as such mark nursing, in Etzioni's (1969) terms, as a semi-profession.

Hugman (1991) proposes that medicine gained its position as an archetypal profession by securing a legal monopoly over the practice of healing through political representation rather than having a discrete empirical knowledge base. Nolan (1993) claims the knowledge base of psychiatry was developed after professional status was conferred. Thus the existence of discrete bodies of knowledge are traits of established professions rather than a professionalising factor. What truly sets conventional professions aside from those seeking professionalisation is their measure of autonomy and self-government, the ability to wield power. Whereas medicine, law and the clergy are collegiate in nature - its members, through self-governance, wield power - nursing finds its practice mediated through others (such as medicine and the state). Such mediation has a profound impact on the ability to develop and utilise an explicit knowledge base (Johnson, 1972). Medicine, having the power to diagnose and prescribe interventions through legal statute, defines both the patient and their requirements, hence nursing finds itself defined in terms of its relationship to medicine. From this perspective, the skills/knowledge used by the nurse are at the behest of the doctor and as such ensure nursing's subordinate position with a corresponding reduction in autonomy and power.

Approach to the Problem

The inability of education reforms to resolve the inconsistencies between mental health nurses' practice and education would suggest that other influences are at work. As identified above, nursing is not made up of a homogenous group, rather having within it distinct occupational groups each requiring its own distinct analysis. Nolan (1993) highlights mental health nursing's own powerful hidden culture and apparent rejection of knowledge associated with other nurse 'occupational' groups. Such

difficulties and differences advocates of professionalisation have failed to recognise in their desire to identify a corporate body of nursing knowledge on which all nursing practice rests. The bodies of knowledge portrayed as central to nursing practice may at best be viewed with suspicion and at worst dismissed as inappropriate by mental health nurses. Thus as Porter (1992, p1565) emphasises there is a need to study the nature of and influences on nursing practice so that nurses will not "lurch blindly into the future".

As the inter-relationship of the concepts of power and knowledge figure largely in the evolution of nursing per se and mental health nursing in particular there is a need to consider a framework in which these two factors can be addressed. Michel Foucault was at the forefront of work in this area proposing that power forms knowledge and produces discourses. It is proposed that a body of knowledge is not formed by a particular individual or group but through the processes and events which impinge and impact on the person/s and the power relations that are present (Foucault, 1979a). It is this approach which will provide a framework within which to consider and develop an understanding of the nature of mental health nurses' knowledge.

Chapter two, therefore, offers an overview of Foucault's work and his conceptual framework, a critique of this and a justification for adoption here. Chapter three, Methods of Investigation, introduces the approaches to be used; Genealogy and Q-methodology, and their methodological underpinnings. Chapter four, as the first part of the Genealogy, is a 'Diagnosis of the Present', a consideration of the present state of mental health nursing and its taken-for-granted backgrounds. The conditions allowing for the emergence of what is to become mental health nursing are discussed in chapter five, charting the rise of moral and medical discourses, the development of the 'Asylum', the need for Asylum Attendants and the emerging of nursing as a respectable discipline. An analysis of the power relations surrounding mental health nursing in the psychiatric setting and in nursing per se are expounded in chapters six and seven with chapter eight identifying the knowledge programmed by these.

Chapter nine offers an overview of Q-methodology and its place within this study. Chapter ten presents the Q-methodology data analysis and factor interpretation. In chapter eleven the findings and implications of the study are discussed offering

recommendations for the future. To aid the reader, a diagrammatic representation of the thesis will be presented at the beginning of each chapter as follows:

- Introduction
- Theoretical framework
- Methods of Investigation
- Genealogy - Diagnosis of the Present
- - Conditions of Emergence
- - Power Relations (part I)
- - Power Relations (part 2)
- - Knowledges
- Q-Methodology - Philosophy and Approach
- - Data Analysis
- Discussion, Limitations and Conclusions

CHAPTER 2

MICHEL FOUCAULT'S THEORETICAL FRAMEWORK

- Introduction
- **Theoretical framework**
- Methods of Investigation
- Genealogy - Diagnosis of the Present
- - Conditions of Emergence
- - Power Relations (part 1)
- - Power Relations (part 2)
- - Knowledges
- Q-Methodology - Philosophy and Approaches
- - Data Analysis
- Discussion, Limitations and Conclusions

It is intended here to provide an overview of Michel Foucault's work, his methods of investigation and the problems associated with these. A justification for the adoption of this approach within this study will be offered. Michel Foucault (1926-84) does not provide a universal theory of discourse, seeing this as an empty enterprise; neither does he adopt the role of intellectual prophet who prescribes frameworks of thought. Rather he seeks to uncover the systems of thought that have become familiar and implicit within perceptions, attitudes and behaviours of individuals "to open up problems ... not take a position on a chessboard" (Foucault, 1984a, p376).

Foucault undertook to examine how systems of thought are created, become fixed in cultural tradition and viewed as self-evident i.e. as the logical/rational approach. Self-evidence, Foucault (1983a) proposes, is a fallacy. What is deemed as 'irrational' is simply another form of rationality based on different truths and structures. Thus his intent is to examine how forms of rationality inscribe themselves on systems of practice, the role these rationalities play within practices and how individuals govern (themselves and others) through the production of truth (Foucault, 1978). Central to Foucault's work is the concept of the 'subject' and an attempt to uncover how individuals are constituted through discourses (the ways in which we know, understand and describe the world) and practices.

He is not interested in creating new schemes to explain society or the validation of existing ones, Foucault's quest relates to how discourses of truth and falsehood are established, how these impact on what can be known - accepted as truth - and the actions that can taken.

Thought and Problematisation

Thought here is that which allows individuals to 'step back' from an event, present it as an object for consideration, and seek to define its meaning. Thus thought is not the representation of a pre-existing object, or the creation of an object through discourse, but the consideration of an object, a questioning of meaning, with reference to present conditions, values and goals (Foucault, 1983a). What Foucault suggests is that certain periods allow certain discourses to appear. His own work, he proposes could only be generated by the relationship between his period and contemporary epistemological configurations i.e. he could only write in this way at this given time. Thus he is asking, "how does it happen that at a given period something could be said and something else has never been said?" (Foucault, 1969a, p66). In doing so Foucault is not looking at how words define objects or how objects are perceived and words articulated to describe them, but rather at discursive practices and the rules of formation of objects, concepts and theories. He is examining rules which explain why a certain thing is seen in a certain way, analysed in a particular fashion and words employed in specific way in certain sentences.

Thought from this perspective provides a freedom in relation to what actions can be taken, allowing detachment from and reflection on an established object. This occurs not as the result of a formal structure but rather as a response to social, political or economic processes that become unstable, unfamiliar or gives rise to particular difficulties (Foucault, 1969a). Such difficulties are subject to 'problematisation', a consideration of the questions that need to be asked/answered in relation to a particular object/issue and the possible solutions to these questions. Thought often intervenes in a creative manner, offering multiple and often contradictory responses with accompanying domains of knowledge being generated and power relations established.

For Foucault (1984a) his work is to understand what makes such diversity possible, what enables such multiform and contradictory approaches to flourish at any particular time and the general forms of problemization that makes them possible. Foucault's inquiry began with the asking, "when one is speaking of psychiatry…what is one speaking of?" (Foucault, 1968, p34). In answering such a question the traditional historical approach would require the identifying of origins and the tracing of natural progression, whilst an empirical investigation would seek a founder of ideas and an accompanying interpretation of his meaning. Foucault rejects both of these methodologies, seeing the former as a tautology and the latter as unnecessary. Rather, he identifies the specific area of thought for consideration and attempts to identify the various discourses surrounding it and marking it out.

Early Approaches and Methods

Although much of Foucault's work bears a close resemblance to Structuralism, Best and Kellner (1991) propose that whilst Foucault's work promulgates the idea of structures these are seen as changing, as only specific to certain historical periods rather than universal and constant. The initial approach adopted by Foucault is 'archaeology'; research seeking to analyse the accumulated existence of discourse in the form of its 'archive' (Foucault, 1969b). Archaeology involves looking at society's body of knowledge and requires one to consider all its texts – fiction, philosophy and politics – accessing the 'general archive' of a period at a given moment (Foucault, 1966).

Foucault uses the term archaeology to distinguish his work from that of hermeneutics and the search for deep or subjective meanings (Best and Kellner, 1991). This alternative form of analysis is proposed as Human Sciences are viewed as caught in a double obligation of hermeneutic interpretation (the understanding of hidden meanings) and exegeses (discovering systems and offering formal, critical interpretations). Whilst these are generally promoted as mutually dependent, Foucault (1967a) claims them to be in opposition. In clarifying this, Foucault asks how can one identify global rules said to underpin and identify the truth of things (exegeses) and yet search for a deeper and more meaningful truth (hermeneutics)?

In his archaeological framework the belief in deep meanings waiting to be uncovered is abandoned and replaced with the assertion that discourses are limited by rules of formation and the conditions of their existence. The idea of a sovereign subject liberating the truth is seen as untenable and is supplanted by the postulate that the role and activity of a subject is defined by a discourse. Finally the suggestion that history reveals lost and obscured origins of thought is proscribed and replaced with the image of discourses as historically defined systems whose birth trajectories and extinctions are fixed.

Discourses

Vital to these methodological operations is the removal of restrictions which fix discourses as merely mediums for the expression of thought, external to the evolution of thought, and thus formed by the speaking subject using particular linguistic and semantic patterns. For Foucault (1968), discourses are not what is meant to be said (or not said) but constitute what can be said and what is actually said at a particular point in time. Thus he is attempting to provide a descriptive analysis of discourses, their conditions of formation, interplays of dependencies, and transformations. Whereas history is normally conceptualised as a sequential narrative, a story of natural progression towards truth and rationality, in Foucault's analysis transformations of discourses occur, a passing from one form of discourse to another.

Transformations are to be detected in changes within discursive formations - the local and changing rules of a given period which identify statements as meaningful or not, the concepts and theoretical aspects of any given discourse. Transformation can also be identified in the displacement of boundaries, the re-positioning of speaking subjects, new functioning of language and new forms of circulation in relation to discursive practices. Often a transformation is seen to have an affect on a series of discursive formations (Foucault, 1967a). In charting such transformations, Foucault envisaged an opening up on the realm of general history where the relation and forms of particular practices could be described.

Knowledge

It is suggested that within every society is an implicit body of knowledge (savoir) related to its general everyday bodies of learning. It is this 'savoir' which generates different

possibilities of knowledge (connaissance) related to particular bodies of scientific knowledge. Thus

> "Connaissance [means] the relations of the subject to the object and formal rules that govern it. Savoir refers to the conditions that are necessary in a particular period for this or that type of object to be given to connaissance and for this or that enunciation to be formulated." (Foucault, 1972, p15)

Within these connaissances are statements which achieve a level of autonomy, passing tests that identify them as 'true' to informed hearers. This bestows on the speaker the status of 'Privileged Speaker', an authorised subject who can lay claim to imparting 'serious truth'. In examining these statements Foucault (1972) is not concerned with their prepositional structure but rather with the 'enunciative function' of the various fragments of language (sentences, prepositions etc). Foucault is looking for and finds the 'statements' that render particular discourses possible and give them birth.

Jones and Williamson (1979) provide an example of this in relation to the British nineteenth century statement that 'popular education should be compulsory'. This, they suggest, raised issues in relation to civil liberties and economic viability, and as such was initially unacceptable. However the reconstitution of the statement within political and economic discourses suggested that the provision of a better educated workforce would increase the competitiveness of British manufacturers. This coupled with education being presented as an individual right and a condition of individual liberty vested the statement with a level of autonomy and as such a serious truth to be acted upon. The discourse relating to public education was born.

Truth

Discourses surrounding 'truth' are not a refusal to recognise certain issues but a result of a machinery of description which identifies the 'true nature' of things. This emanates from a need to produce truth as an ordered system of knowledge - 'the will to truth'. In western society, Foucault (1972) proposes, everyday statements are converted into serious ones in the pursuit of this 'will to truth'.

Justification or refutation of statements lay in their claim to knowledge as defined by discursive formations which produce and systematically form the object of which they speak, providing points of reference, description and definition, and situating the object in a field of knowledge. Discursive practices establish primary relations (those between institutions and techniques) and secondary relations (formulated by the discourse itself as subjects reflectively define their own behaviour) which allow the object to emerge (Foucault, 1972). The establishment of such relations is essential if an object is to be spoken about. Thus new discourses are seen as a result of interdependent elements relating to intra discursive factors (objects, operations and rules of formation), interdiscursive elements (between different discursive formations), and extradiscursive dependencies (between discourses and political, social and economic transformations).

Foucault (1984b) posits that each society has its own regime of truth and types of discourses it holds and sanctions as true. Distinguishing between true and false statements is achieved through mechanisms, techniques and procedures validated as appropriate for attaining this truth. In Western societies he proposed truth as:-

- centred on scientific discourses and the institutions which produce these
- subject to political and economic incitement
- an object of huge consumption, and circulated widely
- produced, controlled and transmitted by identified political and economic machinery - universities, armies, medicine, certain media outlets
- representing ideological struggles

Application of Methods

Foucault chose to analyse discourses which had "the densest and most complex field of positivity" (Foucault, 1968, p44) such as medicine. In his analysis he identifies that within the space of thirty years in the eighteenth century, previously held medical truths were displaced by totally new regimes of discourse and forms of knowledge. The classical structure of medicine revolving around 'the sick man' (sic) gave way to the modern

structure of clinical perception – a particular way of seeing the body, what Foucault (1973) termed the 'clinical gaze'. Such a definable 'birth trajectory' provided, in Foucault's eyes, the ideal opportunity to locate relationships between scientific changes and political occurrences, suggesting that the political practices of this era transformed the conditions for the emergence, insertion and formation of the medical discourse.

Foucault (1973) found statements, which showed not merely changes in the semantic content of the discourse but a reorganisation of syntactic form. Thus there was not an exchanging of one word for another, but a re-arranging of language in relation to the patient / illness / disease. Individuals became objects for scientific scrutiny, being both the subject who investigates and the object of investigation. This represents a change in problematisation of human beings, whereas previously an individual was part of the natural order of things, whose place was pre-ordained by God, now it became conceivable that individuals were more than God's creation (Foucault 1970). There was a proposed potential to understand and shape the world and the individual's place within it, a possibility to know and be known. Exploring this change in discourse Rose (1979) describes how in Cuvier's classical morphology species were of fixed types with defined traits and invariable natures, any variation between individuals of a specific species being of no consequence. However Darwin's book 'On The Origin of Species' in 1859 defined species according to the relations between individuals providing a space in which individuation and variation became possible. In the same way human populations became a 'unity of differentiated individuals' with the possibility of scrutinising the individual as an object.

Individuals as merely objects of nature are finite and limited and it is this finitude and limitation that Foucault (1970) proposes facilitated the emergence of the new discursive practices that arose in the eighteenth century. Foucault suggests that modern individuals both accepted and denied their finitude as they struggled with the paradoxes this presented. He asked, how could humans:

1) As objects of study at the same time provide answers?

2) As the source of understanding bring the 'unthought' into view?

3) As the product of a long history whose beginning could never be reached, uncover that history?

In an attempt to unite these opposing couplets, Foucault suggests, humans sought to identify the difference between finitude as a limitation and finitude as the source of facts and ultimate 'truth'. Thus strategies of reduction, clarification and interpretation were developed and adopted in an attempt to clarify such differences. These strategies became the basic constructs of human sciences with discourses purporting to explain the nature of the world and humans forming from and around these.

Foucault (1984a) asserts that such changes in discourses were not simply the result of one specific individual/group in society, rather they evolve from a variety of sources, each having its own form and purpose occurring over a range of times. What appears as a single event was in reality a complex web of relations between political, economic and social institutions.

Extension of Methods - Genealogy

Archaeology enabled Foucault to provide a description of the discursive practices of an age, but became inadequate to complete the task before him, to "emancipate historical knowledge from subjectification" (Foucault, 1976, p83). He posits a need to attend to 'subjugated knowledges'; those viewed as naïve and dismissed as below the threshold of scientism, those though scholarly, which fall into disuse. For Foucault, such knowledges raise a number of concerns:

> "What types of knowledge do you want disqualified in the very instant of your demand 'Is it a science'? Which speaking, discoursing subjects … do you want to diminish when you say: 'I who conduct this discourse am conducting a scientific discourse, and am a scientist'?" (Foucault, 1976, p85)

To gain an insight into such anomalies Foucault proposed to extend and modify his methodological approach utilising what he terms 'Genealogy'. Here Foucault again rejects traditional historical methodology of development and progress, rather he seeks out discontinuities to discover how scientific objectivity and subjective intentions emerge in a space created not by individuals, but social practices.

Genealogy is seen, (Fox, 1995), to uncover discontinuities and the continual writing and rewriting of discourses. Knowledge is presented as a creation of the struggle to describe the social world and subjects constructed by human sciences in ways that supersede previous descriptions, in response to power relations as opposed to developing rationalities. All occurs in the space defined by the play of wills, subjection and power relations. Gordon suggests that genealogy identifies the present as a composite of particular domains of questions, problems and responses as a consequence of various continuities / discontinuities. Thus the function of genealogy is "not to question the reality of the past but to interrogate the rationality of the present" (Gordon, 1979; p32)

Foucault (1971, p68) is offering a "critique of our own time; based upon retrospective analysis" and proposes to do this through the examination of systems that involve the exclusion/rejection of individuals. By examining those that society neither values nor includes, Foucault believed he would reveal ways of thinking and behaving that are still present in modern day society. Here Foucault is not providing a 'truth', but an insight into present discourses and 'changing authenticities' (Fox, 1995). Neither is he looking to identify whether data supports a given theory but rather why a specific notion of the subject should become part of the regime of truth of a particular human science. In the same way, Henriques et al. (1984) for example, ask why child development theory took the form it did and why monitoring of this development became central to the science of psychology? Foucault began with an examination of the penal system and the discourses surrounding it.

Power-Knowledge Relations

In 1974 Foucault described his first visit to a prison, having the impression of a factory/machine and asking himself what could such a machine produce? Initially he considered virtuous individuals to be the end product, but on further examination Foucault proposes that prisons actually 'break up' and eliminate those excluded from society. Prior to his visit he had envisaged exclusion as having a general function, trying to plot this as a constituent of society, i.e. society could only function if certain individuals were excluded. However he came to view prisons as more complex entities and as such irreducible to a purely negative function of exclusion. In considering the effects of such a system of exclusion and punishment, he proposes that the committing of a crime questions society's functioning in a fundamental way, however rather than being framed in a social context,

crime is given a moral dimension. Imprisonment is thus presented as a mask for the political character of society's elimination of people who attack it.

Foucault (1977b) asserts that prior to the eighteenth century punishment was neither a political nor a moral problem. Previously those who broke the law attacked the sovereign and the ceremony of torture was an affirmation of the overwhelming power of the king. He posits a supplanting of the spectacle of punishment of the few as a deterrent to the many, with the systematic punishment of all. Those who now break the law are seen as attacking society, and punishment is constituted as a moral act. The history of penal law and the history of human sciences are proposed by Foucault to form part of common matrix of a technology of power.

When Foucault speaks of power it is in terms of power relations, proposing that in any human interaction power is evident. Such power relations are not 'bad' in themselves, he asserts, as society could not exist without them. Foucault attempts to describe the types of power relations which exist in society, their relationship to other political and communication relations and how these are implicit within society's behaviours, rules, political systems and institutions (Foucault, 1983c). In turn these power relations reflect the goals and values of such institutions, practices and behaviours. In this venture he also abandons the assumption that knowledge only exists where power relations are suspended, rather power is presented as producing knowledge. Each one directly implies the other; there can be no power relation without a corresponding field of knowledge and no knowledge that does not infer a power relation.

Knowledge is thus presented as an integral aspect of processes that form the social domain (Henriques et al. 1984). Areas of investigation/knowledge are only established if power relations have targeted the area, if it is open to techniques of knowledge and procedures of discourse (Foucault, 1979a). However relations of power-knowledge are not static but subject to transformation, mutations and modifications. In discourse power-knowledge is joined, there is no division between the dominated and the dominant discourse these being both the instruments and effects of power, whilst at the same time a stumbling block, a point of resistance or a starting point for an opposing force. Thus different and contradictory discourses can exist and circulate at the same time. These so called 'polymorphous techniques' of power bring out the 'will to knowledge' both serving and being an instrument of the discourse.

Foucault (1979a, p17) describing a "veritable discursive explosion" relating to sexuality in the eighteenth century, identifies such polymorphous techniques of power. A new regime of discourses is proposed to have appeared with people saying different things from different perspectives to obtain different results. This was not, in Foucault's mind, a binary division - what could / could not be said - but an authorisation of certain discourses and the disallowing of others. Those authorised functioned as an interlocking hierarchy around clusters of power relations. These discourses are not presented as growing apart from/outside of power, but rather as appearing in the space created by, and in the exercising of, power. Through the discourses legal sanctions were identified, the norm defined and described, control mechanisms developed, experts appointed and knowledge generated.

Foucault is attempting to liberate power from its image as 'juridico – discursive' (as negative and repressive in nature, hence related to the dictates of law). Such an image, he asserts, is presented in binary systems - licit/illicit, permitted/forbidden, good/ bad - and centres on statements of law and taboos. This in Foucault's view is popular as power can only be tolerated in western society if it masks itself and hides its mechanisms. Hence, power is generally presented as a pure limit set on the freedom of individuals. Whilst Foucault does not deny this form of power exists, he posits the existence of new mechanisms, with no recourse to the state or the law, which have come into being, taking control of people's existence. These were not mechanisms dependent on 'right' but normalisation. As such:

> "power must be understood as a multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organisation; as processes which through ceaseless struggles and confrontations, transforms, strengthens or reverses them." (Foucault, 1979a, p92)

Biopower

Foucault posits that society in the eighteenth century had become a political target, the state involving itself as never before in ordering and controlling of the population from the smallest activities of the individual to the mobilising of large forces. Sovereign power,

centred on the right to take life or to let live, was replaced by the right of the social body to ensure, maintain and develop its life and with it 'biopower' established its domain.

Such biopower is identified as having two poles, the body as a machine and the body as a species. The pole of the human species relates to the mechanics of life, the biological processes and propagation of the body (Foucault, 1979a). Here birth, death, health and life expectancy are subjected to systematic and sustained political attention and intervention, dealing not simply with subjects or people but with populations. The other pole projects the human body as an object whose forces can be extorted and optimised, manipulated and controlled through procedures of power to provide a 'docile body'. Thus there developed "the possibility of knowledge about and control over the most minute aspects behaviour in the name of the populations welfare" (Rabinow, 1984, p8).

Developing Foucault's theme, the studies of Jones and Williamson (1979) and Parton (1994) suggests popular education and social work emerged in response to the concerns relating to society's wellbeing. Anxieties as to the link between the perceived neglect of certain groups of children coupled with their threat of antisocial/delinquent behaviour in later life necessitated state intervention. Both studies suggest that what had previously been seen as philanthropic activities became absorbed into formal institutions. Education and social work are seen to constitute individuals as objects of discourses generating an accompanying knowledge. The individual as never before became subject to the gaze of state authorities. Similarly Henriques et al. (1984) propose that the key conditions for the production of developmental psychology relates to the growth of state intervention in education, psychiatry, social work, child rearing, criminality and works with common concern relating to promoting the health and capabilities of the general population.

Such methods of power and knowledge Foucault asserts assumed responsibility for life processes and thus sought to regulate, control and modify them. Life was seen no longer as an unfathomable fact, rather it became a field of knowledge susceptible to control and intervention. The taking charge of life processes gave access to the body. Power appraised, measured, quantified and hierarchized the individuals and identified their position to an identified norm. Life became a political object and an issue for political struggles and what Foucault (1983c) terms 'government' came into being.

Governmentality

Foucault's concept of 'government' refers to the way the conduct of individuals/groups may be directed and thus provides the template for possible actions/responses of others to such groups/individuals. Governmentality is viewed as a group of power relations and techniques that have dominated politics from the eighteenth century onwards (Foucault, 1979b). It is not the subjugating of individuals to the rule of law but rather an exercising of power to shape the beliefs and conduct of populations. It involves systems of differentiation encompassed in the laws, traditions and accepted bodies of knowledge within a society enabling the acting of one individual/group upon another in an accepted and prescribed manner. These systems maintain certain privileges, authority and profits through power relations and techniques of discipline, providing regulation through hierarchization and elements of rationalisation. Thus it is identified what is done to and with particular groups in society, their status, where placed, how treated, types of surveillance to be utilised, whether viewed positively, and their economic field. In this way the medical profession are ascribed high status, placed in the higher echelons of society, treated with respect, granted a high degree of autonomy with little surveillance of their works, viewed positively and rewarded financially.

In considering 'Madness' Foucault (1967b) proposed his quest was the problem madness posed for others, how the mad were governed. In his later works he studied the problem that sexual conduct could pose to individuals themselves, thus how one governs oneself (Foucault, 1979a). He was hoping to give light to how government of self is integrated with government of others and how the experience and relation of self and others is linked, to identify the constantly changing alliances between various groups in which each has its own vested interests (Parton, 1994). As such it is not the imposing of social regulation from above but the location of power in the discursive practices of given society.

Technologies of Power

Unequal, local and unstable power relations are proposed, which Foucault (1977a) describes as multifocal and endlessly produced. The binary opposition of ruler and ruled does not exist in these mechanisms. Power is seen as criss-crossing the body of society, being a part of the complex interplay of power relations which propagate one another. Power is not omnipotent as wherever power relations arise so too does the possibility of

resistance. Therefore subjects are not seen as passive and helpless but as active in this process. Power struggles allow a questioning of the status of individuals and the possibility to change this.

Foucault's early work often evoked a picture of humans as subjected to power with little or no action on their part. He states that in his writing up to and including 'The Order of Things' (Foucault, 1970) he had accepted the traditional concept of power as essentially a legal mechanism and an exclusively negative concept. His examination of prisons convinced Foucault that power could be considered as a technology, a tactic and strategy, directly involving it in a political field, with power relations marking, training, and forcing the body to carry out tasks, ceremonies and emit signs (Foucault, 1979). This political aspect of the body, Foucault proposes, is bound to its economic use as a force of production; the body is only useful when productive and subjected. The conquering of the body's forces was achieved through a 'political technology of the body' (Foucault, 1979)

Foucault presents the political technology of the body as a systematic discourse, being diffused through a variety of institutions and state apparatus. Each of these have recourse to the technology whilst utilising a variety of methods and implements. Such power relations are presented as rooted in the very depth of society having innumerable points of confrontation with the inversion of power relations being a possibility (Foucault, 1979). Thus power is not exercised by those who dominate on those who are dominated, but rather a constant warring between groups and individuals alike, transmitted by them and through them, resisted and struggled with at every level of society.

Technologies of Discipline

Disciplines, which provide meticulous control of the body, are focussed upon by Foucault (1977b, p218), seen as "techniques for assuring the ordering of human multiplicities". These, he claims, both increased the forces of the body in terms of economic usage and limit them in relation to individual power. This suggests, (Pratt, 1998), that no one is allowed to stand outside of society, that there is a need to ensure all are made useful. Two strategies are to be utilised; general surveillance through statistics, social surveys and public records; and disciplinary training where individuals are subject to habitual rules and orders. Thus Foucault (1977b) posits a 'Political Anatomy' is created to exert control in the most efficient and effective manner. Such a political anatomy did not appear suddenly

rather being born out of "a multiplicity of minor processes, of different origins and scattered locations, which overlap, repeat, or imitate one another." (Foucault, 1977b, p182).

These processes are passed from one institution to another (often adopted in response to specific needs such as industrialisation or outbreaks of disease) utilising subtle, meticulous, and minute techniques endowed with great power. Jones and Williamson (1979a) provide a description of nineteenth century schools as one such aspect of this political anatomy. Here schools are presented as a means of promoting public morality and reducing the incidence of crime through the provision of a moral foundation and the controlling of the population through moral principles. This is not seen only as impacting on the school generation but also as transmitted through and by them to older generations.

Technologies of discipline, Foucault proposes, function as an integral part of social systems their actions reflecting the wider aspects of a culture/state. This disciplinary power is both omnipresent and constantly alert, yet largely silent and undetected. Disciplinary power derives its success from what Foucault (1977b) describes as three simple tools, 'Hierarchical Observation', 'Normalising Judgement' and a combination of these two in the 'Examination'.

Hierarchical Observation

It is posited that 'Observatories' of human diversities are set up to provide a "hierarchized, continuous and functional surveillance" (Foucault, 1977b, p192) epitomised in John Bentham's panopticon. This architectural design proposed a circular prison construction in which all cells faced into the centre. Such a spatial arrangement allowed inmates and guards alike to be subject to continuous surveillance without knowing when or by whom they are being observed. As a technology of power it created a spatial arrangement, which provided universal visibility and a network of disciplinary 'gazes', ensuring adherence to disciplinary codes. This was translated into and inscribed upon many social spaces such as military camps, schools, asylums, and prisons (Jones and Williamson, 1979).

Such technologies of disciplines, Pratt (1998) suggests, have moved out of the institutions into the social body. He suggests this is fuelled by the proposed failure of such institutions to produce their identified goals. The community based developments whilst hailed as

more humane, recreate the institution through the use of modern technology that enables surveillance in the community such as closed circuit television or electronic tagging.

Normalising Judgements

Punishments invoked by transgression of identified disciplinary codes, Foucault (1977b) proposes, are aimed at normalising individuals and are at the centre of all disciplinary systems. Society is thus no longer ruled by law but rather by the norm promoted through constant supervision and permanent classification. Henriques et al. (1984) identify sciences as helping to construct norms that become blueprints for ideal behaviour and practices in the social realm. As criteria are required to identify the norm, in western society medicine has become the science of the normal and the pathological. Gordon (1979, p38) proposes that "abnormalities came to be understood as effects of a human and social pathogeny which is as natural as the norm itself."

Technologies of normalisation serve two purposes. Firstly they allow the identification of anomalies thus enabling behaviours to be normalised through associated technologies. Secondly these indicate the degree to which one can claim membership of a homogenous social group. However, although homogeneity is imposed, individualisation continues with a measuring of the difference between each person and the imposed norm. Rose (1979) charts the developing role of psychology in the nineteenth century around technologies relating to measurement and individuation so that variations between individuals can be identified. Yet Henriques et al. (1984) identify the belief that the individual can be understood through measurement poses a paradox for psychology. For whilst psychology talks of the individual, it applies measurement tests to whole populations and as such negates a humanistic approach in providing a norm.

Examination

As a form of discipline technology, examination allows the identification of those who stray from the norm. It places individuals under a normalising gaze, providing a visibility and surveillance for classification, quantifying and punishment. Foucault (1977b) proposes that the examination introduces the individual into a field of documentation that fixes them and identifies their individual features. Such documentation allows individuals to be described and categorised as objects for analysis. Each individual becomes a case, an

object of knowledge that can be described, measured and then in turn classified, normalised or trained.

Foucault (1983c) suggests that originally the every day individual was below the threshold of description. It was only the privileged and deserving who were described, but disciplinary technologies reversed this making the description a means of control, a procedure for objectification and subjection. Through this form of power an individual is inscribed with a status, expected behaviours and demeanour. This inscription is not read by the individual but **IS** the individual, their subjectivity produced by the power-knowledge of discourse.

The Subject

As identified earlier, the concept of the subject is central to Foucault's work however the presentation of the subject as an existential or phenomenological being is rejected. In the three areas he examines - madness, delinquency and sexuality - Foucault's concern is with how people are produced as subjects of their own knowledge who exercise or submit to power relations and as moral subjects of their own actions (Foucault, 1984a). He asks, for example:

> "Why was madness problematised, starting at a certain time and following certain processes, as an illness falling under a certain model of medicine? How was the mad subject placed in the game of truth defined by a medical model or body of knowledge?" (Foucault, 1984b, p439)

By 'game of truth' Foucault is referring to the set of rules by which truth is produced aiming to discover why modern society is so preoccupied with this idea of 'truth'.

Two definitions of 'subject' are offered by Foucault (1982). One proposes individuals as subject to someone's control; the other suggests being tied to an individual identity through self-knowledge. Both of these, Foucault proposes, suggest a form of power which subjugates individuals and within such forms of power three types of struggles occur; one against domination; another against exploitation and finally that against those things which bind an individual to self and submits him/her to others - subjectivity. Foucault proposes

that the struggle of the nineteenth century was against exploitation; today it is against subjectivity, - the formation of self through the internalisation of power relations.

Objectification

Foucault (1982) identifies three modes of objectification by which humans become subjects: -

- Scientific classification whereby modes of enquiry give a status to, and objectification of subjects.

- Dividing practices by which a subject is divided within her/himself or from others, giving individuals both social and personal identities.

- Subjectification, the practices by which the individual actively engages in self-formation.

Much of Foucault's early work addresses the first two modes of objectification focussing on discourses and discursive practices. Initially he represented the subject as passive and the object of theoretical discourse. In later works he came to view subjects as more politically active, developing through practices founded in power relations not generated by the individual but allowing for the possibility of change. Here Foucault (1979a; 1984a) develops the idea of technologies of self, whereby individuals create their own identities through ethics and forms of self-construction. Such technologies of self relate to activities undertaken in relation to the body, soul, thoughts and conduct of individuals in an effort to achieve feelings of fulfilment.

In examining the practices that gave birth to the sciences and presented humans/society in the form of objects of analysis, Foucault identifies a need within humans to give deep meaning to their 'being', the need to find the meaning of life. As a social imperative he believes this drove the development of scientific positivism and through increasingly rationalised means humans were converted into meaningful subjects. Providing an example of this Foucault (1967a) maps the history of the 'madman' (sic) and the transformation of madness into insanity with the associated social interment in the asylums. Rather than being viewed as a humanitarian response accompanying the discovery of treatments for mental illness, Foucault proposes it is a response to the

developing scientific (medical) discourses and objectification practices in an effort to give meaning to madness and those who embody it. Through the medical profession the madman is redefined as insane and as an object of investigation. The doctor regulated who entered and left the asylum and transformed the interior space of the asylum into a medical space. Thus through dividing practices, spatially and socially; the madman was given a social and personal identity and became an object of discourse. The medical discourse provided the madman with a scientific classification and the possibility of identifying the 'true' nature of madness (Foucault, 1969a).

Jones and Williamson (1979) replicate this approach as they chart the birth of the schoolroom. Here it is identified how in the nineteenth century social classes in society were formed as objects of scientific analysis. Particular social classes caused concern due to their proposed lack of 'moral' behaviour. Some were viewed as dangerous as a result of their criminal behaviour, yet others presented as susceptible to moral contamination. In the interests of public wellbeing it was therefore proposed necessary to provide moral and educational guidance to the children of such classes to alleviate and pre-empt such difficulties in adult life. Schools provided spatial arrangements whereby children were divided from society, separating them from moral contamination in the streets and furnishing each with a personal identity through individual allocation to particular classes in society.

Subjectivity

Foucault (1979a) proposes the concept of a modern soul, suggesting the surplus power generated around a subjected body through theoretical discourses gives rise to a duplication of the body, a soul, which is supported and maintained by the technologies of discipline and rituals of power. An individual is born, lives and dies but discourses surrounding the individual identify what s/he is and should be. Thus the person becomes 'eternal', perpetuated by power-knowledge relations. Foucault identifies the soul as 'the prison of the body', perpetuating an image of the body to which the individual becomes both subject and object, thus the individual is known and knows self.

Knowledge is seen as playing a different role in the classical image of self, the mastery of self being aesthetic in nature, an art form, where the individual chooses to give their lives over to the pursuit of the betterment of self. Foucault (1983d) asserts this is diametrically

opposed to the modern pursuit of self which relates to hermeneutics, the discovery of a deeper more meaningful inner self as if deciphering a code. Christianity is identified as promoting this change from the classical search for a personal ethic to a morality of obedience to a system of rules through the use of 'Pastoral power' which promised individuals salvation in the 'next world' (Foucault, 1982). The guardians of this power were charged with promoting the spiritual wellbeing of the whole community and individuals alike. To fulfil this obligation there was a need to know the people's minds and souls, and required the revealing of secrets through confession, if salvation was to be ensured. The waning of religious institutions, however, did not result in a disappearance of pastoral power or the confessional, rather Foucault (1982) asserts these continue, incorporated into modern institutions in the form of self analysis and the use of technologies such as confession and examination. Salvation is now promised in 'this life' in the form of health and wellbeing, with new officials of this pastoral power increasing and spreading throughout the social body.

Confession

Confession, originally associated with the confession of guilt and the need for 'wrong doers' to tell 'the truth', utilises methods of interrogation and inquest and has become, Foucault (1979a) asserts, one of the West's most highly prized methods of producing the truth. Thus the western society has become a confessing society with its effects being seen in the judicial, medical, education and family systems. In solemn rites individuals confess to sins, crimes, illnesses, inner thoughts and desires, and are entreated to divulge whatever is most difficult to tell. Such rites are conducted in public and in private, to doctors, teachers, loved ones and self. They take the form of interrogations, consultations and autobiographical narratives, and are subject to recording, transcription, commentary and publication.

Science's claim to speak the truth, identifying itself as a supreme authority places it in a contentious position in relation to confession. To alleviate any dissonance the two are brought together in what Foucault (1979a) identifies as a 'will to knowledge'. This is achieved through the combining of ritual confession with a principal technology of power, the examination. For example, the taking (examination) of a personal history (a confession) and a deciphering of signs places the confession in the field of scientific observation. Thus in the scientific field the most discrete and seemly insignificant

elements are viewed as possibly having a profound impact on outcomes. The collection of detailed information through questioning and a corresponding confession gives validity to the act. Within certain domains of scientific analysis it is suggested that an individual may not be aware that s/he is hiding the truth. Therefore the gradual enabling of individuals to discover the 'hidden' through expert intervention and guidance is essential. The speaker, being unable to reveal or recognise the truth unaided must engage in an exploration with a 'master of truth', a scientific expert who is able to direct, interpret, provide meaning and record the disclosures. Examples of this are seen in medicine, psychology and counselling.

Confession has permeated so many domains of life it is not longer perceived as an effect of power, but as the freeing of truth that power has sought to silence. As a ritual of discourse, the speaking subject is also the subject of the statement and unfolds within a power relation. When linked to the disciplinary technology of examination, the individual speaks in the presence (or virtual presence) of an 'authority' who is able to judge, appreciate and produce appropriate modification of the one who speaks. In this way the subject is objectified in relation to their performance and similarity to others. As the object of the examination the speaker is encouraged to undertake self-evaluation and becomes subjectified in an important and constantly repeated 'ritual of power' in 'a ceremony of objectification'. Foucault (1977b, p189) suggests we have entered an "age of the infinite examination and of compulsory objectification". Thus individuals become objectified, subject to surveillance and discipline both by a hierarchy - their behaviour, thoughts and deeds being subject to constant 'examination' - and by themselves through constant self-examination/reflection.

Practices of Self

Foucault examines how the human subject defines itself as a speaking, living, working individual through scientific discourses considering the relationship between the subject and the game of truth, in his eyes a coercive practice. In his later work (Foucault, 1984a) he attempted to examine the subject in terms of the 'practice of self'; the exercise of self on self by which an individual tries to develop and transform in order to attain a certain mode of being. Rather than proposing a 'hidden' human nature that can be liberated from the deadlock of repression, Foucault is referring to what he terms 'practices of freedom'. Here, again, is a subject socially constructed through discourse and situated in power relations, yet having the ability to define its own identity, master its own body and practice

freedom through technologies of self. However, practices of freedom are not possible where power is not mobile as in some states of domination. Instead freedom is achieved through the extent to which an individual can overcome the socially imposed limitations and achieve self-mastery. Practices of self relate to patterns found in individual cultures and although the individual does not create these, they allow for the active constitution of self.

Conclusion

Foucault offers an alternative framework and form of analysis through which to consider aspects of society, particularly in relation to systems of thought. His attempts to dismantle the concept of 'self-evidence' in relation to dominant forms of rationality present within society create the possibility of viewing events and action from a different perspective and to break away from traditional ways of understanding. The presentation of knowledge and power as being joined in discursive practices and the centrality of this to the creation of human subjects provides an alternative lens through which to access and understand the 'Nature of Mental Health Nurses' Knowledge'.

Critique of Foucault's Approach

Whilst Foucault's work has had a profound impact on the world of social sciences he is notoriously ambiguous and is frequently criticised for not fully explaining his meanings and methods. His staunchest critics insist his approaches and methods lack vigour and are riddled with empirical flaws. This is a response to his apparent lack of concern with historical facts and dates and his tendency to move rapidly backwards and forwards through centuries without giving reference as to sources and universalising obscure and relatively unknown pieces of work. However such criticisms are countered by the claim that many scholars have only read English translations of Foucault's works which are abridged versions (Jones and Porter, 1994).

In considering the development of medicine, Peerson (1995) accuses Foucault of ignoring specific aspects such as surgery, teaching and research. As such Foucault's work does not present the whole picture of what was occurring in the domain of medicine at the time.

Foucault is seen by others to have a tendency towards 'one sidedness' giving precedence to certain aspects over others in all his works. Thus Best and Kellner (1991, p69) identify:

> "His archaeological works privilege discourse over institutions and practice, his genealogical works emphasis domination over resistance and self formation".

Perhaps such tunnel vision reflects Foucault's desire to work on specific areas and explore these fully, or possibly is the result of a particular bias. It is difficult to say whether he would have addressed such issues if his work had continued, as Jones and Porter (1994) identify some of Foucault's final works and lectures have yet to appear in print. However Foucault readily admitted that his interests and direction altered quite radically over time. As his investigative approaches developed, the emphasis, ideas and focus became more refined and defined.

In his analysis of power relations much of what he writes describes and critiques the micro-strategies of power and resistance, with little or no space allocated to the consideration of how these relations and struggles translate in the macro-powers of the state and society. Dreyfus and Rabinow (1982) describe his work as a 'slalom' between traditional philosophic descriptions of the reality of things and the nihilist view of such a reality as 'what ever we take it to be'. Whilst Foucault is seen to mark out his ground by providing particular genealogies relating to madness, punishment and sexuality, he has steadfastly refused to provide an overview as to the place of his theoretic stance in relation to traditional and current thinking. As such he leaves many questions unanswered. This of itself does not invalidate his analysis but is seen by many to detract from 'wholeness' of the theoretical stance. However this lack of macro-theory is a reflection of Foucault's disenchantment with 'grand theories' which he saw as reflecting positivistic discourses. Henriques et al. (1984) whilst accepting the claims relating to the lack of explicit explanation of how global changes occur, suggests that the strengths of Foucault's approach lies at a different level. What this type of framework allows is the exploration of the minutiae of discourse and practices. Nonetheless Best and Kellner (1991) and Peerson (1995) accuse Foucault of playing fast and loose with these concepts, on the one hand vigorously attacking 'globalising discourses' whilst on the other presenting his own analysis of 'particular' as capable of being generalised to the whole.

Best and Kellner (1991) identify that Foucault is guilty of failing to acknowledge the progress made in modern societies, concentrating as he does on the technologies of discipline present within society. Pratt (1998) picks up this point proposing that power and resistance are recurrent threads in Foucault's work but the reader is left with no way of evaluating the efficacy or progressiveness of one or the other. Porter (1996) whilst advocating that the deconstruction of the positivist stance is long overdue is also concerned by Foucault's apparent refusal to acknowledge progress or to attach legitimacy to one body of knowledge over and above another. This he sees as robbing individuals of the ability to see interventions reflecting particular knowledge bases as right and proper which will eventually lead to despondency as no one knowledge is seen to have primacy over another. Implicit in Porter's (1996) criticism is the accusation of relativism, that all discourses have an equal status as truths. However such claims are a reflection of a positivist hegemony which prescribes ways of differentiating between true and false statements and precludes other possible ways of describing and discovering the nature of the problem. Cheek, in debate with Porter, proposes that what is on offer here are alternative ways of viewing and problematising the social world, with the "potential to change and resist otherwise unchallenged assumption..." (Cheek and Porter, 1997, p110).

However the thrust behind Foucault's work is to provide the observer with a set of tools which will enable s/he to see a problem from a different perspective whilst at the same time advocating that this perspective is as valid as another. Foucault's (1984a) argument is that seeing only one version of knowledge as true is of itself both stifling and inhibiting. He also claims that it is essential to question the validity of certain frameworks before advocating their use in judging the appropriateness of principles and ways of understanding the world.

Justification for adoption as a framework

In answer to criticisms that his perspective changed over time Foucault (1984a) asserts that the nature of his undertaking necessitated such developments but maintains that throughout, his goal always remained the same, to uncover the relationship between the subject, truth and the constitution of experience. He is attempting to discover how

domains such as madness, sexuality and delinquency enter the game of truth and the effect of this on the human subject.

Foucault has been allocated various positions on the intellectual 'chessboard', ranging from idealist to nihilist, leftist to new conservative, and subjected to many, often unflattering, descriptions. These he chose to disregard as he conducted a life long analysis of the history of thought (Foucault 1984a). Gordon (1979, p44) proposes that perhaps what Foucault has most to offer is:

> "a set of possible tools, tools for the identification of the condition of possibility which operate through the enigmas of our present, tools perhaps also for the eventual modification of those conditions."

Despite the various criticisms of Foucault's approach here is a framework which provides an opportunity to consider issues from a different perspective and level. Popketwitz (1997) highlights the need to consider the effects of power on the formation of what is viewed as appropriate knowledge. Whereas debates concerning knowledge have usually centred on defining what is 'truth', he proposes a need to focus on the politics of knowledge, the effects of power. The disturbing of accepted rationalities is presented as offering the possibility of creating alternative ways of reasoning.

Traditional approaches to the investigation of mental health nursing have identified shortfalls in the education of mental health nurses and the roles prescribed for them have yet to be realised. It is these traditional studies which have informed educational reforms and the adoption of particular approaches to facilitate changes in mental health nurses practice. Yet despite various initiatives, the knowledge bases advocated as central to mental health nursing have yet to be adopted and embraced by them as evidenced in the various studies relating to the practice of mental health nursing (Altschul, 1974; Towell, 1975; Porter, 1992; Whittington and McLaughlin, 2000). This would seem to suggest that a fresh view of mental health nurses and their knowledge base is required. Foucault's work provides the tools by which an alternative analysis can be provided and through this, a possibility of initiating change.

CHAPTER 3

METHODS OF INVESTIGATION

- Introduction
- Theoretical framework
- **Methods of Investigation**
- Genealogy - Diagnosis of the Present
- - Conditions of Emergence
- - Power Relations (part 1)
- - Power Relations (part 2)
- - Knowledges
- Q-Methodology - Philosophy and Approach
- - Data Analysis
- Discussion, Limitations and Conclusions

Foucault's theoretical framework forms the basis of this study to identify the 'Nature of Mental Health Nurses' Knowledge'. As identified earlier, Foucault proposes that power forms knowledge and produces discourses, thus a body of knowledge is not formed by a 'subject who knows' but rather through the processes and struggles that transverse that subject. Hence it is posited here that Mental Health Nursing does not produce a regime of knowledge but rather power relations inscribe on the nurse forms/domains of knowledge. Thus from this perspective the question to be addressed is *'How is mental health nursing knowledge constituted and made possible in relation to existing discourses, practices and conditions*?'

From the approach adopted here it is also claimed that the subject does not have existence prior to discourse but rather is constructed through discursive practices being "caught in the mutually constructive web of social practices, discourses and subjectivity" (Henriques et al. 1994, p.117). Thus as Cheek and Rudge (1994a) suggest

nurses and nursing practice are formed and understood through the 'texts' which represent the social reality in which they are embedded. Texts from this perspective may be written, spoken or pictorial; being changeable aspects of social conventions through which we come to know and understand the social world in which we exist. This is not in terms of syntax or contextual meaning but as a result of social structures and historical conditions.

A Foucaudian approach considers such social and historical perspectives and uses them in the identification and analysis of certain 'dispositif'/social apparatus, within which power - knowledge relations are visible. These social apparatuses are systems of relations evident between disparate yet interconnected discursive and non-discursive practices. Foucault (1977c, p195) asserts that such apparatus come into being as the result of some "urgent need", serving a strategic function in relation to the identified problem and structuring the way it is seen and understood. However once formed the relations between the various elements of the social apparatus reverberate across society and time, having often unforeseen effects and being subject to transformations and modifications. Here is a tangled, multi-linear formation composed of:

> "lines of visibility and enunciation, lines of force, lines of subjectification, lines of splitting, breakage, fracture, all of which criss-cross and mingle together" (Deleuze, 1990, p162).

Such lines are not contours or perimeters surrounding systems, but rather run through and pull at the system. At times certain lines may converge, at other times drift apart or change direction. The emphasis is on the tracing of these lines and their trajectories. The lines of visibility and enunciation are the ways of seeing and speaking about specific objects/groups, the discourses that are available in relation to an object. Certain discourses gain greater autonomy/validity than others and hence are deemed to represent the 'truth' of the object they describe. The lines of force represent the power-knowledge formations that transverse and ameliorate discourses. However this is not a static configuration but rather one in motion with transformations and reversals being possible.

Lines of subjectification, although not always present in a dispositif, represent the practices by which the individual/group actively engages in self-formation. Foucault (1979, 1984a) introduces the idea of 'technologies of self', whereby individuals strive to mould/form their own subjectivities in an effort to achieve feelings of fulfilment and escape the power/knowledge relations of their social apparatus. The discourses present within mental health nursing concerning what it 'should be' (in this case using knowledge related to therapeutic activities) can be seen as reflecting mental health nursing's struggle for self-formation and thus lines of subjectification.

The concept of social apparatus is a tool to aid in analysis rather than an end in itself and Foucault proposes that when the "strategies of relations of force supporting types of knowledge" and vice versa are identified, one has a dispositif (Foucault, 1977c, p196). The intention in this study is to identify and analyse the social apparatus within which mental health nurses' act. To uncover and chart the discourses available in relation mental health nursing, the power relations evident within these and the domains of knowledge programmed.

A dispositif/social apparatus consists of two parts, (Deleuze 1990), the 'archive' – i.e. what mental health nurses are and are ceasing to be - and the 'current' – what they are and what they are becoming. It is therefore necessary to unravel the lines of the archive (to chart the trajectory of mental health nursing from its emergence to the present) and of the current (their present form and a sketch of what they may become). Deleuze suggests that Foucault's genealogy provides access to the archive but does not fully address the 'current'. Therefore two approaches will be adopted and integrated here, Foucault's (1984c) Genealogy and Stephenson's (1935) Q-methodology. Genealogy in offering a history of the present gives access to the present and its archive, and Q-methodology provides an analysis of mental health nurses' present subjectivity, thus the 'current', and offers an opportunity to offer an interpretation of what mental health nurses are becoming.

Genealogy

Foucault's methodology, Genealogy, is a historical perspective that seeks to identify the multiplicity of factors impacting on the historical beginnings and emergence of phenomena, the genesis of the social apparatus. These 'histories of the present' direct consideration to discontinuities and breaches in thought, the role of chance, and the multiple determinations involved in the beliefs and practices of the present (Peterson and Bunton, 1997). Such an approach has the explicit goal of rupturing the 'taken-for-grantedness' of the present. This is not an attempt to understand the past from the perspective of the present but rather to disrupt the self-evidence of the present.

The apparent internal intelligibility of discourses and their claims to describe reality are evaluated, attention being given over to their specific discursive formations, history and place in the larger context of power relations. The question asked is how certain discourses have come to be accepted as the taken-for-granted background (Foucault, 1981). Thus genealogy offers the opportunity to map new terrains and formulate questions in new ways, rather than providing schemas. What emerges is a serial of histories mapping the threads which make up the present (Nelson, 2000). Foucault's intention is to use historical investigation "as a philosopher seeking to elucidate questions of the present rather than the professional historian providing an empirically sound record of the past", (McCallum, 1997, p54), enabling a diagnosis of present problems through the use of historical investigation.

The rationale for any methodology is based on a theory of knowledge generation, an epistemology. Realist approaches propose a stable reality in which independent observation and measurement generate knowledge (Yardley, 1997). Genealogy, however, brings the objective nature of traditional inquiry into question, claims of objectivity are viewed as masking subjective motivations. Rather the concept of knowledge as 'perspective' is forwarded here, the belief that knowledge is grounded in time, place and subject to discursive practices (Smart, 1985). In this approach the empirical emphasis on accurate measurement and the isolation of variables is replaced with the aim of providing a detailed multi-layered interpretation of a particular situation,

how social practices create the space within which scientific objectivity and subjective designs arise (Dreyfus and Rabinow, 1982).

Interpretation in this context is not the uncovering of hidden meanings. As Foucault (1984c) posits, the secret underpinning history is that there is no secret. Neither is it a search to uncover the unknown in the hope of finding natural progression, the roots of the present in the secrets of the past. Rather here is an identification of the accidents, the reversals, and the miscalculations, which give rise to the things that exist and have value to us today. History is viewed as the imposing of direction and forcing participation in new 'games' through the appropriation of systems of rules. The moment of interpretation – Genealogy – is like an overview from on high, which allows the depth to be scrutinised with a profound visibility as all is seen from afar and laid out for consideration. When issues are viewed from an appropriate distance and with the right vision a profound view of everything is achieved and thus deep meanings and truths are seen to be shams (Dreyfus and Rabinow, 1982).

Donzelot (1979) proposes that Foucault is providing another level of analysis, not in terms of truth or ideology but in relation to knowledge production and thus the power it programmes. Whilst this approach, he suggests, does not provide a faithful truth nor a consummate history, it does provide the possibility of "escaping once and for all from the derisory hope that there exists a place where history is written" (Donzelot, 1979, p74). He goes on to suggest that in traditional analysis, reality is a player placed on the stage for all to see, having clear and concise content and a self-evident status. However genealogy can be seen more as a detective story, though initially incomprehensible and enigmatic in character, it seeks to ruffle the calm and everydayness of a scene, showing events in a different light. The search is for clues, which show how transformations occur rather than the identifying of causation.

Genealogy makes no claims as to ultimate truth or privilege status, seeing it as just one of many possible accounts of events which offers insights into the technologies and strategies present in certain practices. Thus Foucault asserts:

"the hypothesis [as] being that these types of practice...possess up to a point their own specific regularities, logic strategy, self-evidence and rationale. It is a question of analysing a 'regime of practices' - practices understood here as places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect" (Foucault, 1978, p276).

Cautionary Prescriptions

Four rules are offered to guide the analysis, not as methodological imperatives but as 'cautionary prescriptions' (Foucault, 1979).

1. The 'rule of immanence' which dictates that something can only be identified as an area of investigation if power relations have established it. Equally power is only able to take an area as its target if techniques of knowledge and procedures of discourse are capable of endowing it with certain characteristics.

Thus the knowledge of mental health nursing cannot be separated from the power exercised within it and through it. Mental health nursing became an area accessible to knowledge when power relations established it and equally power was able to invest mental health nursing because of certain techniques of knowledge. From this perspective, for example, it could be suggested that mental health nursing came into being as a result of the power relations at play between the medical profession and the insane. The need for an intermediary to observe, interpret and report on the insane individual gave rise to a body of knowledge in relation to what was to be observed.

2. The 'rule of continual variations' suggests that it is not at issue who has or has not power within a particular group of people, but rather the pattern modifications imposed by the processes of power relations and the resulting 'matrices of transformation'. These matrices are subject to constant modifications and continual shifts.

In the case of mental health nursing there is a need to consider how power is distributed, knowledge appropriated and what transformations are present. Here it is possible to address the transformation of asylum attendant to nurse imposed by the power relations present at that time and the roles of the medical profession, mental health nursing and general nursing in this. It is conceivable that an alteration in this matrix occurred when the relations between these groups shifted and general nursing became responsible for the training schemes of mental health nursing, usurping the role of the medical profession.

3. The rule 'of double conditioning' identifies that whilst the local centres of power-knowledge are part of an overall societal strategy and overall strategies require support at the point of application, one is not the enlargement or miniaturisation of the other.

Therefore Mental Health Nursing is not to be viewed as duplicating the state, neither is the state a reflection of the mental health nursing. Rather mental health nursing is an essential local organisation that enables the application of technologies employed at the macro level of society. Thus mental health nursing can be seen as a point of application for technologies of discipline, which provide control of those identified as mentally ill, whilst nurses themselves are subject to surveillance and disciplinary powers. Such disciplinary power circulates throughout the social body, however its application and form is specific to the area in which it is exercised, in this case mental health nursing.

4. The rule of 'tactical polyvalence of discourse' suggests that a multiplicity of discourses is possible. In discourse power and knowledge come together as a series of discontinuous segments, which are neither stable nor uniform. Discourses are viewed as elements that come into play as a result of various strategies.

The task in relation to mental health nursing is to reconstruct the various discourses identifying what is said and concealed, allowed or discounted, considering the effects of who is speaking, their position of power and in what context. Here is a need to identify when discourse is a tool and/or effect of power, or a point of resistance, a strategy of opposition. Thus within mental health nursing it may be possible to consider the present

discourse relating to nursing and higher education as a tool of power aimed at furthering the cause of nursing per se and the involvement of mental health nursing in this as an effect of power. The current discourse disputing the efficacy of an education programme common to all branches of nursing could be viewed as a point of resistance in the power relation between nursing in general and mental health nursing.

Foucault identifies that discourse can programme an institution at one point, at another justify/mask a practice and at another through re-interpretation open a new field of rationality. Hence it could be proposed that the discourse relating to the dangerousness of mentally ill individuals programmed their containment in the 19th century, justified the use of restraining practices in both the 19th century and present day, and through current re-interpretation has brought about a new field of rationality known as 'risk assessment/management'.

Application of Genealogy

The adoption of Foucault's genealogical approach requires the bracketing of truth and meaning of a discourse and asking what historical and political role discourses play, what function they have in the larger context. This is not an attempt to capture the significance/meaning of a time period, or to provide a full picture of an age, nor the underlying laws of history. Rather it is an effort to uncover how our current understanding of individuals came into being (Foucault, 1981; Dreyfus and Rabinow, 1982). The analysis requires an accessing of discourses through the examination of the 'archive', a consideration of all texts available, in all their forms for the time period under consideration. No distinction is made between fiction and non-fiction, primary or secondary sources, as all are viewed as contributing to, shaping and reflecting the possible discourses available.

A number of methods/techniques of analysis are offered by Foucault as facilitating the Genealogy process and two in particular are used within this study, 'Diagnosis of the Present' and 'Eventalisation'.

Diagnosis of the Present

Foucault (1984c) maintains that certain historical situation clear a space within which subject/objects emerge. In this space regimes of practice are precisely and painstakingly established through the interplay of power relations that establish what is right and proper, what Foucault terms 'meticulous rituals of power'. Such regimes of practice become the taken-for-granted backgrounds and form the ways of seeing and speaking of the subject/objects. Thus genealogy begins with an examination of the present and an isolation of these taken-for-granted-back-grounds established through rituals of power. This is not an arbitrary construction but a meaningful attempt to analyse and understand the topic area, which then frees the researcher to ask "how did we get here?" (Dreyfus and Rabinow, 1982, p117).

Eventalisation

Discourse is treated here as 'a set of discursive events' arranged in a series of unpredicted discontinuities that shatter the event into a series of different time-scales and possibilities. To this end 'Eventalisation' is undertaken with the re-instating of the concept of the event. Historical continuity is opposed, discontinuity introduced and the assurance of stability in life rejected, in the search for acute presentations and the unique traits of particular events. An event is seen as an identifiable alteration in power relations, not in battles or treatise, but the haphazard conflicts of humanity with the "iron hand of necessity shaking the dice-box of chance" (Foucault, 1984a, p89). Here chance is viewed not simply as the drawing of lots but the attempt to master chance through the raising of stakes and the risking of all.

Whilst there is a desire for history to show that events are a result of profound considerations and thus provide meaning, the world is seen here as a "profusion of entangled events" (Foucault, 1984a, p89). In these terms the event is not located at a single point or level but is a multiplicity of events/levels with "different amplitudes, chronological breadths and capacity to produce effects" (Foucault, 1984b, p56). There is a need to distinguish between the various events, to trace the links between the levels and identify the networks. Analysis focuses on power relations, strategic developments

and tactics. Self-evidence is challenged through the examination of historical processes, thus allowing a consideration of the consequences of power relation for the generation of bodies of knowledge.

Whilst exploring the event, consideration must then be given to the forms of rationality present within mental health nursing, how these are inscribed on, and the roles they play, in particular regimes of practices. Two axes are addressed:

- codification/prescription – how practices are governed, the collection of rules, ways of doing things. Foucault (1981) cautions not to ask "who has the power and what is his/her goal" but rather "how power works at the level of subjugation, how is the object of attention governed"? Here the question of how mental health nursing constitutes itself and its practices through the rules prescribing forms and regimes of behaviour is to be identified.

- true/false formation – how it is decided which 'true' propositions can be spoken; the discourses that justify practices; and the principles that underpin them. There is a need to ask "What are the common sense, taken-for-granted backgrounds of mental health nursing?" What propositions are held as 'truths' and which are rejected as 'false'?

In this study eventalisation requires a determining of the processes involved in the medicalisation of the madness, the practices of treatment and how mental health nursing came to be part of that treatment. Thus to uncover the strategies, connections, encounters and plays of force which culminated in the perceived necessity of mental health nursing. That there should be a natural progression from asylum attendant (servant) to mental health nurse is questioned.

The intention here is to analyse the 'regime of practices' within mental health nursing - "what is said and what is done, the rules imposed and reasons given, the planned and the taken-for-granted meet and interconnect" (Foucault, 1979, p5). However practices do not exist without supporting rationalities - 'truths', principles, justifications - and knowledge (Dreyfus and Rabinow, 1982). Thus the interplay between such regimes and

the rationalities which justify the practices are to be examined. The practices identified as appropriate for mental health nurses, the reasons given for these, and the knowledge bases generated by/through such practices to both justify and support said practices are to be revealed. This begins by examining the conditions of emergence, how it became possible for power relations to target and establish what was to become known as mental health nursing. Having identified the conditions of emergence it is then possible to reveal the power relations in evidence and through these the knowledges programmed as appropriate to and inscribed on mental health nurses.

A Genealogy of Mental Health Nursing Knowledge

It is proposed, therefore, to begin with the identification of current rituals of power and issues perceived as self-evident within mental health nursing – a diagnosis of the present. Following this is the identification of the mental health nursing trajectory, how mental health nursing emerged, the tracing of the various discourses that led to and from its inception. Within mental health nursing as a body there are various division, the most distinct between inpatient and community settings. As community psychiatric nursing is a relatively new innovation it is intended here to limit consideration to those employed in in-patient settings.

Implicit within these activities is consideration of the rules of tactical polyvalence of discourse, immanence, and double conditioning. Hence it is necessary to identify the discourses through which mental health nursing became seen as a necessity, the power relations invested in mental health nursing, the knowledge bases programmed, and what technologies of discipline mental health nursing serves as a point of application. In this way the archive of the 'social apparatus' can be drawn to reveal the power-knowledge relations of the present and how these came into being.

Q-Methodology

William Stephenson (1953) presents Q methodology as a form of factor analysis that provides a systematic way to examine, and gain an understanding of, individuals' subjectivity. As such it does not objectively measure an individual's subjectivity, but provides an opportunity to examine expressed beliefs through interpretation of the emerging factors.

Stainton-Rogers and Stainton-Rogers (1990) assert that Q methodology is often presented as a specific approach where all Q researchers share common ground, this however is not so. Whilst the operational rules of Q remain central, the under-pinning theoretical frameworks change according to the conceptualisation of subjectivity, and it is this which directs the form of the Q sort, the analysis and the final interpretation of the factors emerging.

Q's growing usage is evident in a variety of intellectual fields including literary analysis (Thomas and Baas, 1993); political science (Dryzek and Berejikian, 1993); communication theory (Barchak, 1984); pharmacy (Mrtek, Tafesse and Wigger, 1996); child psychology (Taylor, Delprato and Knapp, 1994) and nursing (McKeown, Stowell-Smith and Foley, 1999). Its attraction for all these disciplines lies in the possibility of gaining access to and exploring patterns in people's viewpoints/perspectives/ subjectivities.

Links between Q-methodology and qualitative approaches have prompted criticism, in that methods viewed traditionally as quantitative, i.e. factor analysis, are used in a manner which it is proposed reduces their objectivity and as such their perceived validity. However Stainton-Rogers (1991), expounding the employment of Q within a social constructionist paradigm, claims there is little difference between such an approach and experimental methods. Both seek to examine phenomena through culturally endorsed knowledge, but whereas scientific methods are founded on the notion that they construct a 'truthful' version of reality, within social constructionism the researcher acknowledges that this is only one of many possible interpretations.

Whilst this is open to the accusation of relativism, implicit in such an approach is an acknowledgement that there are other possibilities and ways of viewing the world. Positivist claims to truth and objectivity is no more valid than those of others, but simply reflect a dominant cultural view of knowledge generation and the world. In Mulkay's (1991) eyes there is a need to abandon the issue of validity and replace it with a consideration of how knowledge is generated and can be utilised. Brown (1980) theorises that within Q methodology the notion of validity is redundant as no external criteria can be applied to viewpoints given, meaning and significance is determined by the study participant, understanding/knowledge is acquired by the research 'posteriori' i.e. following the collection of data, when the Q sorts are completed. Thus as Stainton-Rodgers (1991, p126) asserts

> "It is more meaningful to ask 'what can it be used to achieve' or 'What are its ideological implications' than to wonder 'is it valid?"

Q-methodology and Mental Health Nurses' Knowledge

Here the underpinning theoretical framework reflects a Foucaudian perspective, as such Subjectivity is viewed as the status, expected behaviours and demeanour inscribed by power relations upon individuals. Such an inscription is not read by the individual but is the individual, subjectivity being produced by the discourses surrounding them. Part of this subjectivity is the knowledge utilised and deemed appropriate in the practice of mental health nursing. It is possible to utilise Q in the examination of the mental health nurses' subjectivity in relation to knowledge, to discover which of the knowledge discourses are inscribed upon them and thus 'what they are'. It is also possible to identify if the lines of self-formation are inscribed upon the practitioner, to consider what mental health nurses are becoming. Through interpretation of the factors, the nature of the transformations occurring will be made visible and it will be possible to posit what mental health nurses are becoming and thus map and analyse the 'current' section of their social apparatus.

The theoretical underpinnings of Q are discussed at length in chapter 10, but briefly this approach requires individuals to rank order (Q-sort) statements, which are a representation (a Q-sample) of a concourse (the universe of discourses surrounding a particular domain). The rankings are intercorrelated (Q-sort by Q-sort) to provide a correlation matrix, which is then subjected to factor analysis and rotation. Factor scores are calculated for each individual Q-sort and formed as a weighted sum to assess each statement's relevance within the specific factor (Stainton Rogers & Kitzinger, 1995; Mrtek, Tafesse and Wigger, 1996). The emerging factors are subject to interpretation and presented in the form of the discourses apparent in the formation of participants' subjectivity.

Terms used

Part of this analysis is historical in nature and language/meaning changes over time. Terms that are now seen to have negative connotations, such a lunatic, simply reflect a diagnostic category of the time, indeed it is often in response to society's perception of certain terms that new ones are introduced. However it is intended here to use the language specific to time period when describing particular eras. Thus those known today as mental health service users/patients are referred to as lunatics, inmates, mental patients and psychiatric patients. Mental health problems/mental illnesses can be spoken of as madness, insanity, lunacy and psychiatric disorder. In relation to mental health nurses they have been variously referred to as Keepers, Attendant, mental nurses and psychiatric nurses. The terms mad-doctors, Asylum physicians, physicians and psychiatrists all relate to those individuals in the medical profession who specialise in the treatment of mental illness.

Although this study relates to mental health nursing at times there is a need to debate issues concerning other aspects of nursing. To aid clarity the term 'mental health nursing' will be used generally to denote individuals working with people identified as suffering from mental illnesses in in-patient settings; the term 'nurse' is used in relation to that group of individual working with people with physical illness in the hospital

setting. All other groups will be referred to using the title relating to their speciality followed by 'nurse' (for example learning disabilities nurse).

CHAPTER 4

DIAGNOSIS OF THE PRESENT

- Introduction
- Theoretical framework
- Methods of Investigation
- **Genealogy - Diagnosis of the Present**
- - Conditions of Emergence
- - Power Relations (part 1)
- - Power Relations (part 2)
- - Knowledges
- Q-Methodology - Philosophy and Approaches
- - Data Analysis
- Discussion, Limitations and Conclusions

The Genealogy of mental health nursing begins with a diagnosis of the present, an analysis of the current social apparatus within which it acts and the discourses available, - the ways of speaking of/seeing mental health nursing. Here the taken-for-granted backgrounds to nursing practice are to be identified; the truths on which nursing is dependent for its own intelligibility are explored. The rituals of power and thus the regimes of practices that have become so embedded in mental health nursing that they have ceased to be questioned are identified and examined.

In literature relating to mental health nursing three perspectives are apparent in relation to regimes of practices; prescriptive – stating what mental health nursing *should* be; descriptive – *how it is*; and evaluative – considering *others' views* such as those of patients and other professionals. Inherent within each of these are specific discourses in relation to mental health nursing and contain its taken-for-granted backgrounds. Thus it is intended here to examine this literature, explore the taken-for-granted backgrounds and through these reveal the current form of mental health nursing.

Prescriptive Literature

The prescribed role in Cormack's (1983) eyes has six strands, historically that of doctor's assistant; more recently multidimensional – requiring technical interpersonal and social skills; sociotherapeutic – relating to therapeutic communities placing emphasis on social behaviour; psychotherapeutic – the utilising of counselling skills and one-to-one contact; behavioural – involving techniques such as operant conditioning; and administrative. Peplau (1988) sees development of the nurse patient relationship as central. Butterworth (1995) advocates a psychosocial orientation whilst Gournay (1996) suggests there is a need to return to basics such as the monitoring of physical health and management of medication.

In 1994 the first major review of mental health nursing in over twenty five years took place and proposed that mental health nurses should be in the forefront of mental health practice promoting therapeutic relationships with service users (D.O.H.1994b). In response to this review the statutory body responsible for the standard/co-ordination of nurse education in England, the English National Board (E.N.B.), proposed that the work of mental health nursing should be based "in the relationship the nurse has with people and their families…" (E.N.B. 1994, p1). This theme is re-iterated in 2000 with the statement that mental health nursing's "focus is the relationship between the nurse, the person and the family" (E.N.B. 2000, p2) with a requirement to interact therapeutically with clients utilising holistic approaches and biopsychosocial knowledge.

Following recent expressed concerns (D.O.H. 1994b; D.O.H. 1999b) as to the effectiveness of mental health professionals, The Sainsbury Centre for Mental Health (S.C.M.H.) was commissioned to provide a framework identifying the knowledge, attitudes and skills required by mental health practitioners – nurses, psychiatrists, social workers. They propose that "evidence based biopsychosocial and health promotional approaches to care" are central (S.C.M.H. 2001, p9). This reflects the conclusions of various studies (Barker, Jackson and Stevenson, 1999; Cutcliffe, 1997; Gijbels, 1995) which identify therapeutic activities as the lynchpin of the mental health nurses' role.

The prevailing image portrayed at present, both by institutions responsible for the education of mental health nurses and nurse academics writing of mental health nursing, is that of nurses engaging in therapeutic activities (mental health promotion, relationship building, use of interpersonal skills, psychodynamic/ counselling technologies). Thus the discourse here is that of nurses as therapeutic agents, their regimes of practice embedded in and supported by therapeutic approaches/rationalities.

Descriptive Literature

If, as proposed by Smith (1988, p30), "nursing is what nursing does", then the various descriptive studies spanning the last thirty years would seem at odds with the prescribed vision of mental health nursing. Here the types of activities that mental health nurses engage in centre on environmental management, patient management, administration of medical treatments and the meeting of the physical needs of patients. Towell (1975) identified that any social interaction between nurse and patient was purely discretionary and tended to be with those patients most able to communicate 'normally'. Gijbels (1995) observes nurses take on roles such as caretaker, role model, container, custodian, mediator, informer, co-ordinator, manager and administrator, but are unable to verbalise their therapeutic role. Both Altschul (1974) and Gijbel claim that administrative duties take priority over therapeutic activities. Cormack (1983) identified that between 0-41% of nurses' time was spent in verbal communication, whilst Tyson et al. (1995) proposed, at most, 27%. In both studies it is posited that such time relates mostly to routine rather than therapeutic activities. According to Handy (1991) only 2% of nurses' time is spent counselling patients.

Robinson (1996) identified that over 60% and Ryrie et al. (1998) 55% of nursing activity involved no direct nurse-patient interaction, but instead revolved round supervisory and administrative tasks. Although up to 31% of time was spent in planned patient activities, when mealtimes and drug administration duties were removed, at best only 20% of nurses' time were spent in planned therapeutic activity. Sandford et al. (1990) found that nursing staff spent twice as much time interacting

with each other as they did with patients. An increase in staffing did not produce a corresponding increase in patient-nurse contact, the percentage of time spent with clients remained constant.

The most recent data available (Whittington and McLaughlin, 2000) re-affirms the previous studies identifying that only 6.75% of nurses time is spent in therapeutic interactions with patients, less than half (42.7%) is spent in direct contact with patients – predominately giving medicines, supervising meals, providing physical care and non-interactive close observation. A large portion of time (33%) was allocated to talking to other staff and office administration.

The picture painted is one of nurses rarely engaging in therapeutic activities, patients contact being generally as a result of task performance in relation to institutional and medical imperatives, with the remainder of the time given over to administrative or observational activities. Thus the discourse and regimes of practice here concern the supervision/control of individuals with mental illness and their environment and the performance of tasks.

Evaluative Literature

In evaluative literature, consumers' perspectives give low priority to the role of the nurse in mental health care. Whilst nurses depict their role as highly relevant to patient care and treatment, patients do not appear to have formed this impression. Patients perceive nurses mainly in terms of their administrative function and largely irrelevant to treatment approaches (Garrard et al. 1988). Similarly Higgins, Hurst and Wistow (1999) identify that whilst patients found nurses helpful, providing information concerning mental illness and the effects of medication, their relationships were superficial, with mental health nurses' being seen as spending most of their time involved in administrative tasks or dealing with untoward incidents. These views reflect the descriptive literature's picture of mental health nursing with therapeutic activities being merely an 'add-on' when there is spare time.

When patients were asked to describe what constituted 'good nursing' in the mental health setting, Beech and Norman (1995) found they valued nurses who

demonstrated certain attributes. These related to abilities to control violent/disturbed behaviour; those who communicated caring by being available, listening and explaining their actions; demonstrated respect for the patients; creating a 'homely' atmosphere; had a good understanding of mental disorders and their treatment; and personal qualities such as friendliness, cheerfulness, kindness and patience. Whilst the highlighting of communication skills could reflect the prescribed discourse, the expressed requirement of patients are at a superficial level rather than for nurses to act as therapists. The work of Cleary and Edwards (1999) support these findings. In their study, however, other aspects of practice such as counselling were included in the nurses role, but nurses were frequently described as 'too busy' to engage in such therapeutic activities due to environment demands.

In a recent survey of patients' views of psychiatric wards, (Mind, 2000), 57% indicated that they had insufficient contact with the staff, with 82% of these stating they had less than 15 minutes contact time per day. The patients generally blamed the lack on staff shortages, negative staff attitudes and ward management. The participants were unsure as to whether the contact with mental health professionals generally was helpful/therapeutic, predominantly describing the ward experience as untherapeutic.

In considering how other mental health care professionals such as psychologists, occupational therapists, social workers and psychiatrists view mental health nursing, Gijbels (1995) found a somewhat indeterminate picture emerging. These groups comment on the large amount of time mental health nurses spend on clerical duties and present a 'generalist' view of nurses, with them being identified as assistants to others rather than having a clearly defined role in their own right. Here nurses are seen as ensuring patients adhere to treatment regimes, such as attending therapy sessions at the appropriate times, and providing other disciplines with information relating to patients behaviour. Thus the emphasis is on managing the environment through a mainly custodial and controlling approach as opposed to facilitative, therapeutic endeavours.

The overall impression of others would suggest that mental health nurses are again seen as rarely engaging in therapeutic activities, the discourse describing them and

their regimes of practice relating to managerial/controlling activities and acting as assistants to others.

Taken-for-granted backgrounds

Evident within the literature and the discourses revealed are issues relating to the mental health nurse as a therapeutic agent; a manager/controller of the patient/environment; and as an assistants to others. These are the dominant discourses and are taken as the starting point in identifying the taken-for-granted backgrounds in relation to mental health nursing.

Moral Panic

People with mental illnesses are subject to social and legal sanction as no others are. Taylor and Gunn (1999) write that when such individuals are involved in incidents of violence they are singled out and scrutinised by both public bodies (Department of Health inquiries) and the media in a way that those deemed mentally healthy are rarely exposed to. Whereas 40 homicides a year are committed by people with an identifiable mental illness, up to 700 homicides occur within that time span, with an additional 300 driving related killings and some 3500-4000 fatal road accidents occurring. Taylor and Gunn suggest that there is little evidence to suggest that the trends in the numbers of homicides have any correlation with mental illness or changes in treatment. The number of people with severe mental illness who kill is small and, though difficult to identify definitively, does not appear to be on the increase. However as Paterson and Stark (2001) highlight the public perception of people with mental illness as dangerous remains high and has been on the increase since the 1950s, irrespective of the facts to the contrary and can be conceived as a form of moral panic. Moral panic as exemplified by Cohen (1972, p9) is when

> "a person or group of persons emerges to become defined as a threat to societal values and interests: its nature is presented in a stylised and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people;

ways of coping are evolved or (more often) resorted to; the conditions then disappears, submerges or deteriorates and becomes more visible."

However at the root of moral panics, generally, is a 'folk devil' - a portrayal of individuals/groups in purely negative terms, created from existing elements but stripped of any positive characteristics. Such folk devils are viewed as harmful to society with the attendant imperative to neutralise their dangerousness (Goode and Ben-Yehuda,1994). Frequently the sense of threat experienced by society is far greater than the actual one as is apparent in the case of mental illness.

Where moral panic is evoked social control ensues, with Cohen (1972) arguing that three conditions must be in place to invoke such control. Firstly 'legitimating values', here societal values must in some way be brought into play to legitimise the enforcing of control. 'Enterprise' as the next condition requires someone(s) to take the initiative in co-ordinating the 'interested' parties. Finally the 'someone' must have access to power through institutions such as the media, legal/scientific bodies or political authorities. Such moral panic may be novel, recur in relation to particular groups, pass into folk lore or have such serious repercussions as to provoke changes in legal and social policy.

Moral panics in relation to mental illness are proposed as recurrent (Paterson and Stark, 2001). The most recent began in the 1990s following the closure of many of the large mental institutions and increasing media coverage in relation to care in the community and homicides committed by individuals identified as mentally ill (e.g. Christopher Clunis in 1994 who attacked and killed Jonathan Zito). Moral panic in relation to mental illness is legitimate in the eyes of society as those marked in this way are portrayed and perceived as dangerous; the medical profession in the shape of psychiatry is identified as the appropriate controlling body having access to power through its scientific discourse. Thus the medical profession and mental health nurses by association, are society's agents in controlling the source of this moral panic – individuals with mental illness - with legislation legitimising this in the form of the Mental Health Acts, which allows for the detention of such individuals.

Legislation

Wells (1998) explores the theme of legislation and mental illness proposing that mentally ill individuals do not enjoy the same fundamental rights as the rest of society. Other groups of individuals who are deemed deviant or dangerous are not treated in the same way; for example alcohol abusers are not banned from driving until they have broken the law. Mentally ill individuals can be subject to supervised aftercare (D.O.H. 1995) because of proposed rather than demonstrated risk, (this designates their place of residence, daily activities and adherence to treatment regimes, with non-conformity resulting in readmission to hospital). Other groups in society – such as young males - are shown to present a greater potential risk of violence and yet are not subject to the same level of sanction (Symonds, 1998).

Much of the recent discussion concerning risk and the assessment of this in relation to those with a mental illness has grown from a government guidance document on the discharge of mentally disordered people (D.O.H. 1994a). Here it was stated that no patient is to be discharged from hospital if they are perceived in anyway to be a risk to themselves or others. Also present within government policy is a firm placement of responsibility for the identification of such risk/dangerousness at the door of the mental health professions. Again implicit within this is the idea of an inherent risk and dangerousness within someone identified as mentally ill. Whilst there is a taken-for-granted assumption that medicine and legislation are objective, value-free, scientific ventures, it can be seen as masking methods of control (Symonds, 1998; Wells, 1998). The belief that once an individual has been identified as mentally ill, the propensity for insanity and thus violence is deemed permanent, which results in individuals being assessed to detect levels of 'madness' and 'dangerousness' rather than to identify their normality and thus control is ensured.

Butterworth (1995) hypothesises that the medical perspective of mental illness as a physical abnormality arising in the brain gives the view of the patient as 'lacking control' and as such feeds the moral panic surrounding this group of people. Hence control must be imposed by others (and in the hospital environment this falls to the mental health nurses) and thus control and restraint are validated as appropriate interventions both by the medical profession and the State through legislation. Chin (1998) suggest that the link between mental illness and dangerousness is so strong

within the medico-legal tradition that claims of moral legitimacy in relation to uses of such interventions and legal sanction pervade the 'psyche' of mental health professions creating an hegemony against which those with mental illness have little defence. For mental health nurses, as part of this hegemony, control and containment are thus implicitly part of their regimes of practice.

Dirty Work

High levels of control are seen to be valued in the psychiatric setting by nursing staff, patients and other mental health professionals (Gijbels, 1995; Muir-Cochrane, 1996; Breeze and Repper, 1998; Cleary and Edwards, 1999; Jackson and Stevenson, 2000). The skills associated with control of aggressive/violent behaviour are perceived by nurses as denoting expertise and being essential to effective practice (Steele, 1993). However nurses also express resentment when called upon by other disciplines to deal with such behaviours, seeing this as doing someone else's 'dirty work' (Gijbels, 1995).

Hughes (1971) suggests that all occupations have some level of dirty work, which must be dealt with either by concealment or through delegation to lower ranks. Those who do 'dirty work' are acting as an agent for society, doing the work that needs to be done but that no one else is willing to do. Work becomes 'dirty' when it runs counter to favoured images of self/society (Hughes, 1971). In the case of mental illness society wishes to be seen as civilised and humane in its treatment of these individuals, mental health nurses as therapeutic. Control and containment runs counter to these preferred images and becomes dirty.

The opposition of dirty work with a proposed idealised way of working serves a specific function for those undertaking 'dirty' activities, allowing individuals to identify their 'true' purpose notwithstanding this unacceptable yet unavoidable aspect of their work (Lawler 1991). Here mental health nursing, in identifying control as dirty-work and prescribing interpersonal working as its 'real' face, morally distances itself from such 'controlling' activities whilst at the same time proposing such work as not their preferred domain (Emerson and Pollner, 1975). Glenister (1997) highlights this opposition of idealised activities with dirty work in his assertions that the ascendance of care in the nursing vocabulary marks an easing of

consciences and the presenting of caring images to others whilst at the same time hiding

> "the centrality of coercion and control in mental health nursing practice…the 'nurse-speak' vocabulary substitutes 'care' for 'control', 'co-operation' for 'conflict', and 'mental health services' for 'psychiatric surveillance'" (Glenister, 1997, p43).

Thus restraining patients is framed as a 'duty of care' rather than an act of social control.

In undertaking dirty work, Lawler (1991) proposes that nurses, with their taken-for-granted access to patients' bodies, have to negotiate their implicit contravention of social norms. For mental health nurses, individuals with mental illness acting in socially unsanctioned ways necessitate physical contact in the use of restraint. This would in other settings be deemed unacceptable, however with their taken-for-granted access to the patients' bodies mental health nurses are expected to contain such behaviours whilst ensuring that certain social dictates are met, hence that this aspect of their role cannot be made visible. Lawler (1991) identifies

> "Nurses find it difficult, if not impossible to talk about their work with anyone other than nurses, and this is a direct result of the extent to which their work involves aspects of life which are considered dirty…therefore nurses conceal their work. Their work is best kept from public discussion because the nature of their work is not a legitimate topic of conversation" (p219).

The role of mental health nurses' in the control and containment of individuals with mental illnesses is an unacceptable topic of conversation and a concealed aspect of the nurse's role not acknowledged in the public arena. If nurses are to make their work visible at all, an alternative 'face' must be presented, hence when identifying their involvement with mentally ill individuals a humanistic and therapeutic approach is described.

Mad/Bad Discourse

Both Towell (1975) and Clinton (1985) posit that mental health wards have informal yet powerful systems of social control, which operate through the timing and pace of the ward routine. Such environments are deemed by Crichton (1997) to rely on rules to function – some explicit in policy guidelines, others a result of custom and practice - and it is these rules which bind staff and patients to certain behaviours. Powell (1982) speculates that whilst the received nursing philosophy of care concerning ward environments management is essentially patient-centred and therapeutic, in practice it is one of social control. One aspect of this relates to the idea of the 'difficult' patient. Here individuals who offer a threat to the mental health nurses' therapeutic competency and control imperatives are labelled as 'difficult' or 'bad' and subject to specific staff responses (Kelly and May, 1982; Breeze and Repper, 1998).

As highlighted above concepts of control and discipline are implicit in the legislation surrounding mental health care, yet the meaning of control and discipline are unclear and the distinction between therapeutic discipline and punishment is not fully addressed. Inherent in this lack of clarity is what Crichton (1997) alludes to as the 'mad/bad' dichotomy. Here it is posited that if someone is perceived as bad punishment is advocated, alternatively if mad then they are absolved of responsibility for their behaviour and deemed to require 'care' and/or treatment. Thus 'badness' is a moral discourse equating to punishment whereas 'madness' is considered a clinical discourse relating to treatment and places such individuals firmly in the hands of the medical profession.

It is suggested that mental health nurses' tolerance of certain patient's behaviours relates to whether an individual's diagnosis meets the criteria of 'illness' and implicit in this is the concept of diagnosis (Towell, 1975). Diagnosis is an integral aspect of the theory and practice of medicine, being the 'lens' through which madness is seen and described (Brown, 1995). It serves as a common language for health professionals providing them with control (through superior knowledge), determining the course of treatment and identifying expected outcomes. Such medical terminology shapes the nurses' worldview of madness, negating other forms

of knowledge, forming nurses' thoughts, behaviours and regimes of practices in relation to certain client groups (Keddy, 1996; Crowe, 2000).

Nurses are found to identify individuals with a diagnostic label of dementia or schizophrenia as ill and therefore as having less responsibility for their behaviour (Towell, 1975). However individuals with diagnoses such as inadequate personality, psychopathy or hysterical personality were deemed not ill and therefore evoked strong normative sanctions when viewed as exhibiting inappropriate behaviour. Crichton (1997) presents similar findings, with staff dividing aggressive behaviours into 'illness', which deserves caring intervention, and 'badness', which deserves punishment with treatment regimes such as seclusion being justified. Again patients with a diagnosis of personality disorder or with a past history of violence are more likely to fall into the later treatment regime. Crichton suggests that treatment and punishment co-exist in the institutional response to patient misdemeanour with punitive sanctions often being presented as therapeutic interventions with care being taken to avoid any reference to punishment. However although identified as a therapeutic there is no evidence to show that other care activities take place following this type of intervention (Steele, 1993). Thus the therapeutic benefits of such activities are highly questionable and would seem to divorce them from the therapeutic discourse.

Nursing Knowledge

Sheppard (1990) suggests that mental health nurses do not appear to have specific principles or values that drive nursing actions, however he does proposes that within the wider arena of nursing per se an over-arching model is present. This model consists of two aspects, the domain –what nursing is *concerned* with - and the context – in which nursing *acts* from the domain. The domain and the context are each concerned with two areas, the patient and the environment. Thus nurses are *concerned* with the patient and their environment *acting* on both the patient and the environment in relation to illness/health issues.

The domain of nursing is presented by Sheppard (1990) as 'biopsychosocial', that is, concerned with how biological, social and psychological factors impact on health. The organisation of the nurse's professional role around such bodies of knowledge

provides nursing with a means of understanding and explaining their behaviours and with a prevailing focus on the individual, knowledge and skills relevant to these. However the context of intervention, Sheppard claims, is focussed primarily on the patient - altering individual's behaviours to bring these within normal ranges – rather than considering the wider context of the environment. Hence when defining the patient, nurses tend to use a problem/need approach with little recourse to the proposed biopsychosocial ideologies. Thus within mental health nursing the domain is explained and prescribed through biopsychosocial knowledge, how these relate to the mentally ill individual and the environment in which care is delivered. Mental health nurses explain their behaviours in terms of promoting a therapeutic environment in which they can create and maintain therapeutic relationships through the use of humanistic approaches. However the context of actions remains problem orientated, concerned with controlling the behaviours presented by patients and the need to manage the environment (the ward) in an appropriate and socially defined manner. Also as medical nomenclature is so integral to mental health nurses' practice, they actually engage with patients in terms of a psychiatric diagnosis and treatment, rather than seeing the person in a wider biopsychosocial context.

The nurse education system has not appeared to reduce the potential dissonance between domain and context for student nurses. Clinton (1985) identified that students placed different emphasis on aspects of learning dependent on their location i.e. whether in the classroom (which emphasises 'patient-centred values' – the domain) or in the ward setting (which was seen as predominantly 'task-orientated'- the context). Students quickly learned to express themselves in the normative style expected in a particular area. Clinton, reflecting earlier work by Towell (1975) proposes that student nurses were most concerned with 'getting the job done'. Students in practice areas are judged in relation to how quickly they perform tasks and their ability to sustain the momentum of the ward routine. Thus whilst in the practice setting students perform in ways that reflect this. The 'classroom knowledge' is viewed as a means to an end, enabling them to gain registration as a nurse, they therefore answer examination questions in the prescribed manner, but once registration is acquired it has served its purpose. Clinton adds that the total education experience somehow manages to alter the perception of the nurses' role

from one of engaging in therapeutic relationships to one of actively avoiding patient contact, with the formation of a relationship with a patient severely sanctioned.

Peplau (1988) proposes a similar knowledge dichotomy but considers mental health nurses as being caught between mechanistic and dynamic knowledge. The former reflects observable aspects of the individual, the labelling of mental illness and its signs and symptoms and treatment procedures – how to do something. The latter relates to the understanding of human problems and ways of intervening therapeutically and it is this knowledge that is advocated for the practice of mental health nurses. Thus mental health nurses should draw on the biopsychosocial knowledge available to them in planning their interactions

Bunch (1985) identifies three structural requirements of mental health nurses in the ward environment - professional, clinical and institutional. Professional requirements relate to the goals and ideologies implicit in the education of nurses for example the belief in the forming of therapeutic relationships - the utilisation of dynamic knowledge. Clinical requirements encompass the skills a nurse utilises in the assessment and care of an individual such as the giving of injections or the making of judgements as to appropriate actions based on observations of clients – encompassing mechanistic knowledge. However these two aspects are seen to be subjugated by institutional requirements, as it is this last category that Bunch claims occupies the vast majority of nurses' time. Here is an expectation that patients and staff will conduct themselves appropriately in relation to the rules and norms of the institution. Often all three requirements are in conflict, but the ordering of the ward most often overrules the professional and clinical requirements with the professional requirements being the last consideration. Bunch further suggests that when nurses do talk to patients, such interactions focus on either institutional or non-institutional business. Institutional business' relates to issues such as medication and seclusion. Only time 'left over' after completing organisational task and institutional business is designated as appropriate for engaging in therapeutic or, more frequently, non-institutional business i.e. social conversations.

Nurse Education

In 1982 institutions for mental health nurse education advocated reforms, which they believed would move nursing practice away from custodial care and produce a therapeutically skilled mental health nurse (E.N.B. 1982). This was later replaced by Project 2000 (E.N.B. 1988) and the 'Making a Difference' (M.A.D.) curriculum (D.O.H. 1999a). The current mental health branch programme is largely based on this syllabus (E.N.B. 2000).

The knowledge bases forming the basis of the 1982 curriculum were divided into three main areas, namely social and applied sciences, nursing studies, and professional studies. This would seem to reflect Sheppard's (1990) assertion of a biopsychosocial nursing domain. However, although these topic areas at first sight seem to address a variety of approaches to mental health care there is an overpowering medical orientation in the identified subdivisions e.g. developmental psychology; human sexuality; social psychology; psychology; sociology; physiology; medicine; psychosomatic medicine; psychiatry; pharmacology.

Huntington and Gilmour (2001) propose the shape and formation of nursing curricula are highly influenced by textbooks, which are seen to take a very predictable form in relation to health and illness. Medical management and illness pathology nearly always precedes discussion of nursing knowledge. They suggest that much of nursing research knowledge appears in the form of 'mentioning', underpinning ideological positions concerning the supremacy of certain knowledge bases (i.e. medical knowledge) remain unaltered, new ideas are simply added in a way that supports such positions, usually as an 'added on' at the end. Thus medical knowledge is positioned prominently in nursing texts and therefore nursing curricula, with nursing knowledge added in, but not developed.

There are also some peculiarities within the Nursing Studies, which are identified as follows - nursing process; psychiatric nursing; rehabilitation studies; community studies; care of the elderly; specialised techniques; personal nursing care; psychiatric emergencies; and first aid (E.N.B. 1982). It seems strange in an educational programme designed for mental health nurses that psychiatric nursing should be separated out as just one aspect of nursing studies, rather than the other aspects being

seen as part of psychiatric approaches. It begs the question if these other things are not part of psychiatric nursing what are they and why is such little emphasis given to psychiatry within the nursing studies? Perhaps this reflects a taken-for-granted dominance of medical and physical care within nursing per se and mental health in this particular instance.

Nursing Process

Nurse education curricula and the review of mental health nursing (D.O.H.1994b) place emphasis on skills associated with the stages of the nursing process (assessment, planning, implementation and evaluation of care). The introduction of the nursing process in the late 1970s, Lawler (1991) proposes, was a way of scientificising nursing, mimicking medical practice and positive methodology. Nursing had begun to embrace empiricism in the 1960s but the lack of nursing doctoral programmes to support and promote a research discipline resulted in a 'borrowing' of paradigms (most frequently positivistic) from others and the application of these to the nursing context. As positivism requires observations to be made by trained scientific personnel, the nursing process, and specifically the aspect of assessment, provided an objective scientific 'nursing gaze'. For nursing the discourses generated within the nursing process place the nurse in a particular relationship with patients, promoting certain discourses, ways of 'seeing' and 'talking' about behaviours presented. Henriques et al. (1984, p236) suggests that

> "discourses make available the positions for the subjects to take up.... In relation to other people...women and men are placed in relation to each other through the meaning which a particular discourse makes available."

Thus mental health nursing discourses relating to mental illness and the nursing process sheds light on the ways in which mental health nurses are placed in relation to others – patients, doctors, relatives.

In the mental health nursing curriculum emphasis is placed on specific skills development in relation to specific aspects of the nursing process. For assessment and planning these relate to self-assessment, patient observation, and the preparing of information for members of the multidisciplinary team. Implementation skills

related to goal-orientated activities, motivating individuals, managing self/others, promoting a safe environment, and meeting patients' physical needs. Skills central to evaluation were proposed to be the defining of results, obtaining feedback from others, assessing results, identifying changes required, and recording/communicating outcomes to others. In various ways the nursing gaze contributes to, supports and feeds the medical one – providing information in a variety of forms - and as Carpenter (1993) suggests, places nurses in a subordinate position to the medical gaze.

The nursing gaze serves the medical discourses in the objectification of individuals with mental illness with Foucault's three modes of objectification - dividing practices, scientific classification and subjectification – being apparent within it (Rabinow, 1984).

- Dividing practices promote the attachment of social and personal identities to individuals, dividing them from others; individuals are categorised, and distributed according to such practices. The skills to be utilised in relation to nursing care give a patient a personal identity through the nursing gaze directed at them and situates them in relation to other mental health patients (for example mad or bad). The knowledge bases utilised by mental health nurses promote attachment of diagnostic labels and advocate the ways of seeing and interacting with the individuals.

- Scientific classification provides ways of knowing individuals through scientific processes, thus the use of skills to collect data, assess and evaluate patients utilising medical, psychological and sociological orientations encourage a specific medical classification.

- Subjectification occurs as the patient comes to know him/herself as the subject (the process of self-formation as a 'mental' patient) and is implicit in the skills to be utilised when planning, implementing and evaluating care. The patients are told what their problems are, how these are to be dealt with and the progress (or lack of) being made. All this is mediated through the mental health nurse who co-ordinates the information gathered and thus facilitates the patient's self-knowledge.

Also evident are the regimes of practice relating to control of the patient and self. Thus the nursing gaze within the nursing process reflects Foucault (1977b) three technologies of discipline – hierarchical observation, normalising judgements and examination (as discussed in chapter two).

- *Hierarchical observation*, - the mental health nurses learn to observe themselves (through self-awareness and reflective practice) and others – specifically the patient (through assessment, counselling and data collection)- providing a form of surveillance. The knowledge bases identify how observations are structured and the form they are to take.

- *Normalising judgements* are evident in the collection of data and the identifying of needs and problems. Technologies of normalisation serve two functions, one to identify anomalies and the other to correct behaviours through therapies and associated technologies. Both these require knowledge to allow identification of such deviations and an ability to control behaviour. These would seem to be present in the knowledge and skills advocated in the education programme.

- *Examination*, which allows for the identification of those who stray from the 'norm', is present in the interviewing skills to be employed and the specialised techniques to be utilised in the care of the mentally ill.

Disciplinary technologies and dividing practices are presented by Foucault (1977b) as central to the promotion of social control and the production of the 'docile body'. This reflects society's need to regulate those who would stand outside of society. The presence of these within mental health nursing highlights nursing regimes of practice in relation to control and as a point of application for technologies of discipline in relation to those individuals identified as mentally ill. Nurses as part of the social domain respond to the social imperative to provide control of those deemed dangerous and promoting technologies of discipline and normalisation. Thus the way in which individuals with mental illness are problematised has a direct impact on the type of skills and knowledge mental health nurses are able to utilise.

Assessment Strategies

Areas identified for the assessment shed light on the problematisation of individuals (Henriques et al 1984). Nursing assessments give an insight into the beliefs inherent in activities undertaken and the particular behaviours to be isolated and deemed as of significance. The ability to identify such behaviours requires those assessing not only to be familiar with the terms used but also to have the ability to discriminate between normal and abnormal, hence again a particular gaze is in operation having its roots in the educational system of those conducting the assessment. The mental health nursing gaze, therefore, requires the nurse to have certain knowledge available to her and results in specialised education, which provides an account of the salient information to be collected. Knowledge to measure and judge individual capacities provides mental health nurses with the tools to assess, observe and quantify individual propensities to mental illness.

It is suggested that written texts in the form of nursing notes and assessments fabricate patients. By reframing individuals' problems in technical language the patient becomes 'fictionalised'. Crawford, Nolan, and Brown (1995) provide an example of someone who has difficulty going out being re formed by the term agrophobia, every act and detail is reframed into diagnostic criteria, signs and symptoms reflecting the 'gaze' which has been engaged. Nursing texts, Mohr, (1999) suggests, support this reframing containing normative and pejoratory statements which distort the image of the patient in an effort to reconstruct the individual in medical terms. Such language can be constructed as a form of control in which the profession becomes the 'expert' and thus empowered whilst the patient is subjugated.

Equally, assessment tools fabricate a person according to the desired outcome. For example assessments can be designed to identify an individual as normal/sane/ rational or to isolate madness/irrationality/abnormality. Assessments that address 'normality' are less likely to mark others out as different from the general population. Indeed if searching for the 'normal', an individual is more likely to fall within the boundaries of normal. If seeking abnormal this is the benchmark from which assessment begins and thus implicit in the findings. Rosenhan (1996) gives evidence of this in his work 'on being sane in insane places'. Here individuals were admitted to mental institutions with fictionalised symptoms of mental illness. Once

in hospital they resumed 'normal' behaviour, however their behaviours were interpreted and described in ways to support the diagnosis of insanity.

Assessments in mental health nursing focus on the isolation of the abnormal with the prime function of reducing the risk to the body of society by identifying the need for social control. Thus society is safeguarded through the observing for deviations, and ensuring aberrant behaviours are dealt with in a prescribed manner. One specific example of this is 'risk assessment', which identifies level of risk, and thus the extent of deviation from the norm rather than level of normality. Noak (1997) asserts that risk assessment is acknowledged as part of the 'core skills' of mental health nursing. O'Rourke et al. (1997, p104) define risk assessment as

> "The systematic collection of information to determine the degree to which the identified risk is present, or is likely to pose problems at some point in the future"

Such undertakings are concerned with a full and detailed assessment of risk factors identifying the propensity for violence towards others and of self-harm in those suspected of having mental illness. Pilgrim and Rogers (1996) identify that the psychiatric professions have a poor track record in this area, being likely to over predict the likelihood of risk in those with a diagnosis of mental illness. Thus it would seem that the elements of risk and dangerousness are already considered to be present, the assessment merely goes on to measure the degree or intensity.

The Current 'Face' of Mental Health Nursing

The three perspectives of mental health nursing practice, whilst seeming to offer at times conflicting images, reveal the discourses describing mental health nursing and the lines of power supporting these. Therapeutic interventions are presented as central to nursing regimes of practice, however evidence would suggest the discourse supporting these has been generated to justify and conceal a custodial role. As Hopton (1997a) suggests, despite mental health nurses' view of themselves as patient centred and innovative, the reality is one of mere lip service to such aspirations. Perhaps the root of this dichotomy lies in what Henriques et al. (1984) term an

individual-society dualism of western societies. Present within this dualism is an assumption that society itself is unproblematic, social breakdowns being considered the result of stray, irrational individual actions. As individuals with mental illness epitomise the societal image of irrationality such individuals present the ultimate threat to society and as such evoke moral panic. However, society is presented with a dilemma when confronted by those who stand outside society and threaten the social body - namely the need to contain and control the perceived danger (through punitive legislation) whilst at the same time presenting a philanthropic social face.

Individuals with mental illnesses are "in the social but not of it" (Rose, 1979, p13) and as such specific disciplinary technologies are necessary to control them. Mental health nursing is identified as the point of application of such technologies. Nursing's former policing body the U.K.C.C. echoes society's imperatives in stating that for mental health nurses "one of your overall duties...is to maintain public trust and confidence in your ability to provide safe and effective care for clients" (U.K.C.C. 1998a, p5). As nursing is an integral part of the processes that constitute the social domain, it functions in relation to the problematisation of those with mental illness as a potential danger to the social body. Thus it conducts society's dirty work – social control - whilst presenting a humanistic nursing face by couching the control in terms of 'care'.

Paley (2001) proposes the knowledge of caring can be seen as merely a description/list of 'things' nursing says caring is, a type of 'thesaurus' knowledge in which a chain of associations are aggregated around the word 'caring'. Such knowledge makes no distinction between knowledge of the object (caring) and knowledge of what is said about the object. These are not theories of caring but merely associations of ideas that are "constantly extended and constantly repeated" (Paley, 2001, p196) as would seem to happen in relation to biopsychosocial knowledge. From this perspective it is possible to consider the 'knowledge' underpinning mental health care as a list of the attributes that mental health nurses say should be present and represent a subjectification discourse generated to escape medical domination, created by mental health nurses to produce their own identity. As discussed earlier such discourses arise in an effort to achieve feelings of self worth and are attempts to escape the power/knowledge relations of their social apparatus. Mental health nursing plays a role in the apparatus of social control

through its custodial function whilst promulgating the humanitarian imperative to provide 'care' for such individuals in the hope of increasing its own status and making its work visible to others.

A further discourse, which is seen as a taken-for granted background, is the medical one. Crowe (2000) proposes that the medical discourses, in particular psychiatric diagnosis have become integral to the mental health nursing culture. Whilst diagnosis is a medical responsibility, mental health nurses support this discourse by collecting and describing patients behaviours to facilitate diagnosis; using the terminology of diagnosis in nursing practice; and engaging with patients on the basis of medical diagnosis and treatment. The power relation between mental health nursing and the medical profession is evident in the subjugating of the nursing gaze to the service of the medical discourse and hence presents mental health nurses as assistants to the doctors.

Summary

* Taken-for-granted backgrounds of mental health nursing relate to:

  - the casting of individuals with mental illnesses as folk devils, inherently dangerous, in need of control sanction through legislation.

  - the control of violent behaviour is invisible, dirty work undertaken by mental health nurses. Whilst deemed necessary it runs counter to society's humanistic aspirations.

  - in an effort to make their work visible and increase their status mental health nurses frame their activities within a therapeutic discourse.

  - nursing knowledge is presented as being biopsychosocial encompassing therapeutic activities, however regimes of practice focus on problem management and are task orientated.

  - the attempt to create a scientific discourse through the use of the nursing process in reality promotes the use of technologies of

discipline to control individuals and their objectification in relation to the medical discourse.

- the mental health nurse's gaze acts in the service of the medical discourse and thus casts the nurse as the doctor's assistant.

* Three discourses are available to describe mental health nursing regimes of practice and reveal rituals of power:

  - Control and Containment
  - Therapeutic activities
  - Assisting the doctor

CHAPTER 5

CONDITIONS OF EMERGENCE

- Introduction
- Theoretical framework
- Methods of Investigation
- **Genealogy** - Diagnosis of the Present
- **- Conditions of Emergence**
- - Power Relations (part 1)
- - Power Relations (part 2)
- - Knowledges
- Q-Methodology - Philosophy and Approaches
- - Data Analysis
- Discussion, Limitations and Conclusions

Having considered the present and the discourses surrounding mental health nursing, the next step is to re-instate the event by which it came into being. This requires an uncovering of the conditions through which it became possible for power relations to target and establish the occupation of mental health nursing. To facilitate the process of Eventalisation there is a need to breach self-evidence and make visible an event where progress and constancy is proposed. In this endeavour the strategies and practices that establish what counts as rational, logical and necessary are exposed (Foucault, 1981). Thus to analyse mental health nursing as an event means to determine the myriad of processes involved in its formation, to trace the links between these and identify the networks that allowed mental health nursing to come into being.

Whilst the concern here is to chart the emergence of mental health nursing, this does not begin by identifying when it first became possible to use the term 'metal health nurse' (which was not until the 1980s). Neither does it relate to the applying of the term 'nurse' to a certain group of individuals performing particular tasks for the mentally ill (the terms attendant, keeper and nurse are used somewhat arbitrary for a

period spanning over 200 years). Rather it is the point at which power-knowledge relations established what is now known as mental health nursing as an area accessible to procedures of discourse thus marking it with particular characteristics and regimes of practice. It is how the attendant came to be defined in an 1853 Act of Parliament as:

> "any person whether male or female, who shall be employed either wholly or partially in the personal care, Control, or management of any Lunatic in any registered hospital, licensed house or of any single patient." (Lunacy Amendment Act 1853, section 1).

and is inherent in Edward Palmer's (1856, p11) assertion:

> "it is only through the attentiveness and good character of his staff of attendants, that a superintendent can only hope to carry out a sound and rational treatment of insanity, or to stamp his institution as an Hospital for the Insane, and not as a Madhouse."

It is posited here that the emergence of mental health nursing is related to the appearance of a particular Moral Discourse, the building of the Asylum, the generating of a Medical Discourse in relation to madness and the rise of 'modern' nursing.

Moral Discourse

Roberts (1980) charts the increase in European population from the late 18th century onwards and suggests that great changes were afoot which where to free the world from its traditional regulation to one of new and undreamed of innovations. He posits that the 19th century was to see more changes in this one hundred years than had occurred in the previous one thousand.

Academic and learned societies multiplied across Europe during the 18th century with an increase in the circulation and discussion of ideas and beliefs. Literacy improved, with Europe by 1800 having the highest level of literacy in the world (Roberts, 1980). This was pushed on by the Protestant reformation advocating

universal education and an increase in the circulation of the written word through books, pamphlets, intellectual journals and the introduction of daily newspapers.

The questioning of the belief that God ordained the nature of the universe and man's place within it in the 17th century was carried forward in the 18th, fired partly by religious fighting between Puritan, Anglican and Papal factions and partly by the changes in moral philosophy (MacDonald, 1980; Porter, 1989). The upper classes developed an antipathy for religious radicalism from the late 17th century onwards. Many commentaries on madness printed in the 18th century pointed to religious enthusiasm as a precursor to insanity, whilst the study of science was presented as its antithesis. Such an association between religious ecstasy and madness is evident in William Hogarth's etching of 'Credulity, Superstition and Fanaticism' published in 1762 (MacDonald, 1980). This was the era of 'Enlightenment', the 'Age of Reason' seeing the rise of empiricist and naturalist tenets. The church as the supreme moral authority was displaced by the philosophical debate concerning the moral status of humans, proposing them rational beings and in control of their own destiny. The work of encyclopedists (generally leading philosophers of the day) and publication of the 'Encyclopedie' over the period from 1751 - 1772 promoted a sceptical attitude towards religion and advocated instead scientific doctrines (Eliot and Whitlock, 1992). These were to influence the future thinking of the nature of humans, ways of understanding the world and from this an opening of the debate as to the source of madness.

Moral Philosophy

Thinkers of particular influence in the development of moral philosophy and on the nature of madness were John Locke (1632 –1704), David Hume (1711-1776) and Jeremy Bentham (1748 –1842). As scientific specialisms began to appear Locke, described as one of the pre-eminent of English philosophers, was seen as instrumental in furthering such classical empiricism (Baly, 1995). He attacked beliefs that presented humans as limited in their capacity to reason; possessing an innate knowledge of truths and whose place was ordained by God. Through these ideas Locke encouraged scientific discourses to develop and flourish. In his 'Essay on Human Nature' (Locke, 1690) man (sic) was portrayed as a 'tabula rasa' thus only limited by his ability to understand what his senses provided him with. Locke went

on to suggest that there is 'something unreasonable' and a 'degree of madness found' in most individuals. Rather than portraying suffering as inevitable, the possibility of finding causes and attendant cures for human maladies became possible. As a physician he had contact with the first Earl of Shaftesbury whose family, in subsequent generations, were to become influential in the development of legislation related to the insane. Locke (1690) wrote that madmen:

> "do not appear to have lost the faculty of reasoning, but having joined together some ideas very wrongly, they mistake them for truths".

David Hume's stance was very similar to that of John Locke's, however whereas Locke had an unfailing belief in the possibility of creating knowledge through reasoning, Hume considers reason to be enslaved by human emotions, experience and culture and thus the possibilities for science built on reason were limited (Roberts, 1997). Hume was interested in creating a science of the mind in the same way as Newton had proposed one of natural science. He set out to explain false beliefs and ideas in a new way and in doing so offered an alternative approach to explaining the ravings of the insane (Baly, 1995).

A somewhat different approach was taken by Bentham. His self-imposed mission, as head of a group of radical philosophers was to improve English institutions in line with his utilitarian philosophy. Here he posits that morality is not a simply following of 'God's ordains', but rather concerned with 'Utility', the promoting of the greater good and the seeking of happiness in this world (Rachels, 1995; Roberts, 1997). Thus actions are judged moral in relation to what produces the greatest happiness for the greatest number of people. The vehicle through which this was to be achieved was legislation, which he saw as defining conditions of living. Bentham was instrumental in initiating the reforms occurring in relation to the penal system and legislation of his time. His interest in insanity related to his desire to abolish the use of chains and fetters in madhouses through the use of architectural design such as the panopticon.

Whilst fundamentally different in their approaches, a common thread representing the change in thinking concerning the insane and insanity is present. The insane had previously been viewed not as rational beings but rather as animals and as such not

privy to normal human feelings. Foucault (1967b) proposes that madness, once viewed as a form of demonic possession had become a thing/animal to be looked at, disciplined and brutalised, thus savage treatment became a duty necessary to control and inure the beast. With the advent of moral philosophy there is a moving away from this to the view of insanity as reason gone wrong.

Rise of Philanthropy

What was also made apparent to the general population through the moral philosophies was the idea of humans as moral beings, with the concept of philanthropy central to such morality. Philanthropy became the hallmark of the gentleman with charity presented as an equal balancing of duty, pleasure and prudence (Porter, 1989). Its place in general discourse can be seen in the popular literature of the day and epitomised by Charles Dickens' work. In 'Christmas Carol' the ghost of Jacob Marley cries:

> "Mankind was my business. The common welfare was my business; charity, mercy, forbearance, and benevolence, were all my business. The dealings of my trade were but a drop of water in the comprehensive ocean of my business!" (Dickens, 1992, p31)

As the gap between the rich and the poor widened as a result of urbanisation and industrialisation, the wealthy found themselves with increased amounts of money at their disposal, and a growing need to show concern for their fellow humans - specifically the poor who were unable to care for themselves. Whilst the poor laws provided for the basic needs of the population, the voluntary hospitals were seen to display what Archbishop Maddox in 1743 referred to as man's humanity to man "where the poor and the rich meet together" (Porter, 1989, p152). The act of giving attested to the gentleman's level of civilisation and sensitivity, placing him above his predecessors and the lower classes.

Porter (1989) proposes that voluntary hospitals provide the ideal site for the exercise of this virtue. Previously the giving of alms to the 'impotent', i.e. those unable to work, had been encouraged as beneficial to the soul by the Church (Baly, 1995). However as the idea of charity as a religious requirement became unpalatable, and the associated role of caring for those in need as a secular activity grew, giving to the

building of hospitals provided a window of opportunity to those who wished to show their philanthropic aspirations. The unpartisan nature of the voluntary hospitals allowed individuals to come together in an expression of civic duty and achievement rather than as a religious requirement. The idea of giving to hospitals became well established throughout the 18th century thus by the time the building programme for asylums was put forward, it was natural that philanthropic gentlemen would contribute.

Building Asylums

Foucault (1967b, p65) suggests that a great confinement of "the debauched, spendthrift fathers, prodigal sons, blasphemers" etc occurred through the 17th and 18th centuries. Confinement in its general usage is proposed as a method of dealing with the idle, the unemployed and the unproductive of society. Whereas previously those deemed unworthy were driven away now they were subject to administrative systems which denied them their liberty – both morally and physically – whilst fulfilling a proposed social obligation to see such individuals housed and fed. However this general confinement was, Foucault proposes, replaced by an identifying of those considered able to be productive and those not. It was soon to become necessary to further distinguish between groups deemed 'unproductive' and in particular between the criminal and the insane. This, Foucault claims, resulted from a demand to protect the sane from the insane.

The separating out of the mad from other transgressors was initially seen as a police matter with the Vagabond Act of 1714 allowing for the detaining of the "furiously mad and dangerous" in a "secure place" (section one). It is this Act that, for the first time, declared the insane and the criminal required different treatment. Over time a fear of 'contagion' developed, a belief that somehow madness could be communicated to others if the social distance was not great enough and dictated the need to create separate places of confinement. This perhaps heralds the beginnings of moral panic in relation to madness. Foucault (1967b) theorises that the medical profession entered the picture not as arbiters between madness and criminality, or to make madness/badness distinctions, but as guardians protecting the sane from the

dangers of the confined, the genesis of the belief that 'dangerousness' is intrinsic to madness.

Porter (1987) refutes Foucault's idea of 'great confinement' suggesting in England at least there is little or no evidence of a co-ordinated drive to sequester the mad, the development of public asylums did not become mandatory until 1845. However private madhouses flourished in England as nowhere else, shrouded in secrecy to protect the good name of their inmates' families, they where unregulated until 1774 and thus little is known of their numbers or histories. The 18th century saw a variety of options available for the care of the wealthy insane - domicillary, boarding out to stay with clergy or physicians, private asylums, houses of correction for the violent, and personal attendants. The spread of private establishments provided an additional option for the families and overseers of the poor. By 1847 in England and Wales there were

> "12 county asylums, 5 county and subscription, 11 partly subscription and partly charitable, 1 military, 1naval and 142 licensed houses, 14 of which last received paupers. The hospital of Bethlem…to be added to this number." (Conolly, 1847, p146)

Porter (1987) asserts that madhouses arose out of a society that found it could now afford them and soon could not do without them. However those who could not afford the licensed houses were soon to be drawn to the attention of society.

The Pauper Insane

The great confinement may not have occurred in the 18th century for the poor but there is evidence to suggest that in Victorian England there was a concerted effort to legislate in relation to them. The lack of mental institutions pre 1800s mirrors the general lack of hospitals in England as a whole, unlike its European counterparts which seemed to have a wealth of religious and civic institutions (Porter, 1987). Medical care had been provided to the poor as part of the Poor Law Acts of 1601. Each parish having its own poorhouse, the sick were cared for by other inmates with a local physician, appointed by the Guardians and providing medical attendance (White, 1978). However various factors converged in the late 18th century which were to promote an increase in the numbers of paupers.

The population was to increase dramatically from the middle of the 18th century. Whilst the birth rate did not begin to decrease significantly until the mid-19th century, the mortality rate decreased rapidly from the late 1700s onwards. The late 18th century saw the agricultural revolution, which promoted a wave of reforms in the methods used in the growing of produce. However the increased mechanisation resulted in job losses and the advent of 'capital farming' robbed workers of the means to sustain themselves - e.g. the enclosure of common land, loss of grazing rights and plots of individual land (Baly, 1973). Industrialisation followed closely on the heels of the agricultural changes and many of the previous 'cottage' industries became the province of factory manufacture. The Poor Law of 1601 could no longer meet the demands of this growing problem. Bethlem Hospital in London, founded in 1547, was the only facility available in the country to provide for the lunatic poor until 1751.

Bucknill and Tuke (1858) identify that the number of insane in England increased in the early 19th century from 1 in 7300 to 1 in 799. The reasons for this rise are unclear. Bucknill and Tuke propose it a response to an increased ability to identify insanity at this point in time and to an improved system of gathering information. Browne (1837, p55) claims that the:

> "occupations, amusements, follies, and above all, the vices of the present race, are infinitely more favourable for the development of the disease then at any previous period.".

The Commissioners in Lunacy reported in 1855 that the burden of paying the costs of the private care of someone often resulted in people being transferred to the pauper list if their illness was protracted and their funds ran out (Palmer, 1856). Others suggested that the building of asylums and opening of workhouses resulted in those previously cared for by families and thus hidden from society being made visible by their transfer into these public institutions (Renvoize, 1991).

Whatever the reason for the increase in numbers of pauper insane, what became apparent was the gross lack of facilities available to deal with this rising tide of madness. John Aitkin (1771, p447) remarks:

"the poor in this kingdom have hitherto been but indifferently provided with public hospitals for the relief of Lunatics"

By 1844 the number of beds available for pauper lunatics was found to be greatly insufficient with the numbers admitted to the Pauper Asylums increasing dramatically and continuing to do so (Bucknill and Tuke, 1858).

Parliamentary Debate

The care of the insane attracted little government attention in the 18th century with only three pieces of legislation appearing on the statute books. The Vagrancy Act (1714, section 1) allowed for "the more effectual punishing...of Rogues, Vagabonds, Sturdy Beggars and Vagrants" and for the arresting and locking up of the mad and dangerous. The Vagrancy and House of Correction Act of 1744 amended the previous legislation to include those who may be dangerous. The third statute followed what Sheppard (2000) proposes as an ambivalent parliamentary inquiry into the state of London private madhouses. The resulting Madhouse Act (1774) was a response to suggestions that individuals were being illegally detained. Hence it legislated for an annual licensing of all houses where the mad were to be cared for, required an annual inspection to be undertaken, stipulated the number of residents and made medical certification mandatory. However it did not legislate for single confinements, the privately boarded nor chancery cases and was seen largely as toothless as no penalties for non-compliance were stipulated and no criteria for licensing were identified. Despite the lack of vigour it did put the private madhouses on the parliamentary agenda and in doing so, provided the medical profession with a degree of professional authority.

The madness of King George III in 1788 fixed lunacy as a topic of government concern by necessitating the consideration of care and treatment for the monarch. Thus madness was opened up for debate. The 19th century was to see madness firmly on the agenda of the government with no fewer than 34 pieces of legislation [i]appearing between 1800 and 1868. By 1807 a House of Commons select Committee was in place with Sir George Onesiphorus Paul suggesting "the lunatic affection is a disease increasing in its influence in the country" (Hunter and MacAlpine, 1963, p623) and Dr Andrew Halliday speculating that the figures relating to the numbers of

pauper lunatics greatly underestimated the problem. The committee found that most pauper lunatics were confined in houses of correction, poorhouse or workhouses in conditions 'revolting to humanity'.

The County Asylum Act (1808) proposed the confining of lunatics in gaols, poorhouses and houses of industry "highly dangerous and inconvenient" and that other provision should be made. This act allowed for the "erecting of proper houses for their [lunatics] reception" in every county in the country "there to be kept safe". Whilst the Act reflects the moral and philanthropic ideals of the time, this was not taken up by the general population with only 9 of the 52 counties building asylums (Jones, 1991). It was not until a number of public inquiries highlighted the state of care provision that general public outcry occurred and brought insanity to the forefront of the public consciousness. This prompted the 1815 Parliamentary Inquiry into madhouses, with a Select Committee appointed to consider the provision for Better Regulation of the 'madhouses' in England.

The Poor Law Amendment (1834) and the Asylum Act (1845) provided a systemised way of dealing with the pauper insane. The Poor Law Amendment curtailed outdoor relief for the poor and allowed for the building of county workhouses, providing a system of management that was to be replicated in other Victorian institutions. The workhouses were run on three principles. Firstly 'less eligibility' where conditions were to be made as unpleasant as possible, more dire than those for the lowest paid employment in an effort to deter any who were not totally desperate. Secondly the 'workhouse test' where no relief other than the workhouse was to be made available to the able bodied and people had to live in the workhouse to access any form of relief. Thirdly, 'centralisation and uniformity' where parishes would form unions for the purpose of building workhouses, which would be overseen by a central commission (Roberts, 1999; Renvoize, 1991). In 1844 a census of the insane showed that over two thirds of insane were paupers with over half of these being placed in the workhouses. The 1844 Report of the Metropolitan Commissioners in Lunacy in acknowledging these statistics suggested that changes should be made to the current legislation to ensure that those deemed insane received prompt and appropriate treatment and that the building of County Asylums should be made compulsory. This came to fruition in the 1845 County Asylum Act. These public Asylums were to follow the template set by the voluntary hospital movement,

generally reliant upon personal charity and the donation of time and services from potential governors. As it was cheaper to care for the mad in poor houses this proposal to build asylum was viewed and presented by parliament as a philanthropic endeavour to which right thinking gentlefolk would contribute.

Asylums as Sites of Cure

Asylums were presented in the medical treatise and journals of the era as more rational and harmonious than society itself. Whereas madhouses had grown up as merely places of confinement, the asylum of the nineteenth century was presented as a site of cure and treatment. Foucault (1967b) suggests that such promises of cure had their roots in two conflicting aspects of society. Its approbation of those deemed unproductive with the resulting confinement of such individuals and the need to mask such confinement under humane and philanthropic aspirations. Hence if the mad were to be made healthy they would become productive, however until this cure was obtained they were confined to the Asylum. A move from containment to treatment of the insane is apparent in the legislation of the day.

Lord Shaftesbury was a prime mover in the 1845 Act, supporting the idea of a comprehensive asylum system to replace the patchwork of provisions in place. He equated the asylum system with the hospital system and spoke in terms of patients, hospitals, doctors and nurses (Nolan, 1993). Shaftesbury told parliament that the admitting of pauper lunatics to Asylums would bring about cures of seventy in every hundred (Roberts, 1999). This reflected the changes that were occurring in the 'general' hospitals of the day. Whereas the hospital of the 18th century was seen purely as a place of containment for the poor and sick, the 19th century version was somewhat different. The conditions outside of hospitals were seen as contributing factors to ill health. The hospital was proposed a haven for the ill providing a calm, rational and humane environment in which scientific treatments would be provided. With the rise of medicine as a science the hospital become a 'space' for scientific practice and the teaching of medical students. Custodial care was replaced with the promise of cure (Foucault, 1973b; Baly, 1995).

This scientific image and possibility of cure was implicit in the portrayal of the modern Asylum. Early admission to an Asylum with the concomitant treatment was

deemed central to this possibility of cure, thus ensuring the availability of benign and therapeutic establishments to provide appropriate treatment became essential. Leading mad-doctor of the day, John Conolly proclaims:

> "whatever the state and circumstances of a newly admitted patient may be, he comes to the asylum to be cured, or, if incurable, to be protected and taken care of, and kept out of mischief, and tranquillised." (Conolly, 1856, p38)

Conolly's counterpart in Scotland, Browne, outlined a number of essentials in relation to what an Asylum should be, including the presence of a suitable physician to direct and order the care; appropriate facilities; and the segregating of individuals according to their classification. If these principles were adhered to the Asylum was said to be:

> "a system…at once beautiful and self-operating…[attendant's] presence is required to regulate the machine, but its motions are spontaneous." (Browne, 1837, p203)

In such a system the cure rate, he insists, could be doubled.

The appropriating of the Asylums as their province allowed physicians to establish a medical discourse and provided a medical space within which to practice. Browne (1837) when identifying the need to provide education for medical students interestingly advocates such training take place in the pauper institutions rather than the private houses. He suggests that whilst the rich can veto treatment as a result of the patronage system, the poor by the nature of their charitable position are unable to do so and as such present a more suitable medium by which to learn the trade. Browne presents such interventions as being of great benefit to the poor, providing them with care and attention they would otherwise be unable to access. However it would seem more likely that they would not resist physicians' orders and treatments.

It is also suggested (Russell, 1988) that the asylums provided a rich seam of information by which the medical profession could advance its scientific discourse. Here were large numbers of people who could be examined, counted, tabulated and subdivided in an effort to open the mysteries of mental illness for scrutiny. As had

occurred in general medicine with the rise of the hospital (Foucault, 1973b) so with the building of the Asylums the categorising, labelling and defining madness as an illness became possible and with it the generating of a 'scientific' medical discourse concerning mental illness.

Medical Discourse and Madness.

Medical degrees appeared in the 16th century, introduced by Henry VIII in the 1518 Act of Parliament to regulate the medical profession. The Bishop of each diocese granted licences to practise to those seeking recognition as doctors. James I in 1617 chartered the Society of Apothecaries. Whilst the possession of a degree improved status it did little to enhance healing arts as education - dominated by the church - tended to centre on classics (Dulake, 1976). To obtain a degree in medicine at the beginning of the 19th century, a student was required to be on the books of the College for five years, observe two dissections and pass an oral examination (Hector, 1973). It was not until the Medical Act of 1858 that the General Medical Council, which was to regulate medical degrees and the medical register, was created. Thus the social status of most doctors was low with practitioners often dependent on wealthy patronage for success. Yet, as identified above, the end of the 18th century saw admission to an Asylum requiring a medical certificate and doctors taking a major role in the care of the 'mad', and asylums becoming a medical space.

The late 18th century saw the developing of a 'medical consciousness' within society. The population became more than just a collection of individuals, but rather an entity in its own right with specific characteristics. The government's requests for information relating to, and statistical supervision of the population's health and status underlined this and with it came what Foucault (1982) identifies as 'pastoral power'. Where as pre 1800 clerics held sway promising salvation of the soul in the next life for obedience in this, the growth of medical influence held the promise of salvation in this life through promoting of health and thus prolonging life.

The increase in the public's awareness of insanity is possibly related to two factors, namely George III's illness and the 'treatises' about the mad written by the growing

body of physicians in madness. Porter (1987) dates the emergence of an awareness of these physicians as 5th of December 1788 when:

> "the failure of the King's physicians-in-ordinary to master George III's delirium was acknowledged by the summons to the specialist, if very much despised, mad doctor Francis Willis."

The onset of the illness in June of that year was initially labelled as a physical illness, but by November the belief was that King George was mad. When the king's madness was said to be improving and he was able to take up his throne again, the possibility of curing madness entered the public domain. Hunter and MacAlpine (1963) describe the public debates, daily press bulletins and thanksgiving ceremonies that followed George III's apparent 'cure' as stimulating public interest as never before.

William Battie writing in 1758 was the first to produce 'A Treatise on Madness'. Whilst other essays and papers had appeared relating to specific aspects of madness, this work was the first to address madness in total and to be based on experiences of working with the insane. Its purpose was to introduce "more Gentlemen of the Faculty to the study and practice of one of the most important branches of physick" (Battie, 1758, p1). Here a scientific approach to the understanding of madness was strongly advocated. Battie suggested that the lack of understanding and of a discernible body of knowledge was largely due to a lack of communication between those employed in the field of madness and the perpetuating of false and irrational theories. John Munro, Physician to the Bethlem Hospital, published a repudiation of Battie's treatise. This public controversy immediately raised the profile of mad-doctoring, provoking both a public and medical debate, which as Hunter and MacAlpine (1962, p17) identify, established the existence of "a sufficient body of experience for experts to disagree".

No doubt these events brought madness and its physicians firmly into the public eye placing the physicians as a respectable profession. This, however, did not promote a 'coming together' of those interested in mental disorder, rather each doctor practiced in his own way. Nevertheless new knowledges were generated and discourses developed in relation to mental disorders, the mad and their treatment. MacDonald

(1980) proposes that cardinal symptoms of insanity had become well established by the late 18th century. Where previously lay and medical men alike had described the mad as "wild incoherent creatures" (MacDonald, 1980, p67), attention was turned to the signs of insanity with delusions and hallucinations as central to utter madness. This, MacDonald asserts, resulted in a more secular explanation of madness and the rise of scientific materialism. An area suitable for investigation was opened; power relations were established and the production of a body of knowledge became possible.

Private madhouses had provided a good living for those who operated them. However Porter (1987) posits that by the second half of the 18th century there emerged a:

> "cadre of ambitious, able people – increasingly medically qualified men –aiming to make a living, and more than that, a career and a name, through asylums."

Madhouse keeping was to become an object of pride and a helpful career step for those engaged in a medical career. Prior to this time physicians had not been in daily contact with the insane, now there was a growing group of individuals who were attempting to manage and even cure madness. Possibly the birth of the consumer society gave rise to the consumption of the madhouse services, not that wealth gave rise to madness, but the commercial ethos made the trading in insanity possible.

Scull (1991) proposes that the first half of the 19th century saw medicine achieve a monopoly over madness. However although the Parliamentary Inquiries of 1807 and 1815 had placed the issue of treatment of the insane in the public consciousness, medical interventions were presented as ineffective, inappropriate and at times as inhumane. Such reports were widely circulated in newspapers of the day and placed madness in the arena of philanthropic endeavours. There was a need for medicine to generate a type of treatment that would allay the public's fears and present the profession in a more positive light.

Bucknill and Tuke (1858) chart the veritable explosion of ideas on madness through the late 18th and early 19th century, which would seem to reflect medicine's efforts to generate a scientific discourse. This discourse eventually was to take on the two axes

of moral treatment and the non-restraint system. Both promulgated philanthropic and moral ideals and laid claims to scientific validity.

Moral Treatment

The inception of moral treatment is laid at the feet of one William Tuke, a Quaker, who in 1796 founded the York Retreat. Following the abuse of a fellow Quaker in the York Asylum he was convinced that the Quaker society should meet the needs of its members by providing a more humane institution. His grandson, Samuel Tuke was asked to write "a history and general account of the Retreat" (Hunter and MacAlpine, 1964, p2). This account was the first to describe in layman's terms the working of an Asylum and appeared to embody the ascending perspectives of the insane as 'reason gone wrong' and the moral obligation to provide for the needs of less fortunate (Tuke, 1813).

The book sparked a heated debate in the local press between Samuel Tuke and the physician of the York Asylum who was affronted by the implicit condemnation of the treatment of lunatics in his establishment. This might have come to nothing had it not been for a case of cruelty at the York Asylum coming to the attention of a local Justice of the Peace. A general Inquiry into the state of the Asylum and eventually a review of its management occurred but not without a great deal of private and public acrimony (Digby, 1985; Nolan, 1993). The battle attracted attention at a national level and led a group of philanthropists in London to instigate an inquiry into the state of their local institution, Bethlem Hospital. The Description of the Retreat and its 'Moral Treatment' appeared to fire the philanthropic zeal of a number of influential people and thus was instrumental in the push for the building of asylums and the regimes under which they were managed (Porter, 2002).

Tuke (1813) identified three aspects of moral treatment - strengthening and assisting the patient's power to control the disorder; appropriate modes of coercion; and promoting the comfort of the patient, which are implicit in considering the current nursing discourse relating to containment, control and maintaining order. Patients were classified in relation to their level of rationality and propensity for violent and/or disorderly behaviour and informed that their treatment was dependent on their behaviour, in the hope of encouraging appropriate behaviour. Violent behaviour was

to be met with mildness and reasoning with restraints used only as a last resort. The basis was not the use of fear to instil obedience but rather the use of moral sanction to promote moral behaviour (behaviour which the individuals sees as being both desirable and socially acceptable). The roots of this approach lay in the perceived difference between animals and humans. Animals could be trained into obedience whilst having no understanding of the need for this, whereas humans are rational beings, thus madness affected this rationality. The promoting of moral reasoning returned the individual to normal. Attendants were encouraged to see the patients as moral and rational beings in need of 'Christian' charity. The promoting of comfort seems to draw heavily on Jeremy Bentham's ideas of promoting greater happiness and in doing so induces the patient's moral constraint and reduces the propensity for irrationality, Locke's work was clearly influential in the approach, with Tuke mentioning him by name.

It was identified that medical treatment within the Retreat "will not add much to the honour or extent of medical science" (Tuke, 1813, p110). Indeed, much of the treatment advocated by medical practitioners was abandoned "the [attending] physician plainly perceived how much was to be done by moral, and how little by any known medical means" (Tuke, 1813, p112). If madness was of the mind then, it was conjectured, treatment should be aimed at affecting the mind and its 'moral powers'. Nevertheless within a short period of time moral treatment as a lay approach was to be presented as the corner stone of medical scientific interventions. Bucknill and Tuke (1858) argued that moral treatment fell within the medical domain as it was simply one of the tools that could be utilised in the care of the insane. A new form of madness, moral insanity, had come into being, described by James Prichard in 1835 as:

> "a form of mental derangement in which ...the moral and active principles of the mind are strangely perverted and depraved; the power of self government is lost or greatly impaired; and the individual is found to be incapable...of conducting himself with decency and propriety in the business of life." (Digby, 1985, p25)

In 1837 Browne wrote, in justification of its medical usage, how the term 'moral treatment' meant different things to different people. He suggested that "kindness,

discipline, and social intercourse, ought to be embraced in an effective system of moral treatment" (Browne, 1837, p156). Within this was a need to reduce the irritations present for the patient by finding a balance between resistance and compliance with patients' wishes. Pinel (1802) described the attributes of moral treatment as those embodied in his mentor whilst chief physician at Asylum de Becetre in France. The physical properties denoting strength, a sound knowledge of human nature, firmness and courage, decision and force, tempered with philanthropic aptitude were presented as key aspects. However when Pinel used the term 'le traitment moral' it was in the French context, with moral meaning mental (Shorter, 1997). Nevertheless, in both versions, a high ratio of attendants to patients was central to its successful implementation.

Moral treatment was presented as an improved approach to the treatment of the insane through methods considered more humane (Bucknill and Tuke, 1858). It also promoted the possibility of cure. It was described by the Commissioners in Lunacy in 1847 as "all those means that, by operating on the feelings and habits, exert a salutary influence, and tend to restore them to a sound and natural state." (Hunter. and MacAlpine, 1963, p489). This was to be initiated through moral injunction, diversional activities and occupation, and it was the attendants who were to promote these aspects of the treatment under the guidance of the physician. Thus the presence of attendants was needed as a deterrent to bad behaviour, acting as 'overseers', on guard to deal with possible outbursts from patients. They were seen as reducing the likelihood of such events occurring. In Bucknill and Tuke's (1858) eyes the same forces were at work in the utilisation of such approaches as were in place in the army and penal systems as advocated by Jeremy Bentham. The knowledge that surveillance and an orderly system were in place was seen as sufficient to quell propensities to violence and bad behaviour.

Such treatment was linked to a requirement to understand what was and was not within the control of the patient and it was here that the physician was viewed as engaging specialist medical knowledge and here can be seen the seed of the mad/bad dichotomy. Behaviour that was not in the control of the individual is attributed to physiological and psychological causes that require physiological or pharmaceutical intervention and was solely in the domain of medicine. Moral treatment provided the

means to "weaken the hold of perverted thoughts and effect the establishment of healthy emotion" (Conolly, 1856, p492).

System of Non-restraint

The use of mechanical restraint (chains, fetters, strait-jackets) in the control the insane was one of custom and practice and had been etched in the public's mind as an appropriate practice when a straitjacket was used to subdue King George III. If it was appropriate for a King it was appropriate for his subjects. However the discourse relating to this approach to treatment of the insane was to change. Pinel's casting off of the chains of the lunatics in 1792 at the Bicetre asylum following the French Revolution, captured the imagination of the English and was commented on in many of the texts advocating reform in relation to such approaches. Browne (1837) marks this as the point at which medicine and legislators radically altered their thinking in relation to the management and care of the insane.

Mechanical restraint was to be replaced by moral restraint with attendants central to its implementation. John Conolly writing in 1847 was seen as the foremost spokesperson for such approaches in the English asylums, W A F Browne (1837) for Scotland. Connolly's non-restraint stance was seen as "humane and enlightened treatment" and became associate generally with "all that was good and new" (Hunter and MacAlpine, 1973, p xi).

In his treatise on the treatment of the insane, Conolly (1856) painted a vivid picture of the methods used to restrain those suffering from madness. These 'old methods of treatment' included chaining individuals to walls and beds via collars and belts of iron, the use of 'strait-waistcoats' leg-locks and fetters. He proposed that "the principal object of all such contrivances is to limit the movements of the patient" (Conolly, 1856, p16). In Connolly's description chaining and mechanical restraint were used as a matter of course when keepers/attendants were not present, i.e. at nights and on Sundays, so that the patients would come to no harm whilst unattended. Also, as Browne (1837) describes how only one attendant was needed to oversee the welfare of large numbers of inmates of madhouses if restraints were used. In his description one Asylum was identified as having only 3 attendants to govern 250 patients, another with 164 inmates and two attendants, and yet another

where each attendant was responsible for 50 patients. Thus Bucknill and Tuke (1858, p503) comment that whilst restraint allowed care to be provided by the smallest number of attendants "there was little need of medical skill".

Conolly (1847, p35) promoted the non-restraint system as "a complete system of management of insane patients". However this system required individuals to monitor and respond to the patient i.e. an attendant. It was essential that attendants were present at all times and in sufficient numbers to allow the system to function. Thus the attendant was central to what Conolly proposed as appropriate medical treatment of the insane and required:

> "most systematic supervision of the physician, with the daily aid of efficient and well-disposed male and female officers, exercised over good-tempered, active, well-chosen attendants." (Conolly, 1856, p54)

In this system the patient was subject to constant supervision, his/her movements and behaviours were monitored. Behaviour that was deemed not harmful but rather an 'acting out' of madness was not interfered with. However if the patient became disturbed and considered dangerous either to themselves or others, then seclusion was advocated:

> "If he resists the most patient of persuasion, or defies the attendants altogether, they are trained to effect the seclusion without a contest, or even more that a momentary struggle. After all words have failed, they close quickly upon him, and three or four of them catch hold of him at once, and so dextrously that he can scarcely kick or strike them…" (Conolly, 1856, p46).

Thus the non-mechanical approach was presented as drawn from philanthropic ideals, with the care of the individual at the heart of them. The physician was seen to embody the higher aspirations of society and thus must safeguard the lunatic who by virtue of his madness was incapable of moral control and the attendant by virtue of his ignorance unlikely to display moral attributes. Thus the physician was one who has "trained his powers for a life time, in penetrating into the depths of the diseased mind" whilst the attendant was someone whose "presence is offensive to all individuals, of either polished minds or manners" (Browne, 1837, p151).

The Medico-Psychological Association founded in 1841 as the representative body of the physicians in madness advocated the non-restraint discourse within the profession promoting the philanthropic ideology. In the first edition of the body's own publication, 'The Asylum Journal' it declared:

> "The physician is now the responsible guardian of the lunatic, and ever must remain so …all civilised countries have recognised the fact, that Insanity lies strictly within the domain of medical sciences." (Bucknill, 1853, p1009)

The acceptance of this discourse by the State and society is visible in the 1842 Act, which stipulates that Commissioners in Lunacy were to investigate whether asylums had adopted "a system of non-coercion, and if so the particulars of such system". A medical discourse had been generated which provided a framework from within which the physicians could lay claim to scientific truth.

Rise of Nursing

Nurses traditionally were from the lower reaches of society, their status little more than that of house servants. Often in institutions such as poorhouses and workhouses the 'well' were pressed into the role of caring for the other inmates (White, 1978). Nurses' proposed lack of moral character is evident in Dickens (1844) novel 'Martin Chuzzlewit' with 'Sarah Gamp', a nurse, portrayed as a drunkard and a laggard.

A nurse's role was often one of cleaning – patients, equipment and wards – and assisting physicians when necessary. With the rise of the scientific medical discourse, the need for someone to monitor the patients' responses developed (Rafferty, 1996b). In voluntary hospitals and pauper establishments it became the norm for 'working-class' women to be employed to do the 'nursing' and middle-class women, with managerial skills gleaned from supervising servants, employed as sisters, to oversee such work (White, 1986; Abbott and Wallace, 1990). By 1897 nursing was establishing itself as a separate occupation and the Local Government Board for workhouses issued instructions that pauper inmates could no longer undertake nursing tasks. Nursing staff, who had undertaken training at a recognised school of nursing, had to be employed to fulfil such duties (Bendall and Raybould, 1969)

The changing demography and economic trends in the mid 19th century brought with it the development of the new middle classes. Here a group of the population found itself with increased money, resources and leisure time and attempted to carve out their own place within society and define their position in relation to the upper and working classes (White, 1978). The falling birth-rate, later marriages and the emigration of men to the growing empire left a number of women with no prospects of marriage and a need to find employment. The census of 1861 showed there were two and a half million widows and spinsters who must find some form of subsistence with most of the usual women's occupations already over subscribed (Hector, 1973). The women of the middle-classes whilst barred from professional employment which placed them, Baly (1973, p129) claims, "in vulgar competition with men", where drawn to an occupation now made respectable – nursing. The promoting of social change and improvements had long been advocated as right and proper for ladies of the 19th century, much as the philanthropic stance was advocated for gentlemen.

Nursing in the physical domain was receiving a boost in its status through the work of Florence Nightingale, the attracting of women from a high social background in the nursing field, and the establishment of various schools of nurse training. That nurses in this arena were of a higher social standing and required special training to enable them to undertake their duties and follow doctors orders was seen as underlining the specialist nature of medicine as a whole (Abel-Smith, 1960; Baly, 1973; Rafferty, 1996b). Physicians in the field of insanity sought to emulate their colleagues. This resulted in the Asylum physicians devising and implementing a training programme for attendants in 1890. The plan was similar to that being advocated in the general sphere of nursing where upper-class women paid for the privilege of undergoing the training system (Nolan, 1993).

Regimes of Practice

The beginnings of mental health nurses' regimes of practice are apparent in the rules and regulations generated within the Asylums, stipulating attendant's daily and often hourly activities. The York Retreat produced an early example of these in 1842, providing 'Instruction as to the Management of Patients' and 'Rules for the

Government of Attendants and Servants' (The Retreat, 1842). These instructions released attendants from the normal tasks of servants such as labouring and placed them firmly in a role specific to the care of patients. Thus the space within which they worked was designated as patient orientated, and more specifically, as the ward.

The attendants were charged with ensuring the "welfare, security and comfort" of the patients and warned to guard against their own natural tendencies to "resent injuries" received from the patients and to "cultivate the strictest habits of self-government" (The Retreat, 1842, p6). However they were cautioned not to see themselves as "masters of the patients" but rather as "servants of an institution". They were to be polite, obedient and unquestioning of their prescribed duties, conducting themselves in a calm manner at all times. These rules and regulations formed the basis for the general duties identified as central to the attendant's role in a handbook produced by the M.P.A. in 1885. This 'Red Handbook', as it became known, was required reading for all attendants and was central to their understanding of who they were and the expectation placed on them, being reproduced and revised over the next ninety years.

Summary

- The changes occurring in Europe and Britain brought with them a change in thinking relating to the nature of humans and their capacity to reason, constituting humans as rational, moral, philanthropic beings. Madness became seen as 'reason gone wrong'.

- The agricultural/industrial revolutions and changing demographics brought with them a rise in the numbers of poor and, for undetermined reasons, a rise in the pauper insane. The apparent mistreatment of the insane gave rise to both a public outcry and parliamentary debate. The philanthropic discourse demanded that such unfortunates should be cared for.

- The madness of George III and his apparent recovery coupled with the increasing development of a medical consciousness within society offered the possibility of

cure and opened the door to the generation of a medical discourse in relation to madness.

- Asylums were presented as sites of cure, with physicians as the architects of such cures. The success of medical treatments - moral treatment and non-restraint systems - lay in the provision of attendants in sufficient numbers to carry out the doctor's requirements and control patient behaviours.

- The rise of modern nursing, the encouraging of high status women into the occupation through the development of education programmes and the associated increase in the status of the medical profession led physicians in madness to promote similar conditions for their assistants, the attendants.

- Power relations marked out the space in which mental health nurses in the guise of attendants were to emerge, their regimes of practice were predicated on the need to control the insane and the medical profession's desire for an assistant.

CHAPTER 6

POWER RELATIONS (PART 1)

- Introduction
- Theoretical framework
- Methods of Investigation
- **Genealogy** - Diagnosis of the Present
- - Conditions of Emergence
- - **Power Relations (part 1)**
- - Power Relations (part 2)
- - Knowledges
- Q-Methodology - Philosophy and Approaches
- - Data Analysis
- Discussion, Limitations and Conclusions

The previous chapter identified the emergence of the attendants and their specific regimes of practice. The intention in this and the following chapter is to continue the process of eventalisation, focusing on the power relations, the strategic developments and tactics occurring in the space within which attendants act and are acted upon. This is the space in which the ways of seeing and speaking about mental health nurses are made evident. In this chapter the power relations present in the mental health care environment are considered; those employed within this environment and imposed upon it. There is an identifying of the power relations that programme and maintain the taken-for-granted knowledges, the 'truths', upon which mental health nursing depends for its own intelligibility. In considering these power relations and the various discourses generated one must also ask, "whom does the discourse serve?"

Attendant/Physician Relationship

An interesting insight into the relationship between attendant and physician is offered in the diary of William Waller, an attendant at The Retreat at York in 1857. Resigning following an altercation with the medical superintendent, he writes:

> "Spoken to something like a dog. And told by J.K. [superintendent] that as a servant he considered me as such." (Digby, 1985, p162)

A mental nurse working in the 1920s re-iterates this sentiment stating that the superintendent "regarded us as mere servants" (Nolan, 1993, p90). Recalling events in the 1960s a psychiatric nurse describes trying to arrange activities for patients with the resulting admonishment from a psychiatrist "Who the hell are you to organise drama with my patients? I decide what happens in this hospital" (Hopton, 1997b, p35). In 1982 a debate as to whether it was appropriate for a mental health nurse to challenge a doctor's decision resulted in a consultant psychiatrist writing "Consultants must be in charge and seen to be in charge. Authority should be delegated sparingly, preferably to other consultants" (Salvage, 1985, p15). As can be seen from these comments a rigid hierarchy dominated the Asylums and continued to do so in more recent mental health establishments.

At the pinnacle of the Asylum's hierarchy was the medical superintendent. The medical superintendent was seen as all powerful, ruling all aspects of his demesne, a rule that was to remain unchanged until the early 1960s when the position of superintendent was abolished and the functions associated with it were replaced by various committees. The most influential of these committees, however, was generally that formed of physicians. It was not until the general management model superseded this in the 1980s that some of this dominance dissipated, although never entirely erased.

The roots for medical dominance of the Asylums are clearly articulated in early writings concerning the provision of care for the insane. Browne (1837) asserts that only the physician by virtue of his position, manner, connections and lifelong study of mental illness is able to meet the challenge implicit in the treatment of the insane. Bucknill and Tuke (1858, p452) add that as "educated and exact observation is required" of those deemed insane, this role must fall to the physician. Implicit in the

positioning of the physician as the advocate for, and protector of the Asylum inmate, is the establishing of the physician's dominance over all other occupational groups who may have access to the insane. Those outside the medical profession but of the same social class, although possessed of the same moral understanding and philanthropic calling, are presented as having no understanding of the principles of treatment regimes. Conolly (1856) gives an impassioned discourse as to why physicians, and only physicians, are suited to the role of governing and ordering the Asylums. He proposes that no matter how well intentioned lay involvement may be they have neither the aptitude, knowledge nor ability to fulfil the duties required of those overseeing the insane or the institution in which they are housed.

Having once established the centrality of the medical role in relation to the care of the insane and, in order to fulfil this appropriately, the necessity of having total control of the Asylum and everything within it, the need for dominance of the attendants is voiced. Conolly (1856) is vehement in his proposal that attendants fall under the jurisdiction of the physician. It is suggested that if the attendants are under the direction of others, abuses of patients are less likely to be punished than if they are entrusted to the medical staff. A medical officer's lack of control of attendant's behaviour, it is suggested, could also result in treatment plans being ignored. The attendants must therefore be subjugated, the relationship being one as between master and servant and made quite explicit in the statement that:

> "It is not intended that they shall consider themselves qualified to give advice or proffer opinions, unless they are asked to do so by their superiors." (M.P.A. 1908, p346)

When reporting on the conduct of the attendants it is clear in Palmer's (1856) accounts that obedience is expected in order to ensure the smooth running of the Asylum. The introduction of the first edition of the Red Handbook for attendants of the Insane (M.P.A. 1885, p ix) provides rules "as will enable [attendants] to do their work with greater intelligence and watchfulness...and should aid attendants to carry out the orders of the physicians". In this edition the first duty of the attendant is identified as the promoting of self-discipline and ensuring patient discipline by example through industry, order, cleanliness and obedience (Nolan, 1993). The fifth edition of the book (M.P.A. 1908) demands that "the rules must be blindly

accepted...and faithfully carried out without argument" (p324). The West Riding Asylum (1922, p15) proposes that attendants "give strict, constant, and ready obedience to the orders of the medical Superintendent and Officers acting under him...strict discipline will be enforced". Within the regulations attendants were required to sign a declaration in which they agreed to abide by the rules and acknowledge that any breach of these could result in dismissal

Underpinning such subjugation is the need to establish the superiority and credibility of the medical discourse in relation to earlier treatment discourses, which fell largely to attendants. If physicians were to achieve dominance and a monopoly as guardians of the rights of the insane, they had to establish their moral right to this. The physicians were to be the site of moral control by virtue of their status and altruistic motivation. The attendants as a subordinate and requiring supervision is to be embedded in the medical discourses surrounding non-restraint systems and moral treatments, rationalised necessary in order to safe guarding patients' interests.

Attendants are presented as lacking in moral considerations and as being driven by baser emotions. Browne (1837) soundly berates attendants, painting a picture of violent, uncouth and inhumane individuals who, if left to their own devices, terrorise and brutalise the insane. He identifies attendants as "the unemployed of other professions" (Browne, 1837, p150) and proposes their status as lower than that of cooks and coachmen. Wright (1996) challenges this description identifying that in fact those taking up the role of attendant were actually highly employable. The volatile labour market meant Asylums would have to increasingly compete with other employers to attract and retain staff. However an acknowledgement of this 'employability' would have resulted in a weakening of the physician position.

Conolly (1847, p86) proposes that the best attendants were to be "found in the class of persons who are qualified to be upper servants". However as Sheehan (1998) identifies the Victorians paid horsemen twice the basic rate of a male attendant and four times that of females, which gives some indication of the attendants place within the servant hierarchy.

Russell (1988) points out that despite this continuous denunciation of the attendants and the call for a 'better calibre' of person, the physicians seemed unwilling or

unable to address this. Dingwall et al. (1988) identify that rather than address such issues attendants were recruited from areas of high unemployment. Although the Commissioners in Lunacy called in 1859 for a higher rate of pay to attract a better quality of person, medical superintendents were reluctant to do this. The reluctance perhaps emanates from the medical superintendents' desire to ensure continuing control of the Asylum, with the associated dominance of the medical discourse, through the subjugation of attendants and the need to attract sufficient numbers to provide the services essential to the treatment regimes.

Such calls for improvements in the pay and conditions of nurses working with people suffering from mental illness has been a recurrent theme throughout the history of mental health nursing and one which has never been fully addressed (Ministry of Health, 1922; Department of Health for Scotland and Ministry of Labour and National Service, 1947; Department of Health and Social Security, 1972; Department of Health, 2000a). Perhaps this also reflects society's and the State's view of the mentally ill and those caring for them. If society is to be viewed as humane and civilised it must provide adequately for those less fortunate and value those charged with the care of such individuals. However if the humane face simply masks a control imperative with little recourse as to how this is achieved there is little demand to go beyond the rhetoric of providing resources. Only when the conditions of care enter the public arena in the form of 'scandals' as seen in the late 19th, early and late 20th centuries engendering a 'Moral Panic', does actual change take place.

Treatment regimes

Where previous systems of treatment such as mechanical restraint were left to the discretion of the attendants, the use of the non-restraint system is placed firmly in the doctors' domain. To establish the credence of one, the other must be abrogated. Hence Conolly asserts:

> "The old system placed all violent or troublesome patients in the same position of dangerous animals. The new system regards them as afflicted persons, whose brain and nerves are diseased, and who are to be restored to health, and comfort, and reason." (Conolly, 1856, p53)

Regimes in which restraint is advocated are presented as "cruel substitutes for a steady system of Watchfulness" (Bromhead, 1841, p 28). Palmer (1855, p13) identifies that the use of restraint on even the most of occasional case was likely to "excite perversity and resistance to moral control [in patients], and on the attendants to inculcate a reliance on coercive measures rather than those of a guiding and directing nature".

The competence of the attendant to utilise moral consideration is repeatedly thrown into question. To this end Tuke (1813, p11) identifies it is essential that "insane patients [be] under the frequent observation of persons of knowledge, judgement and probity" in the form of the superintendent and not attendants who, he proposes, have "few of the qualities necessary for their office" save "limbs of British oak, and nerves of wire". Yet these 'limbs of oak' are still required within the non-restraint systems as the means of control of violent individuals. Thus, whilst it is proposed that attendants must be of a specific stature to encourage patient compliance with treatment – females to be not less than five feet five inches tall and males five feet nine inches (Bromhead, 1841) - this form of coercion is differentiated from mechanical restraint and rationalised in relation to moral treatment. Thus he proposes that:

> "Patients, conscious of their attendants' superiority, do not venture to attack them; and such attendants, confident of the safe issue of any struggle in which they may be engages, can venture to act wholly on the defensive, without giving way to passion and blows." (Bromhead, 1841, p10)

Coercion, when necessary, should be "protecting and salutary" (Tuke, 1813, p163) such as in the use of seclusion in a darkened room, the advocated method of reducing stimulation to an excitable inmate. In Conolly's (1856) and Bucknill and Tuke's (1858), narratives, they are careful to differentiate between seclusion and the 'locking up' of lunatics in cells as occurred under the old system. Humanistic approaches and short time spans are emphasised, with control of such an intervention being seen as firmly in the hands of the physicians. Physicians, able to utilise seclusion in a therapeutic manner, are presented as the patients' guardians who will only sanction such approaches for the patient's 'own good'. Connolly picks up this

theme extolling the virtues of seclusion in promoting tranquillity in violent and excited patients. Thus 'quietness' is presented as a therapeutic tool, achieved through the use of seclusion.

However the physician could not possibly exert moral influence in relation to all in his charge and thus the success of moral treatment and non-restraint systems rested on having attendants in sufficient numbers and imbuing them with the necessary attributes and behaviours. Bucknill and Tuke (1858, p489) suggest "much can be well done vicariously by ordinary attendants" with Conolly (1847, p84) arguing that "all that cannot be done by his [physicians] personal exertions depends upon them [attendants]". To achieve this goal the attendants must again be fully under the control of the physician. Conolly (1856, p98) proposes:

> "Attendants are his most essential instruments; that all his plans, all his care, all his personal labour, must be counteracted, if he has not attendants who will observe his rules, when he is not in the wards, as conscientiously as when he is present."

As it is unavoidable that the role of caring for the insane should fall mainly to those proposed least educated for the task, Conolly (1847) advocates that ward areas should not only provide for the supervision of the patients by the attendants, but also be such as to make the attendants visible to the physician. Thus techniques of discipline are employed, with Esquirol, Pasquier, Elis, Hill (1840) asserting in their treatise on the management of Asylums that:

> "every patient is watched, and knows that he can be controlled…By means of sash-doors, the attendants themselves are liable to continual inspection, and little is left to their undisciplined temper or caprice."
> (Bromhead, 1841, p35)

The act of report writing provides another form of surveillance whereby the actions of the attendants are observed even in the absence of the physicians and also brought to the attention of those charged with regulating the Asylums. Whilst in turn the patients are subject to the surveillance by the attendants who collect information to complete such reports. Hierarchical observation and normalising judgements are brought together in an examination of both the attendant's and the patient's actions.

Conolly (1847) identifies a clear hierarchy in terms of reports. The attendants give reports to the assistant medical officers and matron, these then report to the physician, and the physician alone reports to the committee. All actions are considered in light of the Asylum rules and regulations and legislative requirements. In acts of 'confession' the attendants describe their actions through the day and the physician examines these to determine the truth of the matter and the appropriateness of their behaviours. Such reports serve the added purpose of providing the physicians with information, which enables them to make judgements about the patients, their condition and the appropriateness of treatment. The attendant collects information for the expert –the physician - who has the skill and knowledge to interpret and give meaning to it. The need for regular reports is highlighted in the rules and regulation developed by the various Asylums and appears in all the handbooks produced for the attendants. The 8th edition of the Handbook (R.M.P.A. 1954, p333) advocates the writing of weekly reports on patients by nurses so as to ensure that "the doctor may keep control of the treatment situation" and later, "nurses can do much to help by making accurate reports on the patient's behaviour and on effect of the treatment" (R.M.P.A. 1954, p337). The giving and receiving of reports remains central to the education of mental health nursing being embedded in all recent curricula and subject to special consideration in a pamphlet by the U.K.C.C. (1998b).

Working practices

Constant activity was advocated for attendants, and ensured by the rules and regulations presented to them at the commencement of their employment. A schedule of their day was provided in which each hour (and at times half-hour) had its designated duties with punctual and orderly performance receiving great emphasis. Off-duty space was also regulated in terms of meal times, bedtimes and lights out.

Conolly (1847, p93) asserts that "there is no time in the day in which the attendants can be said to have nothing to do" attendants' duties "begin early in the morning, are incessant during the day, and end late" (Conolly, 1847, p87). Unkempt patients or wards in states of uncleanness were unacceptable and hence the focus of attendant's activities. Wards were visited regularly by matron and medical officers to ensure

these edicts were met. Such activity Clarke (1978) claims reflects the work ethic of the 19th century, which promulgates the idea of work time as something paid for and thus should be spent in activities deemed appropriate for specific occupations. This work ethic Foucault (1977b) views as part of the technologies of discipline, which produce a docile, productive workforce.

The continuance of this technology of discipline is reflected in the accounts of mental nurses throughout the 20th century. Nolan (1993) gives some insight into such activities in his interviews of mental nurses. Individuals employed in the 1920s recount how much of mental nurses activity related to cleaning the wards and keeping the patients quiet, with anything up to 5 hours a day being spent in the 'airing grounds' keeping both the nurses and patients occupied. The 1940s mental nurses tell of those who attended lectures being labelled 'workshy'. The regimes were still rigid with nurses and patients continuing to spend may hours in the airing grounds. Cleaning remained a central role of the nurse with hours being spent polishing ward floors. Practices at this time appeared to continue to revolve around the ability to control violent behaviour and to keep the ward quiet and tidy.

Similarly Greenaway (1995) recalls how, as a student psychiatric nurse in the 1960s, if discovered talking to patients he was likely to be admonished for wasting time and sent to check the linen cupboard. In the 1970s Clarke (1978) found this 'activity' imperative still firmly embedded in psychiatric nursing culture with nurses talking of 'getting the work done' and being unsure of their role once 'work' was completed. Despite proposed moves towards therapeutic approaches and individualised treatment the practices continued to focus on medication and E.C.T. with mental health nurses remaining distant from the patients, interacting only when the need arose. Hence 'talking' with patients can be seen a detracting from the real work of the mental health nurse i.e. activities associated with the managing of the patient and their environment.

Psychiatry as A Science

The status of psychiatry in relation to that of general medicine was of great concern to Asylum physicians. Whereas general medicine was quite rapidly establishing itself

as a scientific discipline, psychiatry was lagging some distance behind. The M.P.A. evolved from meetings and correspondence between the medical superintendents of the pauper Asylums. Originally known as the Association of Medical Officers of Asylums and Hospital, the change in name in 1865 reflects, Renvoize (1991) proposes, a growing confidence in the physicians in this field and an understanding of the need to strengthen their position of dominance in relation to the provision of care for the insane. Thus at the first meeting of the M.P.A. in 1866 it was stated that:

> We now claim as our objects the investigation of all subjects bearing upon the science of mind in connection with the health and disease...We claim even a wider, almost a universal range for the science of Medico-Psychology, and we claim for it a distinct position in science." (Renvoize, 1991, p41)

It was felt that if the M.P.A. did not advance their own position, which was seen as isolated from the general medical profession, their status and standing would be diminished.

It is clear that the Asylum physicians promoted the idea of curability in an effort to establishing insanity as a form of illness and as a scientific discipline. The term Asylum as opposed to 'madhouse' is symbolic of this approach equally the application of the term patient as opposed to 'madman or lunatic' is in recognition of the presence of an illness and the need for treatment. It proposes that recovery is possible if treatment is appropriate. The discipline and routine of the Asylum is compared with the hygiene of a general hospital as "they tend to keep in subjection excitement and disorder, which are as harmful to the mental invalid as microbes are to a patient with a wound or sore" (Conolly, 1847, p315).

In the opening report of Lincolnshire County Pauper Asylum there is an identification of those deemed inappropriate to receive care in the Asylum:

> "poor, aged people, imbeciles and peevish, and tottering under accumulated infirmities; helpless paralytics, prostrate in mind and limb, and requiring the attention of ordinary nurses." (Palmer, 1854, p4)

Palmer, the Lincolnshire County Pauper Asylum Superintendent, consistently identifies that delaying admission to the Asylum is associated with an inability to improve the patients' condition. He lays out, in the second report of 1855, statistics to underpin the proposal that the longer an illness continues unabated, the less the likelihood of obtaining a cure. Thus any lack of improvement or cure is seen to result from forces outside of the control of the doctor

The cases of cure are frequently cited in the various journals and treatise relating to mental illness (Turner, 1991). A picture is often painted of individuals who had previously been mismanaged and mistreated in less reputable institutions being brought to the Asylums and by virtue of new approaches finding relief and cure. Cases of those not cured are also discussed, however the language used suggests that such individuals have been saved from a tragic state of abuse (Bromhead, 1841; Palmer, 1854; Turner, 1991). Whilst these people are still experiencing mental aberration it is a happier state of madness once in the Asylum, being tended by those who best understand their needs and are more well disposed to provide appropriate care. It would seem that physicians were proposing that although their skills at this point were not refined it was only a matter of time before success could be achieved more frequently. The attendants were central to the achievement of this goal as it was they who were to act as the doctor's agents in the delivery of treatment and the gathering of information relating to the behaviour of insane individuals.

However the sheer numbers of people entering the Asylums, never to leave thwarted any promise of cure inherent in the promotion of moral treatment and non-restraint system. In 1800 only a few thousand lunatics were confined by 1900 this became 100000. Asylums were quickly filled with ex-workhouse inmates with chronic mental illnesses, 90% of Asylum inmates were identified as paupers (Bebbington, 1987; Nolan, 1993). Tuke (1878) highlights a 93% increase in those identified as insane between 1859 and 1877. Admission had far exceeded discharges, resulting in a huge accumulation of the insane in Asylums. Any recall to moral treatment and cure was quickly replaced by custodial care.

By 1856 Palmer identified the number of individuals in the Asylum that were considered incurable. He proposed that of 278 patients there were only 23 individuals who had any reasonable hope of recovery. The following year he

explored the reasons for the 'accumulation' of such cases in the Asylum, suggesting that there were a large number considered to have been imbeciles/idiots from birth. This group was later removed from the Lunatic Asylums to institutions specifically identified for their care. The idea that those who had experience mental health problems for more than three months were incurable possibly resulted in treatments and interventions beyond this point being viewed as both futile and unnecessary. However, Palmer (1858) proposed that whilst there were a large number of individuals deemed incurable it must be remembered that the 'asylum' element of the hospital would always be the largest and that the institution could not be considered in purely curative terms. A few years later he re-enforced this with the statement that Asylums were "tranquil only in consequence of the skilled care and supervision with which they are surrounded" (Palmer, 1864, p12). This perhaps is an effort to maintain the physician's status and ensure that the specialist nature of the care/services provided are not to be undervalued. It reflects Connolly's (1856) belief that the incurable insane should be contained and protected in the Asylums. A duty of care is proposed for those with longstanding illness as recoveries in this group have been identified (through infrequently) and thus hope should never be abandoned.

Foucault (2001) proposes that one way that the physicians in madness sought to establish a science discourse was in through aligning their activities to the increasing interest in pubic hygiene. He suggests that with the increased interest in human populations and the rise of 'bio-power' society took on a biological reality which made the practice of general medicine possible. Physicians functioned in relation to public hygiene seeking to reduce and control the diseases, the epidemics, which threatened the 'body' of society. Mad doctors sought to emulate this model by presenting madness as a disease that offered just such a threat. Psychiatrists promoted the image of the insane as dangerous, either to themselves or others, on a variety of levels. The most dangerous was the 'homicidal maniac'. This was propagated by an unprecedented interest/involvement in, and discussion of what Foucault terms 'crimes without reason', i.e. where no recognised motive could be found for the crime. Where previously in the 18th century there had been pleas to distance the mad from the criminal, in the 19th every effort was being made to link madness and certain form of criminality. Although initially the judicial system

resisted the physician's attempts to transform criminals into madmen, the penal reforms of that time advocated the need to identify motives for criminal behaviour, therefore 'crimes without reason' became crimes of madness. However one of the consequences of this amalgamation of crime and insanity, Foucault proposes is the creation of the 'dangerous man' (sic) and the inscribing of this on the 'institution of psychiatry'.

The invention of the dangerous man was necessary to perpetuate the physician's scientific involvement in madness. With large number of inmates now deemed incurable within the Asylums the role of the doctor became limited to ensuring that appropriate supervision was given to attendants to ensure that patients were not ill treated by those proposed as lacking moral fortitude. However the dangerous man provided an alternative object for the scrutiny of the physician. The undetected insanity of those committing crimes proposed a risk to society which required individuals with expert knowledge (the doctors) to make them visible.

Physicians Professional Status

Although the Commissioners in Lunacy had invested the medical superintendent with supreme authority, they had also restricted his working environment, disallowing private and public practice to be undertaken at the same time. As private madhouses reduced in number, the opportunity to move from the Asylum to the more lucrative private sector reduced. Renvoize (1991) suggests that the Asylum doctors experienced a triple blow; low social status, poor conditions of service and financial insecurity.

It is suggested, (Jones, 1991; Renvoize, 1991; Turner, 1991), that the public was generally suspicious of the motives of the physicians in the 19th century and fears of wrongful confinement and abuses of patients abounded. There was a rising tide of negative comments made publicly against the M.P.A. and its members, some emanating from within the association itself relating to the so-called 'trade in lunacy' of the private madhouses. This was reinforced by the novels such as 'Hard Cash' (Reade, 1870), which told the story of a father paying physicians to incarcerate his son in a madhouse and the son's subsequent struggle to escape its walls. Although

such concerns related primarily to those with wealth and thus more in terms of private madhouses such concerns entered the public consciousness. Jones proposes that this public outcry came at a time when the first tabloid newspapers became popular and "sensations were much in demand by the reading public" (Jones, 1991, p94). Parallels can be drawn with today's reporting of incidents involving people with mental illnesses. The profession was regularly lampooned by periodicals such as 'Punch' and its character depicted in popular fictional works such as Trollope's Vicar of Bullhampton as low and cruel. Such denigration led a visiting German alienist to comment at the 1864 meeting of the M.P.A. "our science does not exist at all…every snob has now become accustomed to sneer at 'mad-doctors'" (Turner, 1991, p6).

Added to this sensationalisation was a protest movement known as the 'Alleged Lunatics' Friends Society' who spent a great deal of time berating the Asylum doctors and 'rescuing' patients from them (Turner, 1991). They also instigated a series of legal cases relating to the mental state of one Mrs Georgiana Weldon and the legality of her detention, which were much reported in the press of the day.

Such was that outcry the Select Committees were appointed in 1859 and 1877 to consider if the lunacy laws required attention. Renvoize (1991) suggest this public disquiet found expression in the 1890 Lunacy Act. There would seem to be echoes of the Moral Panic in this series of events. However this time it was in relation to the need to regulate the medical profession in relation to the care of those with mental illness rather than that experienced in recent times as to the dangerousness of the mentally ill. Concern regarding the care and possible abuses in Asylums was to be raised again in 1919 with Piece recounting in the annual report that a number of serious allegations had been made concerning the management of mental hospitals. The publication of 'The Experiences of an Asylum Doctor' (Lomax, 1922) which painted a dismal and damning picture of Asylum practices, did little to alleviate this anxiety. Henry Yellowlees (1922) denouncing the 'shilling shocker' - tabloid press of the day - mentality of the public at that time and the portrayal of all mental hospitals as sites of unspeakable horrors identifies the damage this has done to the reputation of physicians in mental illness. History was repeated in the 1960s when a succession of 18 public inquiries gave voice to cruelties and abuses experienced by

individuals in mental institutions (Nolan, 1995). Again there was a need to establish psychiatry as a credible and worthy science.

As identified above, initially the legal debate in the19th century around crime and insanity also placed the doctors at a disadvantage. With little consensus as to criteria for diagnosis and classification of mental illness when called as expert witnesses in legal cases, their knowledge was frequently dismissed, undermining the doctor's professional position. The medical education of those involved in the Asylums was sadly lacking and one of the aims of the M.P.A. was to institute formal undergraduate and postgraduate education. There was a move pressing for the inclusion of 'mental medicine' in the medical undergraduate programme. It was not until 1888 that the British Medical Association (B.M.A.) added 'mental disease' as a separate section to its annual meeting and the General Medical Council included psychological medicine amongst its compulsory subjects in 1891 (Russell, 1988; Renvoize, 1991). However Turner (1991) suggests that this left the M.P.A. in the shadows with the kudos of the education initiative lying with the B.M.A. Research in relation to mental conditions was often credited to the B.M.A. whilst the running of the Asylums was seen as the remit of the M.P.A. members relegating them to the position of 'keepers', rather than scientists and emphasising the difference between medicine and psychiatry.

The implementation of the N.H.S. Act (1946) bestowed on the mental institutions the same status as general hospitals and provided them with the same administration systems, with the doctors receiving the same title (consultant) and thus status as their general colleagues (Howells, 1991). However Adair (1957) identifies that the public viewed psychiatrists as different to other doctors. She talks of the ridicule with which psychiatrists of her day had to contend. The lack of comparable status often resulted in those who would not be tolerated in general medicine being relegated to psychiatry. In announcing her own intention to take up psychiatry Adair (1957) describes how she was greeted with 'frank derision' from her friends.

Imitating General Medicine

As identified in Chapter 5 the employment of middle and upper class women as nurses in the general field was seen as adding to medicine's reputation. The Asylum physicians sought to emulate this with Robert Baker (1875, p22) highlighting the need to encourage those of a "more educated class" to join the ranks of the Asylum staff. Russell (1997) remarks on the changing attitudes of the Governors of the now Maudsley hospital during the 1880s. Whereas the engagement of 'strong young men' had been cause for celebration in 1881, a few years later they were looking for 'more refined' attendants, particularly lady probationers - women from the upper classes. It was hoped that the employment of females in this capacity would do much to reduce the distance apparent between hospitals and Asylums.

The Asylum doctors fervently wished that Asylums should come to be seen as hospitals for the treatment of mental illness. Physicians in madness were rapidly loosing ground in relation to their general colleagues, the scientific value of their activities was called into question. It was hoped that enticing women of standing into this arena would enhance the status of the science. As a result of this Asylum physicians devised and implemented a training programme for attendants in 1890.

Education was central to political and philosophical debates of the time with this being seen as having the potential to revolutionise working practices through the creation of disciplined workforces (Nolan, 1993). Education had always been available to the upper classes, the benefits of this in relation to the working classes were just being realised. It was felt that by offering training Asylum staff already in post would be motivated to see the work as more interesting and remain in place. It was also hoped that the provision of education programmes would influence and encourage educated women to undertake Asylum work. That they might "more readily do this when it was generally known that mental nursing is a calling worthy of their powers and one that requires special training and discipline and much experience" (Pierce, 1902, p24).

The training for attendants was similar to that being advocated in the general sphere of nursing where upper-class women paid for the privilege of undergoing the training system. In an effort to retain the services of these trained and educated women the

title 'sister' was introduced at the York Retreat in 1901. This carried with it special privileges such as increased annual leave and special dining facilities (Piece, 1901). However, the retention of such staff was a problem with many such nurses taking up posts in private homes or in general nursing as soon as an opportunity presented itself.

The drive to attract the 'appropriate calibre' of staff is repeated at various points in mental health nursing's history. At the Retreat in York a pre-nursing scheme was introduced in 1933 to encourage those not yet of sufficient age to participate in a scheme that was said to prepare them for their nurse training. A promise of one year off the actual training was hoped to tempt 16/17year olds into the profession (MacLeod, 1933). The Wood Report (Department of Health for Scotland and Ministry of Labour and National Service, 1947) identifies the particular problems of recruitment in relation to mental hospitals and advocates a new training scheme to address the issues. In 1970 a special degree/diploma course to attract people with appropriate educational qualification is proposed as being essential to the provision of nursing care for the individual with mental illness (D.H.S.S. 1970). A similar approach is apparent in the education strategy of Project 2000 (U.K.C.C. (1986) and in the current government's document 'Making a Difference' (D.O.H. 1999a). All are attempts to make nursing an attractive proposition to certain sections of the population.

Walk (1961) proposes that whilst the impetus to educate attendants was based on good intentions, the handbook developed by the M.P.A. to support the programme was instrumental in divorcing the qualification of mental nurses from the actual practice of mental nursing. As the book contained a preponderance of physical knowledge and limited application or consideration of the realities of mental nursing Walk proposes it as of little value to the mental health nurse. This he blames on the unreserved imitation of the 'vogue' in general hospitals and the drive by some of the Asylum doctors towards hospitalisation of the Asylums.

One aspect of this 'hospitalisation' movement was the employing of general trained nurses as Matrons in the Asylums. Advertisements for senior nursing staff often stipulated a requirement for so called 'hospital certificated' nurses, particularly for Matron posts. When complaints were made as to the lack of experience in Asylums

such individuals were frequently employed as assistant matrons and promoted at the earliest opportunity. This only served to reduce the status of the attendants and their training. This imitation of general hospitals was, over time, to become a requirement. The publication of 'The Experiences of an Asylum Doctor' (Lomax, 1922) resulted in the commissioning of a government committee to report on the criticisms (Ministry of Health, 1922). This committee recommended that all mental institution should have one qualified 'hospital nurse' and that preference should also be given to physicians who had general hospital experience. By 1954 Psychiatrists were to eagerly proclaim "Keepers and attendants have been replaced by trained mental nurses, while most of the supervisory staff are additionally trained in general nursing" (R.M.P.A. 1954, p4).

This desire for mental hospitals to reflect the roles and managerial formats of the general hospital was re-iterated in the Percy Report (Royal Commission on the Law relating to Mental Illness and Mental Deficiency, 1957) where it was suggested that mental illness should be regarded in the same way as physical ones and that both types of hospital hospitals be 'run' in the same manner.

Legislation

Dingwall, Rafferty and Webster (1988) claim that mental illness had had little attraction to the government pre early 19th century. Whilst legislation was in place to deal with control of land/wealth of the insane, legislation regarding their care was generally sparse. However, as identified in Chapter 5, it was placed firmly on parliament's agenda in the late 18th, early 19th century. Lithiby (1912) identifies that the first half of the 19th century saw a number of Acts appearing which related to the insane but it was not until the 1890 Lunacy Act that these were consolidated into a cohesive form of legislation. Up until this point it was not always clear in statute what was required. However issues that were clearly outlined related to the keeping of records, penalties for abuse/neglect of duties and requirements for the safe containment of those deemed insane (including fines if lunatics 'escaped'). For example the 1808 Act identifies that Asylum are where the insane are to be "safely

kept" and that "any officer through neglect or connivance permit such person to escape...shall for every such offence forfeit and pay a sum" (section 323).

The Lunacy Act of 1845 imposed a powerful administrative system on the governance of mental institutions and this was extended in the 1890 Act. A central commission had jurisdiction over the whole country. Bad practice was to be reduced through the use of elaborate documentation accounting for every aspect of Asylum life and activity. Records were to be kept in large number. Penalties were imposed if books and reports were not appropriately maintained with Lithiby (1912) identifying an asylum clerk being fined £5 in 1900 for failing to supply the Lunacy Commissioners with certain 'returns' in relation to inmates. Many nurse/attendants were subject to fines of up to £20 for proposed ill treatment such as unlawful use of restraints.

Regulations in the Lincoln Asylum Annual Report of 1860 identify that all nurses and attendants are to be supplied with a copy of Section 56 of the 1845 Asylum Act which states that:

> "if any superintendent, officer, nurse, attendant servant or other person employed in any licensed house or registered hospital shall in any way abuse or ill treat any patient confined there in or shall wilfully neglect any such patient, he shall be deemed guilty of misdemeanour."

This practice was to be repeated in various institutions across the country and down the years.

The 1890 Act, Jones (1991, p95) states, is an example of what she terms "closed-texture statute" where nothing is left to the discretion of the individuals involved, all eventualities are accounted for. Treatments, time spans and relationships are specified with penalties for non-compliance identified. From a legal perspective this was an example of a 'good act' however from the medical one it was a nightmare. As a result of all the intricacies involved in implementing the Act, the 'knowing' of it became a virtue with the concomitant emphasis on observation of procedure and form. The 1890 Act had three 'misdemeanour' clauses, which were brought to the attention of the attendant in the subsequent Red Handbooks. These related to ill treatment/neglect, permitting the escape of a patient, and "carnal knowledge of any

female under care" (M.P.A. 1923, p25). The emphasis given to these would seem to encourage the adherence to medical discourse - wilful neglect for attendants included failure to carry out doctor's orders - and control discourses –ensuring that people did not escape. Jones suggests the treatment took a 'back seat' to adherence to the Act's tenets. This is the feeling expressed by the Royal Commission on Lunacy and Mental Disorder (1926) which proposed that the preoccupation with preventing abuse of the system meant that the focus had been on detainment, at the cost of treatment and cure. Such regulation can be viewed as a technology of discipline, not only in relation to the insane but also those charged with their care. The physician and the attendant are subjected to hierarchical observation by virtue of the administrative system imposed and to normalising judgement through the activities of the Commissioners in Lunacy. Thus those who observe and control are in turn controlled and observed.

A swing from legal to medical perspective is apparent in the 1930 Medical Treatment Act, which introduced the concept of 'voluntary' treatment and discharge, advocating the use of outpatient facilities (Jones, 1991). The terms lunatic, attendant and Asylum were replaced with patient, doctor, nurse and hospital again reflecting the general medical model and identifying mental illness as a 'public health problem' and the final hospitalisation of the Asylum. The medical perspective in relation to mental illness came into full ascendance over the legal one with the 1959 Mental Health Act and placed a great deal of power in the hands of the medical profession. However this faith in the abilities of the doctors to provide appropriate care was short lived. The 1960s saw the rise of the anti-psychiatry movement, and Inquiries into allegations of abuse and neglect in mental hospitals were rife. The medical model of care fell into disrepute. The result of this unrest and concern was the 1983 Mental Health Act. To a large extent the changes made focused on ensuring the civil rights of those legally detained in hospital, little alteration was made in relation to informal patients and the services rendered to them. Jones suggest that this resulted in an updated version of the 1890 Act where people were again required to "know their sections and to operate according to the letter of the law" (Jones, 1991, p100). Interestingly this Act also gave nurses 6 hours holding power; the power to prevent informal patients leaving hospital. So despite their claims to therapeutic

relationships with patients, the legislation placed them firmly in the role of controllers of the mentally ill.

The latest proposed changes to mental health legislation identify that:

> "existing legislation has also failed to provide adequate public protection from those whose risk to others arises from severe personality disorder. We are determined to remedy this." (D.O.H. 2000b, p3)

Current legislation, Rogers and Pilgrim (2001) suggest, is swinging towards the control/containment extreme of the treatment-control continuum.

Summary

- The establishing of the physicians-in-madness' moral and professional right to direct and control the care of those deemed mentally ill gave them authority to dictate attendant's regimes of practice and demanded unquestioning obedience ensured through technologies of discipline. This authority became a taken-for-granted background in mental health nursing

- The regimes of practice appropriate to attendants were premised on the attendants acting in the service of the medical discourse – providing information, controlling the environment and patients and ensuring treatment regimes are carried out.

- The promise of curing individuals with mental illness floundered and led to the medical creation of the dangerous man in the form of the criminally insane. Whilst it was believed this would place physicians within the public hygiene discourses it promoted the inscribing of 'dangerousness' of the insane.

- Society's general distrust of doctors in madness, linked with the image of the dangerous man resulted in the implementation of legislation not only aimed at controlling those proposed insane but also the activities of those

charged with their care. With the exception of a brief respite in the mid 20th century, most legislation relating to madness has control and regulation at its centre with little recourse to therapeutic activities.

- In an attempt to raise their status as a scientific discipline, physicians adopted the language and approaches of general medicine. This led to the promotion of an education system for attendants similar to that of the nurses in general hospital and the valuing and rewarding of 'hospital trained' nurses over the attendants.

CHAPTER 7

POWER RELATIONS (PART 2)

- Introduction
- Theoretical framework
- Methods of Investigation
- **Genealogy** - Diagnosis of the Present
- - Conditions of Emergence
- - Power Relations (part 1)
- - **Power Relations (part 2)**
- - Knowledges
- Q-Methodology - Philosophy and Approaches
- - Data Analysis
- Discussion, Limitations and Conclusions

The previous chapter considered the power relation evident within the mental health setting and between those employed within that arena, society and the State. Now the intention is to examine the power relations manifest within and on the body of nursing as a whole. The word 'nurse' is synonymous with an uniformed woman working in a hospital. When asked to name a famous nurse, the first to spring to people's lips is Florence Nightingale, the personification of nursing. So strong is this image that, as Chatterton (2000) identifies, nurses working outside of the recognised field have to use a prefix to proclaim their identity (mental health nurse, male nurse, learning disabilities nurse). This of itself gives some insight into the nature of power relations within nursing.

As identified in Chapter 5, the elevation of nursing to a worthwhile occupation for women of the middle and upper classes had taken place primarily in the general hospitals. Nurses traditionally were from the lower reaches of society, their status little more than that of house servants. Commentators of that time often presented nurses as immoral drunkards, with little concern for their fellow human beings. However various writers (Abel-Smith, 1960; Rafferty, 1996b) suggest that particular

groups may have over-played this low estimation of nurses for particular reasons. For nurse reformer's there was a need to distinguish themselves from the old ways if they were to establish themselves as a credible group. The rising 'scientific' medical profession needed to create trust in their abilities, the old style nurse with her proposed grievous shortcomings provided a convenient scapegoat when treatments went wrong.

Profession or Vocation

The work of Nightingale and the establishment of Schools of Nursing attracted women from the upper-classes into the field of nursing. It was from this group that champions of modern nursing were to be drawn, those who would control the daily activities of nursing – the matrons. These 'ladies' were afforded a significantly different status to those undertaking the day to day work of nursing (Abel-Smith, 1960; White, 1986). As 'lady probationers' they paid for the privilege of being trained, however on completing this training they were rapidly elevated to the role of sister and ultimately matron. The probationers – drawn from the middle classes - were paid a minimal wage. As Baly (1995) points out, this low pay came to have an intrinsic merit in getting the right sort of 'girl'. It can also be seen that 'paying for the privilege' added to the image of nursing as a 'calling', not sullied by material gain. This ethos was to be carried forward well into the 20th century with Joan Markham (1975, p26) writing of her experience during the Second World War stating "our training was a privilege that we were allowed in return for our work".

The numbers of single women looking for a 'vocation' in life had increased in the 19th century, this being an opportunity for upper-class women to answer the philanthropic demands of their station. However the idea of nursing as a vocation was to hinder recruitment to the profession in later years as those entering nursing found it of little comfort in helping them attain better conditions of service (Ministry of Health, 1939). Whilst the image of vocation was strong, factions within nursing in the 19th century strove to establish its place within the new hospital system and advance its status through professionalisation in the form of Registration.

The Registration of Medical Practitioners Act in 1858 had prompted a number of other occupational groups to consider their own advancement through similar legislation. Teachers received this in 1899 and nurses began working towards this in 1886 (Baly, 1973; White, 1986). In pursuing registration there was an attempt to limit the usage of the term 'nurse' to those who met certain criteria and thus create an elite group of individuals. However all members of general nursing did not view registration in the same way.

Florence Nightingale opposed registration in any form, whilst Mrs Fenwick, founder of the British Nurses Association, fought hard and long to achieve state registration. The latter's vision was one of a nursing profession led and organised by nurses providing public recognition of the professional status of nurses. Registration would be of appropriately trained nurses only (Bendall and Raybould, 1969). However others, generally hospital administrators and governors, simply wanted a register of practising nurses that informed hospitals of the numbers and types of nurses available for employment. As Roberts (1996) highlights, in the 19th century the term 'nurse' was applied to a range of individuals who undertook a variety of diverse tasks, having no unifying attributes or identifiable body of knowledge on which it based its activities. The administrators feared that any other form of registration might dramatically increase employment costs and reduce the pool of individuals on who they could draw. This schism lead to much heated debate and wrangling.

Uniting Nursing

The British Nurses Association was in the vanguard of the professionalist movement towards registration with its stated aim in 1893 to:

> "unite all British Nurses in membership of a recognised profession and to provide for their registration on terms, satisfactory to physicians and surgeons, as evidence of their receiving systematic training." (Bendall and Raybould, 1969, p 5)

However this uniting of nurses was not viewed as encompassing the Attendants in the Asylums. Following a meeting of the British Nurses Association where it was

proposed and accepted that Attendants should be allowed to register with the Association, Mrs Fenwick wrote in a 1896 Nursing Record Journal:

> "Everyone will agree that no person can be considered trained who has only worked in hospitals and Asylums for the insane...considering the present class of persons known as male Attendants, one can hardly believe that their admission will tend to raise the status of the association." (Nolan, 1991, p50)

This disdain in relation to mental nurses was to pervade the various nursing associations. For example The Royal College of Nursing, which became the accepted representative of the voice of the nurse, only admitted general trained nurses therefore mental nurses had no voice in the powerful organisation until 1943 when the Society of Mental Nurses' was set up as a subgroup (Nolan, 1993).

The path to registration was a rocky one with various factions fighting for supremacy. Various select committees considered the pros and cons, members of parliament and royalty were lobbied and assorted opinions sought and aired (Abel-Smith, 1960; Bendall and Raybould, 1969; Baly, 1973). Registration was originally to be for upper and middle-class women working in the general sphere of nursing and there was great opposition to the idea of including other groups, and particularly mental nurses in this. Although general nursing had been working purely to enhance its own status, the various lobbying by interested parties resulted in a number of supplementary sections allowing for the registration, among others, of mental nurses. Psychiatrists had a vested interest in mental health nursing being included in this drive towards the professionalisation of nursing. As discussed in Chapter 6 the enticing of such upper and middle class females into the mental health setting was a way of enhancing their status and the registration of nurses was one possible way by which this could be achieved.

Members of the M.P.A. contributed to the various Select Committees formed over the fifteen years of parliamentary debate surrounding the registration of nurses. The medical superintendent of the Retreat in York, Dr Bedford Pierce, was appointed to the General Nursing Council following the Registration Act of 1919. The General Nursing Council was the body which would regulate nursing and its education

(Bendall and Raybould, 1969). There were to be 25 members of the Council but only one of these was from the mental nurse arena.

The 1924 report 'Nursing in the County and Borough Mental Hospitals' proposed that mental nurses needed to be skilled, tactful and kindly and therefore adequately trained. It also advocated that mental nursing should not be seen as separate from, but rather as a branch of the nursing profession as a whole (Nolan, 1993). The report placed general nursing in a superior position to mental nurses by proposing that the latter needed to undertake both types of training whilst the former only required a short period in mental settings. The fact that the education of all nurses had to include one year of common training produced an impression of general training as a prerequisite of other types of nursing. Thus the supplementary trainings were devalued in relation to the general qualification (Dingwall et al. 1988; Nolan, 1993).

Bellaby and Oribabor (1980) suggest that the achievement of Registration did not serve to unite nursing under one banner. The diversity of environments in which nurses' work, negates against such unity, as practice requirements were and are so different. The fact that nurses practice within a framework established by another profession (i.e. medicine) means that medical ideology dominates the working arena and as such dictates nursing actions. The establishment of the G.N.C. did not allow nurses to control their own destiny, the State dictated its membership, which included a number of individuals from the medical profession.

The Battle for Control of Mental Nurse Education

Bendall and Raybould (1969) propose that it was clear from the beginning that there were to be difficulties with the registration of 'mental' nurses. Initially the G.N.C. agreed that the M.P.A. certificate should be accepted for admission on to the register. However the ultimate aim of the G.N.C. was to have a 'one portal' examination where all nurses would undertake the same preliminary examination at the end of the first year of training. Having lost the battle to exclude those aspects of nursing deemed unsuitable by 'hospital' trained nurses, the G.N.C. was intent on gaining and retaining control of all allowed to call themselves nurses. The M.P.A. lobbied for their syllabus of training to be adopted for the full three years. Although this

approach was adopted as an interim measure the G.N.C. was determined that eventually 'mental' nursing should follow the template proposed for all other nurses, taking the Preliminary examination and a similar final examination to their colleagues in other branches of nursing.

The M.P.A. believed that it should continue its role in the education of mental nurses and felt that the G.N.C. should franchise this part of registration to them. However the G.N.C. was determined to maintain a tight grip on the education of nurses in its drive towards professionalisation and the relinquishing of any part of this role was not to be countenanced (Bendall and Raybould, 1969; Nolan, 1993; Arton, 1993). Despite a number of meetings between the G.N.C. and the M.P.A. no agreement could be reached and in 1924 the Council announced it would no longer recognise the M.P.A. certificate for the purpose of registration. The M.P.A. responded by stating it would continue its own form of training and certification. Thus the two forms of training and qualification ran in tandem for 'mental' nurses; the Register Mental Nurse organised by the G.N.C. and the M.P.A. certificate. However the G.N.C. syllabus strongly resembled that of the M.P.A and as the M.P.A. had modelled theirs on general hospital training, the argument seemed somewhat arbitrary.

The wrangling between these two bodies continued in the period up to the Second World War. At various points meetings were held, committees set up and opinions sought as to how the training of 'mental' nurses should be undertaken and who should organise this (Bendall and Raybould, 1969; Arton, 1998). The now Royal Medico-Psychological Association (R.M.P.A.) advocated a form of training that was firmly under their control and reflected medical need. The G.N.C. wanted a training that to all intents and purposes represented a physical approach to nursing. In reality few mental nurses accessed the G.N.C. training. Mental health nurses' response to a perceived subjugation to general nursing was an avoidance of their training programme. It is also possible that medical superintendents of the mental hospital actively discouraged nurses from taking the G.N.C. training (Nolan, 1993; Arton, 1998). Arton comments that there seemed no real desire to settle the dispute. The G.N.C. held mental nurses in contempt, feeling that the R.M.P.A. training was substandard, thus there was no desire to facilitate their entry into the nursing sorority. Mental nurses could achieve charge nurse status with the R.M.P.A. certificate

therefore unless they desired to progress further there was no need for G.N.C. registration. This 'warring', Arton suggests, served to draw mental nurses and psychiatrists closer together in the face of a common enemy – general nursing.

A number of initiatives calling for separate registration of 'mental' nurses and automatic registration by virtue of the R.M.P.A. certificate were forwarded but with no success (Dingwall et al. 1988; Arton, 1993). The G.N.C. wanted a unified profession with a common standard, whereas the R.M.P.A. wanted continued control of the training of what it saw as 'its' nurses and stating that its approach met the specific of the practice demands. The National Asylum Workers Union supported the RM.P.A. due to concerns re job security (Carpenter, 1993). As female workers were paid at a much lower rate than males and the Asylums had large numbers of male workers there was a fear that this female dominated occupation would provide an influx of female cheap labour. However, throughout the various debates the mental nurse's voice was never actually heard, as the discussions took place between general nurse members of the G.N.C. and the R.M.P.A. Each group was attempting to gain control of mental nursing to further its own agenda.

In 1945 an Interdepartmental Committee on Nursing Services again strongly recommended that there should be only one qualification for mental nurses, that the R.M.P.A. should discontinue its examinations and nurses with the Association's certificate should be incorporated into the G.N.C.'s register. There was also a call to improve their conditions of service in an effort to improve that status of the work in the hope of improving recruitment. In 1946 the R.M.P.A. agreed to wind up it training scheme and the G.N.C. agreed to admit those with the RM.P.A. certificate on to the register. The last R.M.P.A. examination was conducted in November 1951. In the 60 years training 48,000 R.M.P.A. certificates had been issued. Walk (1961) suggests that some of the Asylum doctors clung to the RM.P.A. training for mental nurses in the hope of returning it to the principles of training nurses to be mental nurses rather than the inflexible programme of general nursing which presented such a physical perspective. However given that the RM.P.A. administered the training programme for 60 years without substantial changes this explanation would seem unlikely.

Nurses Educating Nurses

Although the G.N.C. had advocated the 'one portal' system it became clear quite early on that there was great opposition to the imposing of the same curriculum on the first year of training for all nurses. The changing face of psychiatry in 1950s through the development of psychotropic drugs and ideas of therapeutic communities saw a series of reports commissioned by the World Health Organisation concerning mental health and its nursing (Nolan, 1993). Here emphasis was placed on the creating of therapeutic environments in which to care for people with mental illnesses and the pivotal role of the mental nurse in this (W.H.O. 1953; 1956; 1963). Thus the 1957 syllabus for mental nurses showed a departure from the G.N.C.'s philosophy, and an incorporating of 'therapeutic' aspects, an inclusion of psychology as a topic area and a proposed removal of the common first year content. This was deemed an 'experimental' syllabus and as such was piloted in various sites. It was not, however, introduced nation wide until 1964.

Although the common preliminary examination disappeared, an intermediate examination was introduced to test knowledge at the end of the first year. The areas addressed in the 'intermediates' were personal and communal health; accidents and first aid; general nursing; physical illness; psychology and psychiatric nursing. A large emphasis was given to physically orientated knowledges. The curriculum remained much the same, content relating to mental issues was brought forward and included in the first year, the 'general' content from the first year simply being spread through the second and third years. With the exception of the adding of sociology and issues concerning community care in 1974, little change occurred until 1982 (G.N.C. 1957, 1964a, 1974a). The content was heavily weighted towards a general nursing model of care set within a medical orientated framework.

Greenaway (1995) recalls the large amount of physical nursing taught when undertaking his psychiatric training the 1960s and being able to recite medically orientated knowledge relating to disorders and its various signs and symptoms, yet learning little about psychiatric nursing. Certain record books of a Nottingham School of Nursing at the time support this assertion with large amounts of time given over to learning general nursing procedures, anatomy and physiology, first aid and 'diagnosis' led sessions. The 'therapeutic' aspect of mental nursing appears absent.

The radical change that occurred with the 1982 curriculum reflects the severe criticisms levelled at the general nursing council as to the content of mental health nurse education. Nicholas and Gooderham (1982) recount the concerns regarding the lack of emphasis on interpersonal skills and therapeutic activities and the over inclusion of medically orientated content. This drastic overhaul of the curriculum can be viewed as a point of resistance to the power relationship between mental health and general nursing. The prevalence of the psychodynamic model within mental health settings made the differences between the two forms of nursing too great, providing an opportunity for mental health nursing to move towards its own educational strategy. Yet still embedded firmly within the curriculum were aspects of nursing such as the nursing process, nursing theories and certain aspects of physical nursing (E.N.B.1982).

The change may however have been an attempt to avert the dismantling of the nursing body and a splitting off into it constituent parts. The Jay Report (Committee of Enquiry Into Mental Handicap Nursing and Care, 1979) had suggested that it was inappropriate to designate mental handicap nurses as nurses, believing them to fit more easily within a social services model if not within a completely new formation. Concerned that the same fate might befall mental health nursing, a new curriculum incorporating the current health initiatives in relation to mental health was quickly devised and implemented. The drive towards professionalisation still required a cogent body of nurses with the appropriate corporate image. The highlighting of the 'therapeutic' aspect of mental health nursing was a tool of power aimed at ensuring the continuance of this nursing 'body' as a whole.

Whatever the motives behind such changes, they were relatively short lived as nurse education as a whole was reconsidered in the mid 1980s. The concerns regarding the falling numbers of students, the proposed demographic time bomb, which would limited the numbers of young people available and the need to encourage people to see nursing as a viable alternative to other forms of employment, required a radical rethinking of the image of nursing. It was untenable to overhaul all other branches and omit mental health nursing, thus any plans must and did include this discipline. The hope was to increase the status of the profession by moving it into higher education, making it attractive to a more selective younger generation whilst at the

same time encouraging mature students by offering a more flexible approach to the programme.

Managerial versus Professional Discourse

Various writers suggest two dominant movements at work within nursing; 'managerialists' and 'professionalists' (Williams, 1978; White, 1986; Abbott and Wallace, 1990). Managerialists see nursing as practical in nature, requiring little underpinning theory, the role of the trained nurse being concerned with the supervision of junior and unqualified staff. In many ways this is a simple extension of the role of upper-class women in 19th century society, with running of the hospital ward being substituted for the management of the house. The concept of hierarchical observation is present within this discourse, with surveillance of others at it root. Professionalists are concerned with the development of a more theoretical form of nursing and the nurse as an autonomous practitioner. Here can be seen technologies of self, a point of resistance to the power relations evident in the space within which nursing acts and an attempt to re-create nurses' identity.

The professionalists are concentrated in educational institutions, their views present in the various nurse education initiatives from the first national curriculum in 1923 to 'The Peach Report' (U.K.C.C. 1999). The establishment of nursing as an academic subject is viewed as essential to the improvement of nursing's status. The managerial faction sees the solution to improving nurses' standing in managerial roles and frameworks and can be seen in policy initiatives such as the Salmon Report (Ministry of Health and Scottish Home and Health Department, 1966), The Griffith Report (D.H.S.S.1983), and the Workforce Planning Report (D.O.H. 2000a). Here precedence is given to the view of routine nursing tasks – the dirty work - being undertaken by junior and/or unqualified staff overseen by a hierarchical managerial framework.

The managerial discourse within nursing has institutional requirements at it heart and as such is founded on principles of economics. Whilst purporting to offer a nursing view, in reality it is an employer's one and here is a discourse related to getting work done at the lowest cost. This economic underpinning is evident in the debate

concerning a 1937 Bill proposing the setting of minimum wages and limiting hours of working (Carpenter, 1985). The then College of Nursing opposed the Bill on the grounds that it was not in the interest of the nursing profession or the public, that students receive a more than adequate remuneration in return for a valuable training. The Bill was defeated. Bellaby and Oribabor (1980) suggest that such attitudes stem from the need of those in managerial positions to retain tight control of junior and untrained member of staff.

The managerial discourse in the mental health setting is highlighted by Hopton (1997b). Mental health nurses practising between 1920 and 1975 portrayed the picture of the ward environment as the undisputed domain of the charge nurse who defined how and what care was to be given. Nolan's (1993) interviewees employed from 1920s onwards, comment that the insights given by sister/charge nurses was seen as of more value in the clinical setting than that gained from the nurse teachers in lectures and recounted the continuing divide between what is taught in school and the regimes of practice in the work place. Brian Greenaway (1995, p44), recounting his experience as a student in a psychiatric hospital in the 1960s, recalls how education establishments were not popular on the wards, being told "what they teach you there, boy, is one thing, but when you're on my ward you do as you're told". He goes on to question the validity of current education practices stating "when today's students become ward managers how will they be able to supervise their junior staff if they are unable to do the work themselves" (Greenaway, 1995, p45). A question which would seem to typify the view of managerialists.

The two discourses are evident in the organisation of education programmes advocated as appropriate for nurses with Jolley (1987) suggesting that these have often been the root of the disharmony surrounding nurse education. The proponents of the managerial discourse are seen to resent the demands of the educational requirements for student nurses, whilst the professionalists see utilisation of the apprenticeship model of training as placing students in an invidious position. As an employee of the hospital they were expected to 'work' whilst as a student there is a requirement for 'learning'. The managerial faction asks for unquestioning obedience to those in senior positions, whilst the professional discourse advocates an application of theory to practice and thus encourages a questioning of tasks allocated to students. Various reports have called for full student status to be given to student

nurses (Royal College of Nursing, 1943; Department of Health for Scotland, Ministry of Labour and National Service, 1947; D.H.S.S. 1972). However it was not until Project 2000 and the proposed move of nurse education into higher education institutions that this ideal was achieved (E.N.B.1986).

The issue of higher education for nurses was raised by proponents of the professionalisation discourse in the 19th century and had begun in America from 1907 (Jolley, 1987). However as Chapman (1975) identifies in Britain, the idea of an 'academic nurse' was something of an anathema, a 'clever' nurse often being met with derision. The Briggs Report (D.H.S.S. 1972) identifies that some ward managers appeared threatened by 'knowledgeable' students. As nursing degree programmes were developed in the 1960s such derision was frequently experienced by undergraduate student nurses, resulting in high dropout rates following completion. However the increasing academic requirements of the traditional curricula also led to an increase in student attrition particularly amongst those with poorer academic qualifications.

The academic status of nurses is evident in the repeated debates as to the appropriate entry qualifications for nurse education. At times when recruitment has been easy such requirements have been sanctioned by parliament, however in periods of difficulty there have been calls and undertakings to widen the entry gate. In 1961 the requirement of specific academic qualifications for entry into nurse education was instigated for the first time (Jolley, 1987). Again in 1980s (U.K.C.C. 1986) the academic nature of the curriculum was emphasised in an effort to encourage people to access the course. However recently with the shortage of nurses and the difficulties of recruitment there has been a call to provide wide access to the programme (D.O.H. 1999a). The vying between the managerial and professional discourses for dominance is evident in the various debates as to the level of education need by students. The Department of Health's advert for nurses in the 1970s suggested that "the best nurses have the essential qualifications before they go to school" (Salvage, 1985, p3). Similarly in 1983 The Nursing Times editorial considered the merits of A-level education for nurses and felt these could be seen as detracting "substantially from skills needed for good basic care". More recent debates have focused on whether degree level qualification will enhance or inhibit 'good' nursing.

It is interesting to see that at times when recruitment is poor and demand outstrips supply either because of health service expansion or hospital personnel were required elsewhere (as during the two World Wars) the managerial discourse takes precedence. In this case the numbers of unqualified staff are increased to meet the requirements of the service and alternative forms of qualification are embraced. However in times of full employment or alternatively when demographic changes have required nursing to try and draw candidates from sources outside of the norm, the academic nature of the work has been emphasised. At various points in nursing history, 'assistant' nurses have been created to supplement the lack of registered nurses. The Nurses Act (1943) allowed for the creation of the 'enrolled' nurse to be the general nurse's assistant (Baly, 1973). These individuals would have a shortened training, being more practice based in nature and to come under the direct supervision of the registered nurse.

Ross and Wilson (1957) state that the Nurses Registration Act (1919) bestowed on nurses the status of 'professional'. However they also propose that the managerial requirements, due to the frequent shortage of and therefore demand for nurses, overshadowed this professional status. They argue that as the numbers of nurses required were matched, so nursing was able to acknowledge its professional status. However as recruitment and retainment of nurses has been a recurrent problem throughout its history, the ascendancy of the professional discourse has always been short lived.

Mental health nursing has tended to have the most difficulty with recruitment, which has resulted in various compromises being made over time. Educational qualifications of those accessing psychiatric training have generally been lower than those entering general nursing (Department of Health for Scotland and Ministry of Labour and National Service, 1947; D.H.S.S. 1970). The high ratio of men in mental health settings also produced a wider age distribution, and an increased continuity of service in one hospital by virtue of the fact that men did not have to leave the profession if they married. There has been a higher ratio of enrolled nurses, with many nursing assistants achieving enrolled nurse status by virtue of length of experience when introduced into mental institutions in 1965. Such factors promote a managerial discourse with emphasis on the registered nurse supervising junior

less/unqualified staff. Hierarchical observation is evident within such arrangements ensuring the control of those subject to this form of surveillance.

Abel-Smith (1960) identifies that there seems to be a recurrent theme within nursing in relation to the creation of a two-tier system. The beginning of modern nursing saw working-class nurses supervised by the 'genteel' sister; lady-pupils and the probationers; registered nurse and enrolled; and more recently the registered nurse and the health care assistant. The striving to maintain a group of 'elite' nurses and their professional status reflects the professional discourse. However the need to create the assistant is embedded in the managerial discourse and the power relation between nursing and the State. Clark (1995) identifies the position within nursing is in contrast with the position in medicine. In nursing, to achieve increase monetary remuneration, the nurse must move further away from the practice of nursing – into management or education – to activities 'other' than nursing. Whereas in medicine the highest point is that of clinical consultancy, in nursing the clinical aspects are not valued reflecting the image of this as unseen 'dirty-work'. The work of nurses is only made visible when attached to other activities.

Although the management discourse is prevalent in the nursing arena and seen as a way of improving their status, nurses generally are not allowed to be fully self-governing. Florence Nightingale, whilst averse to the idea of professionalisation of nursing had intended that nursing would govern itself (Baly, 1995). To a certain extent this had been achieved in the voluntary general hospital of the 19th century, where a tripartite system was in evidence. Medical, administrative and nursing hierarchies co-existed, each having their own area of influence. However in the Asylums the medical superintendent was an omnipotent figure. At the pinnacle of nursing management was the matron (usually a general hospital trained nurse) who, whilst sub-ordinate to the medical superintendent, wielded considerable power in the ordering and day-to-day running of the institution.

The advent of the N.H.S. saw the imposition of the same 'Asylum' hierarchical and linear management structure on all health establishments but where previously matrons had full control of nursing activities, they now found themselves excluded from decision-making processes. Group Hospital Management Committees, often responsible for upwards of 20 hospitals, were put in place, these having no nurse

representatives. The Salmon Report (Ministry of Health and Scottish Home and Health Department, 1965) attempted to address this exclusion and would seem to represent the managerial discourse offering a definitive hierarchical structure. Whilst the Brigg's Report (D.H.S.S. 1972) suggests that it was not intended to draw the most able practitioners away from the bedside, the reality was just so.

The exclusion of nurses from their own management was repeated in the 1980s with the rise of 'new managerialism' (D.H.S.S. 1983). Whilst the underlying intention was to disempower the medical profession, the actual result was to disenfranchise nurses, placing control firmly in the hands of new general managers (who rarely were nurses).

The Therapeutic Discourse

Post World War II technological advances, developing social services and education initiatives offered wide and competing employment opportunities for all. The medical advancements and improvement generally in the population's health resulted in a need to evaluate the nature of nursing itself. The irradication of many acute illnesses and the creation of technology prolonging life saw a change in the people requiring care and the type of care required. Baly (1995) describes how the advent of these new technologies/drugs impacted on and threatened the nurse's traditional role in administering physical treatments to alleviate physical discomfort.

Dingwall, Rafferty and Webster (1988) suggest that mental and general nursing can only be linked feasibly when mental illness is defined as being organic in nature. Reforms in nursing have been based on the idea that there is a common core to nursing and consistently this 'core' has been presented in the 'physical' aspects of care. However the changing face of health care in the 1950s required nursing to redefine its role within this and can be seen to adopt some of the principles assigned to psychiatry, that of therapeutic relationships and the use of interpersonal skills.

The traditional role of 'caring' carried with it an implicit assumption of a close relationship between nurse and patient (Armstrong, 1983). Thus it can be suggested that nursing, in an attempt to re-assert its role and continue it attempts to achieve

professionalisation, began to draw upon and emphasise the human relationship aspect of its work. The development of psychological discourses and the rising emphasis on humanistic approaches offered the opportunity for nursing to transform from the profession that provided care into the 'caring profession'.

Armstrong (1983) proposes the term relationship can simply mean the position of one object to another, however in nursing the term was given a qualitative aspect denoting something specific is implicit in this positioning of the nurse to the patient. He suggests that in early writings (1950/60s) this relationship is presented as wooden and one-sided in nature, emphasising the nurse playing a role in which s/he was seen as healthy, well behaved and trustworthy. For example Ross and Wilson (1957, p24) identify the nurse's responsibilities in terms of " nurse-patient relationship, intelligent interpretation of punctuality, obedience, personal and environmental cleanliness, observation, loyalty to senior and junior staff, and embodying in all these truthfulness". Whilst the merits of using human relationship skills are extolled and psychological and social facets of human behaviour explored with nursing tasks presented as technological and skilled activities, they are nevertheless premised on, and arranged in relation to, medical discourses.

Texts relating specifically to mental health nursing present a similar picture. The term 'therapeutic relationship' appears in the 9th edition of Red handbook (R.M.P.A. 1964, p156) with the writers proposing that "the therapeutic potential in the nurse-patient relationship is very considerable". However this relationship is to encourage trust between the patient and the nurse, for her/him to be seen as a 'safe' figure and thereby enable control of behaviour more easily. Also once this relationship is established it is proposed easier for the nurse to access the information required by the doctor to identify the patient's mental state and the effectiveness of treatments. The role of the nurse in the therapeutic relationship is presented as one of skilled observation not therapeutic intervention. Altschul (1969) develops this idea further suggesting that the nurse's role in establishing appropriate relationships with patients is to promote appropriate ward environments to support the doctors in their interventions.

The advent of 'psychological treatments' in the 1950s warranted discussion in the Red Handbook (R.M.P.A.1954) and the inclusion of a specific section on the

'nurse's place in treatment'. Such involvement is proposed to be 'highly controversial' and only to be condoned where the doctor feels it is appropriate. Even when involvement is seen as appropriate, the nurse is to fully document all events and activities so that the "doctor may keep control of the treatment situation" (R.M.P.A. 1954, p333). The inclusion in the 1964 Handbook of a section describing of the nurse's therapeutic relationship would simply seem an extension of this position.

The Report on Psychiatric Nursing, produced in 1968, suggests that following the Second World War and with the implementation of the N.H.S. Act the concept of therapeutic community gained prevalence (Central Health Service Council 1968). This is an era when it was felt the mental health services could move once more from a custodial to a curative model. The change in the mental health legislation and the advent of medications brought with it a flush of enthusiasm similar to that experienced with the rise of moral treatment in the 19th century. With this came the concept of therapeutic relationships and the possibility of mental health nurses being involved in such therapeutic activities. However much as in the 19th century, the nurse's role as subordinate to that of the doctor is emphasised. In discussing 'relationships' it states that the patient-doctor relationship is frequently of 'greater depth'. The nurse-patient relationship is superficial one, directed at influencing patients' behaviour and gaining information both from patients and their relatives. In this way the discourse relating to control of the patient and the environment is again framed as a therapeutic activity related to cure and moved from its association with custodial care. Much as the discourse surrounding the move from restraint to non-restraint systems of care presented a picture of cure and appropriate intervention, here the move from custodial to curative approaches reframes the nurse activities as part of a therapeutic relationship.

Summary

- The popular image of nurses as females working in general hospital environments underpins the power relation evident within nursing as a whole.

The work of nurses in other environments is invisible and therefore of less value both to nursing and society.

- Nursing provided 'upper-class' women with opportunity to answer the philanthropic demands of their station. However the privileging of this one group over others created a two-tier system which has been repeated throughout nursing history.

- The nature of education programmes advocated by the G.N.C. promote the image of general nursing as a pre-requisite and superior to other forms of nursing. Mental health nursing curricula reflect the dominance of this nursing discourse

- Two competing discourses are evident within nursing – professional and managerial. Each see and speak of nursing in different ways, the former as an activity based on scientific theory, the latter promoting hierarchical frameworks in which nurses increase their status through managerial progression – moving away from the 'dirty work'. The managerial discourse is particularly dominant in mental health nursing as a result of poor recruitment and staffing levels.

- The power relation between nursing and psychiatry is made visible in the battle for the inclusion of mental nurses in the Registration Act (1919) and the 'warring' for control of the education of mental nurses. That mental nurses themselves were not involved in either of these debates highlights their subjugation in relation to both medicine and nursing.

- Nursing's desire to control its own destiny has been frequently confounded by the States need to ensure adequate numbers of nurses are available to provide care.

- An alteration in discourses relating to health and health care provision in the 1950s required a repackaging of nursing giving rise to the 'therapeutic' discourse. However in mental health nursing this discourse was framed to support the medical 'gaze' with nurses continuing their role as providers of information and controllers of patients.

CHAPTER 8

KNOWLEDGES

- Introduction
- Theoretical framework
- Methods of Investigation
- **Genealogy** - Diagnosis of the Present
- - Conditions of Emergence
- - Power Relations (part 1)
- - Power Relations (part 2)
- - **Knowledges**
- Q-Methodology - Philosophy and Approaches
- - Data Analysis
- Discussion, Limitations and Conclusions

The uncovering of power relations that govern the regimes of practices of mental health nurses in chapter 6 and 7 makes it possible to consider the knowledge discourses generated by and supporting these. It is intended in this chapter to identify the knowledges programmed by those power relations and to reveal the knowledges on which mental health nursing depends to justify its practices.

Early editions of the Red Handbook for attendants/mental nurses (M.P.A. 1885, 1908) advocated regimes of practice relating to ensuring the cleanliness of the patients and of the environment; overseeing meals and that patients received an adequate diet; administration of the physicians' prescriptions; superintending the exercise and occupation of patients; and ensuring the patients slept sufficiently. Thus, as discussed earlier, the attendants' days revolved around ensuring the environment was clean and tidy, the patients were clean, appropriately dressed and fully occupied; observing for aberrant behaviour, following the physicians instruction and providing the physician with information as to the patients' demeanour and attitude. The handing over of the education of mental nurses to the G.N.C. and the changes occurring in mental health care in the 1950s resulted in

nursing reforming itself through discourses relating to therapeutic relationships and humanistic approaches.

Within these regimes of practice can be seen the power relations between the mental health nurse, the physician, the general nurse, the state, society and individuals experiencing mental illness. These are also reflected in the discourse identified in Chapter 4 through the Diagnosis of the Present, which see and speak of the mental health nurse as:

- The doctor's assistant – observing and reporting on patient behaviours and carrying out medical treatments
- Controlling the environment/patient/self
- Therapeutic agents.

It is these three discourses, which inform the structure of this chapter.

Doctor's Assistant

The image of nursing portrayed by Florence Nightingale is premised on managerialism and sanitary knowledge, obedience to the doctor and of self-sacrifice. This is re-iterated over time in various texts outlining to the duties of nurse. For example Oswald Browne, M.D. writing in 1894 suggests the first essential quality of a nurse is "implicit obedience…a ready loyalty and for the willing and exact fulfilment of direction that we give" (Browne 1910, p9). This is still being emphasised in the 1960s with Britten asserting that "the nurse must be loyally obedient to the medical staff" (Britten 1968, p9). The Lady Bird children's book 'The Nurse' (Southgate, Havenhand and Havenhand 1963) reveals the image of the nurse as the doctor's assistant as a taken-for-granted background in proposing that "Doctors tell the nurses what to do to help the patients…nurses carry out the doctors orders" (p4). Throughout this Ladybird book doctors 'do' and nurses 'help' indicating the acceptance of this as a 'truth' of nursing by both society and nursing. Such an imperative is equally evident in mental health settings as identified in Chapter 6, with the psychiatrists advocating complete obedience to their authority.

As the doctor's assistant, the mental health nurse must follow the doctor's instructions and act in their service. Williams (1978) asserts such images of nursing present it as servicing medical discourses and giving precedence to medical forms of knowledge.

Such emphasis is evident in the various Red Handbooks produced for mental/psychiatric nurses over a period of ninety years. In each edition the format remains relatively unchanged with the majority of chapters given over to the description of mental disorders, their medical treatments and the mental health nurses role within these. Usually one or two short chapters were dedicated to the general duties and expectations of the mental health nurse. Whilst changes in language or interventions advocated are apparent over time, these simply reflect changes in the dominant medical discourses not in the mental health nurses regimes of practice.

Medical Discourses

Lipowski (1989) identifies psychiatry has tended to swing between two discourses, which present humans as either 'mindless' or 'brainless'. 'Mindless' psychiatry seeks answers to the roots of mental illness and its treatment in biological approaches. Thus the individual is all brain and the mind is absent. In the brainless position the emphasis is on psychodynamic approaches with little recall to the biological considerations. Hence mental illness is of the mind and the involvement of the physical brain in the process is ignored. Sullivan (1995) offers a similar analysis but terms this an 'oscillation' between social science and natural science. It is this swinging between mindless/natural sciences and brainless/social sciences which is evident in the changing language of the 'Red Handbook' for mental health nurses

The regimes of practice for mental health nurses and their knowledge base reflect these mindless/natural science or brainless/social science discourses and the dominance of one at any given time within medicine. For example in relation to the 'mindless'/natural science discourse the 5th edition of the Handbook (M.P.A. 1908) places great emphasis on the attendant's knowledge in relation to hygiene, with a hygienic environment being seen as central to the treatment. The 8th edition devotes space to bodies of knowledge related to treatments such as 'Convulsion Therapy' and

'Insulin Treatment' (RM.P.A., 1954). However the 7th edition reflects the pre-eminence of Freud's theories at this time and the 'brainless'/social sciences discourse, with nurse's role being framed within the language of such theories (M.P.A. 1923). The 9th, and final edition, again emphasises the psychodynamic and therapeutic aspects with the intention of providing background information so that the psychiatric nurse has an understanding of the information the doctor requires (R.M.P.A. 1964).

Observation

The knowledge advocated to inform mental health nurses' practice is merely a simplified version of medical knowledge with an identification of the preferred medical discourse of the time and the associated forms of treatment. Thus diluted medical knowledge underpins nurse's regimes of practices as the doctor's assistant. Nurses are warned that "analytical processes...are not in the province of the nurse" but "it is well that he should have some idea of what the physician has in view when he treats patients in this way" (M.P.A. 1923, p516). The knowledge presented in each textbook enables the mental health nurse to differentiate between what is useful information to collect and what is not. Nurses "learn to describe and report patient's symptoms" (R.M.P.A. 1954, p225). It is seen as important that the mental nurse has a knowledge of the signs and symptoms of mental illnesses to enable them to "give material assistance in a [medical] diagnosis" (M.PA. 1923, p426).

To establish whether behaviours were a result of pathology, close observations were required ensuring that any signs of mental improvement were recognised. Hence, as the doctors' eyes and ears, the attendants were to gather all information, which could then be scrutinised by the physicians who have the expertise to interpret the data. By 1964 this has become 'the art of listening' and the 'skill of observation' (R.M.P.A. 1964). However these are passive undertakings simply informing the doctors' diagnosis. The power relation here is apparent, the information generated is for interpretation by the doctor as the expert. The attendants are merely to be concerned with observation, collection and transmitting of information.

Physicians revisit issues relating to observation time and again in the handbooks and their various treatises aimed at mental health nurses. For example, "the nurse should

continually cultivate his powers of observation" (M.P.A. 1923, p19); "habits of observation and alertness must be especially developed" (R.M.P.A. 1954, p317); and "the nurse becomes a skilful observer...[with] the ability to recognise what is significant" (R.M.P.A. 1964, p8). These become such taken-for-granted backgrounds that texts either written by, or having nurse contributors, re-iterate and justify these regimes of practice and their associated knowledge. Altschul (1969, p39), one of the foremost British nurse writers of her time, proposes that "observation and reporting are amongst the most important functions of the mental nurse" and devotes a chapter of her book on psychiatric nursing to just this. Altschul identifies that psychiatric nurses requires a knowledge of psychiatry and psychology to enable them to detect abnormalities in behaviour and manifestations of disorder, and sociological knowledge to identify if behaviours fall within the normal ranges expected of group and cultural norms. Thus all knowledges are seen to inform the observation process rather than forming part of a biopsychosocial body of nursing knowledge.

Trick and Obcarskas (1982) (psychiatrist and nurse manager respectively) assert that the mental nurses work falls into four categories – observation, nursing procedures, therapy and care/protection of the patient. In relation to observation the nurse is still admonished to be 'objective' in this observation and not to draw her/his own conclusions. They comment on the 'trend' to emphasis the role of the nurse as a therapist to the detriment of the other roles and cast this aspect as no more than allowing the patient to experiment with, and learn how, to make relationships.

As identified above, in order to fulfil the role of observer mental health nurses need to know what they are looking for and therefore theory related to the medical discourse on madness, its presentation, signs and symptoms, is required. Hence knowledge in textbooks generated for nurses tends to be laid out in chapters relating to the various diagnostic labels - schizophrenia, depression etc - and an identifying of their requisite parts. It is this knowledge that was frequently tested when nurses were required to take a state final examination (discontinued in 1991).

Mental/Psychiatric Nurses' Final Examination through the 50s, 60s and early 70s were taken in two parts. A morning paper contained questions proposed to relate to 'Principles of Psychiatric Work', directed at knowledge relating to psychiatric

conditions and describing signs, symptoms and treatments. An afternoon paper on 'Principles and Practice of Psychiatric Nursing' asked about the nurse's role in relation to certain illnesses, the nursing care to be given, observations required and the recording of such information.

These early examination papers ask directly for signs and symptoms or descriptions of medical treatment. However with the proposed move away from the medical model in the 1960/70s and the advent of the 'radical' curriculum in 1982, later papers avoid the use of diagnostic labels, rather they ask for 'reasons underpinning certain behaviours'. Yet in 1991 medical diagnosis is once again firmly re-instated with one examination question asking the candidate to "Describe nursing observations which may confirm a medical diagnosis of schizophrenia" (E.N.B.1991). Diagnosis has returned, and with it the role of the nurse as provider of such information is once again made explicit.

The arrival of the nursing process sees nursing knowledge arranged in accordance with the four activities of the process, that is assessing, planning, implementation and evaluation. This promoted a transformation of observation into 'assessment'. The skills required in undertaking assessments are identified as self-awareness, observation, data collection, interviewing, identifying need, and recording/disseminating information (E.N.B. 1982). In assessment, as previous texts have stipulated in relation to observation, the mental health nurse is to know how to observe, collect data, identify appropriate information and conduct themselves in the appropriate manner. The centrality of this knowledge is re emphasised in the 'Review of Mental Health Nursing' some 12 years later (D.O.H.1994b).

Reporting observations

Coupled with 'observation' is the need to feedback or provide reports in relation to the data gathered. Mental health nurses are provided with a volume of information as to how information should be presented both verbally and in written form. These range from sudden changes in patients' states to details of activities of living. Psychiatric nurses were told that even the most trivial aspects of patients' lives are to be reported (R.M.P.A. 1954). Altschul (1969) provides a commentary on the nature and form of reports and the various syllabi of training identify it as a subject to be

addressed (G.N.C. 1957, 1964a, 1974a). With the implementation of the 1982 curriculum this has become enveloped in the vocabulary of the nursing process which talks of skills associated with "arranging data in a logical way" and "disseminating information" (E.N.B. 1982).

Medical treatments

Examination questions frequently test knowledge concerning the presentation of different mental illnesses, their medical treatments and the nurse's role in these. This would seem to emphasis the nurse's role as doctor's assistant, with the nurse carrying out those aspects of medical treatment deemed appropriate. Most frequently these questions relate to medication or care of the patient following interventions such as Electro-Convulsive Therapy, abreaction or neurological investigation. The knowing of how to do certain things, the mechanistic knowledge that Peplau (1988) talked of, is present in the knowledge questioned in examinations. It is also a recurrent theme in the both the syllabuses directing training and the various textbooks generated to inform nursing practice (R.M.P.A. 1908, 1937, 1954, 1964; Trick and Obcarska, 1968, 1982; Altschul 1969).

Control

As discussed in chapter 5, the non-restraint system and moral treatment required a group of individuals to monitor and respond to patients i.e. an attendant. The creation in the public's mind of the 'dangerous man' and the injunction through statute to ensure the mad were kept safe generated a control discourse. However the casting of the attendant as lacking in moral fortitude also required the inculcation of self-control. Thus the power relation between physicians, attendants, society and the State required the controlling of the environment; of the attendant; and the insane, propagating knowledges in these areas. These power-knowledge formations can be seen in the textbooks and nurse education curricula advocated for attendants and mental health nurses alike.

In the 5th edition of the Red Handbook (M.P.A. 1908) care of the insane is portrayed as an adherence to rules, a dealing with specific behaviours promoting daily living

activities and the personal behaviours of the Attendants. The syllabuses of training from mental health nurses in 1957, 1964, 1974, although by then prepared by the General Nursing Council, bear a striking resemblance to this early work. The introduction of the 1957 syllabus proposes that in drawing up the scheme it has been aware of "the modern concept of the mental hospital as a therapeutic community with its consequent effect on the role of the mental nurse." (G.N.C. 1957 p2) marking the beginning of the therapeutic discourse within mental health nursing. However the concept of control remains central to what was then termed the "Principles and Practice of Psychiatric Nursing". Here the relationship between the nurse and patient is addressed. Ward management is designated its own sub-section, as is general care of the patient and nursing care in relation to psychiatric treatment. The items listed under each section reflect the practices identified as appropriate in 1908 and the earlier works of Conolly (1856) and Tuke (1813).

The syllabus of 1982 reflects a change in terminology and in the organisation of nursing practice. The language used mirrored the move in nursing toward therapeutic activities and interpersonal skills. The swing towards psychodynamic approaches in medicine is evident with a reduction in the reliance on biological explanation of mental illness and an increase in the social and psychological approaches to understanding. The promotion of the individual as a holistic being is present and the need to acknowledge individuality is central. The syllabus is divided into two sections, 'The Knowledge Base' which is to form the basis of professional practice representing the 'knowing that' of nursing and 'Nursing Skills', the 'knowing how' to do certain things. The two forms of knowledge reflect the professional/managerial dichotomy of nursing. The former is seen in the 'knowing that', (professional knowledge) and the latter in the 'knowing how' (the tasks of nursing).

As stated earlier this document marked the arrival of the nursing process as the preferred approach to delivering nursing care, hence Nursing Skills were allocated a place in each of the four aspects (assessment, planning, implementation and evaluation) of the process. It is in the implementation section, i.e. the interventions nurses are to make, that knowledges in relation to control are presented. Here they appear as understanding the effect of nursing care on the individual and the group, ensuring a safe environment, motivating the patient, managing self, handling

conflict, maintaining a positive attitude, meeting personal care needs, such as providing a safe environment and maintaining an optimum physical state. The adherence to the rules and regulations of the Asylum advocated in the Red handbook, has become a need to "carry out practical procedures...in line with agreed local policies" (E.N.B. 1982).

Control of Self

A Report on the Training of Nurses in 1890 described the attributes of an ideal nurse as relating to morality, suitability, and proficiency (Digby 1985). In the introduction of the first edition of the 'Handbook for Attendants of the Insane' (M.P.A. 1885) the first duty of the attendant is identified as the promoting of self-discipline and ensuring patient discipline by example through industry, order, cleanliness and obedience (Nolan 1993). Certain moral qualifications are presented as essential to carrying out this work such as endurance and cheerfulness, firmness, self-control, honesty of purpose and altruism (M.P.A. 1908). Attendants were told the first of their duties relates to discipline. It is suggested this has two aspects, one imposed on the attendant through legislation, Asylum rules and orders from superiors and one relating to the discipline attendants impose on patients. In relation to the former, attendants were expected to provide a good example to the patients in relation to dress, demeanour and punctuality. This imposing of discipline on the mental nurse is later expanded to include not only legislation, hospital rules, orders of superiors but also the knowledge of 'right' conduct (R.M.P.A. 1923). The R.M.P.A. (1954, p27) insists that "a good nurse has...attained self-control, he knows his own mind and possesses moral qualifications." Thus the need to ensure that the mental health nurse has certain characteristics and the drive to inculcate these within them is clearly highlighted.

Such ideas would seem to have grown out of Tuke's Moral Treatment where it was believed that providing an appropriate role model for the patient and encouraging patients to emulate acceptable behaviour, control of aberrant behaviour could be achieved. By 1982 mental health nursing students were told that the development of 'self-awareness' skills is central to the ability to interact therapeutically with patients (E.N.B. 1982). They were then asked to draw on psychological theory associated with self-growth and reflection. However this type of knowledge can be seen as

representing technologies of discipline whereby mental health nurses measure their ability and appropriateness against a pre-given framework such as reflective models and code of conduct. Their practices are examined in light of these.

Over the years many of the mental health examination papers have posed questions related to aspects of nurse behaviour and attitude. For example in 1970 students were told "patients sometimes complain about attitudes and behaviours of nursing and medical staff. These complaints may be justified. – Discuss". In 1976 "In what ways might the nurses personality influence the nature of the relationship?" 1987 brought "How may the nurse's own values and beliefs influence their work?" Finally in 1991 "Discuss how beliefs and feelings of the student may influence to relationship".

Control of the Environment

Central to moral treatment and approaches was the idea of promoting 'calmness' and remaining calm. Tuke (1813) mentions this on a number of occasions. Connolly (1856, p54) proposes that:

> "all the arrangements of the Asylum…should be calculated to calm the troubled spirits of the insane persons; that everything should be done regularly, and everything done calmly….Perfect order, perfect cleanliness, and great tranquillity, should prevail everywhere."

This is seen to lie in the hands of the attendants, the promotion of such an environment is chiefly their domain.

The syllabus of training and examination in 1908 divides the nursing into two aspects – 'nursing the sick' and 'nursing and care of the insane'. Each appears to have elements relating to the control discourse. The former is seen in terms of management of the sick room in relation to ventilation, temperature cleanliness, warmth and quiet. Here the influence of Florence Nightingale and her pamphlet 'Notes on Nursing – what it is and what it is not' is clear. Nightingale intended the book for all women so they could learn "how to put the constitution in such a state as that it will have no disease"(Nightingale, 1969, p1). She identified her approach as concerned with 'Sanitary Knowledge' relating to ventilation; cleanliness; controlling

the environment in relation to noise, air, light; providing diversions for the patient as appropriate; and diet. However it was to become the basis for care delivery in general hospitals and appears in various forms in the handbooks for attendants. This inclusion reflects the physicians' intention to co-opt general nursing approaches into the Asylum setting and their movement towards hospitalisation. However Nightingales' tenets remained located within mental health nursing with more recent students having to demonstrate they have address such issues in their 'Record of practical instruction and experience' (G.N.C. 1964b, 1974b). This document, then necessary for the completion of the training programme, was counter-signed by qualified members of staff stating such issues had been addressed in practice. They are also implicit in the 1982 curriculum appearing as "personal nursing care" and "providing a safe therapeutic environment" (E.N.B. 1982, p8). By 2000 this had become "maintaining a safe environment of care" (E.N.B. 2000, p4).

Control of the Patient

In relation to the care of the mentally ill individual mental health nurses were told repeatedly that their patients required a different approach to those within the general sphere. Mental nurses were told "in a mental hospital…the whole life of the patient must be ordered for him, day and night" (R.MP.A. 1923, p 3). Thus the mental health nurse is expected to control all aspects of person from their personal hygiene to their religious activities. In the Rules and regulations of the Retreat (1842, p6) it was identified that Attendants "must consider themselves as…responsible" for the "welfare, security and comfort" of the insane. This includes meeting their bodily needs for food, rest and exercise. Again this is repeated in the various treatise and curricula relating to mental/psychiatric nursing, culminating in the presentation of knowledges relating to principles of hygiene, concepts of dignity, and theories of spirituality underpinning what has become 'personal nursing care' and 'activities of living' (E.N.B. 1982).

Special duties required of mental /psychiatric nurses were identified in relation to those who may self-harm/attempt suicide, be violent, destructive or have 'faulty' habits (M.P.A. 1908; R.M.P.A. 1923; 1954). Bucknill and Tuke (1858) saw discipline and order as paramount in ensuring the good behaviour of potentially violent or deviant patients. They liken it to the miscreant youth that on entering the

armed forces becomes obedient simply through becoming part of the system and being influenced by others. Both Tuke (1813) and Bucknill and Tuke (1858) identified a need to differentiate between behaviour that is under the patient's control and that which is the result of pathology. They warned that to try to use moral approaches on behaviour that is a result of pathology in inappropriate at best and destructive at worst. It was seen as essential if behaviour was deemed to be in the patient's control and it was the physician not the nurse that made this distinction by virtue of his 'clinical expertise'. This may explain mental health nurses' responses to certain diagnostic labels and the bad/mad debate. Behaviours not deemed to be the result of pathology are seen as under the control of the patient so they are labelled as bad. Failure to improve following treatment regimes is seen as the patient's refusal to let go of their morbid pre-occupations rather than failure of the treatment and again the behaviour is labelled as bad.

To help deal with aberrant behaviours Bucknill and Tuke (1858) advocated diversion tactics. The patients were to be engaged in activities that both exercised and distracted their thoughts. Occupation of patients was advised to prevent them from dwelling on particular issues. This approach is re-iterated in the various 'Red Handbooks' and syllabuses of training with mental and psychiatric nurses respectively being instructed in the use of such approaches (MPA 1923, R.M.P.A. 1954, 1964). In the 1982 syllabus this appears as 'studies in specialised techniques' which include industrial therapy, recreational therapy and occupational therapy.

These issues are present in the final examination papers for mental nurses. Questions frequently test knowledge of a particular mental illness, observation in terms of signs and symptoms followed by examination of knowledge relating to the management of a patient – either control in relation to the individual or control of the environment. Most frequently asked questions are those concerning the appropriate care of suicidal and aggressive individuals which places these knowledges at the centre of mental health nurses' regimes of practice. John Gibson (1972) provides a model answer for just such questions in his book aimed at helping students pass nursing examinations. Interestingly the answer he gives bears a startling resemblance to the approaches advocated by Conolly in 1856.

Therapeutic Discourse

The two discourses of managerialism and professionalisation represent a particular power relation within nursing itself. The managerial faction values practical skills, seeing these simply as tasks to be done. The professional thread is representative of the prescribed discourse and here can be seen the attempt to create a credible body of knowledge to promote an image of nursing practice as more than simple tasks but rather a series of complex skills developed in response to a defined evidence base. Thus feeding a patient in the former is concerned with providing a meal, whereas in the latter it relates to nutritional components, tissue requirements and rehydration (Williams, 1978; Abbott and Wallace, 1990).

Such a dichotomy reflects Clinton's (1983) concept of classroom learning and ward-based knowledge. The professional discourse is evident in the class room learning and the managerial one in the ward based activity. Thus the two faces of nursing reflect the knowledge bases deemed appropriate within nursing as a whole and mental health nursing in particular. In the managerial discourse nursing tasks are premised on 'sanitary knowledge', 'knowing how' to do things. Whilst in the professional one the tasks are based in scientific knowledge and skilled interventions, a 'knowing that' particular knowledges drive appropriate activities.

As discussed in chapter seven the need to redefine nursing in the 1950s lead to the rise of the 'therapeutic' discourse and the embedding of this within mental health nursing. However an analysis of mental nursing final examination papers suggests that the questions simply reflect the changing terminology of the day in relation to the medical dominant discourses and as such the regimes of practices are unchanged. What is present is an attempt to cast these practices in a therapeutic light and demonstrate an underpinning theoretical framework. The use of terms such as therapeutic and the inclusion of therapies are an attempt to differentiate between practices that occur at that time and practices that occurred previously. Encouraging work becomes 'industrial therapy', recreational activities become 'occupational therapy', promoting personal hygiene and attendance to bodily requirements becomes 'social skills training'.

The R.M.P.A (1954) identify psychotherapy as a complex activity, however 'encouragement' is a simple aspect of this, which they propose is used instinctively by every good nurse. In outlining the mental nurse's specific place within this, the R.M.P.A. advocates observation as to the impact of the doctor's psychotherapeutic interventions with the patient and the providing of reports. This remains the stance in 1964 with the R.M.P.A. (1964, p275) commenting "the doctors too needs information concerning the patient's behaviour so he can assess progress." As other therapeutic interventions come into vogue information relating to these is included in both mental health nursing textbooks and curricula. However much as with the inclusion of medical knowledges relating to mental illness and treatments in earlier books, these would appear simply to provide the mental health nurses with sufficient background knowledge to allow them to play their role in the management of the patient not as a therapeutic agent in their own right.

In his model answer for the mental nurses' final examination question on psychotherapy, psychiatrist John Gibson (1972, p178) writes:

> "Psychotherapy, in its simplest form, is being given all the time – by a good nurse. By friendly encouragement, understanding and sympathy...specialised forms of psychotherapy are given by the doctor."

The nurse contribution to creating a therapeutic community is to display these aspects of psychotherapy, promote the patients physical wellbeing and encourage involvement in recreational and occupational activities. Thus control of self, environment and patient.

January 1974 sees one of the final examination questions ask, "Write an essay on the role of the psychiatric nurse as a therapist". However in the syllabus of training issued that year (G.N.C. 1974) the knowledges advocated in relation to this would seem to be awareness of patient's feelings, recognition of own attitudes, rapport, the art of listening, helping people to talk and diversional activities. As proposed earlier these knowledges relate to the nurse as the doctor's assistant and as controller of self and patients. Trick and Obcarskas (1982), in describing the appropriate therapeutic interventions for mental health nurses, see this as simply the forming of an

appropriate relationship, which they propose is often achieved instinctively by nurses. Thus there is no need here for any formalised techniques driven by psychological theory. The nurse, in their opinion, simply needs an understanding of psychological concepts such as transference to enable her/him to understand why patients may act in certain ways and thus not give into her/his own 'hostile' feelings, rather than to use this knowledge to engage in therapy with patients. Also it facilitates insight into her/his own behaviour and that of other staff and helps to modify this appropriately. Here can be seen a repeating of the 'control of self' imperative. Therapeutic relationships are concerned with ensuring nurses presents themselves in the approved manner exerting appropriate self control and forming appropriate relationships with patients. Much as the early writers such as Connolly (1847) and Tuke (1813) proposed the intention here is to promote the gathering of information, and making patients more amenable to treatment and control.

A number of the examination questions seek to test knowledge related to the creation of therapeutic environments. However the form of such questions relate to controlling the environment whilst reflecting the dominant discourse of the time concerning 'therapeutic' approaches. Again the term therapeutic can be seen to differentiate between the current practices deemed appropriate and those of previous regimes. As in the Asylum era when there was a need to differentiate between the madhouses that chained the lunatics to the wall and the 'new' thinking of the asylums, so there was a need to differentiate between the practices of the 1940s and 50's and the therapeutic interventions of the 1960s.

As the therapeutic discourse in mental health nursing reached its peak with the introduction of the 1982 curriculum, the format of the examination papers changed. Here people-based scenarios were introduced in an effort to personalise the care and to remove the emphasis on medical diagnostic. The intention was to present a more humanistic and therapeutic picture of care delivery. However the requirements for observation and control are evident, with questions frequently being asked about the 'therapeutic' value of controlling interventions and how nurses can engage people in 'therapeutic' activities. For example, students were asked in 1989 to discuss the merits of a suggested response to a patient query and "offer an alternative response and discuss its therapeutic rationale". A 1990 paper asks "how may the nurse...form a therapeutic relationship with John specifically referring to his anger, petulance and

abusive behaviour?" 1991 sees such questions as "How would the staff nurse...manage the following situations..." and "...describe a programme of anger management which may help Gary". In this way the therapeutic discourse simply masks the control requirement on mental health nurses and the doctor's assistant role.

Summary

- Knowledges relating to the mental health nurse as the doctors assistant encompass:
  - Observation, premised on medical knowledge and enabling the identification of what is being 'looked' for.
  - Psychosocial knowledge enabling the mental health nurse to differentiate between 'normal' and 'abnormal' behaviours.
  - Report making ensures data gathered was transmitted appropriately.
  - Knowing how to performing of tasks related to medical treatments.
- The power relations advocating the need to control the patient, the environment and the mental health nurse resulted in the generation of knowledge relating to these three areas and are evident in the curricula, textbooks and examination question accessed by mental health nurses.
- The therapeutic discourse merely represents a swing in the dominant psychiatric/medical discourse toward a social science explanation of mental illness. Mental health nurses continue their traditional regimes of practice with the knowledge advocated in relation to therapeutic activities simply masking the requirement for control and supporting their position of doctor's assistant.

Genealogy and the Archive

The intention of this study is to consider *'How is mental health nursing knowledge constituted and made possible in relation to existing discourses, practices and conditions?'* through the identification and analysis of mental health nurses' social apparatus. As discussed in chapter 3, such an apparatus has two parts, the archive and the current. Chapters 4, 5, 6, 7 and 8 used a genealogical approach to access the archive and chart the trajectory of mental health nursing from its emergence in the form of the attendant to the current time. Here is an attempt to make visible the space within which mental health nurses act, their regimes of practice, the power relations in evidence, and the knowledges programmed. This is now complete and the implications of this genealogy will be discussed further in chapter 11.

CHAPTER 9

Q-METHODOLOGY – PHILOSOPHY AND APPROACHES

- Introduction
- Theoretical framework
- Methods of Investigation
- Genealogy - Diagnosis of the Present
- - Conditions of Emergence
- - Power Relations (part 1)
- - Power Relations (part 2)
- - Knowledges
- **Q-Methodology - Philosophy and Approaches**
- - Data Analysis
- Discussion, Limitations and Conclusions

As discussed in Chapter 3 the overall intention of this study is to construct the social apparatus within which mental health nurses act and through this gain access to the knowledges supporting their regimes of practice. This social apparatus is viewed as having two parts, the 'archive' (what mental health nurses are and are ceasing to be) and the current (what they are and what they are becoming). The former has been charted through the use of genealogy and presented in chapters 4 – 8. Q-methodology provides an opportunity to glimpse at 'the current', to examine mental health nurses' current subjectivity in relation to knowledge claims, to reveal the knowledge discourses inscribed on the bodies of mental health nurses. Q allows the accessing of individual's subjectivity in a systematic manner. It provides an opportunity to examine expressed belief through the use of a form of factor analysis.

It is intended in this chapter to explore the underpinning philosophy and the processes involved in Q-methodology in more depth and detail how this approach is used to gain access to mental health nurses' subjectivity in relation to knowledge.

Q-methodological underpinnings

Q-Methodology uses a form of factor analysis. However whereas traditional approaches, usually known as R methodology, involve an assessment of some kind (intelligence, personality, ability etc), Q factor analysis is concerned with enabling an individual to present their perspective in relation to a specific topic that has meaning for them (Brown, 1991). In R the focus relates to correlations between tests and the objective measurement of individual differences. In Q, correlation is between people and their subjective interpretation of something (Stephenson, 1953; Brown, 1980). Hence R conceives people as a mass of characteristics, which are to be studied in terms of individual differences and Q deals with wholes and description.

R factor analysis fixes attention on the relationship revealed between *n* people and *N* traits, representing individual differences within the sample (see table 9.1). Scores for each trait are statistical distributions in terms of the unit of measurement for each trait (e.g. if measuring weight, score represents kilograms; height equates to metres). Thus columns are single centred scoreable traits where the units are represented as standard scores/pure numbers. Stephenson (1953) describes this conversion into a standard score as one of the most remarkable devices in psychology as it removes the problem of having to work with diverse and multiple units of measurement.

		Traits			
		A	B	C	N
p e o p l e	a	aXA	aXB	aXC.....	aXN
	b	bXA	bXB	bXC.....bXN	
	c	cXA	cXB	cXC.....	cXN
	n	nXA	nXB	nXC... ...	nXN

Table 9.1 Basic R Data Matrix

aXA = score identified for person *a* in measuring trait *A* (Brown, 1980, p12)

However he asserts that this can only be done in respect to columns, as standard scores are required for coefficient arrays. Correlation produces an *N* x *N* matrix, resulting in *m* factors reflecting how traits cluster in relation to said factors (Brown, 1980). Correlation and factor analysis here proposes linearity i.e. that A>B>C in particular ways.

Factor analysis as adopted in Q methodology draws on alternative epistemological underpinnings, the structuring of the samples and the emphasis on subjectivity are taken to offer a unique analysis of data and the interpretation of the area of study. Here traits/statements form rows and subjects columns. This is more than a simple transposing of 'normal' factor analysis procedures, as such an action would mean attempting to identify the *m* clusters of individuals around *N* traits. As this would require a comparing of non-compatible units of measurement (e.g. trait A could relate to intelligence quotient, trait B weight), the linearity associated with factor analysis is not possible. Meanings cannot be attributed to average scores where differing forms of measurement are in place. As each trait in Q is single-centred on subjectivity – the individual's identification of 'significance for me' - correlation becomes possible.

To illustrate these differences in approach and epistemological underpinnings, Brown (1980) describes a study in which body measurements (traits) are identified from 20 people. The resulting R factor matrix dissects the body parts across eight factors, with shoulder width, arm length, palm measurements and foot size significant in one, chest, nose and waist in another. In this way R analysis is seen as reductionist, breaking the whole into parts, and leads Brown to comment that any attempt to resemble the data into a recognisable human form would result in a modern day Frankenstein's monster.

When the data matrix is transposed and re-factored as in Q factor analysis an inter-correlation between the parts emerges and only one factor is identified – as human bodies are generally, proportionally the same. The data, when given to an artist to represent, results in a figure easily identifiable as a human. Whilst demonstrating the centrality of synthesis in Q (i.e. identification of interrelationships between parts) and

relieving the investigators of the necessity of deciding what goes with what, Q, nevertheless, remains objective in mode.

When the same 20 people are asked to rank their body parts according to their 'significance for me' a different set of factors emerge. Here greater emphasis is placed on eyes, head and mouth resulting in one factor, another factor relates to trunk, hips and chest. Such results when given to an artist in a drawing, bears small resemblance to a human figure, having an enlarged head, huge eyes, and vestigial neck and arms. It is this ability to access 'significance to me' or individual's subjectivity that makes Q methodology attractive to researchers.

For Stephenson (1935) Q approach represents one of two data matrices possible within factor analysis procedures. It is this that lies at the root of the controversy surrounding Q-methodology; R factor analysis proponents consider only one data matrix as possible. As a result of this dichotomy Stephenson's approach has been severely criticised and proposed to reflect unclear thinking. However Brown (1986) proposes that the criticism results from conceptual differences and a clinging of orthodox psychologists to the classical paradigm of determinant causation. Curt (1994, p88) concurs with this describing Stephenson as "a man out of his time...a lone voice in a positivistic wilderness".

Stephenson (1953) is concerned with subjective communicability, bringing subjectivity into focus and the generation of an approach through which it can be made visible. For others, such as Stephenson's contemporaries Cyril Burt and Hans Eynsenck (representing an academic world of psychology concerned with objective measurement, causality and universal traits), such an undertaking is neither necessary nor appropriate. These views overshadowed Q methodology usage for a number of years. However the last decade has seen an upturn in interest across both psychology and social sciences mirroring a growing interest in subjectivity and a wavering in the commitment to the positivist inquiry.

The Q Methodology Process

Q-Sample

It is the Q-sample that is given the greatest attention in Q methodology, not that the person (P) sample is unimportant, but rather this approach denotes an emphasis on the selection of items which comprehensively represent the chosen stimulus population. The Q-sample is derived from the 'concourse', the various ways of talking about, and representing, a particular issue in a particular cultural setting. These discourses surrounding the specified object, can be accessed in a variety of ways such as interviewing people (incorporating academic, professional and public perspectives), literature, art, and the mass media (Brown, 1991). From the concourse statements are drawn which are seen to typify the various discourses present within it. These statements form the Q sample/set.

The Q concourse may be naturalistic or ready-made and formed through either a structured or unstructured approach. Naturalistic statements are drawn either from interviews or written communications with the target P-sample. Readymade samples utilise other sources such as texts, newspapers, pictures, or cartoons. Neither is given status above the other with McKeown and Thomas (1988, p28) asserting:

> "possibilities for sampling Q-items is enormous, bound only...by the researcher's imagination and by the nature of the problem."

For example Kitzinger and Stainton Rogers (1985) in addressing lesbian identities drew a Q sample from semi-structured interviews with lesbian women, supplemented with items from lesbian subculture and literature. Alternatively Barchak (1984) utilised statements drawn from Jacob Bronowski's (1973) text 'The Ascent of Man' in an attempt to establish paradigms evident in the field of communication. To access pre-school children's phenomenological worlds Taylor, Delprato and Knapp's (1994) Q sample was made up of fashion magazine pictures of children representing various ethnic groups, ages, gender and activities.

As identified, samples may be structured or unstructured. Unstructured sampling occurs where all items of a concourse are taken to be relevant and as providing a comprehensive survey of the position at issue. With this approach there is a risk of

under or over representation of particular perspectives. To address such issues Stainton-Rogers (1991) emphasises the need to achieve a balance (not opposites) of statements. This is facilitated through pilot testing the statements to enable the clarifying of meaning/words, refining of statements and removing of repetitions. Structured samples are seen as offering a more systematic approach whereby items are selected either through deductive means as a result of theoretical frameworks, or inductively as patterns emerge as statements are collected. In both cases, whilst there is a need to provide an adequate range of statements from which the participants can provide their standpoint, Cordingley, Webb, and Hillier (1997) point out it is not possible for the researcher to 'make' a certain view appear through the limiting of certain perspectives. None-the-less, it is important that the strategies for selecting the sample are clear and evident. From this, statements are drawn which are deemed to represent the various discourses present within the concourse to form the Q sample/set. The typical number of statements in the Q-sample ranges from 40 – 80 (McKeown and Thomas, 1988; Stainton Rogers and Stainton Rogers, 1990).

Q-sort

Q – sort can be utilised either within an 'essentialist' or 'constructionist' framework (Kitzinger and Stainton Rogers, 1985). In the former it is presumed there is a 'correct' manner in which a specific Q sort should be completed with specific meaning being allotted to certain items (for example Brock's (1961) work compares participants' ranking of statements with those of a proposed expert). Within a constructionist approach no a priori framework is imposed on the Q-sort. Items are not viewed as having 'objective' meanings or special significance in relation to the topic area under consideration. Each item/statement simply represents an aspect of the concourse surrounding the area of study. As, from this perspective, it is proposed that a factor cannot emerge unless defined by participants, it is they who are seen as in control not the researcher. Thus the investigator's ability to impose their 'framework' on the participant is diminished, as each Q sort is individually constructed.

Conditions of instruction define how the Q-sort is to be conducted. This usually involves simple instructions asking participants to arrange the statements on a continuum from 'most agree' (+5) to 'most disagree' (-5), or 'most like X' to 'most

unlike X'. However, more complex instructions can be used asking the respondent to consider the Q-sort from a variety of perspectives. For instance in Taylor, Delprato and Knapp's (1994) study conditions of instruction asked children to sort pictures according to what they/mommy/teacher/big bird/friend would think was most/least like them; most/least like child when grown up; most/least like friend; and the very best/not very best girl/boy.

A Q-sort can either be free (with participants placing as many items in the specified conditions – agree/disagree - as they wish) or forced, that is the distribution of the items is to adhere to a fixed pattern. Generally in the forced approach fewer items are to be placed at the extremes of the most like/unlike continuum, with the majority of cards in the 'no-strong feeling' section. Cordingley Webb and Hillier (1997) proposes that this may be seen as contrary to the proposal of participants being free to identify their own perspective, however Brown (1986) and McKeown and Thomas (1988) insist that forcing does not significantly affect the factors that emerge but does enhance the decision making process of the participants.

The statements, which make up the Q sample are typed on to cards and randomly numbered, these are then shuffled and sent/given to the participants with instructions as to how to proceed. Participants are asked to sort the statements according to the format chosen, allocating the number on the card under each score to a predefined scoring grid as appropriate. Curt (1994) suggests that a list of the statements should also be provided enabling participants to make comments relating to the process. Whilst this is not part of the statistical analysis it is suggested that this can aid in the interpretation of the emerging factors.

P (people) - sample

A large P (person) sample is not at issue in Q as the items (statements) not the participants are the units of analysis (Dennis, 1986). The 'n' of the study is the number of items drawn from a concourse - the discourses representing and surrounding the area of concern (Brown, 1991). In some instances one person, chosen because of their relevance to the study, is asked to perform the Q sort a number of times utilising a variety of conditions of instruction. Extensive samples (utilising more than one person) are more commonly used.

The person set size in extensive samples is determined by the number of subjects required to facilitate the emergence of factors in the Q sort factor analysis. It is these factors that are interpreted in order to explore the number of discourses available relating to a particular issue. Thus what is at issue here is the number of perspectives available not how many people share a perspective (Mrtek, Tafesse and Wigger, 1996). Brown (1980) proposes a theoretical/ dimensional sampling approach where there is an overt requirement to identify the size of sample required to address the investigator's theoretical interests. Glaser and Strauss (1967) originally put forward the notion of theoretical sampling. Such methodological operations are not about providing a perfect description nor the accessing of all issues related in a specific field from random sampling but rather to generate theory that provides an explanation of the phenomena, based on selected cases. As the main thrust is to generate theory not verify facts the structure is seen as flexible. The researcher begins with a framework in which the principle concepts are identified. Individuals selected to participate are those judged to have theoretical purpose and relevance. Hence the researcher chooses the people that will facilitate the emergence of the elements under consideration. Glaser and Strauss identify that all too often emphasis is placed on the obtaining of facts and the verification of theory at the expense of understanding how theory can be generated from data. They argue theory generation should be based in the description of evidence rather than the logico-deductive framework, which relates to the acquiring of *accurate* evidence and the validation of facts. In the former, theoretical concepts are *indicated* by the data; in the latter, concepts are the data. Thus the researcher must be clear on the basic types of participants to be considered in an effort to facilitate the acquisition of appropriate data which will describe the phenomenon.

A factorial design as McKeown and Thomas (1988) identify can also be useful in overtly focusing on the people of theoretical interest to the work. Here an attempt is made to select participants who are expected to represent specific dimensions within the area of interest and within each dimension the types of group available. No claim is made that all relevant populations are included or that the factors identified are exhaustive, simply these are the groups, which may reveal the variety of viewpoints available. Utilising a gay rights study they propose that certain demographic categories such as sex/age/level of education group may influence perspectives

therefore representatives from each type of demographic group would be required. Contrasting of the attitudes of gay rights activists and certain religious groups is also seen as important and a delineation is made between liberal mainline denominations and conservative evangelical branches. In such a case the P set structure would be as follows:

Dimensions	Types	N
A. Sex	a)Male b) Female	2
B. Age	c) 20-40 d) 41-60 e) 61+	3
C. Education	f) college g) no college	2
D. Orientation	h) mainline Protestant church i)evangelical churches j) gay/lesbian organisations	3

P sample (n) = (Dimensions) (Types) = (A) (B) (C)(D)

A B C D = (2) (3) (2) (3) = 36 combinations

Such a formulation indicates people who may reasonably be expected to express particular subjectivities in relation to the topic under consideration. In the above example there is the possibility of 36 variations, however the number of factors revealed are much smaller as the factor analysis method employed within Q is Orthogonal which aims at identifying a small number of powerful factors which are independent of each other. Brown (1980) exemplifies this in discussion of his work concerning the examination of public attitudes about land use policy study. Here 40 possible view points where identified utilising the factorial design (A. Interests = experts + authorities + special + class; B. sex = male + female; C. region = NW + NE + Central + SW + SE). However only 3 factors emerged from the data. To explain this apparent anomaly Stainton-Rogers (1995) puts forward the notion of 'finite

diversity'. Here it is suggested that although social issues are subject to debate and differing values, when individuals are asked about specific element of a topic only a limited number of culturally available alternatives are possible.

Kitzinger and Stainton-Rogers (1985) in discussing the implications of this concept for the size of the P-sample propose simply a need to ensure representativeness – that the diversity possible within a specified group is considered and addressed. Brown (1980) and Stainton-Rogers (1995) both assert that generally a P sample of 40 –50 is more than adequate, as it is not considered necessary to assure a representation of each combination is present within the P sample. Brown (1980, p194) proposes that the underpinning principle is one of providing a sample of:

> "breadth and depth so as to maximise confidence that the major factors at issue have been manifested using a particular set of persons and a particular set of Q statements."

Data analysis

Data analysis involves three procedures applied sequentially, correlation, factor analysis and computation of factor scores. The data analysis consists of a consideration of the inter-correlation of *N*Q-sorts as variables - i.e. individuals ***not*** traits or Q-sample items are correlated – with an $N \times N$ correlation matrix being the focus of factor analysis. As previously identified the individuals performing the Q-sort are the variables not the statements themselves, with each individual's factor loading indicating the degree of 'like-mindedness' (McKeown and Thomas, 1988).

The correlation and factor analysis of the Q-sorts enables patterns across people and clusters of similar standpoints to be identified. To optimise the separation between factors, 'rotation' is undertaken (Kitzinger and Stainton-Rogers, 1985; Dryzek and Berejikian, 1993). With each factor a loading measure is generated (a correlation with the factor) for the sorting pattern of every participant. Exemplificatory Q-sorts, those that gain a high loading to a specific factor, are merged to produce factor scores for each statement; this is an 'averaging' of the scores given to particular statement by the Q sorts associated with it. From this a model Q-sort for each factor is generated with distinguishing and consensus statements being identified. The end

point of a Q study is the interpretation/summarising of the views emerging from an interpretation of the factors.

Using Q Methodology to Access Mental Health Nurse Subjectivity

The Q Sample

A *ready-made* concourse was made available through the genealogy framework used in the first part of this work. Here the general archive relating to the education and knowledge bases deemed appropriate/ascribed to mental health nurses is accessed through both historical and current literature encompassing both the official and the public/popular discourses. Thus, sources for the Q study include examinations questions; various curricula and syllabuses for nurse education from 1892 to present day; textbooks ranging from various editions of the 'Red Handbook' first issued in 1893 to present day texts; studies specific to the role of mental health nurses and their knowledge bases; policy documents; legislation: popular media sources; and evaluative works of mental health nurses (service users/other health workers). These form the Q concourse from which the sample is identified.

To facilitate the generation of an *inductive, structured sample* the computer package QRS NUD*IST (Sage, 1997) was utilised. Although other of computer assisted qualitative data analysis software (C.A.Q.D.A.S.) are available (e.g. Atlas/ti) familiarity with NUD*IST was the deciding factor in its use here. A growing body of literature supports the utilisation C.A.Q.D.A.S. Barry (1998) identifies its ability to facilitate the development of conceptual/theoretical frameworks and the inductive process. However the appropriateness of the current drive towards the use of C.A.Q.D.A. packages particularly within the post-modern paradigm has been questioned and must be given consideration (Coffey, Holbrook and Atkinson, 1996; Kelle, 1997).

The concerns relate to two aspects, the possible development of an 'orthodoxy' of one approach to data analysis within approaches that value and promote 'multivocality' and the possible distancing of researchers from the subject of their research, the text. Kelle (1997) proposes that the crux of this lies in whether the

computer programme is used as a means of storing and retrieving data or truly as a means of 'analysing' data as found in computer statistical package. If it is the latter and this is undertaken without full consideration of the methodological principles underpinning the research then indeed the consequences may be dire.

In this study the distancing from the texts is not at issue, as the genealogy required a full engagement with the texts. The C.A.Q.D.A. was used here simply to facilitate the identification of the discourses present within the concourse relating to mental health nursing's knowledge and then to extract the appropriate sample, Q-methodology provides the guiding principles by which this should be achieved.

The majority of the concourse literature was scanned into the computer and imported as separate documents to the Nud*ist programme. Literature such as books and media sources were examined as external documents and a summary of the finding imported into the CAQDAS. An index system was created identifying nodes for each type of knowledge that emerged from the concourse database. Following this initial examination of data the nodes were returned to, considered and where overlap/repetition was apparent nodes merged. For example nodes entitled 'signs and symptoms – physical illness' and 'physical illness' were felt to address the same knowledge areas and therefore merged. Some areas were expanded, initially only one node related to 'activities' so this data was divided between four sub-nodes relating to recreational, occupational, rehabilitation and industrial therapy activities. This was an inductive process, no a priori framework was imposed. Each node was simply seen as representing an aspect of the concourse surrounding mental health nursing knowledge.

The final stage was to consider each node in turn and identify the statement/s that best represented the knowledge contained within them. This close scrutiny also resulted in the relocation of data and the merging of various nodes (see appendix one for initial, interim and final nodes). To generate statements representing each node it was considered appropriate, where possible, to use the broad descriptors from curriculum documents as these were framed in simple terms that would be familiar to mental health nurses. For some of the nodes more than one statement was identified where it was felt that that particular knowledge base encompassed a number of different aspects that could not be reflected in one statement.

At the end of the process 66 statements were created to represent the concourse surrounding mental health nurses' knowledge. In handling the data I felt that it would be possible for participants to confuse the concepts of 'Role' and 'Knowledge' when considering the statements. Role encompasses both knowledge and action and as here the focus required a specific attention to knowledge it was felt appropriate to ensure this focus was maintained. Therefore each statement was prefixed with the words 'Knowledge concerning'. These statements were numbered and printed onto cards. As it was intended that the participants conducted the Q sort unattended, general information/instructions regarding Q methodology; instructions for the Q sort; a printed list of statements allowing for open comments; and a scoring sheet were generated.

A forced sort approach was adopted with the conditions of instruction asking participants to, "*Consider your practice as a mental health nurse. Which knowledges are you **LEAST/ MOST** likely to use in <u>your</u> activities as a nurse?*" This format was chosen, as it was necessary for the participants to consider what knowledges they feel/believe they use rather what is said to be appropriate.

Further information was also requested on the scoring sheet, i.e. gender, qualifications, date of registration as a qualified nurse, staff grade and area of practice. It was felt that these details might be of significance when interpreting the data. Information relating to gender is requested as traditionally within mental health nursing it is male nurses who intercede when dangerous or violent behaviour is presented. Practice areas talk in terms of 'having no male cover' by which is meant that no male member of staff is in the immediate vicinity during a specified shift and contingency plans are made should the need (violence) arise. It could be argued, therefore, that men prioritise knowledge relating to control and aggression differently and are subject to different discourses than women.

It is not unusual for nurses who trained pre Project 2000 to have a dual nursing qualification such as General Nursing/Mental Nursing/ Learning Disabilities. Also there is a growing number of nurses accessing degree programmes. This, coupled with a professional imperative to undertake post-registration education programmes, reflects the current emphasis on life long learning. Such forms of education may

indicate exposure to other knowledge discourses and hence have an impact on subjectivity.

A date of registration enables the identification of which pre-registration nursing curriculum the participant was educated on. As various changes have occurred in the knowledge bases identified as appropriate for the education of nurses so the discourses relating to the knowledge bases deemed pertinent to nursing practice have altered and thus may have implications for those inscribed upon the nurses in question. Discourse may also vary according to patient/ward needs and thus the emphasis placed on specific areas of knowledge may differ. For example, it could be argued that those caring for elderly people with mental illness give priority to knowledges relating to physical disorders due to the increased incidence of physical ill health in the elderly population. Alternatively nurses working in an acute setting where a higher incidence of aggression is in evidence, may highlight the use of knowledges related to these aspects. Therefore information regarding area of practice is of importance.

Finally the grade of the staff member is significant as each grade denotes an expectation that certain levels of responsibility/skill are present within that individual. Also the higher the grade, the greater the managerial responsibility. The differences in responsibility may be reflected in the knowledge bases used.

Pilot Study

A pilot study was conducted, as recommended by Stainton Rogers (1991), to ensure the representativeness/appropriateness of statements and clarity of instruction in relation to the Q-sort. Five volunteers drawn from the mental health nurse education setting and practice were asked to perform Q sorts. Various suggestions relating to the wording of the instructions and statements where offered and incorporated into the study increasing clarity and reducing ambiguity. All participants in the pilot study felt that the breadth of discourses had been addressed. However one volunteer identified that death/dying and the grieving process was not included/implicit in the statements. Whilst I had thought this incorporated within the aspect of knowledge related to therapeutic interventions on further consideration and in discussions with

colleagues it was felt important to include this aspect (see appendix two for reflection on pilot study process).

Following the pilot study the decision was made to:

1. Alter the stem/conditions of instruction to read "Consider your practice as a mental health nurse. Which knowledges are you least/most likely to use in your ***daily*** activities as a nurse."

2. Alter some of the statements in line with comments from the volunteers.

3. Include a list of statements for comments. Despite reservations expressed by one volunteer as to their usefulness, it was felt that the participants would make their own decision as to whether or not they added comments.

4. The potential geographical spread of participants necessitated a flexible approach to how the Q sorts were delivered. Where possible those willing to participate were to be approached either personally or by telephone. If this proved difficult due to shift work, annual leave etc they would be contacted by letter identifying telephone numbers and e-mail addresses through which they could contact me.

The Q sort packages were assembled in readiness for the main study (appendix three contains information included in the Q-sort packages).

P sample

An extensive sample, i.e. more than one person, is adopted here. The choice of participants draws on Glaser and Strauss' (1967) ideas of theoretical sampling where individuals are selected according to their relevance to the study. Central to such an undertaking is 'theoretical sensitivity' which Glaser and Strauss view as encompassing two aspects, these being the researcher's personal/temperamental leanings, the ability to have insight and make use of these in the area of study. Thus in selection of appropriate participants, my own experiences/understandings of the area under consideration were used.

As the study addresses the nature of mental health nurses knowledge in inpatient settings it is necessary to consider all environments in which nurses would utilise such knowledge bases. Thus nurses from acute, rehabilitation, care of the elderly, and specialist areas (Mother and Baby Unit and Forensic Unit) were included. As identified above this may have implications for the knowledges utilised by mental health nurses.

Within nursing two levels of registration are apparent, First Level (traditionally known as Registered Nurses) and Second Level (known as Enrolled Nurses), however education programmes leading to second level registration were discontinued in 1989. The pre-registration education experienced by these two groups is distinctly different in that the former are seen as the 'managers of care' and as requiring in-depth knowledge. The latter are seen as 'practical nurses' acting under the direction of the First level nurse. The current trend is to provide education programmes enabling second level nurses to 'convert' their registration to First level. The numbers of second level nurses are reducing and it is anticipated that those practising under this form of qualification will disappear within a few years. Given the differences in education programmes and the added power relation apparent in the knowledges deemed appropriate to First and Second Level nurses, the decision was made to include only First Level nurses in the sample.

It was seen as essential to include all grades of staff involved in the actual delivery of care. As discussed earlier the differences in responsibilities inherent in the grade structure may have implications in relation to knowledge bases. The grades range from staff nurse (Grade D/E/Level 2[1]) to Sister/Charge nurse (Grade F/G).

Accessing the subjectivity of the mental health nurses identified above provides a group reflecting the diversity of the mental health nurses practising within in-patient settings and thus allows the major factors related to mental health knowledge emerge. A sample of between 40 and 50 mental health nurses representing the areas identified is considered appropriate in facilitating the emergence of factors.

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[1] The grades Level 2 reflect a new grading structure in the area of study. The Trust ceased differentiating between Grades D and E, producing contracts defining what they identified as 'Level 2' responsibilities. Nurses employed before the introduction of the contracts continue to be identified as either Grade D or E but have duties commensurate with Level 2.

Accessing Participants for the Study

The Research Ethics Committee of a Midlands' N.H.S. Health Authority was contacted and permission sought to approach nurses within the Mental Health Directorate. The research protocol was approved and access to nurses granted. Letters were sent out to 94 people, that is, all the first level registered mental health nurses working within the mental health directorate inpatient environments, asking as to their willingness to participate in the study. 53 replies were received with 51 indicating they were willing to take part. Each nurse was contacted either face-to-face or by telephone/letter and the nature and process of the Q sort explained. The Q sort packages were given or sent to the participants with the request to return the items within one week. Of the 51 participants receiving the study material, 45 returned their Q-sorts, but 4 of these were spoiled i.e. incorrectly completed, resulting in a total of 41 Q-sorts for analysis. These were then prepared and analysed as identified in the following chapter.

Summary

- Q-methodology offers an alternative form of factor analysis in which each factor reveals the available subjective discourses in relation to a particular object, in this case the knowledges used by mental health nurses in their daily practice.

- Statements are drawn from and representing the concourse – various discourses - surrounding the topic area form a Q-sample, which participants are asked to 'sort' in relation to specified conditions. A ready-made concourse was available here in the form of the genealogical archive

- A structured approach to formulating the Q-sample was adopted facilitated through the use of C.A.Q.D.A.S. in the form of QRS NUD*IST. This provided a systematic method for the identification of discourses present within the concourse with patterns being allowed to emerge inductively. Statements (66 in total) representing the discourses present were selected and formed the Q-sample.

- A constructionist approach was adopted in that there was no assumption of a 'correct' solution. Mental health nurses were asked to perform a forced Q-sort (i.e. place items according to a predetermined format) in relation to the specific instruction - 'Consider your practice as a mental health nurse. Which knowledges are you most/least likely to use in your daily activities as a nurse?'

- Participants for the P-sample were identified using theoretical sampling; those seen as having relevance to and facilitating the emergence of the elements under examination were selected. The emphasis here being on the generation of theory rather than the validation of facts.

- Of a potential sample of 94 people, 51 indicated their willingness to participate, 45 returned completed Q-sorts, 4 of which were spoiled. 41 Q-sorts were available for analysis thus falling within the limits proposed (40 –50) as appropriate.

CHAPTER 10

Q-METHODOLOGY - DATA ANALYSIS

- Introduction
- Theoretical framework
- Methods of Investigation
- Genealogy - Diagnosis of the Present
- - Conditions of Emergence
- - Power Relations (part 1)
- - Power Relations (part 2)
- - Knowledges
- **Q-Methodology** - Philosophy and Approaches
- **- Data Analysis**
- Discussion, Limitations and Conclusions

The analysis undertaken here is a form of Factor Analysis followed by an interpretation of factors which emerge. A number of computer packages are available to assist in the statistical analysis of Q data, in this case PQMethod-2.09 (Schmolck, 2000) was utilised. The data (Q-sorts) are entered into the programme as 'piles' of statement numbers, utilising the format in which they are collected. A correlation matrix is computed which is then factor-analysed, the resulting factors are rotated to simple structure, defining Q-sorts for each factor are identified/ 'flagged', weighted in relation to loading on the specific factor, and a factor array of a model Q-sort for each factor produced. Each model Q-sort is examined and an interpretation of the factor it represents is offered.

Factor Analysis

Brown (1990) suggests that there are few statistical procedures more daunting than factor analysis and with the advent of modern day computer packages such as the one used here, there is little need to fully grasp the underpinning mathematical

principles. Simply put, factor analysis examines the correlation matrix to identify how many fundamentally different Q sorts are in evidence and which are highly correlated. In this way factor analysis identifies how many different factors there are and those people, sharing a common subjectivity, defining the same factor. Two methods are generally advocated to extract unrotated factors and are available within the PQMethod package, Centroid analysis or Principal Component methods. Centroid is frequently recommended by the American dialectic in relation to Q, Principal Component by the British social constructionist lobby. Centroid method is advocated due to its association with theoretical 'lee-way', that a number of solutions are possible and there is no 'one' right answer. The Principal Component method offers a 'best solution' generally producing one general factor followed by others. However McKeown and Thomas (1988) propose that irrespective of which process is used little difference is apparent in the resulting structures.

Two forms of rotation are available to the Q methodologist, judgmental (hand) or analytical (varimax). Once again the former is recommended by American researchers and the latter by the social constructionist movement. Q methodologists generally prefer theoretical/judgmental rotation where theoretical considerations drive/inform the rotation rather than the need for a 'best solution' (Brown, 1980). Often one Q sort is identified as of specific interest and used as the basis for the rotation, the other factors being viewed and rotated in relation to it and the underpinning theoretical principles.

Alternatively Varimax rotation is presented as an objective rotational process, which provides a statistical solution for the achievement of simple structure (Kline, 1994). The attainment of simple structure - when specific Q sorts have high loadings on one specific factor and low/nil loadings on the others - is seen as essential as it renders factors open to interpretation. Varimax rotation ensures that no participant loads on more than one factor thus maximising the difference between factors. Social Constructionists advocate this approach in conjunction with the Principal Component method as the statistical aspect of Q methodology, in their eyes, is simply a means to an end i.e. facilitating the emergence of patterns of discourses available in relation to their specific areas of study, in the form of factors (Stainton Rogers and Stainton Rogers, 1990). These patterns are then examined and an interpretation offered, in an effort to identify the discourses evident within the expressed subjectivities.

It is Principal Components analysis and Varimax rotation that are utilised here, in the belief that these will provide the 'best' solution in relation to the data, and facilitate the 'best estimate' of the discourses evident in relation to knowledges and mental health nursing.

Factor Rotation/Extraction

How many factors to rotate is subject to some debate and there appears to be little consensus as to how to arrive at the appropriate number. Convention in social construction approaches holds that factors with eigenvalues above unity are rotated. However Kline (1994) identifies that to rotate all factors with eigenvalues over 1.00 is to greatly over estimate the number of factors. McKeown and Thomas (1988) suggest that simply because a factor has an eigenvalue of above 1.00 does not necessarily mean that on rotation significant loading will be apparent. Gross (1992) proposes that the intention in this form of orthogonal factor analysis is to identify the smallest number of factors that can account for the variance between subjects. The attainment of simple structure also depends closely on the number of factors rotated – too few result in over broad factors, too many in factors being split. However the greatest accounting of the variability in the correlation matrix as possible should be present in the final set of factors and it is also suggested, (Brown, 1980), that the more participants loading significantly on a factor, the higher its reliability. McKeown and Thomas bring the debate to a close by simply advocating 'common sense' in determining the number of appropriate factors, the significance of factors should be considered in relation to the problems, issues and theoretical concerns of the research study.

Here rotation began with seven factors – those with eigenvalues of above 1.0. However examination of solutions provided with rotation of seven, six and five factors proved unsatisfactory, as the factors produced lacked clarity/definable attributes or resulted in only single participants loading significantly on certain factors. It was the extraction of four factors, which provided the clearest solution, accounting for 61% of the variance in the correlation matrix. At this point 30 (73%) participants (out of 41) defined factors and the remaining 11 participants loaded

significantly on the factors. Distribution of participants on factors according to area of practice, curriculum, grade and gender is identified on table10.1. below.

	Factor 1	**Factor 2**	**Factor 3**	**Factor 4**	**Not Loaded**	**Total**
Area						
Acute	12	3	1	-	4	20
Rehab.	-	1	2	1	3	7
Elderly	2	-	1	3	-	6
M&B	1	1	-	-	1	3
Forensic	3	-	-	-	2	5
Total	18	5	4	4	10	41
Curriculum						
1964	3	-	2	-	1	6
1974	4	-	-	-	1	5
1982	1	-	2	-	1	4
Diploma	7	4	-	3	7	21
Conversion	3	1	-	1	1	5
Total	18	5	4	4	10	41
Grade						
Staff nurse	17	5	-	3	7	32
F	1	-	2	1	2	6
G	-	-	2	-	1	3
Total	18	5	4	4	10	41
Gender						
Female	12	3	3	2	7	27
Male	6	2	1	2	3	14
Total	18	5	4	4	10	41
Degree	1	1			1	3
Registration x2	2	-	-	-	1	3

Table 10.1: Distribution of participants on factors by practice setting, curriculum, staffing grade, gender and qualifications/dual registration

Model Q-sort

Factor loadings equate to the extent to which each individual Q sort correlates with each of the various factors. Sorts that load significantly on one factor and without a substantial or low loading on other factors are utilised in the analysis and definition of factors. These so called 'exemplicatory cases' are 'flagged' as associated with particular factor[1] (see appendix four for factor matrix). Each factor's exemplicatory Q-sorts are then merged to produce a model Q-sort representing that factor. To achieve this each Q-sort is 'weighted' in relation to its specific factor, this acknowledges the closer association of some sorts with a factor than others (Brown, 1980). The weight is calculated utilising the formula $w = f/(1-f^2)$ (where f =factor loading). A composite weight for each statement within the model Q-sort is then calculated by multiplying the score given to each exemplificatory Q-sort (e.g. +3) by the weight allotted to that sort and totalling the various exemplificatory weights. These are then returned to the original Q sort format (+5, +4 etc.) for convenience when later interpreting of the factor. Thus the 3 highest composite weighted statements are assigned + 5; the next four assigned + 4 and so forth. This resulted in the generation of 'factor array' for each factor, where statement ranking can be considered in relation to a factor and across factors (see appendix five).

Factor interpretation

The law of parsimony states that the simplest explanation that fits the facts should be offered (Kline, 1994). It is this rationale that is adopted here. The factors, as McKeown, Stowell-Smith and Foley (1999) identify, provide access to the culturally available discourses that the participants of the study draw on when expressing their subjectivity. Thus the simplest form of presentation of the factors is through the use of a descriptor/label and a narrative account of each. Each factor is presented as a coherent discourse in relation mental health nurses subjectivity and their knowledge bases.

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[1] In the PQMethod package flagging occurs in response to the algorithm 'Flag loading **a if (1)** $a^2 > h^2 / 2$ (factor 'explains' more than half of the common variance) **and (2) a** $> 1.96 / \text{sqrt}(n)$ (loading 'significant at p>. 05') (Schmolck, 2000).

However as Dryzek and Berejikian (1993) identify such a narrative account is more that a simple 'cutting and pasting' of the statements at the extreme ends of the sorts. Rather it is drawn from a consideration of each statement's placement in relation to the others and how this compares with the placement in the other factors. Supplementary data from the comment sheets are also utilised in the interpretation and the formation of the narrative accounts (appendix six).

It is also possible to identify distinguishing statements for each factor which give access to the inherent subjectivities present within them. A statement is considered to significant/defining where a difference of 2 +/- is evident across the factor scores. These distinguishing statements are considered and form part of the interpretation.

Thus the interpretation offered here includes a general overview of each factor, including the defining statements, followed by a narrative account. The four narratives, whilst presented as distinct discourses, are supported by reference to the relevant statements from the factor arrays - the numbers in brackets reflect the statement numbers (in black) and the statement score (in red).

Factor 1

This factor accounted for 25% of the total variance with 18 (39%) of the participants loading with exemplificatory sorts. All clinical areas are represented in this factor, as are the five possible curriculum (1964, 1974, 1983, P2K and Conversion from second to first level nurse). The grade of staff is predominantly staff nurse level with one F (sister) grade. The ratio of male to females is similar to that within the sample itself. However, this is the only factor on which participants with dual registrations load significantly and one of two that are exemplified by someone who has studied at undergraduate level. Defining statements are presented in table 10.2.

Factor 1 Narrative - The Control Subjectivity

Mental health nurse's knowledge in this discourse relates to control of the patient and the environment (58, +5; 9, +4; 16, +3; 8, +3), paramount is the need to prevent individuals from harming themselves and/or others through control of the environment (59, +5; 10, +4). Whilst the maintaining of individual's privacy and

No.	Statement	R	S
58	K.C. assessment/identification of suicide risk,	5	1.79*
59	K.C. the management/care of a suicidal patient	5	1.75*
9	K.C. prevention of aggression/violence	4	1.56
10	K.C. the management of aggression/violence	4	1.49
26	K.C. personality disorders	2	0.76*
46	K.C. sleep	1	0.42
13	K.C. management and co-ordination of staff	0	0.06*
64	K.C. ward/unit administration/management	0	0.02*
47	K.C. nutritional requirements for physical/mental wellbeing	-1	-0.52
51	K.C. patient/user empowerment	-2	-0.66*
6	K.C. human growth and development	-2	-0.84

Table 10.2: Distinguishing statements for Factor 1 (K.C. = knowledge concerning; R = Ranking; S = Score). $p < .05$; Asterisk (*) indicates significance at $p < .01$.

and dignity (18, +1) is acknowledged as important, other knowledges promulgating individuality (31, -3; 44, -3) are not, which suggests that knowledge pertaining to control and prevention overshadow those concerned with interpersonal/humanistic approaches. The need to remain in control also negates the ability to utilise knowledge relating to user empowerment (51, -2). Central to the control discourse is the need to observe (36, +5), gather information (29, +4; 35, +2) and recognise the signs and symptoms of mental illness (23, +3). The ability to discriminate between 'bad' and 'mad' individuals, and thus ensure those deserving of care receive it, requires an understanding of the nature of mental illness (23, +3) and personality disorders (26, +2). The medical model of treatment (65, +2; 55, +4; 54, +3) is given precedence over other forms of knowledge relating to the nature of mental illness, and its care/treatment (42, 0; 43, 0; 22, -1). Issues relating to planning of activities and social skills training (5, -2; 7, -2) are no longer viewed as the remit of mental health nurses rather falling to other health professionals such as Occupational Therapists.

Communication skills (56, +3) linked with the statement 'knowledge concerning the ability to develop therapeutic relationships' (57, +2) are viewed as those required to facilitate the nurse's ability to carry out the control aspects of her/his role. Ethical knowledge and codes of practice (15, +1) professional responsibility/ accountability (40, +1), reflective practice/ self- awareness (12, +1) and problem-solving

approaches (34, +1) are understood in relation to the control imperatives. These are seen as underpinning the knowledge bases in relation to control of the environment, self and the individual. Knowledge relating to management (13, 0; 17, 0; 19, -1) is viewed as part of senior staffs' domain.

The mental health nurses' subjective remit in relation to the provision of care appears limited to the immediate care environment, i.e. the ward/unit. Knowledge relating to national policies and the organisation of mental health services (45, -3) is infrequently used, whilst knowledge relating to the Mental Health Act (11, +2) which has a direct impact on the care delivered, is rated highly. Research (38, -4) and nursing models/theories (30, -2) would seem to have little relevance to the mental health nurse in the planning and delivery of care (33, +2) in this discourse. Thus the mental health nurse is expected to 'know' the appropriate ways of behaving in relation to the control dynamic. This includes observation strategies and the adopting of appropriate methods to deal with the behaviours presented, drawing primarily on knowledges relating to the medical model of care/treatment and the social imperative to control individuals with mental health problems.

Factor 2

This factor accounts for 12% of the total variance, the model array generated from the sorts of 5 nurses (12.19 % of participants) all at staff nurse level, four representing the Diploma curriculum and one conversion from second to first level first registration. The acute, rehabilitation, elderly and mother and baby speciality practice areas are represented within this discourse. One has studied at undergraduate level. The ratio of males to females reflects that within the sample as a whole. Table 10.3 presents the defining statements for this factor

Factor 2 Narrative – The Therapeutic Subjectivity

In this discourse the knowledges given precedence present the mental health nurse as an active participant in the delivery of care to individuals with mental health problems/ illnesses. Planning of activities (5, +2), social skills training (7, +3), family involvement (22, +4) and activities of daily living (49, +1) linked to

No.	Statement	R	S
57	K.C. therapeutic relationships	5	1.99*
52	K.C. therapeutic interventions (such as counselling, C.B.T.	5	1.86*
22	K.C. families, family dynamics, working with families	4	1.42*
42	K.C. sociological issues impact on mental health/illness	4	1.39*
12	K.C. reflective practice, self awareness	4	1.36*
7	K.C. social skills training	3	1.08*
62	K.C. mental health, mental health education/promotion	3	1.06*
43	K.C. psychological concepts and relevance to mental health	3	1.01
60	K.C. community care/services/resources	2	0.91
5	K.C. planning programmes of activity (work, etc	2	0.91
16	K.C. creating and maintaining safe environments of care	1	0.39*
29	K.C. assessment	0	-0.03
9	K.C. prevention of aggression/violence	0	-0.25*
18	K.C. concepts of privacy and dignity	-1	-0.36
37	K.C. the recording and sharing of information	-1	-0.55*
35	K.C. the collection of information relating to patients	-2	-0.65
66	K.C. promotion/maintaining of personal hygiene	-2	-0.96
17	K.C. policies/procedures in relation to care and hospital	-4	-1.38*
28	K.C. observations on and collection of specimens	-5	-1.93

Table 10.3: Distinguishing statements for Factor 2 (K.C. = knowledge concerning; R = Ranking; S = Score). $p < .05$; Asterisk (*) indicates significance at $p < .01$.

problem-solving approaches (34, +2) advocacy (41, +2) and mental health education/promotion (62, +3) present the mental health nurse as a holder of knowledge which enable direct action and the nurse as an autonomous practitioner in her/his own right. Although knowledge relating to medication (54, +2; 55, +3) is high on the 'most used' continuum this can be viewed as an integrating of the knowledges relating to the interventions available for the treatment of people with mental health problems/illnesses.

Reflective practice/self awareness (12, +4) is more highly ranked here than in any of the other discourses and suggests an emphasis on the development of professional practice. The knowledge relating to professional responsibilities and accountability (40, +2) would seem to underpin this. There is also a knowledge remit wider that the immediate environment of care with knowledges relating to community care (60, 0) and the provision of mental health services (45, +2) being utilised more frequently than in the Control Subjectivity.

Knowledge relating to therapeutic relationships (57, +5), therapeutic intervention (52, +5) and communication/ interpersonal skills (56, +5) are ranked most highly. There is a rejection of the medical model as the only discipline within which an understanding mental illness can be gained, with sociological (42, +4) and psychological concepts (43, +3) being part of the nurses considerations. Observation of a patient's mental state (36, +3), the general nature of mental illness (23, +4) and responding to abnormal behaviours (8, +3) are all ranked highly but, set amongst these are other knowledge disciplines, signifying a synthesising of knowledge bases deemed appropriate to mental health nursing. However this results in a rejection of the traditional knowledge bases in relation to diet (47, -3; 48, -1) and promotion of personal hygiene (66, -2)

Although nursing activities are presented as being based on humanistic and multidisciplinary approaches, there is a rejection of the knowledges related to spirituality (31, -3) and sexuality (44, -2) suggesting that individuality is not fully acknowledged. The rejection of knowledges concerning research (38, -2) and to a certain extent, nursing models/theories (30, 0) presents a discourse that is dependent on anecdotal experience and, to a certain extent, custom and practice.

The knowledge bases concerned with control (58, 0; 59, 0; 9, 0; 10, 0) are consistently ranked at a lower level than the Control Subjectivity and, whilst obviously drawn upon, also suggests that other aspects are given higher precedence. However the placing of empowerment (51, 0) makes it evident that whilst the mental health nurse sees her/himself as an active practitioner this remains paternalistic in nature, the balance of power remains with the nurse who 'knows best' and so an element of control remains.

Factor 3

This subjectivity accounts for 15% of total variance and was generated solely from the Q-sorts of 4 nurses (9.75 % of participants) in ward management position (Sister/Charge Nurse Grades) in the acute, rehabilitation and elderly environments. The 1964, 1983 and Diploma curriculum are in evidence here. The ratio of male to

No. Statement	R	S
13 K.C. management and co-ordination of staff	5	2.12*
64 K.C. ward/unit administration/management	5	2.12*
19 K.C. time management/co-ordinating admin/ clinical requirements	5	1.95*
17 K.C. policies/procedures in relation to care/ hospital requirements	4	1.51*
10 K.C. the management of aggression/violence	2	0.72
38 K.C. the use/significance research in nursing practice	1	0.26
5 K.C. planning programmes of activity for patients	0	0.22
57 K.C. therapeutic relationships	0	0.02*
20 K.C. procedures for admission/discharge of patients	0	-0.06
65 K.C. medical treatments for psychiatric illnesses	-1	-0.31

Table 10.4: Distinguishing statements for Factor 3 (K.C. = knowledge concerning; R = Ranking; S = Score). $p < .05$; Asterisk (*) indicates significance at $p < .01$

females is 1:3 here as opposed to 1:1.9 of the sample as a whole. The defining statements are given in table 10.4.

Factor 3 Narrative – The Management Subjectivity

Knowledges relating to management issues (13, +5; 16, +4; 19, +5; 64, +5) and hospital policies and procedures (4, +4) are significant within this form of subjectivity. The knowledges relating to communication (56, +4) and professional responsibility and accountability (40, +4) are embedded within these management imperatives as are those relating to information (37, +3), which suggests that these are utilised in relation to management issues rather than patient centred activities.

The low rating of those knowledges relating to direct patient contact (48, -3; 47, -3; 46, -3; 35, 0; 49, 0; 58, 0; 66, 0) promotes a discourse in which these mental health nurses are supervisory figures rather than givers of care. Whilst knowledge concerning therapeutic relationships (57, 0) is given low precedence, that relating to therapeutic intervention (52, +2) is rated amongst the most frequently used. However its relationship to administration of drugs (55, +3: 54, +3), issues to do with aggression (9, +3; 10, +2), and observing/ responding to behaviours (8, +3; 36, +2) suggests therapeutic interventions relate to the control discourses rather than the nurse as a therapist. The management subjectivity requires that such activities are carried out in an appropriate and 'therapeutic' rather than punitive manner. When

linked to knowledge relating to ethics (15, +1) these would seem to underpin a requirement for supervision and a responsibility to ensure appropriate practice. However the 'appropriate' practice is closely aligned to the control discourse.

This is the only subjectivity in which research (38, +1) is placed on the continuum of knowledges most likely to be used. Statements relating to teaching and assessing (14, +1), and psychological concepts (43, +1) also appear at the same position. The role of manager is seen as encompassing the supervision and education of junior staff, and thus an awareness of current thinking/research is required.

Factor 4

This factor accounts for 9% of the total variance being made up from the exemplicatory Q-sorts of 4 individuals (9.75 % of participants) –3 from the care of the elderly setting and 1 from rehabilitation. They represent the curricula for the diploma – 3 participants - and 1 conversion from second to first level registration. 3 are staff nurses and one F grade ward manager. The distinguishing statements for this factor are identified in table 10.5.

No. Statement	R	S
16 K.C. creating/maintaining safe environments	5	2.15
66 K.C. promotion/maintaining of personal hygiene	4	1.35*
48 K.C. promoting food intake (assisting eating/drinking)	3	1.22*
49 K.C. activities of daily living	3	1.16
39 K.C. physical care needs of patients (moving/handling, etc.)	2	0.59*
47 K.C. nutritional requirements for physical/ mental wellbeing	1	0.55*
2 K.C. general anatomy and physiology	1	0.24*
31 K.C. the spiritual needs of patients/clients	1	0.17*
28 K.C. observations on and collection of specimens	0	0.16*
46 K.C. sleep	0	-0.19
52 K.C.therapeutic interventions (counselling, etc)	-2	-0.56*
8 K.C. how to respond to 'abnormal' behaviours...	-2	-0.86*

Table 10.5: Distinguishing statements for Factor 4 (K.C. = knowledge concerning; R = Ranking; S = Score). $p < .05$; Asterisk (*) indicates significance at $p < .01$

Factor 4 Narrative – The Protector Subjectivity

Knowledges relating to physicality (2, +1), physical care needs (39, +2), and helping individuals meet their daily physical needs (47, +1; 48, +3; 49, +3) appear dominant in this discourse. This, linked with the priority given to safe environments of care (16, +5), suggests in this subjectivity the person with mental health problems/illness is portrayed as dependent on the nurse to meet her/his needs and ensure her/his safety. In this light the nurse's professional responsibility (40, +5) relates to ensuring patients come to no harm. This not only concerns harm as a result of mental illness but also in relation to potential for exploitation by other and thus the need to utilise knowledges relating to advocacy (41, +1) and empowerment (41, +1). Precedence is also given to those aspects concerning individuality such as dignity (18, +2), and spirituality (31, +1), which present the nurse as humanistic in their perspectives.

However the medical model of care holds dominance (23, 0; 54, +2; 55, +4; 65, +2) with knowledges relating to observation (28, 0; 29, +4; 37, +2; 35, +2; 36, +4) gathering (29, +4) and sharing of that information (35, +2) appearing consistently.

Communication (56, +5) is given high status, as is knowledge related to therapeutic relationships (57, +3) however this would seem to be in relation to that carrying out of tasks and the gathering of information rather than in therapeutic interventions (52, -2) and activities (53, -4; 5, -2; 7, -2). Thus the mental health nurse, drawing on humanistic and interpersonal approaches, is the giver of medically orientated care, mediating for the patient to ensure exploitation does not occur and rights are upheld.

Consensus statements

In conducting this form of orthogonal factor analysis the aim is to identify a small number of powerful factors which are independent of each other. However the factors here present a weak to moderate correlation which reflects a general similarity in the factors and thus the subjectivities of the participants, which is to be anticipated when all participants are mental health nurses. This shared subjectivity is represented in consensus statements, those statements that do not distinguish between any pair of factors.

Knowledge relating to anatomy and physiology of the nervous system is said to be non-significant at both p>. 01 and p>.05, however greater emphasis has been placed on this aspect of mental health nurses' knowledge in recent years. Comments from the participants suggest that this knowledge is *'useful'* and *'desirable'* particularly in relation to medication. However it remains low in the prioritising of the usefulness of knowledge. It possibly represents a rejection of knowledge viewed as more pertinent to general nursing, the physical workings of the body being seen as having no bearing no the activities of mental health nurses. This is born out when considering other statements relating to physicality and their ranking in discourse 1, 2, and 3 (general anatomy and physiology (2, -4, -3, -5); physical illness (1, -4, -1, -3); observation on specimens (28, -3, -5, -3); and physical needs (39, -3, -3, -4)). Although the 'protector subjectivity' adopts some of these knowledge bases (2, +1; 28, 0; 39, +2), this would seem to be client group related. Participants associated with this discourse are predominantly from the care of the elderly setting, as the older person is viewed as likely to present with physical needs and so such knowledge becomes legitimate.

Why negative consensus occurs regarding first aid knowledge is unclear. The comments available show a varied response to this item, one participant designating such knowledge as *'desirable'* whilst another from the same area of practice indicating that it is *'only used occasionally'*. It is possible that incidents requiring first aid intervention are relatively rare and thus this knowledge is 'least likely to be used' in the general scheme of mental health nursing. Data identifying the frequency of 'untoward' incidents, as they are known, requiring first aid are not available and therefore it is only possible to speculate.

Summary

- The factor analysis revealed four subjectivities in relation to mental health nurses' knowledge.

- The first factor suggests knowledges are used in relation to a control discourse and are related to 'knowing how' to behave to ensure the patient and environment is appropriately maintained. Medical forms of knowledge dominate the

Six consensus statements are identified in this study (see table 10.6), three relate to knowledges least likely to be used and three to knowledges most likely to be used. Considering these consensus statements in light of their position within the model Q-sorts provides an added dimension to the analysis, hence here they have been part of the interpretation of each factor. The positive consensus statements relating to knowledges concerning communication, ethics and medication although apparently reflecting a 'general' subjectivity of mental health nurse, have differing forms and uses within the various discourses, as is identified in the above narratives. However the same does not seem to be true for those consensus statements placed within the negative range. These appear to represent knowledges that are no longer used, rejected or genuinely infrequently used by mental health nurses.

No.	Statement	Factors	1	2	3	4
4*	K.C. anatomy and physiology of the nervous system		-5	-4	-4	-3
15	K.C. ethics in healthcare, the nursing profession ...		1	1	1	0
21	K.C. first aid		-1	-3	-3	-1
27	K.C. learning disabilities		-5	-5	-5	-5
54	K.C. therapeutic use and action of common drugs...		3	2	3	2
56	K.C. communication/interpersonal skills		3	5	4	5

Table. 10.6: Consensus Statements - Those that do not distinguish between ANY pair of factors. $p > .05$; Asterisk (*) indicates significance at $p > .01$

The negative placement of the statement relating to learning disabilities may reflect the changing structure of service delivery. Two decades ago it was considered usual to have patients with learning disabilities within the psychiatric setting, however the care of these individuals has increasingly fallen to the social services and learning disabilities nurses so it is no longer seen part of the mental health nurse's remit. Whilst some of the comments regarding this statement suggest that a knowledge is desirable, others suggest that this is seen as specialised knowledge relating to a field other than mental health nursing. One participant suggests that as one bed per ward is designated for the care of people with learning disabilities, a nurse with that specific qualification should be employed. Another proposes that *"I feel they should be nursed in their own sphere of nursing in order to have full quality of life and correct care and treatment"*. Hence this would seem to be knowledge which no longer perceived as part of mental health nursing.

conceptualisation of mental illness and support the mental health nurses' regimes of practice.

- Factor 2 indicates a 'therapeutic subjectivity' in which knowledges proposed as used are those associated with the mental health nurse regimes of practice as a therapeutic agent. The mental health nurse draws on a variety of knowledge bases in the conceptualisation of mental illness and appropriate interventions with those deemed mentally ill. However it is suggested that mental health nurses, in drawing on certain 'control' knowledge and rejecting those related to empowerment, remain paternalistic in nature. The rejection of knowledges relating to research and nursing theories highlight mental health nurses' ambivalence towards the current education initiatives and the validity of nursing theories for mental health nursing.

- The third subjectivity relates to management regimes of practice and the knowledge bases which underpin these. Embedded within this is also the control discourse with the imperative to ensure that such activities are carried out appropriately. There is a prioritising of knowledges relating to management issues over those concerned with practice activities suggests the dominance of the managerial discourse and a rejection of the professionalising one. Here mental health nursing is seen as merely a series of tasks with the manager ensuring that these are carried out appropriately.

- The final subjectivity in many ways reflects the control discourse giving precedence to knowledges relating to the maintaining of safe environments and observation. However emphasis is also given to knowledges underpinning physical aspects of care and possibly reflects the care environments of the mental health nurses loading significantly on this factor – i.e. the need to ensure the physical needs of the older person and the person with enduring mental illness are met. The medical discourse is dominant but the mental health nurse also mediates for the patient, protecting them from possible abuse by others.

Q-methodology and The 'Current'

The intention of this study, as previously stated, is to consider *'How is mental health nursing knowledge constituted and made possible in relation to existing discourses, practices and conditions*' through the identification and analysis of mental health nurses' social apparatus. This is viewed as being composed of two parts, the archive and the current. The archive was made visible in the earlier part of the thesis, the current accessed through the use of Q-methodology as discussed in Chapters 9 and 10. In the use of Q an attempt was made to reveal mental health nurses' subjectivity in relation knowledges underpinning their present regimes of practice and to identify how these may be changing. The methodological aspects of Q are now complete and the implications of these for mental health nursing's social apparatus will be discussed further in chapter 11.

CHAPTER 11

DISCUSSION, LIMITATIONS AND CONCLUSIONS

- Introduction
- Theoretical framework
- Methods of Investigation
- Genealogy - Diagnosis of the Present
- - Conditions of Emergence
- - Power Relations (part 1)
- - Power Relations (part 2)
- - Knowledges
- Q-Methodology - Philosophy and Approaches
- - Data Analysis
- **Discussion, Limitations and Conclusions**

The intention of this study was to identify the nature of mental health nurses' knowledge, to understand how mental health nursing knowledge is constituted and made possible in relation to existing discourses, practices and conditions. My aims in undertaking this research were to:

- Uncover the factors influencing which knowledges are used and which knowledges are presented as central but disregarded by mental health nurses.

- Identify the knowledges that underpin present mental health nursing practice.

- Offer a post-modern interpretation of the nature of mental health nursing, its knowledge bases and from this propose whether change is desirable and/or feasible.

To achieve this, the two approaches of Genealogy and Q-methodology were combined, in an effort to uncover the lines of enunciation, visibility, force and subjectification, which form the social apparatus within which the practice of mental health nursing occurs. The social apparatus has two parts the archive (what mental health nursing is and is ceasing to be) and the current (what mental health nursing is and is becoming). In accessing these two aspects of the social apparatus the discourses describing mental health nursing, the power relations in evidence and the knowledges programmed and inscribed upon them are revealed. It is intended in this chapter to identify the form of the social apparatus, its archive and the current; the nature of mental health nurse's knowledge; and the future issues facing mental health nursing and nurse education. The limitations of this research, recommendations for future research and general conclusions are also included.

The Archive

Foucault's (1981) Genealogy reveals the archive and begins with a diagnosis of the present, an identification of current discourses concerning mental health nursing's regimes of practice and the power-knowledge formation evident within them.

Regimes of Practice

The literature relating to mental health nursing revealed three perspectives – prescriptive, descriptive and evaluative. The prescriptive literature gave precedence to therapeutic relationships and the nurse drawing on knowledges relating to this. It was reflected in various works (Barker, Jackson and Stevenson, 1999; Cutcliffe, 1997; Gijbels, 1995; D.O.H. 1994b; Peplau, 1988) and forms the basis of nurse education programmes. The descriptive perspective provided a somewhat different picture with mental health nurses viewed as rarely engaging in therapeutic activities, time most frequently being spent undertaking managerial and supervisory tasks (Towell, 1975; Robinson, 1996; Whittington and McLaughlin, 2000). The evaluatory view was similar

to the descriptive one with mental health nurses being seen largely as 'generalists' and acting as assistants to others (Garrard 1988; Gijbels 1995).

Although the three discourses appeared to offer differing ways of seeing and speaking of mental health nurses and their regimes of practice, the central tenets were identified as acting as the doctor's assistant - encompassing the providing of information and performing tasks in the service of medical discourses; control - of the environment, self and patients; and therapeutic activities. Each discourse was proposed to have arisen as a result of specific rituals of power and as such programme particular knowledges. As discourses do not grow apart from/outside of power, but rather appear in the space created by, and in the exercising of power, it was necessary to chart the emergence of mental health nursing, its endowing with certain characteristics through discourse and the establishing of power relations.

Emergence of Mental Health Nursing

It is proposed here that the genesis of mental health nursing in the form of the attendant happened as a result of, and in response to the rise of the medical and moral discourses and the building of Asylums in the of the $18^{th}/19^{th}$ centuries. The striking of the chains from the mad by Pinel in France captured the mood of philanthropy and moral concern prevalent in England at the time and propelled the possibility of an alternative treatment into the public and professional domains. Where chains and fetters had previously served to contain the mad, the rise of moral concerns had made this option unpalatable. Moral discourse therefore provided a means through which treatment (moral treatment and non-restraint systems) of the insane could be articulated in a socially condoned manner. The medical discourse concerning the treatment of the insane necessitated the involvement of another, but subservient group, attendants. Such treatment and systems of care were dependent for their success on the surveillance and monitoring of the insane to ensure the safety of society. Although physicians were to be the arbiters of this, attendants were to replace the fetters and chains providing moral and, if necessary, physical restraint.

An assistant was also required to provide information concerning the presentation of illnesses and the efficacy of treatments. Attendants were deemed appropriate for such a role. The rise of nursing in general medicine had provided a degree of respectability to doctor's activities. Physicians in madness sought to emulate them through the creation of their own competent yet biddable assistant. The power-knowledge formations in relation to control and as doctor's assistants would appear to have their roots here.

Medical Dominance

The illness of George III had placed madness both in the public consciousness and on the parliamentary agenda whilst opening the door to a discourse on cure. The Asylum was designated by the medical profession as the most appropriate site for such cures where the patient was to be placed under the control of the physician as the arbitrator of moral treatment and the embodiment of philanthropic aspirations. The rising numbers of pauper insane presented society with a problem which was to be resolved through the building of the Asylums. The creation of the Asylum provided a space within which physicians could practice and establish their moral right to dominance as guardians of the inmates' wellbeing. Thus presented as a philanthropic undertaking for which the poor should be grateful, the physicians were allowed to practice unhindered.

The attendant however was presented as potentially morally degenerate and in need of constant surveillance, but if given the appropriate supervision and education was capable of delivering the treatments required in the medical discourse. Technologies of discipline ensured that the attendant was constantly active and produced a docile and productive worker concerned with 'getting the work done' rather than interacting with patients. This ethos was to become a taken-for-granted background of mental health nursing.

The physicians' constant denouncements of the attendants, whilst necessary in maintaining their control of the institution, fed society's fears and concerns as to the care delivered and the propensity for abuses to occur. This coupled with the public's distrust of the mad-doctors led to legislation that not only dictated every aspect of the patients' lives but also of those charged with their care.

Although doctors were able to establish their discourse relating to the care and treatment of the insane, the accrediting of this as a scientific undertaking was somewhat elusive. Their efforts to emulate their general medical colleagues resulted in the creation of the 'dangerous man' (sic), an image to become firmly embedded in society and the genesis of the 'folk devil' of the moral panics relating to madness. These discourses created a workforce characterised in regimes of practice concerned with observation and collection of information in the service of medicine. Delivering treatments as directed by the doctors included controlling of the patient and promoting an environment conducive to treatment. The discourses also promote the mental health nurse as a point of application for the technologies of discipline, being charged by the State at the behest of society to contain and control madness.

Management v Professional Discourse

Nursing in the 19th century was re-formed and made respectable by the middle and upper classes. Philanthropic aspirations of upper class women cast the nurse in a vocational form, seeing it as a calling rather than a profession. Their role was simply a replication of that in the home of supervising the duties of others and ensuring that all was conducted in the proper and appropriate manner. This was to be translated in hospitals into a managerial discourse, the status of the nurse established through their seniority in the nursing hierarchy and their ability to 'manage' junior staff in the performance of tasks. However others grasped what they saw as an opportunity to achieve a level of autonomy through professionalisation in the form of registration. The goal of limiting the use of the term 'nurse' to a select few (female, middle/upper class general hospital nurses) through legislation in the form of registration, was to fail because others, particularly physicians in madness, saw the acceptance of their own assistants in this project as beneficial to their own aspirations. However having won the battle for inclusion of mental health nurses in the Registration Act (1919), the psychiatrists were to lose in terms of control of their education. The placing of mental health nurse education in the hands of the General Nursing Council (G.N.C.) linked it closely to their drive to produce evidence of common underpinnings in the form of nursing theory and gave further precedence to physical aspects of care.

Dominance of the Managerial Discourse

The two discourses, managerial and professional, present within nursing represent a battle between technologies of discipline, that is the production of an efficient, docile and obedient workforce, and the practices of self-formation i.e. the achievement of autonomy, overcoming socially imposed limitations and producing a reversal in power relations. At times when conditions have required the presentation of nursing as an attractive and coherent occupation the professional discourse has achieved ascendancy with discourses relating to what nursing 'should be' being dominant, presenting nursing activities as underpinned by academic bodies of knowledge. However more frequently the power relations evident between nursing and both the State and the health institutions have given precedence to the managerial discourse with hierarchical observation and normalising judgements combining to provide a compliant and cost-effective workforce. The conditions within mental institutions, such as poor recruitment, large numbers of unqualified staff and the subjugation of mental health nurses to general nurses and psychiatrists, have favoured the managerial discourse.

Therapeutic Discourse

The changes in health intervention/services and the growth of technology and pharmacology resulted in a need to re-assess the role of the nurse. Implicit in the role of caring is the idea of a 'special' relationship and from this came the possibility of therapeutic relationship. This 'therapeutic' ideal, prominent within humanistic and psychological discourses, provided nurses with an opportunity to further their self-formation discourse and metamorphosis from deliverers of care into the 'caring profession'. The therapeutic and psychological discourses were given particular emphasis in relation to care of people with mental health problems. However the therapeutic discourse simply masked and justified the traditional practices of mental health nurses, with their role remaining that of doctor's assistant providing information and creating a suitable environment in which medical treatments could be given. Much as the moral treatment and non-restraint system had been transformed into a medical discourse and presented as offering a curative approach in the 19th century, so the therapeutic approaches were the realm of the doctor again promising a movement from

custodial care to cure with mental health nurses being subjugated to service the medical profession.

Knowledges Programmed

Control

Society's and the State's imperatives to ensure the safe containment of the insane is present within the control discourse and the 'knowing how' to do this appropriately supports such activities. Thus control is seen primarily to relate to 'sanitary knowledge' and encompasses cleanliness and activities relating to promoting normalcy - eating, washing, work and so forth; security/prevention of untoward incidents; promoting calmness; awareness of legal statutes. Self-control in the mental health nurse is deemed essential in the smooth running of the institution, and is seen in the cultivation of attitudes necessary in promoting patient well being, in providing an appropriate role model to the patients and in knowing their place in the general scheme of psychiatric care.

Medical

As the doctor's assistant the knowledges supporting mental health nurse's regimes of practice reflect the dominant medical discourse of the time. Hence mental health nurses 'know how' to perform tasks and activities to service these medical discourses. An understanding of the dominant medical discourse of the time whether encompassing Psychodynamic (brainless) or Biological (mindless) (Lipowski 1989) concepts is essential in ensuring the mental health nurse knows how to carry out the associated treatments; what observations are appropriate; and the nurse's identified regimes of practice within the discourse. Hence at certain times knowledges relating the biological discourses take precedence, at other times it is those relating to psychodynamic discourses.

Therapeutic

The move from the predominantly custodial care of the first half of the 20th century to the possibility of cure in the second, generated a 'therapeutic discourse' and supporting rationalities. In the hands of the psychiatrist this discourse can be seen as a 'tool of power' through which they hoped to cement their scientific standing within medicine as a whole. For nurses it was a point of resistance in the battle to extricate themselves from the traditional role of doctors' assistant, a strategy to achieve their goal of professionalisation. The act of self-formation is evident in the growth of reflective practices in efforts to inculcate therapeutic imperatives and the presentation of nursing's regimes of practice as separate from, and independent of medical interventions. However the therapeutic discourse frequently masks the continuation of the power relation between mental health nursing and the medical profession. The term 'therapeutic' simply reflects a dominant psychodynamic medical discourse in which mental health nurses frame their activities and makes their regimes of practice visible.

Individuals with mental illness act in socially unacceptable ways, frequently requiring physical interventions. The role of mental health nurses' in the control and containment of individuals with mental illnesses is 'dirty work' (Hughes, 1971), necessary for society's wellbeing, but crossing the boundaries of normal interactions between individuals into a terrain which is not usually discussed openly in social settings. To make the work of mental health nurses visible and socially acceptable there is a need to offer an alternative 'self'. The presentation of their activities as therapeutic and based in humanistic approaches allows such work to become visible.

Sheppard's (1990) proposals re the *domain* of nursing (what it is concerned with) and the *context* of nursing (in which it acts from the domain) highlights the tension between the therapeutic activities and the dirty work of mental health nursing. He asserts that nurses tend to identify their domain as biopsychosocial proposing it is these knowledge bases that support their regimes of practice. Hence the domain of mental health nursing is represented as the use of psychosocial knowledge in therapeutic activities. However the context in which the nurse acts is behaviour driven with little recall to the proposed knowledge base. Thus the context of mental health nursing requires a doing of the 'dirty

work'. The ongoing battle between the managerial and professional discourse within mental health further exacerbates the divide between context and domain. The managerial discourse requires junior staff to do the 'dirty work', the status of the senior nurse is achieved through the supervision of others. The professional discourse requires work to be reframed in relation to certain knowledge bases in order to further the development of nursing as a profession. Mental health nursing is caught between the 'knowing how' of the dirty work and a requirement for the 'knowing that' of evidence based practice.

What Mental Health Nursing Knowledge Is/Ceasing to Be

Mental health nursing's regimes of practice and the discourses surrounding them require a knowing how to undertake certain tasks. The power relations crossing the body of mental health nursing inscribe these forms of rationalities on them. The presence of the professional discourse and generation of the therapeutic discourse are an attempt to modify power relations and allow nursing to become active in its self-formation. However the power-knowledge formations within the social apparatus constructed around mental health nursing negate the success of a subjectification discourse related to therapeutic activities and use these instead to justify traditional regimes of practice. Knowledges programmed through the Archive are concerned with mental health nurses' as doctor's assistants and as controllers of the environment, the patient and themselves.

The Current

The analysis undertaken through Q methodology allowed the emergence and interpretation of four factors, giving insight into mental health nurses' subjectivity. Each factor represented a coherent expression of mental health nurses' subjectivity in relation to their knowledge bases. These were identified as the 'control', 'therapeutic', 'management' and 'protector' subjectivities. The managerial discourse is inscribed on three of the subjectivities - 'control' 'management' and 'protector' - expressed by

mental health nurses. The professional discourse is only evident within the therapeutic subjectivity.

Control Subjectivity

It is clear that the regimes of practice concerning control are indelibly inscribed upon these mental health nurses. The control subjectivity gives precedence to knowledges relating to controls of the patient and the environment. Nursing models/theories generated by the professionalising discourse would seem to have little relevance to the mental health nurse in the planning and delivery of care. The knowledges underpinning understanding of mental illness and regimes of practice appropriate for mental health nurses reflect a medical discourse. The mental health nurse expects to 'know' the appropriate ways of behaving in relation to the control imperative and the dominant medical discourse.

Management Subjectivity

The managerial discourse revealed in the Genealogy reverberates most clearly within the management subjectivity. The supervision of junior staff takes priority, seeing tasks are performed in the appropriate manner and adherence to hospital policy is central to the subjectivity of such nurses. Interestingly the need for medical knowledge is rejected, possibly as the senior nurse's status is achieved through management skills, thus there is a moving away from those knowledges associated with the work of nursing.

Protector Subjectivity

The protector subjectivity contains many of the elements relating to the nurse as the doctor's assistant and control discourses. Knowledges concerning physical aspects of care and supervising of patient's daily living (eating, hygiene, and sleep) reflect traditional 'sanitary knowledge' advocated by Nightingale. This would suggest that the managerial discourse is dominant here with nurses knowing how to perform tasks with little recall to underpinning theories. Whilst knowledges relating to therapeutic relationships are rated positively, those related to therapeutic strategies are ranked negatively, suggesting that here 'therapeutic' is used in terms of gaining trust and

accessing information as part of the observation imperative in the doctor's assistant discourse, rather that as the nurse as a therapist in her own right.

The highlighting of such 'sanitary knowledges' possible also reflects specific discourses present within environments related to care of the older person. Here society's requirement that older people need only physical care is apparent. However the mental health nurse is also presented as protecting the patient from abuse, acting as an advocate for their needs. As a number of older people in the mental health setting suffer from dementia and are viewed as vulnerable to abuse, this may again be specific to care settings relating to the older person.

Therapeutic Subjectivity

The therapeutic subjectivity presents the mental health nurse as an active participant in the delivery of care to individuals with mental health problems/ illnesses. There is also a knowledge remit wider than 'knowing how' and medical forms of understanding mental illness, although these still remain prominent. Alternative bodies of knowledge figure in the mental health nurse's repertoire and are said to underpin regimes of practice.

What Mental Health Nursing Is/Becoming

Within the four subjectivities revealed, the knowledge bases identified within the Genealogy are obviously present, i.e. those relating to control and the mental health nurse as the doctor's assistant. Thus these continue to represent what mental health nursing is. However a therapeutic subjectivity is identified. It is difficult to be clear as to what this represents in terms of 'what mental health nurses are becoming'. It may be a manifestation of the professional discourse that has been present within nursing since Mrs Bedford Fenwick's time and evident in the pursuit of registration. It could also represent the phenomenon identified by Clinton (1985) whereby nurses give the response expected dependant on their situation. As participants were asked to identify the knowledges used as part of a research study they may have provided the prescribed 'classroom' knowledges rather than the practice reality. However as other subjective discourses were also clearly found to be present, this would seem unlikely.

Alternatively it is possible that this represents a transformation in certain nurses subjectivity with the lines of subjectification achieving a degree of self-formation and thus an inscribing of the therapeutic discourse on these individuals. Knowledges relating to therapeutic relationships, therapeutic intervention and communication/ interpersonal skills are seen as integral to the work of mental health nurses. However knowledges concerning the observation of a patient's mental state, the general nature of mental illness and responding to abnormal behaviours are presented as those used frequently. These may represent dissonance created by the managerial discourse and the dominance of the discourse relating to the mental health nurse as the doctor's assistant.

As identified in chapter ten, consensus statements can be seen as representing the shared subjectivity of participants. Whilst the positive statements were considered in relation to the four subjectivities they occurred in, in light of the Genealogy it could be proposed that these reflect the three discourses describing mental health nurses' regimes of practice – control, doctor's assistant and therapeutic relationships. Knowledges relating to ethics in health care encompass control of self and appropriate interventions with others. Therapeutic use of drugs is directly related to the discourse concerning the nurse as the doctor's assistant. Communication skills are central to both the therapeutic discourse and the nurse as the doctor's assistant. How these are placed within the four identified subjectivities gives insight into the dominant discourses present in each and the ascendancy of one over another. Nevertheless, this confirms the centrality of these three regimes of practice within nursing subjectivity. These discourses represent the 'truth' of mental health nursing.

The Nature of Mental Health Nurses' Knowledge

The dominance of the managerial discourse over the professional one can be seen as giving precedence to the 'knowing how' over 'knowing that'. Thus Mental health nursing is task orientated, encompassing knowledges relating to knowing how to do something rather that those concerning 'knowing that', the esoteric knowledges of professions.

The concept of 'knowing how' and 'knowing that' in nursing is well documented. Peplau (1988), as discussed earlier, proposed two forms of knowledge as evident in mental health nursing, mechanistic (performing tasking, knowing how to do something) and dynamic (knowledge of facts a knowing that of evidence based practice). Benner (1984) writes of 'knowing how' and 'knowing that', proposing that the former is often acquired first in practice based professions to be followed by the latter as the nurse moves from novice to expert. Maeve (1994) asserts 'knowing that' is implicit in the organised knowledges presented in curricula whereas 'knowing how' is intrinsic to clinical activities.

Schon (1995) suggests a professional knowledge hierarchy, in which scientific knowledge is seen as superior to concrete skills orientated knowledge. Skills knowledge (knowing how) is often seen as a secondary type with Schon proposing a certain discomfort is evident in the linking of skills to knowledge. Thus occupations premised on this secondary knowledge fail to cross the threshold of scientism (Foucault 1972). Hence nursing has attempted to promote its 'knowing how' as just one aspect of its repertoire, with the modern nurse being a "knowledgeable doer" (U.KC.C. 1986), having an esoteric body of knowledge on which to draw. However attempts to generate what Foucault (1972) terms 'connaissance' – scientific knowledge - and to imbue this knowledge in its members through various education programmes, appears to have had little success. In relation to mental health nursing it is posited here that the regimes of practice and the knowledges underpinning these have altered little in over a hundred years of organised education. Where changes in knowledges are apparent these relate to movements in medical forms of treatment rather than as a result of self-formation discourses.

As the regimes of practices for mental health nurses relate to 'doing' and rationalities supporting these relate to skills knowledge, mental health nursing fails to achieve scientific status and are therefore subjugate to the service of other 'scientific' discourses, namely medicine. Attempts at 'knowing that' as portrayed by the professional discourse simply mask the skill base preferred by doctors and are denigrated by the managerial discourse, thus have no value or currency for mental health nurses in the clinical

environment. As Jarvis (1999) comments both scientific knowledge and practical knowledge have to be legitimised by their applicability to practice - if it is appropriate/useable it is adopted. Thus as nursing scientific knowledge proposed to guide practice frequently has no resonance for mental health practitioners, it is rejected. In the case of mental health nursing the bodies of knowledge prescribed as guiding their practice are nullified by the experience of practice.

The Possibility of Resistance

Foucault (1979a) identifies power as a productive force and is at pains to emphasis that wherever there are power relations so too are possibilities for resistance. Distinguishing between what he terms serious and dubious sciences Foucault (1972) identifies a need to uncover what role these 'dubious sciences' play in the greater scheme of things. Thus when considering mental health nursing (as a dubious science, having failed to achieve the level of scientism) it is necessary to consider what role it and the discourses surrounding it play and the possibility of resistance.

The Nurse as the Doctor's Assistant

The Project 2000 curriculum (U.K.C.C. 1986) was seen as placing nurse education within an academic framework and in doing so enhancing nursing's status and academic credibility (Jowett, Watson and Payne, 1994). However over a decade on from its implementation this educational initiative is being roundly criticised for "failing to facilitate the development of practice knowledge and skills" (U.K.C.C. 1999, p38) and the belief that there has been an over emphasis on the academic aspect of nursing to the detriment of practical ability. Concerns have been specifically expressed regarding a proposed lack of core practice skills in newly qualified mental health staff (Sainsbury Centre for Mental Health (S.C.M.H.) 1997; D.OH.1994a).

The media has at regular intervals discussed the apparent failure of the education system to produce 'good' nurses and lambasted nursing for its attempt to create an academic nurse, calling for the return of matrons to control nursing and for students to be put back

on the wards where they belong (Meerabeau, 2001). This reflects the image of a good nurse as a 'docile' and 'obedient' worker – rather than autonomous practitioners - created through technologies of discipline in the form of hierarchical observation (with the matron at its pinnacle) thus giving precedence to the managerial discourse.

The Government's paper 'Making a Difference' (D.O.H. 1999a) proposed the need to strengthen practical skills in pre-registration programmes. Thus both society and the State can be seen as placing more value on the knowing how than the knowing that of nursing. Nursing Education's response to this has been to advocate an overhaul of the curriculum placing emphasis on developing 'competency' (U.K.C.C. 1999). Competency is defined as "the skills and ability to practice safely and effectively without the need for direct supervision" (UKCC 1999, p35) and thus emphasising 'knowing how'. However the stated aim to "develop higher order intellectual skills and abilities *and* the practice knowledge and skills essential to…nursing." (U.K.C.C. 1999, p4 original emphasis) would seem to reflect a call to ensure an appropriate balance between academic and practical knowledge is achieved – echoing the professional discourse. Thus there remains a tension between what society deems as appropriate regimes of practice and associated knowledges and what nursing itself aspires to.

The S.C.M.H. (1997) identifies the core skills, knowledge and attitudes of mental health nursing as relating to management and administration, assessment, treatment and care management emphasising medical approaches and collaborate working – i.e. the nurse as the doctor's assistant. The current dominant medical discourse within psychiatry is a 'mindless'/biological sciences one, genetic/organic explanations of mental illness and pharmaceutical treatments are dominant within the medical arena. This dominance of the disease orientated 'biological' discourse within mental health care provision has been highlighted in a number of Foucauldian studies (Keddy, 1996; Crowe, 2000; Hannigan and Cutcliffe, 2002). Psychiatric medical discourses are viewed as directing mental health nursing practice and promulgate particular ways of working. The current emphasis on mental illness as essentially a biochemical disorder to be alleviated through the use of medication casts the mental health nurse's role as that of controlling the patient until medical treatments/medication take effect.

Foucauldian studies examining nursing documentation in intensive and acute care settings shows medical discourses to be clearly dominant, these transforming the patient into an object for scientific scrutiny. The nurse records all aspects of the patient experience but rather than this being holistic in nature (as advocated by the professional discourses) the language used suggests a fragmentation of the patient's body, thus it is seen as being reductionist in nature and serving the medical scientific gaze. The nurse's role as carer is generally absent (Henderson 1994; Heartfield 1996). Mohr (1999), deconstructing the language used in mental health nursing documentation, identifies the most frequently entered information relates to observations and laden with psychiatric 'jargon'. She proposes that language used in the documentation is representative of the power and knowledge discourses inscribed on the mental health nurses subjectivity. It is suggested that the medical discourse is so dominant within mental health nursing that other forms of interventions such as counselling are all but totally neglected (Keddy, 1996). Only those knowledges legitimated by the medical discourse and seen as valid in directing mental health nursing practice.

Whilst medical knowledge has value to nursing, it is its legitimisation above others that gives rise to concerns (Huntington and Gilmour, 2001) and it seems highly unlikely that this will change. Thus it is improbable that resistance to such a dominant discourse will be successful, without a major shift in both society's and mental health nursing's thinking.

The Mental Health Nurse and Control

Mental health nursing is a point of application for the technologies of discipline in relation to those deemed dangerous to the social body. The knowing how to control environment and patient is implicit in this. Moral panic was made visible in the various Lunacy Acts of the 19th century and carried forward in the Mental Health Acts of the 20th. The 21st century sees this moral panic raising its head again in the form of forth-coming legislation strongly advocating control and confinement. However the promoting of the therapeutic discourse in relation to mental health services remains essential to the masking of society's need to detain those proposed most dangerous. Through hierarchical observation, normalising judgement and the bringing together of

these in a mental health nursing's gaze, individuals are subject to surveillance and subjectification framed as humane and therapeutic activity.

The recent review and imminent implementation of new legislation in relation to those with mental illness (D.O.H. 2000b) reflects a resurgence of the idea of the dangerous man (sic) and a growing moral panic in relation to individuals with mental illness. The need to control and contain these individuals is implicit within the directives and proposed regimes of practice for the mental health nurse. These developments are likely to perpetuate regimes of practice and knowledge relating to mental health nurses as the doctor's assistants and controllers of patients and their environment. Whilst current government policy identifies that the majority of people with mental illness do not pose a risk, great emphasis is given to those who do and the need to protect the public from such risk whilst at the same time emphasising the need for compliance with medication regimes (Hannigan and Cutcliffe, 2002). Highlighting the dominance of the control and medical discourses, Porter (1992) suggests that irrespective of how sophisticated the education programme for nurses are, as long as the imperative for custodial care remains within the institutions it is likely to take precedence.

The Mental Health Nurse as a Therapeutic Agent

The therapeutic discourse, whilst generated as a point of resistance to the medical dominance of nursing, conceals the power relationship evident between nursing and medicine, perpetuating regimes of practice as the doctor's assistant. Popkewitz (1997) proposes modern 'knowing' gives precedence to the 'eye' as the producer of reason, whereby objects are made 'transparent' in the act of observation. He asserts that modern empirical methods are based in the idea that observation provides truth. Thus medicine's drive to establish itself as a science required the generation of such empirical truths and set nursing the task of observing and gathering appropriate information in pursuit of this empiricism. Hence 'knowing how' to make observations/reports and carry out tasks as the doctor's assistant is required of mental health nursing by the medical profession.

Bloor and McIntosh (1990) propose that surveillance is inherent in all therapeutic activity in the mental health setting. Ordinary everyday activities are 'transformed' into aspects of therapeutic work, the need to monitor (surveillance) is implicit using what they term the 'therapeutic gaze' which observes behaviours and interprets these in light of the therapeutic discourse. For example the task of washing one's hands can be cast for someone within the mental health setting as either an aspect of social skills training which requires observation to ensure this is carried out appropriately and at the right time; or as part of the assessment of someone proposed to be suffering from obsessive compulsive disorder to ensure that they are not exceeding the identified norm. In both cases the individual is subject to surveillance and their actions interpreted in light of the therapeutic gaze.

Curtis and Harrison (2001) postulate that therapeutic strategies used by practitioners can be viewed as part of the process of subjectification. Here scientific discourses define and mark out people's position within society, embedding certain attitudes within and about particular groups. These not only shape society's responses but also impact on the individual's perception of self – their subjectivity. Thus in the above examples of hand washing the individuals are separated from society by the attachment of the label of mental illness, divided from others identified as mentally ill by diagnosis (in the former perhaps schizophrenia and in the latter obsessive compulsive disorder). This label and diagnosis shape the interactions and the forms of therapies the individuals' experience and how they experience themselves. In the service of these therapeutic endeavours it is seen as right and proper that the mental health nurse has access to all aspects of patients' lives firstly to observe and collect information to secure the diagnosis and secondly to administer and evaluate the efficacy of treatment regimes. That they are required to observe, control and contain people with mental illnesses becomes a taken for granted background to all activities both for the patient and the nurse.

The therapeutic discourse was intended to assist nursing in achieving its goal of professionalisation and is seen here as one of the lines of subjectification within mental health nurses' social apparatus. A discourse aimed at self-formation and a distancing nursing from medicine. However self-formation is possible only for those who were

able to achieve a certain level of autonomy (Foucault 1979a) and nursing is yet to achieve this.

Education Strategies

The aspirations of nurse education to produce an autonomous practitioner engaged in therapeutic activities has been promoted through the use of certain education strategies namely reflective practice and deep learning strategies (U.K.C.C. 1986, 1999). It is proposed that by embedding these in both pre and post-registration programmes that nursing will achieve is goal of producing autonomous practitioners who embrace the professional discourse.

Reflexivity has been at the heart of nurse education initiatives since Project 2000 (U.K.C.C. 1986) however some commentators suggesting that nursing adopted the concept of reflection wholesale without having a full understanding of its nature or requirements (Scanlan and Chernomas 1997; Burton 2000). What is known as 'reflection' in nursing can be seen as part of its technologies of discipline whereby nurses are encouraged to examine their regimes of practice in light of a particular discourse and make normalising judgements as to their performance. Gilbert (2001) suggests that these are forms of surveillance and technologies of discipline prevalent in the self-formation activities of those promoting the professional discourse.

Cheek and Rudge (1994b, p590) propose that resistance to certain power relations can be facilitated through "reflexive questioning" in relation to a power-knowledge nexus and through this an identification of possible new discourses. Curtis and Harrison (2001) suggest that by gaining an understanding of how subjectification occurs the possibility of resistance is brought into play. For health professionals resistance can be achieved through reflective practices, where behaviours are seen for what they are – responses to power relations – and thus change becomes possible. However the effectiveness of reflection in facilitating the development of 'professional' knowledge and practice within nursing has been questioned (Burton, 2000). For some the discourses associated with reflection attain 'truth' status and are adopted as appropriate regimes of practice, for others they do not and are rejected, perhaps a manifestation of the management/profession dichotomy. At present there is little evidence to suggest

such strategies will provide mental health nursing with the means to adopt the regimes of practice and the knowledges prescribed as appropriate for them in the self-formation discourses.

Alternatively the failure of education to change nursing's culture and knowledge bases is proposed to relate to the lack of 'deep learning', enabling students to make the shift from one domain of knowledge to another (U.K.C.C. 1999). Superficial learning strategies, traditionally used in nurse education, do not enable the student to engage with the knowledges promoted by the professional discourse. Entwhistle (2002) proposes students bring with them established beliefs and values concerning the nature of learning, for those entering nursing the discourses available to them present nursing as practical in nature and its knowledges relating to 'knowing how' to do things. Thus to promote the professional discourse students must embrace the concept of nursing as based in esoteric knowledge. To facilitate such a change Savin-Badin (2000) asserts students must be enabled to confront their previous experiences of the world, encouraged to understand their environment from a different perspective and empowered to challenge the taken-for-granted contexts in which they work. Such challenging of accepted truths requires a valuing by the student of the stance so that rather than being passive and 'acted upon', action in relation to the belief becomes possible.

The adoption of deep learning strategies such as problem/enquiry based learning are advocated for the delivery of the most recent nursing curriculum (UKCC 1999) in the hope that these will facilitate internalisation of knowledge bases deemed appropriate for professional practice. However, as with reflective practice, nursing has adopted and implemented the strategy wholesale with little or no understanding of its likely efficacy within nursing. The first pre-registration nursing courses using this approach are yet to be completed and the results of systematic research in this area not yet available. The ability of such strategies to promote the professional discourse will not be known for some time.

Medical Dominance

Burton (1997) identifies a three fold increase in the number of health related articles and advertisements in the 'Good Housekeeping' magazine from 1959 to 1995. This, he suggests, is evidence of the increasing 'marketing' of medical knowledge as a product for consumption by the general public and as such perpetuates the dominance of the medical discourse in underpinning societies understanding of the human condition. The medical discourse is so dominant within society's thinking that as Harding (1997) argues, within western society that it is virtually impossible to contemplate an 'un-medicalised body' as it frames all aspects and understandings of bodily processes and experiences. Similarly Eckermann (1997) identifies how the psychiatric aspect of the medical discourses pervades society, its diagnostic criteria classifying and objectifying individuals, identifying who is and isn't mad, its language having "an influence on the way people 'can be'". (Eckermann, 1997, p163) and thus shaping society's and nursing's (as part of that society) ways of seeing and speaking of what is understood as madness. Lupton (1997) argues it is almost impossible to contemplate resistance to medical discourse as it is part of a set of power relations which bring into being the subjects 'doctor', 'patient', 'nurse' and form society's understanding of how these groups interact/ respond/behave. This possibly reflects Street's (1992) assertions concerning what she sees as two distinct but competing discourses within the health care setting, - the objective scientific discourse of medicine and the nurturing subjective discourse of nursing. Nursing and its nurturing discourse is seen as encompassing knowledges which are deemed 'natural' to women, relating to 'knowing how' to care for people, thus being subjective and of low status. Alternatively the medical profession is viewed as basing its practice on what are viewed as objective, scientific knowledge, which reign supreme in the hierarchy of knowledge. Street proposes that the hegemony of the scientific discourse associated with medical practices invalidates the nurturing discourse and thus nursing is subjugated by the medical profession. Such dominance is likely to continue unabated.

Mental Health Nursing's Future

The final question to be asked relates to whether or not nursing is able achieve the aspirations generated through its professional discourse, and mental health nursing's vision of itself as therapeutic agents. The original education format advocated by the M.P.A. was based on curricula designed to meet the demands of general hospitals and reflected their desire to improve their status through association with general medicine. The educational initiatives implemented by the both the G.N.C. and U.K.C.C. have given precedence to nursing's knowledge and theories to underpin practice. The appropriateness of these to prepare mental health nurses has been called into question with unerring regularity but to little effect (Central Health Service Council, 1968; D.O.H. 1994a; S.C.M.H. 1997). In reality the format of nurse education has changed little since the Registration Act of 1919, a period of 'common content' followed by 'branch specific' input is the norm. The occasions on which curricula have strayed from this have been few and relatively short lived. Never the less the effectiveness and appropriateness of bringing the branches of nursing together for such a common foundation is increasing questioned by students and educators alike (Ferguson and Hope, 1999). Mental health nurses and teachers seeing this, at best, as simply providing an adult orientation to common underpinning theories and at worst as having no relevance at all to the practice of mental health nurses. Yet it seems unlikely that mental health nursing will be able to distance itself from the body of nursing and its education. Indeed a recurrent theme is one of creating a 'generic' education programme for all nurses with specialism post–registration (U.K.C.C. 2001; D.O.H. 1999a; D.O.H. 1994b).

Nursing's attempts to improve its status and generate a professional discourse were thought to have come to fruition with the implementation of Project 2000 (U.K.C.C. 1986) and the moving of its education into higher education institutions. However the apparent failure of education initiatives to provide nurses with the skills demanded by their employers, the National Health Service and the public's dissatisfaction with the care delivered to them made apparent in the plethora of media publication has lead to a re-thinking of the type of education nurses require. The emphasis placed on 'competencies' and implicit within this a prioritising of skills ('knowing how') evident

within current curricula (U.K.C.C. 1999) negate the professional discourse and place nursing firmly in the role of doctor's assistant.

Despite nursing's attempt to present itself as a profession based in scientific knowledge, young people continue to view it as an unattractive and low status occupation (Helmsley-Brown and Foskett, 1999). They remain unaware of nurse education's move into higher education institutions and when considering attending university, advocate medicine as opposed to nursing. Thus the ability to attract people into the occupation remains a problem. The present shortage of nurses in general (D.O.H. 1999a) and mental health nurses in particular (S.C.M.H. 1997) supports the continuing dominance of the managerial discourse over the professional one because it is likely that unqualified staff will be employed to fill the void.

The resurgence of the 'dangerous man' (sic) within the public mind and the emphasis within current mental health policy on safety, casts the mental health nurse firmly in the role of custodian for people with mental health problems/illnesses. The contemporary dominance of the biological model within psychiatry illegitimatises other forms of treatment/intervention and the mental health nurses' role within them. The mental health nurse's regimes of practice, as identified above, become those concerned with controlling the patient until medications or medical treatments take effect. It seems that mental health nursing at present adheres to the regimes of practice advocated for, and inscribed upon it over 150 years ago and is likely to continue to do so for the foreseeable future.

Limitations of the Study

Silverman (1997) speculates that it is often 'odd' impulses that provide an aesthetic 'feel' for the appropriate form of a piece of research. One of my stated aims at the beginning of this thesis was to provide a post-modern interpretation of the nature of mental health nursing and its knowledge bases and it was this 'urge' which shaped the work presented here. Qualitative approaches such as grounded theory, were initially

considered as it was felt this would give generate social constructs relating mental health nursing. However Prior (1997) points out such research designs give precedence to the 'knowing subject' who is encouraged through the use of interviews and questionnaires to reveal the 'truth' of the issue under scrutiny from their perspective. The appropriateness of these methodologies has been called into question (Prior 1997) with Paley (2001) asserting that in relation nursing knowledge such research techniques have frequently resulted in the listing of attributes associated with particular nursing practices rather than a cogent understanding of the knowledges used. Miller (1997) proposes that a Foucauldian approach offers the opportunity to understand how social realities and practises are constituted through discourse and knowledge formations. Rather than offering an understanding of issues from the subjects perspective, this form of analysis considers the origin, structure and ordering of discourses - ways of understanding and speaking of the world. As a further stated aim here is to uncover the factors influencing which knowledges are used/disregarded by mental health nurse a Foucauldian methodology provided the opportunity to more fully address this aspect.

Cheek and Rudge (1994b) propose that analysis of nursing practice from a postmodern perspective has much to offer in the understanding of the power/knowledge issues surrounding nursing practice. Gastaldo and Holmes (1999) show that this form of analysis has gained popularity in recent years and Foucault's work has formed the basis of a number of studies relating to nursing in all its guises (for example see Mason 1990; Cheek and Rudge 1994a; 1994b; Henderson 1994; Fraser 1995; Heartfield 1996; Mohr, 1999; Huntington and Gilmour, 2001). However as Prior (1997) identifies, the task of translating Foucault's framework into a methodological approach is not easy, this of itself may have implications for the coherence of the work and the interpretation of the material. Also the adoption of Foucault's theoretical framework within this research leaves it open to accusations of bias as certain aspects are brought to the foreground for consideration and others pushed back, particularly in relation to power and knowledge. As such it must be read as an interpretation of the world in light of these concepts rather than a presentation of reality.

D'Cruz (2000) identifies that there is a need to recognise the power/knowledge evident in the research activity itself and issues these raise in relation to whether the research is 'reliable', 'credible' and 'valid'. She outlines how research can be presented as having 'asymmetrical' power relations, with the researcher being dominant in that relationship, or 'dynamic' with the power/knowledge relation fluctuating according to time, place and need. These aspects of power/knowledge require researcher reflexivity, a reflection on the research and personal positioning in relation to this.

My personal positioning is made evident in the autobiographical details provided in the introduction and was part of the impetus for maintaining a reflective research diary. The power relations at play when I as a nurse educator asked mental health nurses to participate in research related to mental health nursing knowledge were considerable. These could have impacted on individual's willingness to participate and/or their ability to say 'no'. Attempts were made to ameliorate this through the use of letters inviting interested individuals to participate. As 41 of 94 potential participants did not respond at all and 2 actively declined to do so the ability to say 'no' does not seem at issue. However it is possible that willingness to do so was. Some participants when asking for further details of the research expressed concerns that I intended to 'test' their knowledge. Such concerns could have been alleviated by a fuller and clearer explanation of the intent of the study in the initial letter and may have resulted in a greater number of people participating.

To reduce asymmetrical power relations in the data collection itself, participants were provided with materials, when and where they performed the task was left to them giving an element of control over the activity. I felt that my presence could impact on the process and reduce the spontaneity of participant's response. Nevertheless the desire to 'giving the right answer' may still have been present and despite the assertion in chapter 9 that a specific discourse cannot be made to appear it must be a consideration. However as discussed above the appearance of 4 distinct subjectivities would seem to suggest this was not an issue.

The dominant research paradigm guiding this study can be said to be qualitative and the debate around the suitable criteria by which to evaluate qualitative research is ongoing.

Some commentators identify that the application of quantitative concepts such as reliability and validity are inappropriate seeing the two paradigms as mutually exclusive. Others advocate that an adapted form of these can be used. Still others propose the identification of criteria specific to qualitative research (Winter, 2000; Murphy et al. 1998; Hammersley, 1992; Guba and Lincoln 1994). Hammersley (1992) cautions that there is no simple way of judging the 'goodness' of research, rigid criteria can be themselves stifling to the research process. However the four criteria offered Guba and Lincoln (1994) specifically for the evaluation of qualitative research provide one way of judging this research. These are:

- Credibility (ensuring accurate description of the subject under consideration).
- Transferability (ability to apply results to alternative settings).
- Dependability (whether outside influences are identifiable and the impact of these on the phenomenon understudy).
- Confirmability (the presence of an audit/decision trail).

It is difficult to apply these to the genealogical aspect of the study, as this is essentially a historical undertaking offering a possible interpretation of the issues under consideration. However, that I am a mental health nurse gives some credibility to the interpretation as I have indepth understanding of the mental health setting. Peer debriefing is advocated by Robson (1993) as a method of enhancing credibility and was undertaken in the form of seminar presentations at various points in the genealogy process. Transferability is apparent in relation to other branches of nursing; the power/knowledge formations have resonance for areas such as learning disability and children's nursing.

In the case of Q-methodology the four criteria can be considered. Credibility of the Q-sort statements used was enhanced through the piloting of the Q-sorts and the checking of statements by both practitioners and teachers in the mental health field. Peer debriefing in relation to the emergent factors and analysis was undertaken again through seminar presentation and also through discussion with others familiar with the approach.

However the subjectivity narratives were not returned to participants, doing so may have increased the credibility of the interpretation given. Murphy et al. (1998) propose, while such exercises may provide extra information they do not of themselves validate research findings.

The issue of transferability is less easy to address in that this study relates to the subjectivity of mental health nurses. It is possible to speculate as to its transferability to other mental health professional groups but given that the power relations are likely to be different this would seem an empty exercise. However it is possible to tentatively suggest that these findings may reflect the subjectivities of mental health nurses in other geographical locations.

In relation to confirmability a decision trail is available through the memos written whilst using the NUD*IST programme, the reflective diary produced and the discussion of approaches in chapters 9 and 10. However, although decisions made are identified and supported one aspect can be seen as flawed. The collection of personal information (gender, qualifications etc) from the participants proved difficult to use and as such was not required. It was impossible to draw any conclusions as to the impact of these factors on the subjectivities identified and as such only appeared as part of the descriptive data of those who loaded significantly on specific factors.

One area that requires particular attention is that of gender. The history of women as nurses, and the gender issues inherent within this, is almost exclusively told from the perspective of those working in the physical environment, little consideration has been given to women working in the mental health setting (Chatterton 2000). Equally notable by their absence are studies considering gender perspectives relating to men's role in nursing and, as men are represented in larger numbers within mental health nursing (Brown et al. 2000), the gender factors at play in the mental health setting and the development of mental health nursing. The concepts of femininity and masculinity and the regimes of practice identified as appropriate for such gender groupings may impact on the power relations and the knowledges programmed.

Considerations in relation to dependability are addressed in the discussion of the methodology however certain further issues require discussion. Although above it is suggested that transferability is possible it must be remembered that this research was undertaken in one particular National Health Service Trust. As such it may reflect the dominant culture within that area rather than a picture of mental health nursing as a whole. This work therefore should only be viewed as a 'snap shot' and requires further investigation in other mental health settings.

Murphy et al. (1998) proposes one further criterion, not addressed here, by which to judge qualitative research i.e. the clarity of its description in relation to data collection and analysis. Whilst every attempt has been made to ensure this, only the reader can fully evaluate if this is achieved.

Recommendations for further research

- This study only addresses the subjectivity of mental health nurses in one particular geographical setting. Further research considering the subjectivities of mental health nurses in other areas is required to provide a clear picture of the knowledges used and the current state of mental health nursing.

- The role of gender in the development of mental health nursing, its power relations, regimes of practice and the programming of knowledges requires closer scrutiny.

- The presence of two warring discourses (managerial and professional) within nursing is seen to have serious and negative implications for the effectiveness of its education programmes. Despite continuous debating as to the appropriate designation of nursing, either as profession or practice-based occupation, no consensus has yet been reached. There is a need to understand what nurses and mental health nurses 'want' to be, the differences and similarities apparent between the two and the way education initiatives can align this. Therefore research accessing the opinions/attitudes/perspectives of those in clinical practice would be of value.

- It is suggested that the basing of regimes of practice on prescribed knowledge bases may be facilitated through the use of strategies, which inculcate deep learning and reflective practices. Research evaluating the impact of such strategies on mental health nurses' knowledge bases and practices is necessary.

Conclusions

- The regimes of practice deemed appropriate for mental health nursing relate to acting as the doctor's assistant and control of patients, environment and self.

- Mental health nurse's knowledge relates to task orientated 'knowing how' rather than the 'knowing that' of evidence based practice.

- Power relations support these knowledge bases and inscribe them on the subjectivity of the mental health nurse; as such they become taken for granted backgrounds on which all activities are premised.

- The therapeutic discourse, in most cases, masks the power relation between mental health nursing and medicine and mental health nursing and society. The former programmes knowledges servicing medicine's need for information; the latter requires the containment of those deemed insane whilst at the same time presenting society as humane and caring.

- Nursing has yet to achieve the level of autonomy required to attain self-formation as envisaged in the professional discourse. It is not the intention to argue whether or not self-formation is a desirable goal for wider society, though clearly benefits would flow to nursing and nurses. However it is unlikely that current education initiatives will enable mental health nurses to offer resistance to the dominant medical discourse and thus negates their ability to take on the prescribed role of autonomous therapeutic agents.

APPENDIX ONE:

NODE CREATION

Initial Nodes	Interim Nodes	Final Nodes
Physical Illness	Physical Illness	Physical Illness
Physical Illness/A & P	Physical Illness/A & P	Physical Illness/A & P
Physical Illness/Impact On Mental State	Physical Illness/Impact On Mental State	Physical Illness/Impact On Mental State
Signs And Symptoms – Physical illness		
Observations – Physical		
Observations		
Physical Care		
First Aid		
Equipment		
Activities	Activities	Activities
Activities/Management Of Activities	Activities/Management Of Activities	
Activities/Social Skills	Activities/Social Skills	Activities/Social Skills
	Activities/Recreation	
	Activities/Occupational	
	Activities/Rehabilitatio n	Rehabilitation
	Activities/Industrial Therapy	
Control Patient	Control Patient	Control Patient
Control Patient/Observations	Control Patient/Observations	
Control Patient/Outside Hospital	Control Patient/Outside Hospital	
Control Patient/Legal Requirements	Control Patient/Legal Requirements	Legal Requirements
Control Patient/Aggression	Control Patient/Aggression	Aggression
Control - Self	Control - Self	Control - Self
Control - Colleagues	Control - Colleagues	Control /Colleagues
Control /Responsibilities	Control /Responsibilities	
Ethics	Ethics	Ethics
Managing The Environment	Managing The Environment	Managing The Environment
Managing The Environment/Procedures	Managing The Environment/Procedure	Managing The Environment/Procedure
Admissions	Admissions	Admissions
Institutionalisation	Institutionalisation	
First Aid	First Aid	First Aid
Family	Family	Family

Initial Nodes	Interim Nodes	Final Nodes
Mental Illness	Mental Illness	Mental Illness
Mental Illness/Treatment	Mental Illness/Treatment	Mental Illness/Treatment
Mental Illness/ Examinations	Mental Illness/ Examinations	Mental Illness/ Examinations
	Mental Illness/User Views	
Mental Illness/Nursing Care	Mental Illness/Nursing Care	
Nursing Care/Nursing - Knowledge	Nursing Care/Nursing - Knowledge	Professional Aspects of Care
Nursing Care/Assessment	Assessment	Assessment
Nursing Care/Research	Research	Research
Crisis Intervention	Crisis Intervention	
Nursing Care/Care - Physical	Nursing Care/Care - Physical	Physical Care
Social Perception Of Mental Illness/	Social Perception Of Mental Illness/	
Impact Of Social Factors On Mental Health	Impact Of Social Factors On Mental Health	Social Factors
Psychological Factors And Mental Illness/	Psychological Factors	Psychological Factors
Mental Illness/Sexuality	Mental Illness/Sexuality	Sexuality.
Mental Illness/Biological.	Mental Illness/Biological.	
ADL - /Diet	ADL - SLEEP	ADL - SLEEP
	ADL - /Diet	ADL - /Diet
ADL - /General	ADL - /General	ADL - /General
ADL - Elimination - Bowels	ADL - Elimination - Bowels	
ADL /Skills	ADL /Skills	
ADL /Elimination - Urine	ADL /Elimination - Urine	
Observations	Observations	
Observations/Record Keeping	Observations/Record Keeping	Record Keeping
Observations/ Physical	Observations/ Physical	
Developmental	Developmental	Developmental
Social Factors	Social Factors	
Social Policy	Social Policy	Social Policy
Multi-Disciplinary Teams	Multi-Disciplinary Teams	Multi-Disciplinary Teams
M.D.T./Users In Care	M.D.T./Users In Care	M.D.T./Users In Care
Therapies - Types Use	Therapies - Types Use	Therapies - Types Use
Drug Therapy	Drug Therapy	Drug Therapy

Initial Nodes	**Interim Nodes**	**Final Nodes**
Communication Skills	Communication Skills	Communication Interpersonal Skills/ Skills
Groups	Groups	Groups
Nurse As A Therapist	Nurse As A Therapist	Nurse As A Therapist
Therapeutic Relationship	Therapeutic Relationship	Therapeutic Relationship
Interpersonal Skills	Interpersonal Skills	
Suicide	Suicide	Suicide
Skills	Skills	
Psychology	Psychology	
Health Promotion.	Health Promotion.	
Community Resources.	Community Resources.	Community Resources.
Health Issues.	Health Issues.	Health Issues.
	Mental Health Promotion	Mental Health Promotion

APPENDIX TWO:

REFLECTION REGARDING PILOT STUDY

Diary Entries

Volunteer 1 – Nurse Educator. Identified a number of discrepancies in continuity in the 'Instruction for sorting the cards' and suggested alternative ways of phrasing statements. Suggests that the aspect of death and dying has not been included in the statements and that it reflects a knowledge base not present in the Q sample. I believe, on reflection, that this is a valid point and a statement reflecting such Knowledge should be incorporated into the Q sort. Discussed whether I should see participants personally, or conduct the study via letter/telephone. Each was seen to have its pro's and con's. Found it took a long time to complete the activity, but mainly because of the time spent offering alternatives and correcting errors.

Alterations to the instruction to be made before further volunteers piloted the Q sort

Volunteer 2 – Teacher/Practitioner. Found the activity relatively easy – done within 40 minutes. Wanted initially to justify actions on the comment sheet. Felt the cards were all relevant. Perhaps the cards need to be smaller. No additions necessary. In the information gathered from participants suggested perhaps could add in 'current study being undertaken'. Some suggestions regarding phrasing of card statements

Volunteer 3 – Teacher/practitioner. Found the activity relatively easy. Wanted to place more cards in the positives that the negatives, the format forced the making of choices. Some suggestions regarding phrasing of card statements. Took 40 minutes to do.

Volunteer 3 – Nurse Educator. Felt 'it' was good - no problems. It took approximately 40 minutes. Discussed whether it would have made a difference if the instructions asked about 'daily' activities rather than simply activities. Volunteer identified that whilst he had considered what he would be doing if working on an acute ward, adding the word 'daily' might make it more explicit that this is about what actually occurs in practice not what they would like it to be.

Discussed the use of 'daily' with other volunteers who agreed this would help to focus participants on the actual rather that the potential.

Volunteer 4 – Nurse Educator. Found the activity hard. Feels some of the statements are very similar and difficult to chose between therefore rather than

grouping them together, made a decision as to which reflected his thoughts and put the other/s on the least likely pile. Also did not fill in the comment sheet as the exercise itself took so long. Commented that he saw some as the statements as skills rather than knowledges. Discussed the view that skills are 'knowing how' rather that what is typical portrayed as knowledge 'knowing that', but that each are an embodiment of knowledge

Volunteer 5 – Practitioner. Sorted the cards easily, no problems except making the decision as to what was a priority and what was not. Discussed the use of 'daily activities' in the stem and again it was felt that this would focus participants on knowledges actually used. Discussed wording of statements and possible changes – volunteer identified that such changes would clarify certain issues. Also felt a statement re death and dying should be included.

Issues I need to consider

1. Do I change the stem to include either 'actual' or 'daily' practice?
2. Rather than include all the statements for comment do I simply include a sheet asking, "make any comments as you see fit"?
3. Do I do it via mail or in person?
4. Cards smaller or larger?

PLUS

I need to alter certain statements:

- Knowledges concerning activities ADD (work, recreational, occupational)
- Knowledges concerning therapeutic activities/groups REMOVE /groups making this a separate statement and ADD (counselling, C.B.T., P.S.I.) here

Remove the statement on counselling as now incorporated in the therapeutic strategies

Remove statement on the 'history of nursing' this is not part of practice and is reflected in professional aspects.

Add in statement on personal hygiene – whilst I thought this was included in the 'activities of daily living' it would seem from comments that this an important aspect. Re looking at the literature confirms this.

Add statement on death and dying – it is an aspect that has been missed

APPENDIX THREE:

Q-SORT PACKAGE SENT TO PARTICIPANTS

General Instruction

The aim of this study is to develop an understanding of the knowledges that mental health nurse's use in practice. The approach being used here is Q methodology, where you are asked to rank statements on a scale ranging from –5 to +5 according to how much they 'fit' with your point of view, this is known as a Q-sort. In this instance I am asking you to sort the statement cards in relation to the following: -

Consider your practice as a mental health nurse. Which knowledges are you ***least/most*** *likely to use in* ***your*** *daily activities as a nurse?*

The pack includes: -

- Pack A - 14 distribution marker cards
- Pack B - 66 statement cards
- scoring sheet (pink) to record final positioning of statement cards and personal details
- instructions for 'sorting' the cards (green)
- printed list of statements (yellow)

You will also need a table/desk on which you have sufficient space to lay the cards out

Process

1. Spread the distribution markers on the desk in the pattern indicated on the scoring sheet.
2. Follow the sorting instructions and complete the score sheet.
3. Record any comments you may have regarding the statements and/or the process on the printed list of statements.
4. Place all the equipment and documents in the addressed envelope provided and return contents via internal post.

Instructions for sorting the statement cards

1. Read through all the cards and get a general feel of their content
2. In relation to the statement: '*Consider your practice as a mental health nurse. Which knowledges are you* ***Least/most*** *likely to use in* ***your*** *daily activities as a nurse'* divide the cards into three piles: -

   •mostly likely •least likely •no fixed opinion/ neutral/unsure

   placing the 'most likely' pile to the right, the 'least likely' pile to the left and the neutral cards in the centre
3. Starting with the 'most likely' pile select the 3 cards that most reflect your position and place them under vertically under the +5 marker (the order of the items is not important).
4. Turn to the 'least likely' pile, study them and place 3 that are most unlike your position under the –5 marker (again the order is not important)
5. The process is repeated, working from side to side alternately, with the required number of items being placed under each marker as indicated.
6. If at any point you wish to change the position of a card, please do so.
7. All spaces on the grid must be allocated a card.
8. Once the sorting is complete, review and make any adjustments you feel necessary

Please record the position of the card on the score sheet provided using the number accompanying each statement.

SCORING SHEET

*Consider your practice as a mental health nurse. Which knowledges are you **LEAST/ MOST** likely to use in <u>your</u> daily activities as a nurse?* Sort the statements –5 (least likely to use) to +5 (most likely to use) allocating the number of cards under each score as indicated. When you have completed the sorting, fill in the boxes below with the number accompanying each statement.

Knowledge neutral Knowledge

LEAST LIKELY **MOST LIKELY**

to use to use

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
3 cards	4 cards	6 cards	7 cards	8 cards	10 cards	8 cards	7 cards	6 cards	4 cards	3 cards

<u>Personal information</u>

Sex: Male /Female **(delete as appropriate)**

Professional Qualifications:.....

Registration Date/s:.....

Academic Qualifications (diploma, degree).....

Current Post (e.g. acute/elderly/rehab):.....

Grade:.....

Statements

1. Knowledge concerning causes of physical illness/disease

Comments:.....

.....

2. Knowledge concerning general anatomy and physiology

Comments:.....

.....

3. Knowledge concerning psychosomatic disorders

Comments:.....

.....

4. Knowledge concerning anatomy and physiology of the nervous system

Comments:.....

.....

5. Knowledge concerning planning programmes of activity for patients (work, recreation, occupational therapy)

Comments:.....

.....

6. Knowledge concerning human growth and development

Comments:.....

.....

7. Knowledge concerning social skills training

Comments:.....

.....

8. Knowledge concerning how to respond to 'abnormal' behaviours that occur as a result of mental illness

Comments:.....

.....

9. Knowledge concerning prevention of aggression/violence

Comments:.....

.....

10. Knowledge concerning the management of aggression/violence

Comments:.....

.....

11. Knowledge concerning mental health legislation

Comments:.....

.....

12. Knowledge concerning reflective practice and/or self awareness

Comments:.....

.....

13. Knowledge concerning management and co-ordination of staff

Comments:.....

.....

14. Knowledge concerning teaching and assessing

Comments:.....

.....

15. Knowledge concerning ethics in health care, the nursing profession and codes of practice

Comments:.....

.....

16. Knowledge concerning creating and maintaining safe environments of care

Comments:.....

.....

17. Knowledge concerning policies and procedures in relation to care and hospital requirements

Comments:.....

.....

18. Knowledge concerning concepts of privacy and dignity

Comments:.....

.....

19. Knowledge concerning time management - co-ordinating administrative and clinical requirements

Comments:.....

.....

20. Knowledge concerning procedures for admission and discharge of patients

Comments:.....

.....

21. Knowledge concerning first aid

Comments:.....

.....

22. Knowledge concerning families, family dynamics, working with families

Comments:.....

.....

23. Knowledge concerning general nature of mental illness/disorder – signs/symptoms, classification

Comments:.....

.....

24. Knowledge concerning the epidemiology of mental illness

Comments:.....

.....

25. Knowledge concerning the aetiology of mental illness/disorder

Comments:.....

.....

26. Knowledge concerning personality disorders

Comments:.....

.....

27. Knowledge concerning learning disabilities

Comments:.....

.....

28. Knowledge concerning observations on and collection of specimens

Comments:.....

.....

29. Knowledge concerning assessment

Comments:.....

.....

30. Knowledge concerning models and theories of nursing

Comments:.....

.....

31. Knowledge concerning the spiritual needs of patients/clients

Comments:.....

.....

32. Knowledge concerning information technology

Comments:.....

.....

33. Knowledge concerning care planning

Comments:.....

.....

34. Knowledge concerning problem-solving approaches

Comments:.....

.....

35. Knowledge concerning the collection of information relating to patients

Comments:.....

.....

36. Knowledge relating to the observation of a patients behaviour/mental state

Comments:.....

.....

37. Knowledge concerning the recording and sharing of information

Comments:.....

.....

38. Knowledge concerning the use/significance of research in nursing practice

Comments:.....

.....

39. Knowledge concerning the physical care needs of patients (moving and handling, pressure area care, mouth-care etc)

Comments:.....

.....

40. Knowledge concerning professional responsibility/accountability

Comments:.....

.....

41. Knowledge concerning advocacy

Comments:.....

.....

42. Knowledge concerning sociological issues and their impact on mental health/illness

Comments:.....

.....

43. Knowledge concerning psychological concepts and their relevance to mental health/illness

Comments:.....

.....

44. Knowledge concerning human sexuality and gender

Comments:.....

.....

45. Knowledge concerning national health/mental health policies

Comments:.....

.....

46. Knowledge concerning sleep

Comments:.....

.....

47. Knowledge concerning the nutritional requirements for physical and mental wellbeing

Comments:.....

.....

48. Knowledge concerning promoting food intake (assisting people with eating and drinking)

Comments:.....

.....

49. Knowledge concerning activities of daily living

Comments:.....

.....

50. Knowledge concerning multidisciplinary teams

Comments:.....

.....

.....

51. Knowledge concerning patient/user empowerment

Comments:.....

.....

52. Knowledge relating to therapeutic interventions (such as counselling, cognitive behavioural therapy, psychosocial approaches etc.)

Comments:.....

.....

53. Knowledge relating to groups

Comments:.....

.....

54. Knowledge concerning therapeutic use and action of common drugs used in psychiatry

Comments:.....

.....

55. Knowledge concerning administration of drugs –routes, dosage, prescribing/storing etc

Comments:.....

.....

56. Knowledge concerning communication/interpersonal skills

Comments:.....

.....

57. Knowledge concerning therapeutic relationships

Comments:.....

.....

58. Knowledge concerning assessment/identification of suicide risk,

Comments:.....

.....

59. Knowledges concerning the management/care of a suicidal patient

Comments:.....

.....

60. Knowledge concerning community care/services/resources

Comments:.....

.....

61. Knowledge concerning the nature of health and health education/promotion

Comments:.....

.....

62. Knowledge concerning mental health, mental health education/promotion

Comments:.....

.....

63. Knowledges concerning death and dying (grieving process etc)

Comments:.....

.....

64. Knowledge concerning ward/unit administration/management

Comments:.....

.....

65. Knowledge concerning medical treatments for psychiatric illnesses/disorders

Comments:.....

.....

.....

66. Knowledge concerning the promotion/maintaining of personal hygiene

Comments:.....

.....

General comment:

.....

.....

.....

.....

.....

.....

.....

.....

.....

Thank you, for your help

APPENDIX FOUR:

FACTOR MATRIX

Factor Matrix with a X Indicating an Exemplifactory Sort

QSORT		1	2	3	4
1	acute1	0.4813	0.0689	0.6210	0.3937
2	acute2	0.5186	0.2239	0.3928	0.3667
3	acute3	0.2282	0.5641X	0.2067	-0.0576
4	acute4	0.5921X	0.1629	0.4373	0.1867
5	acute5	0.6504X	0.3786	0.3220	0.1393
6	acute6	0.5153	-0.1009	0.3319	0.3863
7	acute7	0.5234	0.2119	0.4570	0.3790
8	acute8	0.7358X	0.2246	0.3218	0.1502
9	acute9	0.6987X	0.1468	0.3735	0.1191
10	acute10	0.6242X	0.1758	0.2906	0.2850
11	for1	0.5568	0.2741	0.5127	0.0544
12	mab1	0.4530	0.5708X	-0.0501	0.1382
13	for2	0.6201X	0.2134	0.4393	-0.0053
14	for3	0.6088X	0.5646	0.0905	-0.1669
15	for3	0.4629	0.3559	0.5264	-0.0497
16	for5	0.5487X	0.1884	0.4555	-0.2090
17	acute11	0.6429X	0.3381	0.1220	0.2510
18	acute12	0.2166	0.7380X	0.2609	0.0473
19	acute13	0.0209	0.6045X	-0.3185	0.1093
20	acute14	0.3769	0.5513	0.3260	0.3557
21	acute15	0.3727	0.4990	0.0505	0.4210
22	acute16	0.3616	0.1448	0.7495X	0.1701
23	mab2	0.7094X	0.3152	0.0770	0.1371
24	acuteN1	0.6836X	0.3790	0.2977	0.1901
25	acuteN2	0.7305X	-0.0184	0.0226	0.4237
26	rehab1	0.1647	0.2036	0.2418	0.6926X
27	rehab2	0.3898	0.4947	0.4006	0.0296
28	acuteN3	0.6579X	-0.0376	0.2469	0.1916
29	acuteN4	0.7149X	0.1353	0.2741	0.2471
30	rehab3	0.2582	0.0898	0.7024X	0.2142
31	rehab4	0.4108	0.1837	0.4554	0.3654
32	acute17	0.6094X	0.3860	0.2582	0.0257
33	rehab5	-0.0644	0.7674X	0.3199	0.0981
34	rehab6	0.0300	0.4355	0.4609	0.3430
35	eld1	0.5584X	0.0681	0.0071	0.3893
36	eld2	0.1098	-0.0079	0.8379X	0.1003
37	eld4	0.5986X	0.1806	0.3342	0.0546
38	eld5	0.1330	0.1650	0.1117	0.7464X
39	eld6	0.0692	-0.0773	0.1258	0.6035X
40	eld7	0.5669	0.0554	-0.1479	0.6135X
41	rehab7	0.2977	0.3973	0.6934X	0.1134

APPENDIX FIVE:

FACTOR ARRAY

Factor Arrays

No.	Statement	No	1	2	3	4
1	K.C. physical illness/disease	1	-4	-1	-3	-1
2	K.C.general anatomy and physiology	2	-4	-3	-5	1
3	K.C. psychosomatic disorders	3	0	0	-2	-3
4	K.C. anatomy and physiology of the nervous system	4	-5	-4	-4	-3
5	K.C. planning programmes of activity for patients	5	-2	2	0	-2
6	K.C. human growth and development	6	-2	-4	-5	-5
7	K.C. social skills training	7	-2	3	-2	-2
8	K.C. how to respond to 'abnormal' behaviours	8	3	3	3	-2
9	K.C. prevention of aggression/violence	9	4	0	3	2
10	K.C. the management of aggression/violence	10	4	0	2	0
11	K.C. mental health legislation	11	2	1	2	1
12	K.C. reflective practice, self awareness	12	1	4	-1	-2
13	K.C. management and co-ordination of staff	13	0	-2	5	-2
14	K.C. teaching and assessing	14	0	1	1	0
15	K.C. ethics in healthcare, the nursing profession	15	1	1	1	0
16	K.C. creating and maintaining safe environments of	16	3	1	4	5
17	K.C. policies and procedures in relation to care and	17	0	-4	4	1
18	K.C. concepts of privacy and dignity	18	1	-1	1	2
19	K.C. time management - co-ordinating administra	19	-1	-1	5	-3
20	K.C. procedures for admission and discharge of	20	3	1	0	3
21	K.C. first aid	21	-1	-3	-3	-1
22	K.C. families, family dynamics, working with families	22	-1	4	-1	-1
23	K.C. general nature of mental illness/disorder - signs/sympt	23	3	4	1	0
24	K.C. the epidemiology of mental illness	24	-2	-1	-4	-5

Factor Array (continued)

25	K.C.	the aetiology of mental illness/disorder	25	0	0	-2	-3
26	K.C.	personality disorders	26	2	-2	-1	-4
27	K.C.	learning disabilities	27	-5	-5	-5	-5
28	K.C.	observations on and collection of specimens	28	-3	-5	-3	0
29	K.C.	assessment	29	4	0	2	4
30	K.C.	models and theories of nursing	30	-2	0	-1	-4
31	K.C.	the spiritual needs of patients/clients	31	-3	-3	-2	1
32	K.C.	information technology	32	-5	-5	-1	-4
33	K.C.	care planning	33	2	0	1	3
34	K.C.	problem-solving approaches	34	1	2	2	0
35	K.C.	the collection of information relating to patients	35	2	-2	0	2
36	K.C.	observation of a patients behaviour/mental state	36	5	3	2	4
37	K.C.	the recording and sharing of information	37	1	-1	3	2
38	K.C.	the use/significance research in nursing practice	38	-4	-2	1	-1
39	K.C.	the physical care needs of patients (moving/handling, p	39	-3	-3	-4	2
40	K.C.	professional responsibility/accountability	40	1	2	4	5
41	K.C.	advocacy	41	-1	2	-2	1
42	K.C.	sociological issues and their impact on mental health/i	42	0	4	0	-2
43	K.C.	psychological concepts and their relevance to mental he	43	0	3	1	0
44	K.C.	human sexuality and gender	44	-3	-2	-1	-1
45	K.C.	national health/mental health policies	45	-3	2	2	-3
46	K.C.	sleep	46	1	-4	-3	0
47	K.C.	the nutritional requirements for physical and mental we	47	-1	-3	-3	1
48	K.C.	promoting food intake (assisting people with eating and	48	-2	-1	-3	3
49	K.C.	activities of daily living	49	-1	1	0	3
50	K.C.	multidisciplinary teams	50	0	-1	3	3
51	K.C.	patient/user empowerment	51	-2	0	0	1
52	K.C.	therapeutic interventions (such as counselling, C.B.T.,	52	2	5	2	-2

Factor Array (continued)

53	K.C.	to groups	53	-4	-3	-2	-4
54	K.C.	therapeutic use and action of common drugs used in psyc	54	3	2	3	2
55	K.C.	administration of drugs - routes, dosage, prescribing/s	55	4	3	3	4
56	K.C.	communication/interpersonal skills	56	3	5	4	5
57	K.C.	therapeutic relationships	57	2	5	0	3
58	K.C.	assessment/identification of suicide risk,	58	5	0	0	1
59	K.C.	the management/care of a suicidal patient	59	5	0	1	-1
60	K.C.	community care/services/resources	60	0	2	0	0
61	K.C.	the nature of health and health education/promotion	61	-3	1	-2	-1
62	K.C.	mental health, mental health education/promotion	62	1	3	-1	0
63	K.C.	death and dying (grieving process etc)	63	-1	-1	-4	-1
64	K.C.	ward/unit administration/management	64	0	-2	5	-4
65	K.C.	medical treatments for psychiatric illnesses/disorders	65	2	1	-1	2
66	K.C.	promotion/maintaining of personal hygiene	66	-1	-2	0	4

APPENDIX SIX:

PARTICIPANTS' WRITTEN COMMENTS

Participants' comments

Statements are colour coded according to factor they define. Only statements from exemplificatory Q-sorts included

Key: □ = Factor 1 □ = Factor 2 □ = Factor 3 □ =factor 4

Statements

1. Knowledge concerning causes of physical illness/disease

For 5 Placed in neutral. Feel medical staff facilitate a wrong diagnosis dangerous.

Acute 8 Not very relevant to mental nurse practice.

Acute N3 Training in Mental Health, doctors don't explain enough when asked

Acute 13 Physical illness is usually a secondary illness caused by social conditions in most of our clients e.g. asthma etc. mental illness is paramount.

Eld 6 Because of client group age sound basic knowledge needed.

2. Knowledge concerning general anatomy and physiology

For 5 Is used but I have put it least likely to use in our sphere of work!

Acute 8 Not very relevant to mental nurse practice.

Acute 13 Useful to understand how many conditions are caused and therefore how drugs interact to create mental well-being.

3. Knowledge concerning psychosomatic disorders

For 5 Placed in least likely as I feel often knowledge more important.

Acute 8 Aware as many patients look for a physical symptom of their illness.

Acute N3 Important as we get so many but doctors treat with pills more than cognitive/talking therapy.

Acute 13 Limited experience of these due to newness of post.

Eld 5 Somatisation occurs more frequently with functional illnesses rather than dementia.

4. Knowledge concerning anatomy and physiology of the nervous system

For 5 Use regularly, important to know.

Acute 8 Again not used a great deal.

Acute 13 Useful to understand how many conditions are caused and therefore how drugs interact to create mental well-being.

5. Knowledge concerning planning programmes of activity for patients (work, recreation, occupational therapy)

For 5 Placed in neutral as I feel occupational therapy roll in this.

Acute 8 Aware of beneficial effects but too often blocked by patient's negative attitudes to this therapy.

Acute N3 OT and nurses used to overlap; now they don't. Doctors listen to OT's and ignore nurses. Occupational./recreational needs are not met.

Acute 13 I have previous experience in this area from working in Occupational therapy and as a special needs teacher.

6. Knowledge concerning human growth and development

For 5 Have put in least likely but is used frequently.

Acute 8 Useful to be aware, but cannot address in stay on acute ward.

Acute 13 Useful to help patients cope with their families problems – aged parents and children.

7. Knowledge concerning social skills training

For 5 Placed on least likely our Occupational Therapist does most work on them.

Acute 8 Again time constraints on implementing.

Acute N3 It would be appropriate to use in acute psychiatry but don't, probably due to staff numbers and their inclination.

Acute 13 I feel comfortable and experienced in this area.

8. Knowledge concerning how to respond to 'abnormal' behaviours that occur as a result of mental illness

For 5 Very important for us. My 4th important Most Likely.

Acute N1 I work on an acute admission ward so encouraging rapport, patient safety whilst preserving patient dignity is a must.

Acute N3 Normally staff learn from appropriate handling by others but sadly now it's from situation to situation in an intervention and containment

style. No proper discussion as to who, what, why and how, so no development in learning/practice. Also negative attitudes by senior staff – comments etc have a pervasive effect on communication with patients particularly with junior staff.

Acute 8 Used extensively but acquired in early years of practice.

Acute 13 I am learning through experience how to do this with the theoretical background.

9. Knowledge concerning prevention of aggression/violence

For 5 Very very important as we do have violent/aggressive patients. Second most likely used.

Acute 8 Increasingly important in current practice and changes in attitudes.

Acute 10 This would seem to be becoming a more substantial part of my work.

Acute N1 Increase in patients under the influence of drugs/alcohol be admitted.

Acute N3 See number 8.

Acute 13 Understanding the social environmental and physiological causes provides a firm base to try and prevent/alleviate violence and aggression. However actual hands on experience is limited due to the newness of my post – 6 months to date.

Eld 5 A daily task on a Dementia Ward due to confusion.

10. Knowledge concerning the management of aggression/violence

For 2 Needed for safety of staff and other patients.

For 5 Very important due to Unit Forensic.

Acute 8 Important and increasingly utilised.

Acute 10 This is becoming a more significant part of my work.

Acute N3 See number 8.

Acute 13 Knowledge of local policies provides guidelines as to correct procedures.

Eld 5 Important in reducing likelihood of person with dementia injuring themselves or others.

11. Knowledge concerning mental health legislation

For 2 All our patients are held under sections of Mental Health Act (1983)

For 5	Very important to know MHA 1983 as we have patients.
Acute 8	Again vital in today's litigation atmosphere.
Acute N1	Often I have to advise DMO on MHA 1983.
Acute N3	None. It has to change and soon.
Acute 13	Provides insight into the way ahead.

12. Knowledge concerning reflective practice and/or self awareness

For 5	Need to use reflection regularly as part of our job.
Acute 8	Improves practice.
Acute N3	The climate of wards and staff numbers do not allow this to happen much.
Acute 13	Training in this area enables me to reflect on the days events to examine them to see if I could have done better.

13. Knowledge concerning management and co-ordination of staff

For 2	Very necessary when in charge of shift.
For 5	Neutral as I feel ward managers should plan this roll.
Acute 8	Not used extensively by student nurses.
Acute N1	Role includes acting as Duty Senior Nurse.
Acute 13	In this, my first post, I am not concerned with this area but post training helps me to appreciate how the unit works by appreciating managerial priorities and budget etc.

14. Knowledge concerning teaching and assessing

For 5	Important, especially with students to work with.
Acute N3	Staff want to teach, students don't always want to learn and their supernumerary status handicaps them sometimes.
Acute 13	Past experience has given me the confidence to use this daily as an integral part of the healing process in nursing.

15. Knowledge concerning ethics in health care, the nursing profession and codes of practice

For 5	Important especially to non professional staff.

Acute 13 Knowledge of UKCC Codes of Practice provides framework on which to base practice.

16. Knowledge concerning creating and maintaining safe environments of care

For 5 Certainly in our sphere of work important and used frequently.

Acute 8 Relevant for patient and nurse.

Acute N1 Acute setting with vulnerable patients.

Acute N3 The health authority is at fault in not responding to the reality of psychiatric patients. More than 2 out of 3 smoke as part of their own coping. The smoke room is smaller than the office. I've seen 15 people in there at a time because that's where all the chatter is. I know of a dozen non-smokers .

Acute 13 Governed by the above along with ward policies which help inform practice.

Eld 5 The most crucial of aspects of nursing mentally disordered patients.

17. Knowledge concerning policies and procedures in relation to care and hospital requirements

For 5 Neutral as I feel yes we should have knowledge but W/N roll.

Acute 8 Increasingly important from management perspective.

Acute 13 Provide a useful framework for practice.

18. Knowledge concerning concepts of privacy and dignity

For 5 As each patient has own bedroom and are able to bath or shower on own this is least used. Only time when 1-1 observations then. Full privacy and dignity carried out then by same agenda as patient.

Acute 8 I try to balance with poor ward layout.

Acute N3 We have 3 outstanding. It should be all female, 1 male, 1 mixed. Since I've been on the wards I can talk of six episodes where dignity and privacy has been compromised indeed where intercourse has taken place.

Acute 13 Followed in accordance with ward policies and UKCC guidelines on a daily basis.

Eld 5 Important on mixed sex wards with Dementia patients due to loss of Social Functioning and inhibitions.

19. Knowledge concerning time management – co-ordinating administrative and clinical requirements.

For 5 Neutral as I feel Ward Managers should take this roll leaving us more time with patients.

Acute 8 Aware but haven't time to accomplish all tasks as I would wish.

Acute 13 Limited experience to date learning through experience. Little/no training for this on the course.

20. Knowledge concerning procedures for admission and discharge of patients

For 5 Very important as we have a good turnover at times in emergency.

Acute 8 Used daily.

Acute N1 I work on an acute admission ward which is a 24 hour a day service.

Acute N3 So much duplication of information seems a waste of time.

Acute 13 I am growing daily in this area and use skills here on a daily basis.

21. Knowledge concerning first aid

For 5 **Is important but medical staff should take more active roll.**

Acute 8 Also used frequently.

Acute 13 Training on the course has been invaluable on the ward on a day to day basis.

22. Knowledge concerning families, family dynamics, working with families

For 5 Have placed in least likely as I feel social work input.

Acute 8 Aware and used on ward.

Acute 10 Many patients display the positive or negative effects of their family relationships.

Acute N3 I have knowledge from reading and previous practice – but no longer practice.

Acute 13 Invaluable in treatment of patients. Knowledge of Neuman's nursing model has been invaluable.

23. Knowledge concerning general nature of mental illness/disorder – signs/symptoms, classification

For 5 Important on Forensic until used frequently.

Acute 8 Learnt in training and continued through practice.

Acute N1 I need to be able to recognise psychiatric symptoms to plan appropriate care.

Acute 13 This is only learnt through practical hands-on experience as each individual is unique.

24. Knowledge concerning the epidemiology of mental illness

For 5 Important used regular basis.

Acute 8 Learnt in training and continued through practice.

Acute N3 Not enough information is fed back to nursing staff.

Acute 13 The course provides a framework upon which to build future practice.

25. Knowledge concerning the aetiology of mental illness/disorder

For 5 Feel important used regularly.

Acute 8 Learnt in training and continued through practice.

Acute 13 The course provides a framework upon which to build future practice.

26. Knowledge concerning personality disorders

For 5 Very important as most of our patients have personality disorders. Going to workshop – lecture in May.

Acute 8 Increasingly encountered on acute wards and difficult to manage.

Acute 10 On qualifying I felt that I had insufficient knowledge for this significant area of my work.

Acute N1 In my opinion I am nursing more people with a Personality Disorder re-admission than ever before in my 20 year career – approximately 60% of patients.

Acute N3 The reality is different to the book! But staff attitudes dictate treatment and results.

Acute 13 Very limited – not covered so well on the course and complicated and rare on the ward.

Rehab 1 Although filed under (-3) I feel my knowledge is limited yet have to draw upon this quite regularly.

Eld 5 Rare in nursing patients with dementia.

27. Knowledge concerning learning disabilities

For 5 Important as we do have patients with learning disabilities but I feel they should be nursed in their own sphere of nursing in order to have full quality of life and correct care and treatment.

Acute 8 Rarely used.

Acute N1 One bed per ward designated for Learning Disabilities but no RMHN employed.

Acute N3 I have little problem, new staff have more.

Acute 13 Extensive knowledge and training in Learning Disabilities colours my practice daily.

Eld 5 No input.

28. Knowledge concerning observations on and collection of specimens

For 5 Used most frequently for drug screening.

Acute 8 Drugs and urine testing increasingly used.

Acute N1 Usually collected during office hours.

Acute 13 Limited experience in this area not used daily. No training for this on my nursing course.

29. Knowledge concerning assessment

For 2 Assessment is a continual process.

For 5 Assessment is ongoing.

Acute 8 Used daily.

Acute N1 Mostly risk assessment for self-harm/danger to others to aid effective care.

Acute 13 Used daily in nursing and continually in past teaching posts.

30. Knowledge concerning models and theories of nursing

For 5 Important but at present time not using models.

Acute 8 Not part of daily practice.

Acute N1	Senior becoming more medical model run due to ↓ staffing, morale.
Acute N3	There are too many and some confusion. They can get in the way of effective communication with medical staff.
Acute 13	I base much practice on Neumans Model even though we have no regular model in use on the ward.

31. Knowledge concerning the spiritual needs of patients/clients

For 5	Patients request priest of their denomination to visit them.
Acute N3	Sadly often ignored and left to the vicar if asked by the patient.
Acute 13	Tolerance of creeds, cultures of clients and previous training in Religious education helps me recognise the importance of this area to some patients and their mental health.

32. Knowledge concerning information technology

For 5	Least likely as I feel nurses are to nurse not do clerical work.
Acute 8	Would like to have training.
Acute N1	A computer on the ward, limited use, data concerning mental health issues.
Acute N3	I admit to being hostile to it. Not technophobic.
Acute 13	Useful for gaining information but rarely used in day to day practice.

33. Knowledge concerning care planning

Acute N1	Encouraging individualised care.
Acute N3	We all spend a lot of time using them. By that I mean writing them, but they are of value and in the ward rounds, where different yardsticks apply, totally useless, and in some instances a handicap.
Acute 13	This has only come with daily experience and past training – little covered on nursing course.

34. Knowledge concerning problem-solving approaches

For 5	Neutral feel occupational/psychology should play this roll.
Acute N3	Not used enough with patients.
Acute 13	Wide experience and opportunity to visit many facilities whilst out on community placements help me to have a broad base for this.

35. Knowledge concerning the collection of information relating to patients

For 5 Least likely other disciplines roll at times but then should relate to nursing.

Acute 13 Learning to look at an individual's support network and multi-disciplinary team working helps this.

36. Knowledge relating to the observation of a patients behaviour/mental state

For 5 Placed high position. Used daily without this knowledge system fall down.

Acute 10 I feel this to be the foundation of all other areas of my work.

Acute N1 Continuous assessment of patients during their stay is required.

Acute 13 I am becoming more experienced at using more observation tools on the ward.

37. Knowledge concerning the recording and sharing of information

For 2 Vitally important for safety and security and continuity of patient care.

For 5 Least likely feel that we record information given.

Acute N3 Too much duplication.

38. Knowledge concerning the use/significance of research in nurse practice

For 5 Least likely feel should be research groups for this then they can reach back.

Acute N3 A nurse's idea of research is a trip to a library which is pathetic.

Acute 13 Useful to back-up methods used and provide individual care. Little time for this generally on the ward.

39. Knowledge concerning the physical care needs of patients (moving and handling, pressure area care, mouth-care etc)

For 5 Not used patients fully movable. Mobility and personal hygiene present.

Acute N3 There should be courses as it is so easy to forget if you haven't done it for a while.

Acute 13 Course training good in this area.

Eld 5 Important especially in the elderly.

40. Knowledge concerning professional responsibility/accountability

For 5 Very important code of practice. UKCC.

Acute 13 Highlighted well through UKCC Code of Conduct and ward policies.

Eld 5 Always important.

41. Knowledge concerning advocacy

For 5 Feel other disciplines should advocate (specialist).

Acute N3 Very important – often overlooked.

Eld 5 Advocacy is important especially in confused patients.

42. Knowledge concerning sociological issues and their impact on mental health/illness

For 5 Used regular basis.

Acute 8 Very relevant when ward draws from deprived region.

Acute 13 This is used daily on the ward. The diploma course has been a very good preparation in area.

43. Knowledge concerning psychological concepts and their relevance to mental health/illness

For 5 Used regular basis.

Acute N3 This is usually left to staff to read up on themselves.

Acute 13 The diploma course training prepared me well as a practitioner recognising these concepts in the individuals in my care.

44. Knowledge concerning human sexuality and gender

For 5 With Forensic patients not used regularly.

Acute N3 See question 43.

Acute 13 Real life and practice on the ward make a dry subject come to life impinging on mental health due to ward policy. National policies do not take into account sexual difference.

45. Knowledge concerning national health/mental health policies

For 5 Neutral. Have policies and procedures guidelines incorporated we have to adhere to.

Acute N3 See question 43.

Acute 13 Up-to-date information given out on the course provides god starting point. Watching it filter down takes time.

46. Knowledge concerning sleep

For 5 Important as many patients do have sleep problems.

Acute 8 Necessary to educate clients.

Acute N3 There is not enough information.

Acute 13 Until you work on the ward you do not realise how widespread sleep problems are in mental health.

Eld 5 Good sleep = better mental health – just ask the Sleep Council!!!

47. Knowledge concerning the nutritional requirements for physical and mental wellbeing

For 5 Least likely. Rehabilitation roll.

Acute 13 The diploma course prepared us well for this.

Eld 5 Important in the Elderly particularly.

48. Knowledge concerning promoting food intake (assisting people with eating and drinking)

For 5 Not used at all due to patients hearty appetites and fluid intake.

Acute N1 I work at night so usually only snacks available and reduced appetite etc tends to be more noticeable at mealtimes.

Acute 13 Past training's have been useful in this area

49. Knowledge concerning activities of daily living

For 5 Least likely in our sphere.

Acute N3 This area is usually left to [staff member] which is a shame.

Acute 13 Past experience in teaching Special Needs and extensive experience in Learning Disabilities has helped to make this an area I feel confident in.

50. Knowledge concerning multidisciplinary teams

For 5 Neutral. Feel that MDT should give relevant information on this.

Acute N3 Theory is fine, practice leaves a lot to be desired.

Acute 13 I enjoy this area of work and feel positive about the disciplines helping one another.

51. Knowledge concerning patient/user empowerment

For 5 Least likely feel this roll from other disciplines.

Acute N3 There is not enough and it's not encouraging.

Acute 13 Used in the background via communication and interpersonal skills training which we are well covered on during the diploma course.

52. Knowledge relating to therapeutic interventions (such as counselling, cognitive behavioural therapy, psychosocial approaches etc)

For 5 Important used regularly perhaps daily basis.

Acute 8 Unable due to time restraints to use effectively on acute setting.

Acute N3 Resources dictate.

Acute 13 The broad base of the diploma Course has been invaluable here. Basic counselling skills have been invaluable.

53. Knowledge relating to groups

For 5 Least likely feel other disciplines – social workers etc.

Acute 8 Not used on acute ward.

Acute N1 Group work tends to be during the day – I work at night.

Acute N3 I used to do groups all the time. They don't do them anymore.

Acute 13 There is little time for group work on the acute ward.

54. Knowledge concerning therapeutic use and action of common drugs used in psychiatry

For 5 Important to know side effects etc. used daily.

Acute 13 This is growing daily under the guidance of consultants and through personal observation of individual clients.

Eld 5 Used everyday.

55. Knowledge concerning administration of drugs – routes, dosage, prescribing/storing etc

For 2 Accountable for correct administration of drugs.

For 5 Very very important first. Most likely, card, accidents could happen without this.

Acute N1 At times DMO's need guidance on psychiatric drugs i.e. trainee GP's, 1st placement.

Acute 13 Used daily. Assignments in this area have been useful preparation for transition from theory to practice.

56. Knowledge concerning communication/interpersonal skills

For 5 Important to communicate.

Acute N1 I often need to establish trusting rapport with distressed/scared/psychotic people.

Acute N3 Practice makes perfect and familiarity breeds contempt leading to bad practice.

Acute 13 Diploma training has been invaluable in this area – used daily in reflection.

Eld 5 Vital in confused patients.

57. Knowledge concerning therapeutic relationships

For 5 Not every day occurrence but used on frequent basis.

Acute N1 Although not always the patient's Psychiatric nurse they need a person they 'trust' to confide in.

Acute N3 There is not enough dynamic discussion of this subject on the wards.

Acute 13 The diploma course emphasised the importance of these. Transferring to practice has been easy.

Eld 5 A must for all areas of nursing.

58. Knowledge concerning assessment/identification of suicide risk.

For 5 Important used frequently, medical staff take a greater roll.

Acute 8 Used frequently.

Acute N1 Emergency admissions at night tend to have an element of perceived self-harm.

Acute N3 Sadly some patients will get through but situations not helped by DSH and these magic words "I want to kill myself".

Acute 13 Little preparation in this area learning these skills on the job.

59. Knowledge concerning the management/care of suicidal patient

For 5 Important – especially in Mental Health nursing.

Acute N1 Nursing in an acute admission setting requires these skills.

Acute 13 Communication training has been vital in this area.

60. Knowledge concerning community care/services/resources

For 5 Neutral feel social worker roll.

Acute 8 Used in CPA and at discharge.

Acute N3 Communication between the real world and the hospital can always be improved.

Acute 13 Wide experience in the community has helped in this area along with previous work experience.

61. Knowledge concerning the nature of health and health education/promotion

For 5 Least likely feel specialist should be involved.

62. Knowledge concerning mental health, mental health education/promotion

For 5 Neutral – feel again specialist should be involved.

Acute N3 There's so much could be done with TV in soaps etc and re-run of wouldn't go amiss either.

Acute 13 The course has allowed me to confidently approach clients and offer them help in health education and promotion on an individual basis.

63. Knowledge concerning death and dying (grieving process etc)

For 5 Least used on daily basis but patients could be going through grieving process.

Acute 13 Little experience of death and dying in my present post.

64. Knowledge concerning ward/unit administration/management

For 5 Important especially when in charge of shift.

Acute 8 Very important.

Acute 10 Presently an increasing part of my work due to the devolution from managers to ward staff.

Acute 13 Little experience in this area, little touched on in daily practice.

65. Knowledge concerning medical treatments for psychiatric illnesses/disorders

For 5 Most likely but medical staff involved.

Acute N3 Pills are cheaper than personnel.

Acute 13 This post is allowing me to observe and participate in this area expanding knowledge and experience.

Eld 5 Have to keep an eye on the doctors – making sure they do it properly!

66. Knowledge concerning the promotion/maintaining of personal hygiene

For 5 Certainly need prompting at this but on the whole have a good regime.

Acute 13 Can only be used gently because clients individual choice and dignity must be respected.

Eld 5 Self-neglect is the main reason for admission of person with dementia.

General Comment

For 2 Difficult to do but interesting.

For 4 I found this particularly challenging as I feel that I use all of the statements of knowledge throughout integrated practice as an independent practitioner. All of the statements represent skills that are vital in the consideration of achieving best practice on all levels (clinically, managerially, accountability etc) and therefore do not easily fit into categories of use.

For 5 I didn't realise until completing this research just how much knowledge we need to have. All in all I think all of this knowledge

and information is used regularly and found it very difficult to decide which roll used.

Acute 5 Sorry I haven't commented on each one. I identified some as over lapping for me. Such as – Activities of Daily living could be used instead of using 2 cards for nutrition, personal hygiene. I used sleep separately as I find it a very large issue for inpatients.

Acute 8 I was amazed at the scope and variety of knowledge that was incorporated in my practice.

Acute N1 You may receive a small response as Q methodology appears daunting at first, however it was easier than at first glance. Additionally, it also made me think about the many skills used during a working shift.

Acute N3 I wish you success in your endeavour but found I may have erred by doing it at 3am! I found myself drifting to what I liked/didn't like as opposed to what I used/didn't use.suspect others may have done the same.

Acute N4 Quite difficult to choose most pertinent statements, many in the minus section seemed important. Also, hard to choose just 3 and 5's. Worried I've made a mistake but tried not to keep changing my mind. Good Luck!

Acute 13 It was difficult sorting into piles with the correct number of cards. I found I had far too many cards in the neutral column. There is a difficulty/difference between theory and practice and an individual's past training and experiences do have a large impact on how we perform. This type of sorting without the additional comments would not reflect this, however, the comments sheets do help to redress this issue.

Rehab 5	This was an extremely difficult exercise as all statements are valuable. There seemed to be more + statements than negative making minus 4 to 0 the hardest to complete.
Rehab 1	Found this difficult to identify use of knowledge as most are used on a daily basis. Results can also vary depending on characteristics and mental health disorders of client group on ward at time of study.
Eld 5	Most of the cards could have all been put in the Neutral → Most likely criteria. I have put some things in a lesser light, but this does not mean that it is any less important in the sphere of elderly mental health care.
Eld 6	Looking at the study I generally feel we need a good sound basic knowledge of all the statements, although those concerning learning disabilities less so.
Eld 7	Difficult to proritise as in elderly care it seems you need knowledge of everything to ensure total patient care. I felt the statements heighten awareness of the 'hands on care' or 'paper work' issues i.e. they don't seem to intermix
Eld 2	Found it at times difficult to prioritise near the +5 end of scale!
For 1	I was surprised how many 'knowledge's' or 'skills' I actually use very frequently. Difficult to put a hierarchy on +5, +4, +3 as I use them all fairly constantly. Very interesting. Would like to hear your findings!
Acute 1	I realised that the knowledge I would most like to use on a daily basis is ranked lower due to administration duties.

Acute 14 After sorting my 3 piles of cards I had only 5 in the least used and majority of cards in most used pile. Difficulty separating into least used knowledge.

Rehab 2 It was very difficult to carry out this exercise as knowledge in all these nursing interventions are equally important. Also it depends on individual needs. Advocacy was not on issue 3 weeks ago and therefore would have been knowledge. Least likely to be used, now it is a very big issue in my work area. I think what I'm trying to say is you draw on knowledge when the occasion arises.

Rehab 4 Knowledge used changes from day to day depending on ward. When ward is busy majority of statement cards would be in '+' end and vice versa. Very hard to determine what is a 'typical' day and what knowledge is used.

Rehab 6 Often perceptions/priorities may shift from patients "well being" to staff safety i.e. following policy/procedures = preservation of the organisation.

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