# How is nursing practice with suicidal consumers in acute mental health inpatient units constructed?

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This thesis is dedicated, with all my love, to my children Amelia and Isaac. It is also dedicated to their mother, and my friend, Jennifer Partington, who passed away in February 2011.

# Table of Contents

# Summary

The need for quality nursing practice with suicidal consumers in inpatient mental health units is axiomatic. Such consumers are, by the nature of their distress, often vulnerable and in need of support. However at the beginning of this study there was good evidence that nursing practices varied between individual nurses, teams and wards. This study examines why this variation occurred, by asking the research question "how is nursing practice with suicidal consumers in acute inpatient units constructed?" To answer this question a critical ethnographic research study was undertaken in four acute mental health inpatient wards across two cities in New Zealand. Data were gathered from observations, interviews with nurses, other clinicians and with consumers, and by examination of consumer and other clinical records.

The findings show differing ward or team cultures relating to the treatment/care of suicidal consumers and the expected practice of nurses. The cultural expectations in wards or teams were one significant factor in the construction of nursing practice. Two cultures, which I have labelled 'bio-medical/risk' and 'psychological', differed markedly from each other, and as such produced very different expectations of nursing practice. A third type of culture was marked by the process of struggle for dominance, and as such I have called this a ward in 'partial change' where differing understandings of suicidality and of practice had resulted in sub-groups of nurses working in dissimilar ways.

A second factor in the construction of nursing practice with suicidal consumers was the dispositions (why people behave in certain ways, and how they act). Dispositions in this thesis refers to why people act in certain ways, and dispositions were relational to dominant cultures, meaning that practices aligned, or not, in a variety of ways. A re-interpretation of the findings using key theoretical ideas of Pierre Bourdieu allowed identification of five dispositions. These are (i) *practice through passive alignment* (nurses unconsciously imbued with a dominant bio-medical/risk culture and therefore practicing in ways aligned with its expectations)*;* (ii) *practice through reluctant alignment* (nurses consciously, but reluctantly,

practicing in alignment with the dominant bio-medical/risk culture, while being critical of it)*;* (iii) *practice through deliberate non-alignment* (nurses consciously practicing in ways that were inconsistent with the dominant bio-medical/risk culture)*;* (iv) *practice through misalignment* (nurses misinterpreting a new way of understanding suicidality and practice, either by returning to previous ways of working or by practicing in new and unexpected ways)*;* and (v) *practice through deliberate alignment* (nurses consciously aligning with a new way of understanding suicidality and practice, and practicing in a way consistent with this). The findings from this study are important as they give insights into why nursing practices with suicidal consumers can vary so markedly, even within the same wards or hospitals. The results suggest that that any attempt at sustained improvement of nursing practice with suicidal consumers' needs to consider the constructing influences of both ward and team cultures and of nursing dispositions. This understanding allows for suggestions for future nursing education, practice, and research that attempt to support nursing practices that result in positive outcomes for suicidal inpatient consumers.

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# Chapter One: Background to the research

## 1.1 Introduction

Nurses working in inpatient mental health units provide 24 hour, day-to-day care (Cutcliffe & Stevenson 2007), and it is somewhat axiomatic to state that good nursing practice with suicidal people (hereafter referred to as 'suicidal consumers') is needed. Although there is growing evidence about which practices are effective, there are strong anecdotal indications that nursing practice differs markedly between individuals, teams, and inpatient wards in New Zealand, with little policy guidance as to what practice should be. Why practice variations occur is unclear, with few evidence-based examinations apparent in New Zealand or in international literature. This thesis is an attempt to understand what shapes inpatient nursing practice with suicidal consumers by asking the question 'How is nursing practice with suicidal consumers in acute mental health inpatient units constructed?' Throughout this thesis the terms 'practice', 'nursing practice' and 'clinical practice' mean the everyday work that nurses do with suicidal consumers in mental health inpatient wards. The term 'practice' is also premised by the notion that external factors may partially construct practice and that meaning for practice may be derived from these factors.

## 1.2 The extent of the clinical problem of suicide

Suicide remains a world-wide problem, with a current predicted suicide rate of over one million people per year (World Health Organization [WHO] 2014). Despite a proliferation of national policy initiatives to lower the suicide rate, the world-wide rate of suicide has increased by 60% since 1950 (Cutcliffe 2014; Cutcliffe & Stevenson 2007; WHO 2014). In New Zealand, the suicide rate has dropped 23.6% since a peak in 1998, but still represents 478 deaths, or 10.6 deaths per 100,000 of population (Ministry of Health [MoH] 2014a). The New Zealand literature shows that:

- There were 369 male suicide deaths (16.6 deaths per 100,000 male population, age-standardised) in 2011.

- There were 109 female suicide deaths (4.7 deaths per 100,000 female population, age-standardised) in 2011.
- There were 108 Māori suicide deaths in 2011. This represents an age-standardised rate of 16.8 per 100,000 Māori population.
- There were 9.1 non-Māori deaths per 100,000 population (age-standardised) in 2011.
- There were 24 suicide deaths among Pacific peoples and 28 among Asian ethnic groups in 2011. (MoH 2014a, p.ix)

In 2011 2647 people were hospitalised for intentional self-harm (MoH 2014a), indicating that for every completed suicide, many more are given treatment/care in inpatient wards. Hospitalisations of suicidal consumers continue to decrease (MoH 2012), but this change is likely to be due to a change in emphasis of mental health service responses. The MoH (2012) note that:

> This decline may be due to a real change in behaviour within the population, but it is also likely to be due to changes in clinical practice and clinical administration over the last decade. For example, the move towards community-based mental health care is likely to have reduced the number of people who may previously have been admitted to inpatient mental health services following an intentional self-harm event. (p.39)

## 1.3 Why examine the construction of practice

The *New Zealand Suicide Prevention Action Plan 2013-2016* (MoH 2013) cites improving the care of people who have made a non-fatal suicide attempt as one of seven key strategies in a nationwide approach to suicide prevention. However, this is no simple task. Feelings of suicide are common across the lifespan, may have many causes (International Association for Suicide Prevention 2014), and many suicidal people do not seek professional help. Of those that do, many are seen in community settings by a myriad of health professionals and lay persons. Some suicidal consumers are referred (for example, by general practitioners, counselors or by self-referral) to public mental health services. Clinical assessment and treatment of suicidal people occurs mostly in the community, although a minority of suicidal people are admitted to acute mental health hospitals or units. Of these, some are forced to accept admission to hospital through legislated coercion mandated by the Mental Health (Compulsory Assessment and Treatment) Act 1992.

In hospital, treatment/care is provided ‘around-the-clock’ by nurses. Good, efficacious treatment/care of suicidal consumers is obviously needed at such a time. However, anecdotal evidence suggests that nursing practice differs between individuals, teams, wards and hospitals, and these differences may be partially caused by factors that either support or hinder good practice. The initial impetus to undertake this research stemmed from my experiences in clinical practice, education, and research in two cities, as well as having a national seclusion reduction role that meant I had the privilege of travelling to mental health hospitals around New Zealand, and being able to meet management, clinical and non-clinical staff, and consumers. In these roles I have heard consumers describe the impact of their experience of being suicidal and being in a mental health hospital. I was struck by the marked differences in these experiences, which appeared to me to be unrelated to the clinical diagnosis given to individuals. A suicidal consumer could, for example, have different levels of restrictions in movement placed upon them, despite being considered at a similar risk of attempting suicide.

Consumers also had very different experiences of nurses’ practices with them. An example of this was the way in which nurses communicated about issues of suicide. Some consumers were effusive about the support they received from nurses. While these consumers often acknowledged the need for structured interventions (such as medications), they considered that the nursing practices of day-to-day support and therapeutic conversations (about their suicidal thoughts and life events that led them to have these) were equally important in their recovery. Others’ experiences were different; they described feeling largely ignored and neglected whilst in hospital, and that their experience of hospital would make them unlikely to accept inpatient treatment in the future. Others suggested that because of this, they did not disclose suicidal thoughts to clinicians, including nurses. Consumers’ experiences suggested that nurses had differing ways of working with suicidal people, which led me to consider whether there was a unified nursing practice in this area, or whether there were multiple practices that were, perhaps, related to the context in which they occurred. My hunch was the latter, which informed the research question central to this thesis.

Although the empirical literature on what inpatient mental health nurses do with suicidal users is scant (Crowe & Luty 2005; Cutcliffe & Stevenson 2007; Cutcliffe 2014), there is growing evidence that nurses' therapeutic work with consumers is considered vital by consumers and nurses alike (Cutcliffe & Stevenson 2007; Lees 2013; McLaughlin, 2007; Sun et al. 2005). The literature does not conclude that therapeutic work is the *only* important aspect of inpatient nursing with suicidal consumers. On the contrary, many other nursing aspects are highlighted, but the central place of nurses' therapeutic work with consumers is apparent. However while nurses are theoretically well-placed to support suicidal consumers (Lees 2013), their practice is often considered less important than that of other health professionals (Cutcliffe & Stevenson 2008a). There is evidence that some mental health nurses fear that talking to consumers about their suicidal thoughts and feelings could actually bring about suicidal behaviours (McLaughlin 2007). Similarly there are suggestions that nurses do not spend much time with consumers in inpatient units (O'Hagan 2006), and that contextual issues in inpatient environments make therapeutic relationships with consumers difficult.

When considering practice with suicidal consumers, Maltsberger (1994) suggests that the culture of mental health hospitals favours a protective stance that focuses on minimising risk of injury or death, because "…suicidal proclivities universally evoke intense counter-suicidal responses in caretakers. The threat to commit suicide typically excites clinicians to prevent it by every possible means…" (p.203). While Maltsberger considered inpatient practices with suicidal consumers in a different time and context, this did correspond with some of what I had seen in my various roles. More recently, Gilje and Talseth (2014) suggest that 'observations' – a common nursing role with suicidal consumers – often "serves the organization [sic]…and does not relieve the despair of suicidal persons" (p.20). At the beginning of this study it seemed reasonable to consider whether differing issues influenced inpatient practices. Although the research literature is limited, contextual issues appear to have a negative influence on inpatient nursing practice, including the general demands of ensuring wards function (Buus 2008; Cleary 2004; Deacon 2003; Deacon & Fairhurst 2008; Jones & Bowles 2005; Quirk et al. 2006); the short length of inpatient stays for mental health consumers (Quirk et al. 2005, 2006); an increase in the acuity of consumers, coupled with a pressure of severe limitation in hospital placements (Rydon 2005); hierarchical relationships with medical professions (Hummelvoll & Severinsson 2001); unequal power relationships between nurses (Buus 2008), and the need to manage risk (Crowe & Carlyle 2003; Quirk et al. 2005). There is less evidence about contextual issues that positively impact on nursing practice, with only one study (Deacon & Cleary 2012) identifying the impact that nursing teamwork had on practice in an acute inpatient ward.

There is limited empirical evidence about contextual factors affecting nursing of suicidal consumers in inpatient hospitals or wards. Commenting on the extant research literature rather than their own study, Cutcliffe and Stevenson (2007) consider an ‘observations’ position of practice dominates theoretical literature on nursing practice, and is borne out in research studies into nursing of suicidal consumers. An ‘observation’ position is one where there is a focus on medically treating the suicidal consumer whilst observing and containing that person within the inpatient environment. My reading of Cutcliffe and Stevenson’s work is that such a position shapes nursing practices while having limited evidence of positive outcomes for nurses or consumers. Other issues identified in studies of nursing practice with suicidal consumers are the distress caused by working with suicidal consumers (Carlen & Bengstsson 2007; Long & Reid 1996; Talseth et al. 1997; Talseth & Gilje 2011), limited education in suicide (Meerwijk et al. 2010) and, in New Zealand, an emphasis on working within a medical understanding of suicide causation (Murtagh 2008).

The research literature, as it is, gives some indication that contextual factors are likely to impact on nursing practice with suicidal consumers in inpatient wards. As I show in chapter two, the treatment of suicidal individuals is influenced by the socio-political context of the time. Suicide prevention and treatment has been a focus of attention within New Zealand in the last decade, yet it has been unclear how this has influenced nursing practice. At the time of writing no published study has solely attempted to examine this issue. This thesis attempts to address this through its aims, which are:

(i) to identify the contextual factors that influence nursing practice with suicidal consumers in acute mental health inpatient units, and

(ii) to describe how these factors construct practice.

The research undertaken for this thesis identifies these factors, and the way they both shape and give meaning to nursing practices. As I show in chapter eight, nurses interpret these factors in different ways, creating varied meanings about nursing work, and different day-to-day practices.

## 1.4 Research framework and methods

The research in this study was undertaken by conducting a critical ethnography of two mental health hospitals, each with two 'open' wards that usually had unlocked doors. Critical ethnography as a methodology attempts to elicit why social beings practice in the way they do through an understanding of historical and socio-political factors. This was particularly useful in a study that attempts to expose factors that construct practice. I discuss critical ethnography and its relationship to this study in more depth in chapter three.

The findings represent the results of 75 in-depth interviews with nurses, other clinicians and consumers who were able to reflect upon the day-to-day clinical treatment/care given by nurses to suicidal consumers, and their views on what factors contributed to practice; almost 700 hours of participant observation of clinical practice; and examination of written records, including consumers' clinical notes and relevant hospital policies. These three data-gathering methods were used as no one method on its own was considered sufficient to capture an understanding of the influences on nursing practice, and each method afforded unique information and aided in triangulation of data gathered from one or both of the other methods. The results were analysed using a modified version of a process suggested by Spradley (1979), along selected works of Pierre Bourdieu 1977; 1979/1984; 1990; 1997/2000; 1998; 2001). Bourdieu can be seen as a practice theorist (Ortner 2006), with an interest in how people come to 'act' in the way they do. His concepts of field, capital and habitus (discussed in chapter three) were useful in extricating understandings of how nurses' dispositions further constructed nursing practice.

The results from the analysis allow for a description of two types of acute ward or team, each with a differing internal understanding of the cause of suicidal thinking and behavior, the purpose of inpatient treatment/care for suicidal consumers, and what nursing practice should be. A third ward was in the process of changing treatment/practice with suicidal consumers, with somewhat limited success. The results, described in chapters five to seven, give an understanding of what constructs nursing practice with suicidal consumers. The analysis also shows that nursing practices differ, even when nurses work within the same ward or team culture. An understanding of the relationship between nurses' dispositions to the socio-political and historical factors constructing nursing practice shows how different groups of nurses make sense of their practice world and reproduce or transform it. As such nurses' dispositions are in of themselves, constructing elements of practice.

## 1.5 My positioning

I am a registered nurse, and I have already briefly described some of the nursing and other health related practice, education and research roles I have held. These have undoubtedly influenced my belief that therapeutic work with suicidal consumers is central to nursing practice. This position has been reinforced by my readings of research literature for this thesis. Critical ethnography is necessarily political, and makes no pretence at neutrality (Denzin 1997), and I undoubtedly had a view on what 'good' practice was during the process of data collection. This thesis is, however, about the construction of nursing practice with suicidal consumers; at the beginning of data collection I did have some pre-conceived notions of what 'constructing factors' were, but I attempt to make these explicit throughout this thesis. Importantly, I have attempted to recognise these and minimise their impact on analysis of the data.

I have used the term 'treatment/care' when describing the work done with or to consumers during their inpatient admissions. These terms of course can be interpreted in many ways, and, on the face of it, might mean very differing things. I have chosen to use both in the absence of another term that is not value-laden and implying a particular perspective. I could have used either term at different times, depending on what practices were occurring to or with consumers. However the changing of these terms caused confusion in earlier iterations of the writing of this thesis. While ‘treatment/care’ is not overly satisfactory, it does allow for a consistency of understanding.

Throughout this thesis I have used the pronoun ‘I’, accepting that the process of considering the research question through to the final writing of the thesis is determined by me. However I have attempted to maintain a position of reflexivity by the use of supervision during the research process, multiple readings of the data and of theoretical and empirical literature, and by often identifying where other explanations of material is possible. In this way I have attempted to make explicit my thinking and add rigour to the process of producing this thesis.

I have also used the term ‘consumer’ throughout this thesis to describe persons receiving inpatient treatment/care. Throughout the literature varying terms are used, including ‘patient’, ‘service-user’ and ‘client’. In addition some consumer participants in this study preferred the Māori term ‘tangata whaiora’ (people seeking health). Clearly there are a myriad of philosophical views about which term should be used, and there was no homogeneity within consumer participants to guide me. In the end I have opted for the term ‘consumer’, as this was suggested by one consumer team who offered me advice at the outset of this study.

I have also referred to consumers’ ‘suicidality’ often. Throughout this thesis I am referring to a consumer's thinking related to undertaking a deliberate act to end his or her own life, and the actions taken to make this occur.

Throughout the thesis I have used the term ‘suicidology’. Suicidology is commonly used in academic literature to mean the ‘science’ of studying suicide (Maris et al. 2000), often (but not exclusively) undertaken by the disciplines of sociology and psychology.

## 1.6 Organisation of the thesis

In *chapter two* I examine the relevant literature about what constructs nursing practice with suicidal consumers in acute inpatient units. I use theoretical and research literature, as well as New Zealand policy initiatives to describe some potentially key areas of practice construction. I also acknowledge that the evidence about how these translate into practice is often not strong.

In *chapter three* I identify the methodological framework that underpins the research in this thesis. I describe background features of critical ethnography and how this informed the process of data gathering and analysis. I then describe selected works of Pierre Bourdieu, and show how these works allowed a consideration of the data that is discussed in chapter eight.

In *chapter four* I describe the methods used in this thesis, particularly the ethical considerations undertaken, the process of entry to the field, and the consequent data analysis processes. I also reflect on the limitations and strengths of these methods, and areas in which the research process could have been improved.

I describe two types of ward or team in *chapters five* and *six*, each of which had particular ways of understanding the aetiology of suicide, the purpose of inpatient treatment/care of suicidal consumers, and the expectation of what nursing practice should be and what actually occurred. I show how the dominant ward culture impacted on nursing practice, while examining how other nursing factors meant that practices were not homogenous.

In *chapter seven*, the third data chapter, I examine a ward that had attempted to change the purpose of treatment/care of suicidal consumers, including nursing practice. The change was only partially ‘successful’, and the consequent differing nursing practices and the influence of nurses' own beliefs in shaping these, offers useful information about how practice is constructed.

In *chapter eight* I use selected theories of Pierre Bourdieu (1977; 1979/1984; 1990; 1997/2000; 1998; 2001) to demonstrate a theoretical understanding of how nursing practice is constructed by both dominant cultures within and external to wards and team, and by nurses' dispositions. This understanding is vital as it shows that practices, while very different, are constructed through a complex social process. This information is significant and informs the final chapter.

The limitations of the research and the methodology underpinning it are considered in *chapter nine*. I consider the relevance of findings about nursing care with suicidal consumers in acute mental health inpatient hospitals and wards. The construction of practice through processes described in chapter eight are considered, as these have a potentially important meaning for nursing practice, education and research.

## 1.7 Conclusion

This chapter has introduced the rationale for the study and the methodological processes by which the research was undertaken. In addition I have described the layout of this thesis, one that allows for an understanding of the process by which I undertook the research. This builds to the final chapters, which answers the research question 'how is nursing practice with suicidal consumers in acute mental health inpatient units constructed?', and allows a consideration of the relevance of knowing the answer to that question.

# Chapter Two: Literature review

## 2.1 Introduction

This chapter analyses the literature about the construction of nursing practice with suicidal consumers in acute inpatient mental health units. In searching the literature I necessarily read a vast array of theoretical, policy and research papers. There is some empirical evidence about what nursing practice with suicidal consumers in acute units is; however the research-based literature about the construction of nursing practice with suicidal consumers is sparse. There are, however, themes in the literature that indicate what might construct practice, and this chapter outlines these. I have updated these themes throughout the research process, but only describe themes that were evident at the outset of this study. This chapter is therefore a literature review of the existing research evidence, and a literature-based argument about what might construct nursing practice with suicidal consumers in acute mental health inpatient units.

## 2.2 Parameters of the literature search

This chapter examines the literature that indicates the construction of nursing practice with suicidal consumers in inpatient mental health hospitals using (i) research literature, (ii) New Zealand policy directions, and (iii) theoretical literature about historical and current 'western' societal responses to suicide prevention.

### 2.2.1 Research literature

The research literature was obtained by searching the electronic databases CINAHL, Medline, PubMed, PsychINFO, Web of Science, Proquest Health and Medical along with searches in the Cochrane Collaboration and The Joanna Briggs Institute. The searches were undertaken using individual and combined search terms, namely 'suicide', 'suicidal', 'suicidality', 'suicidology', 'practice', 'care', 'inpatient', 'ward', 'hospital', 'nursing', 'mental health/psychiatric nursing', 'psychiatry/mental health', 'policy', 'consumer, patient, tangata whaiora/client', 'history', 'recovery', 'therapeutic engagement/relationship', 'observations', 'teamwork', 'barriers', 'influences', 'construction', 'shaping', 'support', and ‘enablers’. In addition I cross-checked the accuracy of searches by examining the reference lists of articles on an on-going basis. This literature was obtained before the research began and updated at regular intervals afterwards. The obtained literature largely informs the research cited in this chapter.

### 2.2.2 Policy direction literature

The policy direction literature was largely gathered by ongoing searches of electronic databases of the WHO, the New Zealand Ministry of Health, The New Zealand Guidelines Group, along with the New Zealand nursing discipline specific websites Te Ao Maramatanga (New Zealand College of Mental Health Nurses) and the New Zealand Nurses Organisation

### 2.2.3 Western societal responses to suicide prevention

This theoretical literature was gathered at the beginning of the research study by searches of the databases identified in 2.2.1 above, by searching the catalogues of New Zealand universities and polytechnics, as well as the on-line book wholesaler Amazon. I was particularly looking for literature that might position societal (including formal mental health services and nursing) responses to suicide. This literature includes research, theory and New Zealand policy directives, and has been helpful in shaping my understanding of the place of the most common ‘western’ understandings of suicide and societal responses to the problem. These were useful in considering what might construct nursing practice with suicidal consumers in acute mental health inpatient units. As such they were meant to be part of a narrative from multiple literatures that foregrounds the dominant positions of thinking and action around suicide within western society practice. They were, however, not meant to pre-empt the findings of this study in any way.

## 2.3 The construction of nursing practice with suicidal consumers in acute units

### 2.3.1 Introduction to this section

This section examines the literature that suggests how nursing practice with suicidal consumers in acute inpatient units is constructed. There is a dearth of literature that specifically examines what constructs nursing practice. However the broad parameters of this search meant that I was able to identify themes in that indicate significant issues that may influence practice. The rest of this chapter describes these.

### 2.3.2 Suicidality as located within medical and risk discourses

In this section I summarise a substantive literature gleaned from multiple sources. New Zealand policies for the prevention and treatment of suicide are located within discourses of suicide as a bio-medical event and of the need to recognise and minimise the risk of people attempting suicide. My understanding of the concept of ‘discourses’, identified in this chapter and throughout this thesis, is informed by my reading of Bourdieu (1991). Bourdieu suggests that discourses are a medium by which the established order is imposed as ‘being natural’ or ‘normal’. I am not suggesting that locating suicide as a bio-medical or risk event is intrinsically ‘wrong’ (a consideration of which would be outside the realms of this thesis) or to debate the fact that there is a substantial research base showing a correlation between suicide and mental illness. I am instead using the literature to consider that New Zealand ‘mainstream’ mental health responses to suicide are located within these discourses. By extension the literature suggests that inpatient treatment/care and mental health nursing practices are both likely to be impacted by these discourses. At the outset of this study I did not know how such discourses might impact on practice, and in what way (if any) they contributed to the construction of nursing practice.

McManus (2004), a sociologist, undertook an extensive review of the history of New Zealand suicide policy. McManus considers that New Zealand approaches to suicide can be divided into three areas: the ‘criminalization [sic] of suicide’ (1840-1893), the ‘pathologization [sic] of suicide’ (1893-1974) and the ‘riskification of suicide’ (1975-2000) (pp.193-201). In the first of these, New Zealand was “governed through criminalization [sic]. This mode of governance focused regulatory efforts in particular upon completed suicides, on punishments directed at their bodies and their properties” (p.193). The view of suicide was, as McManus notes, guided by British judicial rule which was in place in New Zealand following the signing of the Treaty of Waitangi in 1840. Suicide was therefore seen as a crime requiring requisite governmental responses, and matched approaches in the United Kingdom. Similarly, the 'pathologisation' of suicide in New Zealand followed western trends, as I show next. Later in this chapter I show that New Zealand's 'riskification' of suicide also reflects a western stance on suicide that has emerged in the latter half of the 20th century.

Historically, western societal attitudes towards suicide and persons who have attempted suicide have in some ways mirrored other changing societal viewpoints. For instance, Battin (1995, p.3) notes:

> Stoic philosophy in classical Greece and Rome... held that suicide was to be permitted or even encouraged when undertaken for reasons such as ill health, poverty, slavery or insanity, or to protect the welfare of one's family or nation. Some post-Enlightenment thinkers of the eighteenth century held an even more liberal view: Suicide was for them among the fundamental rights of humankind, to be abridged in no way except where it might seriously damage the well-being of others. Romantics of the nineteenth century glorified suicide as the heroic choice of the truly free person, an act of final self-assertion against the claims of the world.

Suicide was seen as permissible, romantic or even heroic act (Battin 1995; De Leo et al. 2006). In contrast, more recent Judaeo-Christian tradition "has maintained an increasingly negative position towards suicide" (Battin 1995, p.3). While early Christianity showed an acceptance for suicide that contrasted with the stance taken against the killing of others, by the Middle Ages Christianity took a more negative moral position. In 533 the church decreed that a Christian burial was needed for individuals to get into heaven, but this was denied to persons who 'suicided' whilst accused of a crime. Such a stance can be viewed as a form of social control against criminal activities; nevertheless it also foregrounded an increasingly conservative position held against both the act of suicide and those persons who attempted the same. By 562 all suicides were denied a Christian burial, and by 693 those who even attempted suicide were excommunicated from the church. This was based on the proclamation of St Augustine, and on a blanket interpretation of the biblical commandment 'thou shalt not kill'. Even today the Christian church "has held, and continues to hold that suicide, except when excused in cases of mental illness, is gravely morally wrong" (Battin 1995, p.3). Interestingly, the church, as well as considering suicide immoral, has located itself within a viewpoint that mental illness can have a role in causing suicide.

A change in viewpoint that privileged a bio-medical viewpoint came about in the 19th century, where suicidality came under the realms of medicine and was seen as a medical, treatable event.  Minois (1999) suggests:

> At that time [the 19th century] there seems to have been a movement to destroy all the progress that the preceding three centuries had made [about suicide thinking]… in the direction of interpreting suicide as a social phenomenon that deserved to be approached without prejudice, as an undeniably tragic act, but one that must be understood without *a priori* condemnation… After the break of the French Revolution, the moral authorities (and even the political authorities), inflamed by a spirit of reaction and restoration, worked vigorously to return  suicide to what they felt was its rightful place among acts that are forbidden and counter to nature. But because those authorities were no longer able to coerce people into moral conformity, they moved the repression of suicide inward, shifting it to the individual conscience. Their efforts were made all the more effective when – surprisingly enough – the development of the humane sciences helped, quite involuntarily, to strengthen the individual and collective guilt complex regarding suicide. The emergent science of statistics permitted measurement of the extent of the phenomenon. Psychiatry and sociology pointed out that in suicide individual moral and mental failings play a role along with the insufficiencies and injustices of social structure. (pp. 314-315)

Since the eighteenth century, western 'mainstream' understandings of suicide have moved from theological and philosophical texts, to becoming the domain of 'science' which undertook to recognise, prevent and treat suicide and suicidal persons (Cutcliffe & Links 2008a, 2008b; De Leo et al. 2006; Minois 1999). After the eighteenth century three discourses of suicide causation (and therefore treatment) have dominated in literature: a sociological perspective; psychological views, and an understanding of suicidality as being the result of an individual's mental illness, which suggests the subsequent need for bio-medical treatment of the mental illness to reduce suicidal thinking. I discuss each of these.

### *A sociological perspective of suicide*

In the eighteenth century, the study of suicide become a statistical one with the publication of sociologist Emile Durkheim's treatise, *Suicide: A study in sociology* (1897/1951). Durkheim used statistical evidence to argue that suicides could be categorised through an understanding of how societies regulate citizens, and, in turn, how well individuals are integrated into society. From this Durkheim categorised suicides as:

- Egoistic suicide: This occurs in societies where individuals have weak ties to society, with a low level of social integration. These societies are usually categorised as ones that focus on individual rights and interests above all else. Individuals in such societies are encouraged to have self-responsibility and to make their own decisions. The principle of autonomy is seen as a primary driver, and suicide being the choice of an autonomous individual.
- Altruistic suicide: This occurs when individuals subsume their individual rights and needs to that of a greater cause, and therefore can be viewed as having high integration into society. In such societies there would be little need for suicide to occur. However, there would be instances where a person would self-sacrifice. Suicides in such situations are seen as noble and morally correct.
- Anomic suicides: According to Durkheim, there is a moral framework of behaviours acceptable to a society; when these moral codes are weakened through low societal regulation, individuals revert to their natural selfish-interest. Durkheim locates such changes in moral codes to societal changes, arguing that societal changes such as the industrial or financial crises can alter rates of suicide in a given society.
- Fatalistic suicide: Durkheim suggests that some societies can be overly oppressive, through high regulation, to the point where living was not seen as a viable option for some persons. Such societies are not necessarily formulated on a macro level such as a state, but can be seen in smaller ones, such as prison.

Durkheim's theories were highly influential in moving western consideration of suicide from a moral question ('is suicide acceptable?') to examining suicide from an epidemiological perspective. The question of suicide became one of 'who suicides?' and 'why do they suicide' (Stone 1999). The statistical enquiry into suicide enabled it to be examined from a perspective of risk. Such a perspective is highly influential in national initiatives that aim to prevent suicide, including New Zealand policy direction discussed later in this chapter. However, statistical examination does not show why an individual kills him or herself, who will attempt suicide, why there are national differences in numbers of completed suicides, or why there are rates of difference between groups of people. The usage of epidemiological inquiry to attempt to determine the risk of any individual attempting suicide has been critiqued by some. Amery (1999) for example, is critical of suicide statistics when he states "...how simple it all is: you need only to follow and pay attention to the professional literature and then you know — what? Nothing." (p.3). McManus (2004) is critical for a different reason. She suggests that "suicide in Western culture suffers from a lack of critical engagement. It is cloaked with a very intense moral imperative that, within academia, demands researchers find the cause so that suicide can be stopped" (p.192). McManus' point is that academic inquiry has been captured by an unquestioned need to prevent suicide, and that governments should act to stop the occurrence of suicide.

### ***Psychological perspectives of suicide***

Research into psychological aspects of suicidal persons suggests that certain temperaments, personality traits, psychological vulnerabilities, and cognitive and coping styles may act as predisposing factors in suicidal behaviour. The common thread in these psychological constructs linked with suicidal behaviour is that they all predispose the individual to react in negative ways to perceived stressful situations (Beautrais et al. 2005). Beautrais and colleagues suggest that these 'temperaments' include "hopelessness, neuroticism, anxiety, timidity, cognitive rigidity, impulsivity, aggression and a strong sense of personal independence" (p.26).

Beautrais et al. note that one of the difficulties with research attempting to determine psychological traits of suicidal persons is that these traits may be associated with other causative effects (especially major depression) rather than being particular to an individual. In other words, these traits may be a secondary symptom rather than being a singular, or (more likely) be part of a complexity of causative factors of suicidal ideation. However, research into hopelessness appears to be independent of other factors. Hopelessness is a strong predictor of suicide in follow-up studies of 5 to 10 years of inpatients, outpatients and suicide attempters (Beautrais 2004). One form of treatment for hopelessness is the use of psychological approaches. There is a large literature on psychoanalytical theories of suicide. Although I was unable to cite the original literature, these theories appear well summarised by Leenaars (2004, cited in Cutcliffe & Stevenson 2007):

- A *psychoanalytical understanding* whereby suicidal thoughts and feelings of an individual are caused (unconsciously) by the loss of a significant object (often a person) and the suicidal person rejects the object and turns the anger/hatred in upon him/herself.
- A *cognitive behavioural understanding* in which suicidal people are seen as having a constricted view of the world, have a strong sense of hopelessness, and see suicide as the only way out of their situation.
- A *social learning view* where suicidal people have learnt to turn aggression (in the form of suicidal thoughts and behaviours) inwards on themselves.
- *A multidimensional view* of suicide, espoused by Edmund Shneidman (1987), whereby suicidal thoughts and feelings are caused by 'psychache', an intolerable psychological pain. This pain is caused by unmet or unfulfilled needs, and leads to constricted thoughts in the suicidal person, with suicide seen as being a way of ending the pain.

In addition, research undertaken by Cutcliffe and Stevenson (2007) found that suicidal people have a sense of disconnectedness from society, a lack social integration, have a sense of loneliness, and, building on Shneidman's (1987) theory of suicide, suffer *psychache*. Cutcliffe and Stevenson argue that their study results indicate that mental health nurses need to priorotise therapeutic work with suicidal consumers in order to help them address the psychological issues that underpin their suicidal thinking.

### *Suicide as mental illness*

Since the mid-1800s New Zealand followed the lead of other western countries in re-interpreting suicide as largely a problem of mental illness, rather than a criminal offence. McManus (2004) describes this as the "pathologisation" of suicide (pp. 196-199). She states that:

> Driven by the authority of the medical regime, suicide was transformed from a matter of legally accountable reason into an issue of mental health. Rather than a completed crime to be judged, suicide signalled an individual’s psychological dysfunction, a system of encroaching death, medicine’s ultimate foe. (p.196)

Suicide had moved from being seen as a crime to being conceptualised as part of mental illness, supported by the professionalisation of medicine in the 19th century (Shortt 1983). Suicidality was incorporated into new psychiatric diagnostic categories, and seen as curable with the correct treatment (McManus 2004). Treatment largely occurred within asylums, much as occurred overseas (Cutcliffe et al. 2014), through physical interventions and moral management from asylum staff who were meant to provide guidance to suicidal consumers (McManus 2004). Medical authority over the treatment/care of consumers, including those who were suicidal, was further increased when asylum administration was moved from lay persons to medical administrators. Prebble (2007) notes:

> Establishment of the Lunacy Department in 1876 marked the beginning of a centrally administered system of mental hospital care in New Zealand that lasted for almost a century. Made possible by the abolition of provincial governments, the change from provincial asylums to central government administration was driven by a desire to raise the standard of asylum conditions by introducing medical control and national standardisation. This signalled the end of lay administration of mental health. A medical officer was appointed as Inspector-General of Mental Hospitals and medical superintendents were put in control of individual asylums. (p.30)

In the 1920s treatment in the asylums for suicidal and other consumers included hot baths and massage, while in the next decade more intrusive interventions such as electroconvulsive therapy and insulin therapy were introduced (McManus 2004). These were gradually replaced as treatment modalities by neuroleptic medications which began to be developed in the 1950s.

Despite the view that suicidality was ‘treatable’ as a mental illness, nursing in early New Zealand asylums was largely custodial. Although medical understandings of suicide dominated discourses of treatment (McManus 2004), other factors limited what nursing practice could be with suicidal consumers. Prebble (2007) notes:

> Between 1939 and 1959 the introduction of somatic treatments did not substantially change nursing practice in mental hospitals. Overcrowding, understaffing and poor resources necessitated the continuance of custodial care. The asylum-type institutions were dependent on a male attendant workforce to ensure the safety of disturbed male patients [sic], and the maintenance of hospital farms, gardens, and buildings. Although female nurses provided all the care and domestic work on the female side, the belief that psychiatric nursing was physically demanding, potentially dangerous, and morally questionable, characterised the work as generally unsuitable for women. Introduction of psychiatric nursing registration which was a move toward professionalisation did little to change the dominance of a male, working-class culture. (p.ii)

However the more custodial role for nursing was challenged by a move to a change towards therapeutic practices. Prebble advises that:

> During the 1960s, the psychiatric nurse's role was conceptually redefined as therapeutic rather than custodial. Influenced by international nursing literature, tutor sisters taught the concepts of interpersonal relationships as being fundamental to the nurses’ role. Student nurses learned about the value of interpersonal skills and how to apply them with different types of patients and in various circumstances. Psychology was included as a subject in the curriculum as it was believed important for nurses to gain a better understanding of themselves and their patients. They learned the importance of treating people as individuals and that their duty was to assist patients to ‘regain self-confidence and self-respect’, develop ‘better relationships and tolerance of others’ and ‘face up to problems and demands of everyday life’. (p.208)

Prebble’s historical analysis is informative in identifying changing expectations of nursing practice with suicidal consumers from a custodial focus to a more therapeutic stance. However the dearth of New Zealand research into inpatient nursing practice with suicidal consumers limits knowing whether the educational change in emphasis played out in practice, or has been maintained in the 21st century in New Zealand. The international literature on nursing practices with suicidal consumers, as I show later in this chapter, suggests that while nurses often attempt to work therapeutically, bio-medical and custodial discourses remain in ascendance. I show in the rest of this section that discourses of bio-medicine and risk predominate in New Zealand clinical policy direction, supported by research literature that shows a strong correlation between mental illness and suicide, with one study showing 98% of people who have completed suicide having a diagnosable mental illness (Berlotte & Fleishman 2002). An earlier review of other studies indicates a mental illness/suicide relationship of between 81 percent and 100 percent, with a median of 93 percent (Lonnqvist 2000). While this association is compelling, research into suicide causation is fraught with methodological problems and a dominant discourse of bio-medicine. This point is acknowledged by two of New Zealand's leading researchers into suicide when they note:

> It is clear that the way suicide is conceptualised by societies is shaped by their prevailing shared spiritual, cultural and scientific beliefs. Scientific and medical enquiry is also shaped by social forces. The paradigms within which scientific and medical researchers develop their work are influenced by social and political systems... and by the shared beliefs of the scientific community itself about what kinds of research questions, methods and knowledge are of value...Furthermore, the statistical methods and other technologies available to make discoveries related to the causation and prevention of illness are applied in ways that are determined by these contextual factors (Collings & Beautrais 2005, p.14).

The plethora of studies into suicide causation has a laudable goal of contributing knowledge to determine public policy to prevent suicide, and to give 'treatment' to those persons who are suicidal. My intent is not to suggest that this literature is not useful, but rather, to reiterate Collings and Beautrais' point that predominant suicide research is contextually situated within a 'scientific' medicalised discourse, and the results further add to this way of thinking about suicide prevention and treatment. This can be seen in the New Zealand Ministry of Health approach which has led to substantive reviews of causation of suicidality in New Zealand publications in recent years (Beautrais et al. 2005; Collings & Beautrais 2005). Beautrais et al. (2005) undertook an analysis of the available evidence of causation of suicide in order to advise the New Zealand Ministry of Health in guiding the New Zealand suicide strategy. The authors considered that:

> [While] there is no argument against suicide representing a complex set of variables ... a fundamental discovery was made in the late 1950s…: the majority of suicides were committed by people with clinical depression. This finding has been replicated over and over again and we believe that many, like us, have concluded that this connection has been replicated enough to be proven. We have also presented evidence that suicides occur infrequently in people with depression taking antidepressant medication…. Thus, in spite of the extreme complexity of the phenomenon of suicide, a simple and testable hypothesis can be stated: depression is a necessary cause of most suicides. Based on this proposition, it has been suggested that effective suicide prevention must focus on improving identification and treatment of depression in the population…. When we look at the declining suicide rates over the past decade or so, we see a great deal of support for that theory. (p.22).

Significantly. Beautrais et al.'s comprehensive review supports the need for the treatment of underlying mental illness as the basis of treatment by mental health clinicians, and this approach has underpinned New Zealand policy for inpatient treatment/care. Two New Zealand longitudinal studies (the Dunedin Multidisciplinary Health and Development Study and the Christchurch Health and Development Study) have revealed significant data about the mental health of local populations. Although these studies were not designed to specifically look at suicide, the findings, along with a suite of reports drafted by the New Zealand MoH, have utilised epidemiological data to identify risk amongst the population, and have formed the basis of the New Zealand strategies to prevent suicide. These initiatives include *The New Zealand Youth Suicide Prevention Strategy* (MoH 1999) and, more recently, *The New Zealand Prevention Strategy 2006-2016* (Associate Minister of Health 2006). The latter document outlines a multi-sectorial approach to suicide prevention, which attempts both to direct social policy initiatives that tackle causation of suicide, and indicates the need for the mental health clinical sector to engage with non-clinical agencies. This strategy cites improving the 'care' of people who have made a non-fatal suicide attempt as one of seven key strategies in a New Zealand wide approach to suicide prevention.

Most clinical treatment/care for suicidal people occurs outside of hospitals. Many suicidal people either do not seek treatment, or do so through private general medical practitioners or counselors. A smaller proportion will be seen by community clinical services, ranging from a ‘one-off’ consultation during a period of crisis to ongoing treatment for underlying mental disorders over a period of months to years. In New Zealand, population health, including public hospital treatment for suicidal patients, is the responsibility of District Health Boards [DHBs] (MoH 2014b). Although suicidal persons might be seen by any number of providers (including general medical practitioners and counselors), it is likely that when a consumer is thought to be at imminent risk of suicide, specialist community mental health crisis teams are called in to conduct an assessment of risk of suicide for the patient. Similarly, people who have made a suicide attempt or self-harmed and are admitted to emergency departments in public hospitals are seen by specialist mental health crisis teams. The purpose of these assessments is to determine:

- whether the person’s injury was caused by self-harm;
- how serious the deliberate self-harm was (including the seriousness of intent);
- the key precipitants to self-harm/ideation;
- the current level of risk;
- the urgency for assessment by mental health services; and
- the best way to keep the person safe and supported until further assessed (New Zealand Guidelines Group [NZGG]/ MoH 2003, p.25)

Once assessment has occurred, many people are supported as an outpatient (that is, they are not admitted to hospital). New Zealand clinical guidelines suggest that “a key factor in determining whether a person can be managed in the community or would benefit from a hospital admission is the person’s safety. In general, the most acutely suicidal people are best managed as inpatients” NZGG/MoH 2003, p.26). The guidelines indicate admission when there is a need for:

- medical management of an attempt
- more intensive psychiatric management (for example, acute psychosis)
- psychosocial support (for example, no suitable caregivers/support people are available). Serious consideration should also be given to the need for inpatient admission when:

- establishing a treatment alliance and crisis intervention fails and the person remains acutely suicidal, or
- the person has insufficient support to remain in the community. In this case, respite care options may provide the care needed to support the person through the immediate crisis (NZGG/MoH 2003, p.263).

Some people are admitted to mental health inpatient hospitals as a ‘voluntary’ consumer (not subject to compulsory assessment and treatment legislation). For another group of consumers, coercive assessment hospital treatment is instigated under The Mental Health Act (Compulsory Assessment and Treatment Act) 1992 (MHA). The MHA allows compulsory assessment and treatment of people who both have signs of a mental disorder (as stipulated in the act) and are considered a serious danger to self or others or have a seriously reduced ability to care for him or herself. The MHA defines mental disorder as an abnormal state of mind shown by delusions or disorders of mood, perception, volition or cognition (MHA 1992). Anecdotally, suicidal thinking is generally seen as a ‘disorder of mood’. Even though this is not a specific diagnostic category of mental illness, the use of a ‘disorder of mood’ to enable compulsory assessment and treatment is indicative of a prevailing association between mental illness and suicidality. In addition it allows for statutory coercion of people who may not have made an actual suicide attempt, moving the suicide treatment/care into the realms of risk.

McManus (2004) suggests that New Zealand suicide policy is predicated on ‘riskification’ (p. 199). McManus’ work is a decade old; however I have not been able to locate any updated analyses of New Zealand suicide policies, and my own readings of these suggest that her critique is still relevant. McManus considers that:

> We live in an age of suicide risk. In the preceding, medicalized [sic] mode of governance, the executive [that is, the New Zealand government, my notation] framed suicide as a problem to be dealt with upon ‘presentation’. People had to attempt suicide before the practices attendant to pathologization [sic] were visited upon them…Since the 1970s, however, the executive approach transformed to…anticipating [suicide attempts]. (p.199)

The examination of suicidal behaviours within a mental health and risk framework means that risk interventions must necessarily follow, as the presence of risk itself, rather than disease, is grounds for treatment (Shim, Russ & Kaufman 2006). Mental health risk assessments of suicidal consumers are seen as clinically necessary (NZGG/MoH 2003); however, risk assessment can only determine a *risk* of suicide, but cannot predict whether a particular individual will attempt the act (Sullivan et al. 2005). Although one of the most written about topics in mental health, little advancement has been made on the ability of clinicians to determine the risk of suicide with a particular consumer (Cutcliffe & Stevenson 2007; Smukler 2012). Cutcliffe and Stevenson (2007) suggest that the focus on risk assessments has translated into policies that emphasise this at the exclusion of more therapeutic interventions in mental health. This, according to Cutcliffe and Stevenson, has resulted in prevention polices that locate the 'problem of suicide' within individuals, locating the ability to 'cure the problem' with psychiatrists, and leading to ever more restrictive interventions (Cutcliffe & Stevenson 2007). Certainly small studies in New Zealand (Murtagh 2008) and Taiwan (Sun et al. 2006) suggest that nurses perceive their practices with suicidal consumers is limited by their perceptions of working within predominantly medicalised discourses of practice.

### 2.3.3 The acute ward environment

A second element that appears to construct nurses' practice with suicidal consumers is evident in literature: the acute ward structure and environment. Although inpatient units are meant to provide safety for suicidal consumers, the latest review I could locate suggests that there is ambiguity about whether acute mental health hospital suicide rates are increasing, decreasing, or remaining static (Bowers, Nijman, & Banda 2008). In an earlier review, Wolfersdorf (2000) hypothesises that the increase in inpatient suicides seen in the previous decade may be due to a number of issues, including changes in hospitals; a lack of structured activity in hospital wards; changes in consumer groups (including a possible increase in overall acuity of hospitalised consumers); altered societal attitudes towards mental health; depression caused by medications; 'forced' rehabilitation of some consumers; less time in units for suicidal patients; and greater periods of 'leave' whilst still an inpatient. Wolfersdorf points to some evidence for these contentions, and it appears likely that the issues he highlights will impact on nursing practice. Just how this occurs is, however, unclear.

Wolfersdorf's review suggests problems with the structure and purpose of acute mental health hospitals, and these issues have been the subject of a New Zealand evaluation report, *The Acute Crisis*, undertaken by the Mental Health Commission (O'Hagan, 2006). While the report examined other forms of mental health acute services (for example, respite services and day hospitals), it noted that acute inpatient units had never been formally evaluated for quality of treatment/care or for outcomes of practices in New Zealand. The report however suggested "…evaluations of similar services in other countries reinforce what we anecdotally hear—that acute inpatient services are often unpopular with service users [sic] and families, as well as staff who tend to find them stressful and unsatisfying to work in" (O'Hagan 2006, p.6). The description of New Zealand inpatient units identified in the report is therefore worth repeating at length:

> In New Zealand acute inpatient units are typically 15 to 60 bed wards on the sites of general hospitals with an institutional ambience. The older inpatient units are often run down, do not have single rooms and lack private living spaces. Dining is communal and the nurses' office is often placed strategically where they can view different corridors. Most inpatient units in New Zealand have seclusion rooms and secure areas for people in intensive care.
>
> The main interventions in acute units are medication and containment. Many people are there under the Mental Health Act and the vast majority are on medication. Typically, there are few other treatments or services available to people—such as peer support, advocacy, psychological treatments, or even staff members to talk to. Often there are not enough focused activities to keep people occupied (O'Hagan 2006, p.5).

In addition, the report suggested that acute mental health inpatient units are often overcrowded, with people being discharged too soon to free up spaces (O'Hagan 2006).

I located details (although not the original report) of one investigation into deaths by suicide in a New Zealand mental health inpatient unit (Otago Daily Times

2008). Professor Graham Mellsop led a team that investigated ward processes and treatment/care practices at one hospital after the deaths of three inpatient consumers by suicide in 2008. A number of recommendations for structural changes were given, including establishing more Intensive Care Unit beds for suicidal consumers, and better coordination of clinical multi-disciplinary teams. Additionally, Professor Mellsop suggested enhancing the clarity of models of treatment/care given. My reading of the recommendations (albeit without the ability to access the original report) is that some of the suggested changes should focus on clinicians increasing restrictive practices for suicidal consumers, without adding to therapeutic interventions.

Although somewhat dated, overseas literature suggests that practices of restrictive containment are the norm. The results from a South Australian Coroner's inquiry into inpatient suicide and a National Confidential Inquiry in the United Kingdom both suggest that "when it comes to the environment of inpatient care, there is still a focus on monitoring and control…" (Patfield 2000, p.371). Patfield suggests that the direction of mental health hospital wards produce environments that exacerbate feelings of despair and loneliness in suicidal consumers, rather than providing a therapeutic environment at a time when suicidal people need it most. One study investigating the impact of sentinel events (where unwanted serious outcomes, such as a consumer suicide, homicide, or serious assault, occur) on three wards in the United Kingdom showed that clinicians experienced negative emotional impact while risk assessments and containment practices increased (Bowers et al. 2006).

The ward environment appears to have an impact on the time nurses spend with suicidal consumers. Although this literature is again somewhat dated, research in Australia indicates that consumers highly value time spent with nurses (Cleary 1999), but time to be with consumers is diminished because of high workloads (Cleary 2004). This finding is supported by McLaughlin's (1999) research, that indicates that only 50% of suicidal consumers report daily contact with their nurses, and only a small proportion (38%) of that time is spent discussing the consumer's problems.

The literature, such as it is, indicates that the acute inpatient environment may be problematic for suicidal consumers. Although the literature could be improved by more current research, it does indicate that the environment may be a constructing element in nursing practice, although at the start of this study any relationship was not clear in the literature.

### 2.3.4 Nursing practice with suicidal consumers in inpatient units

Some small-scale qualitative studies into suicidal consumer' experiences of nursing treatment/care have been published, few of which are contemporary. Although the research occurred in disparate geographical locations, the findings are similar. Carrigan (1994) interviewed six hospital consumers who had been admitted for self-poisoning in an attempt to highlight their psychosocial needs. Although the study did not only focus on nursing, the findings resonate with other literature that does. Carrigan found that consumers have "the need to be loved" (p.641), to maintain self-esteem, to gain control of their lives, and to be supported, but concluded that these needs were rarely met by staff. The findings of a comparable study also emphasised the need for suicidal consumers to be well cared for and to receive understanding and confirmation of their personhood (Samuelsson et al. 2000). Reports from participants in this study suggested that a lack of such confirmation may have even been a contributing factor in later suicide attempts when they had requests for discharge denied, or felt their presence on the unit was burdensome to others. Similarly, Talsbeth et al. (1999) found that suicidal consumers who felt 'emotionally confirmed' by nurses gained hope, whereas those who did not experience such confirmation felt redundant as human beings. Fletcher (1999) and McLaughlin (1999) both undertook studies involving both nurses and consumer participants, with both confirming that consumers found nurse engagement to be vital to their sense of recovery.

A more recent study in Taiwan (Sun et al. 2006) of both nurses and consumer perspectives of nursing practice suggested that observation-focussed 'safe' practice could be prioritised without negating the importance of engagement with consumers. However this research has been critiqued as being simplistic and methodologically problematic (Cowman 2007; Cutcliffe et al. 2006; Lees 2013), with the implication that the positions of control of consumers through observation and therapeutic engagement have not yet been shown through research to be achievable aims of nursing.

Lees (2013) considers that Cutcliffe et al.’s (2006) grounded theory study of previously suicidal consumer’s experiences of mental health care to be seminal in that it “provides a substantive theory of how mental health nurses help facilitate the movement of a person from a death-orientated position to a life-orientated position” (Lees 2013 p.54). However, as Lees notes, it does not consider why nursing does not always follow such an approach.

The only New Zealand study showing consumers’ experiences that I have is a doctoral thesis by Brian Phillips (2004). Philips undertook interviews with four men who had been suicidal. Phillips found that contact with mental health services (not necessarily inpatient units) confirmed the participants’ experiences of past failures by diagnosing their experiences within a psychiatric framework that labelled their experience of being suicidal in a bio-medical way. Furthermore, the emphasis from health workers on the “need” to take medication as the primary form of treatment in order to “be normal” (p. 169) reinforced their self-view that they were ‘abnormal’.

One particular type of nursing practice with suicidal consumers is evident in nursing literature. ‘Observations’, in the context of practice with suicidal consumers, are a practice designed to prevent suicide by ensuring that the consumer is within visible sight of a nurse. The best evidence about the efficacy of observations comes from the *City 128* study in the United Kingdom. This showed, amongst other findings, that constant observations (where a nurse or other person is able to view a consumer continuously) does not reduce rates of self-harm. Intermittent observation (where a consumer is ‘checked-upon’ at frequent intervals), however, does have a positive relationship with self-harm reduction (Bowers et al. 2008). The evidence about observations was not available to inform the NZGG/MoH (2003) guidelines on treatment/care of suicidal consumers (including inpatient treatment/care).

Older research on observations has mostly taken place in the United Kingdom, and been largely limited to descriptive studies (with some exceptions). A postal survey of hospitals in the United Kingdom (UK) Goldberg (1987) found 92% used special observations for suicidal consumers. Another review of hospital records in a singular hospital (Goldberg 1989) found that 2% of consumers were on special observations at some point during their admission. Of these, 46% were placed on observation to primarily protect them from attempting suicide. I was unable to find any New Zealand data that shows either the prevalence of observations between hospitals, or within wards. Anecdotal evidence suggests that the majority of New Zealand hospitals (if not all) use observations.

There is little consistency with which clinicians can initiate observations, although the relevance of this research to New Zealand hospitals is hampered by the age of existing research, and the absence of New Zealand data. Golberg's (1987) study found that two thirds of nurses considered that their practice included the ability to initiate observations. In contrast, Duffy's (1995) grounded theory research in a UK hospital found that observations are usually initiated and terminated by medical doctors. There also appears to be variation in the actual practice of observation. Duffy (1995) interviewed ten registered nurses in one hospital and found that that some modified observations, despite policy direction about this practice. For example, policies stating that nurses should remain at 'arms-length' were not always followed. Some nurses considered that it was important to allow consumer privacy at certain times (for example, whilst toileting).

There are only a small number of studies that begin to determine the other potential benefits or drawbacks of observations. Moorhead et al. (1996) surveyed 68 consumers at two hospitals in England. Whilst just under half (45%) of the consumers surveyed noted discomfort during observation, none was actually asked how this discomfort was manifested, nor what, in particular, caused this feeling. Of more help is the report of a qualitative study of fourteen consumers under observation that showed that the interpersonal aspect of constant observation was helpful, with supportive interactions with staff enhancing feelings of hope and safety. In contrast, a perceived lack of support had a deleterious effect (Pitula & Cardell 1996). The same authors undertook a further qualitative study (Cardell &

Pitula 1999) with twenty hospitalised consumers, who indicated that the positive effects of observation were enhanced when the observers engaged them in interaction and displayed a positive attitude. Similar results were found in another qualitative study of consumers' experiences (Jones et al. 2000). Some nurses see periods of observation as times of therapeutic interaction with consumers. Cleary (2003) interviewed ten Australian nurses, who indicated that the therapeutic relationship and consumer safety were both of vital importance during these periods. However, other research suggests that the coercive nature of observations can make therapeutic interactions problematic. Interviewees in Duffy's (1995) research found it difficult to have conversations with consumers because of the paternalistic stance of observation. Instead they used the time to assess consumers' mental status, to modify behaviour, and use distraction techniques (getting the consumer to focus on something other than their suicidal thoughts).

Horsfall and Cleary (2000) used discourse analysis methods to critique nursing's involvement with the practice of observations. They found that some of the assumptions underlying the practice were problematic. These included the association of observations with forced detainment when suicide itself is not illegal; the assumption, without research evidence, that observations are efficacious in preventing suicide; and that observations are premised on a need to provide protection of consumers, rather than any facilitation of a therapeutic relationship that emphasises consumers' emotional state. This later theme is emphasised by Cutcliffe and Barker (2002) who consider that actions such as observations have eroded nursing care, and do not meet the needs of consumers' physical or emotional safety. Similarly, Cutcliffe and Stevenson (2007, p.29) consider observations to be "a crude, 'custodial' orientated form of intervention" that does little to meet the needs of suicidal consumers.

The nursing literature on practice with suicidal consumers is quite sparse, with most emphasising risk minimisation interventions. This emphasis is also prevalent in general mental health nursing texts that I examined for this study. Morrison (2013), for example, discusses crisis management and persons at risk of suicide, whilst only briefly stating the need for nurses to work with the feelings of consumers. Perhaps unsurprisingly in a general text, how this can be done is not addressed. The only general mental health text I have found that emphasises the ways nurses can actively intervene is Barker's *Psychiatric and Mental Health Nursing: the Craft of Caring* (2009). In it, the chapter by Santa Mina and Gallop emphasises the need for nurses to promote safety; however it also directs nurses to explore suicidal consumers' precipitants to suicidal thoughts and plans, and to promote alternative coping strategies. In a similar vein McLaughlin's 2007 *Suicide-Related Behaviour: Understanding, Caring and Therapeutic Responses* and Cutcliffe and Stevenson's *Care of the Suicidal Person* (2007) are texts (the latter based on a 2006 grounded theory study) that emphasise the need for therapeutic responses from nurses' with suicidal consumers. McLaughlin (2007) gives examples of the ways that nurses should actively intervene by helping with problem management and actively challenging negative cognitions of suicidal persons. Cutcliffe and Stevenson (2007) show how nurses can help move suicidal consumers from 'death orientated' positions to 'life orientated' ones, and reconnect the person to humanity. Apart from Santa Mina and Gallop's (2009) necessarily brief chapter, McLaughlin (2007) and Cutcliffe and Stevenson (2007) were the only written works I could locate that emphasised active therapeutic nursing with suicidal consumers.

### 2.3.5 Nurses' attitudes, emotional responses and educational preparedness

There are few studies that investigate mental health hospital nurses attitudes towards suicidal consumers, and most of these were undertaken some time ago. Some use questionnaires with a variety of suicide attitudinal scales. An early survey indicates that hospital psychiatrists are more empathetic than nurses (Ramon & Brater 1978). Gender, age differences, and frequency of clinical contact were found to be significant determinants of nurses' understanding of suicide in a survey of 197 nurses in a number of mental health settings (Samuelsson et al. 1997). Women, older nurses, and nurses who worked in areas where contact with suicidal people was frequent (such as acute hospitals) were seen as more sympathetic. Conversely, consumers who displayed anger were seen as less deserving of nurses' sympathy. Other qualitative studies found that nurses viewed suicidal consumers positively (Long & Reid 1996; Talseth & Gilje 2011; Talseth et al. 1997), with only one showing that nurses saw suicidal consumers as a label associated with stereotypical behaviours that can be applied to individuals (Carlen & Bengstsson 2007). These results may give some insight into a relationship between nurses' attitudes and their practice with suicidal consumers.

Other studies identified nurses' personal responses to caring for suicidal consumers. These included finding the work distressing at times (Carlen & Bengstsson 2007; Cutciffe et al. 2006; Long & Reid 1996; Talseth & Gilje 2011; Talseth et al. 1997), could cause feelings of despair (Gilje & Talseth 2007; Long & Reid 1996) and anger (Carlen & Bengstsson 2007); and difficulties in negotiating the boundaries between being close to suicidal consumers whilst maintaining a professional distance (Talseth et al. 1997). Like nursing attitudes, it is unclear how personal responses affect practice, if at all.

The research evidence indicates that nurses may require educational preparation to help them understand the actions of suicidal consumers and the emotional responses that nursing such consumers can bring. Despite this, some nurses feel unable or educationally unprepared to care for suicidal persons. One study found that that 38% of nurse participants felt unable or unprepared in caring for suicidal people (Reid & Long 1993). Ramberg and Wasserman (2003) undertook a random survey of 1543 hospital clinicians, including nurses. Most (74%) psychiatrists considered they were sufficiently trained, although fewer nurse and nurse assistants considered their own education adequate (43% and 35% respectively). Similarly, a Swedish survey of 191 nurses found only a quarter (25%) thought their training was adequate (Samuelsson et al. 1997). Other studies found that nurses have limited education to prepare them to work with suicidal consumers (Meerwijk et al. 2010) and that nurses considered themselves to be powerless to influence the overall treatment of suicidal consumers due to insufficient education in suicidology and lack of nursing competencies in this area (Sun et al. 2006).

Taken together the research evidence about attitudes, emotional responses and limited educational preparedness indicates that these might be factors that construct practice. However as I have noted, the evidence about how these 'play out' in practice did not exist at the beginning of this study.

## 2.4 Conclusion

The literature that directly shows what constructs nursing practice is sparse, and usually focuses on barriers, without an attendant understanding of what might support practice. The methodologies used in these studies also do not allow an understanding of how construction translates into practice. Overall the research evidence for what constructs nursing practice is weak. However there are predominant themes in the broader literature that are suggestive of significant issues that might influence how practice comes about.

Clearly the research question underpinning this thesis, “how is nursing practice with suicidal consumers in acute mental health inpatient units constructed”, had not been sufficiently addressed in the literature. The next chapter of this thesis describes the theoretical framework that enabled me to answer that question.

# Chapter Three: Theoretical framework

## 3.1 Introduction

The methodological and theoretical framing of a research study is an important factor in the production of a final research product. These provide epistemological and ontological ways of considering approaches to the research process, and ensure the use of consistent methods. In this chapter I discuss the methodology of critical ethnography, and the theoretical framework provided by selected works of Pierre Bourdieu (1977; 1979/1984; 1990; 1997/2000; 1998; 2001). I consider how these fit together, and how they are applied in this thesis.

## 3.2 Methodology used in this study: Critical Ethnography

Critical ethnography is a methodology that, in this thesis, allows an examination of what constructs practice. In this section I briefly discuss significant movements in ethnography after the 1930s to identify key epistemological issues that are important in this thesis.

### 3.2.1 Ethnography – An Overview

A prime goal of ethnography is to describe a culture within a bound setting, with the purpose of making "the familiar strange, the exotic quotidian [commonplace]" (Clifford 1986, p.2). As this section shows, the idea of culture and how to describe it is problematic, and has been a focus of significant stages in the history of ethnography. Although ethnography has been associated with the disciplines of anthropology and sociology, ethnography is also utilised by researchers from other disciplinary backgrounds. A risk of this utilisation, however, is that ethnography is used as a set of methods, set apart from the political and philosophical nuances underpinning the approach. Although these underpinnings are complex and sometimes contradictory, it is vital that these are understood so that a consistent and reflective positioning of the methodology, including that of the place of the researcher, can be articulated.

After the 1930s, ethnographic writings were influenced by functionalism and the consequential focus on the method of data collection. Academic dialogue was primarily focussed on the machinations of ethnography (Denzin 1997). According to Denzin, attempts were made to formalise the techniques of qualitative research, notably (but not exclusively) in Glaser and Strauss' (1967) formulation of grounded theory. The formalisation of qualitative methods reflected a focus on methodological rigour with the "rhetoric of positivist and post positivist discourse" (Denzin 1997, p.63). The perceived link between rigour and objectification meant that ethnographers were viewed as scientific (and hence objective) gatherers of data who conveyed a truth about the cultures or institutions they researched. Texts from this time were presented as objective truths, with the researcher largely, or wholly, absent. Focussing on ethnography as merely a methodological technique has been described as behaviourist, functionalist, and positivist (Denzin 1997). Such a focus deflected the disciplinary gaze from the role of the ethnographer. Identifying this as problematic, Geertz (1973) introduced the concept of 'textualisation' into anthropological work. Textualisation suggests that the written word is needed for any reader to interpret ethnographic findings since writings are a step away from immediacy of the discursive experience of the researcher (Clifford 1988). Behaviours, such as the speech of those under study, are put into text form by the researcher and through this a reader experiences the field. However, for a reader to understand the essence of texts, they need to be detailed, localised, and be context bound (Emerson et al. 1995). The writing of such text is known as 'thick description' (Geertz 1973), allowing readers of texts to understand both what was occurring and the processes that led the researcher to, for example, include or exclude information in the final written product.

Geertz's (1973) considerations of the contextual nature of behaviours led to a disciplinary reflection upon ethnographic practice and the notion of culture. The influence of a multitude of ideas from other places (for example, sociology, phenomenology, structuralism, and the Frankfurt School of critical theory) resulted in what Denzin (1997) has termed an era of 'blurred genres' in ethnography. According to Denzin, the influence of these various paradigms, strategies, and methods caused the demise of the predominance of the functionalist model of ethnography. This instead gave way to a pluralistic notion that all work, rather than being ‘true’ because of the usage of ‘objective’ methodological techniques, are in reality, researchers’ interpretations. Attention was increasingly focussed on the nature of discourse as a marker of culture and as a representative of the production of text by the ethnographer. The concept of symbolic interaction dominated theoretical structuring of much ethnography of these periods. Symbolic interaction focuses the researcher to identify the way that people make sense of social interactions and the interpretations they make of social symbols (Huber 1973; Polit, et al. 2006). The usage of symbolic interaction requires that culture be interpreted through detailed analysis of the parts and the form of everyday interactions between persons within that culture (Peacock 1986). The language used by and between participants is considered a primary source of data for the researcher. Language, like other symbolic interactions, is viewed as often being a metaphor for other functionings of the society and therefore open to interpretation by the researcher (Clifford 1986). The link between experiences and expression, though, is problematic, as the original experience can never be recaptured (Denzin 1997). These experiences can instead be seen as analogies (Bruner 1986), with final texts being constructed by the positioning of researcher (Crapanzano 1977).

Academic questioning of the place of discourse in ethnographic writings brought about a return to a focus on the place and voice of research participants, including the ethnographer him or herself (Denzin 1997). The ethnographer, rather than being considered an objective conveyer of a discernable truth, was instead seen as principal in the construction of texts. The reflexive positioning of the researcher within textual constructions became important in ethnographic writing. Reflexivity positions the writer not only by the way texts are written (for example, by the use of the pronoun ‘I’ in places), but also by making explicit the writer’s experiences in determining and refining the inquiry and the problems they faced in the field (Denzin 1997). The acceptance of the need for researcher reflexivity was recognition of the inter-subjectivity of the experience of field work. Researchers could no longer be seen to be able to capture lived experience or culture. The notion that text and author were separate, with the trained researcher mirroring the world, “clinging to a ‘world-out-there’, that is truthfully and accurately captured by the researcher's methods" (Denzin 1997, p.6), was considered flawed. Denzin notes that "representations and speech do not mirror experience: they create experience and in the process of creation constantly transform and defer that which is being described" (p 5).

Questions arose over who was being privileged by the constructed texts of the researcher, especially with the positioning of class, gender, and race when most ethnographers were middle class, male, and white. Criticism coincided to some degree with an emergent (from the period beginning in the 1950s) critique of colonialism, as the portrayal of cultures as the 'other' by a (usually) European outsider (Clifford 1988). Said's (1978) text *Orientalism* was seminal in its influence on casting doubt on procedures based on a Eurocentric gaze (Clifford 1988), recognising that "enduring power inequalities had clearly constrained ethnographic practices" (Marcus & Fischer 1986, p 8). Said (1978) argued that a history of European colonial rule had influenced the way in which academic authors had represented persons from colonised localities. Ethnography, like other academic methodologies, was seen to have interpreted the culture of 'others' through such a lens.

The questioning of the privileged position of the ethnographer's viewpoint came to be known as a 'crisis of representation' for ethnography (Denzin 1997; Marcus & Fischer 1986). Whilst the issue of representation of subjects' views had previously been legitimised by using techniques with methodological rigour (such as triangulation and member-checking), post-structural critiques of ethnography challenged these claims (Clough 1992; Denzin 1997). Agar (1996) argues that 'representing' culture became problematic because of the recognition that outside forces are crucial in the way that local communities operate. Such attention to the content of ethnographic studies was indicative of a shift away from issues about methodological process to epistemological concerns, a focus that is still somewhat prevalent in ethnographic discussions today.

### 3.2.2 Ethnography Now

The ‘crisis of representation’ in ethnography has led to a position where “paradigms of experience and interpretation [from the perspective of the researcher] are yielding to discursive paradigms of dialogue and polyphony [multiple voices]” (Clifford 1988, p.41) in representing cultures under study. Whilst there is no longer a singular view of a standard structure of ethnographic text (Denzin 1997), contemporary ethnographic writings are commonly discursive and concerned with context and interlocution of researchers and participants. Research is not a neutral activity, and researchers cannot presume to present an objective world. Rather, the world represented in texts is an interpretation shaped by researchers’ values and by particular participants (Wolcott 1999). Ethnographic researchers generally consider culture from particular theoretical frameworks, rather than describing a culture from a neutral position (Wolcott 1999). Whilst customs, conventions, practices, and traditions are (albeit interpretable) observable behaviours, culture is not considered a sum of such behaviours but rather “shared understandings that guide and are expressed in behaviours” (Peacock 1986). Because there is no singular way in which people in cultures think (Wolcott 1999), ethnographies, and the culture described therein, are considered only ever to be representations of culture (van Maanen 1988).

### 3.2.3 Critical Ethnography

Wolcott (1999) suggests that early ethnographers were, to some degree, “romantic optimists” (p.183) who positioned participants as admirable ‘underdogs’ (Quartz 1992). This positioning was influenced by the context of the time, with ethnographers trying to rise above that which offended or bothered them. In contrast, critical ethnography focuses on these very issues in an effort to make visible why a culture is organised in a particular way. Critical ethnographies almost always include an analysis of power relations (Thomas 1993), often with a Marxist edge (van Maanen 1988; Wolcott 1999). Not all critical ethnographers accept the Marxist notion that economic factors dictate all others (Kincheloe & McLaren 2005), with many researchers viewing power relationships between individuals and groups as ambiguous. In this view all groups and individuals are simultaneously ‘empowered’ and ‘disempowered’. Relationships are contradictory and complex, with some people being both super-ordinate and subordinate to others (Quantz 1992).

Denzin (1997) suggests that "a good critical, emancipatory, standpoint text is one that is local, multivocal, collaborative, naturalistically grounded in the worlds of lived experience, and organised by a critical, interpretive theory" (p.67). Whilst the results must be grounded in data, "… data become[s] meaningful to the researcher only when the researcher brings a theoretical focus to it" (Quantz 1992, p.459). Central to this is the notion that data is produced, rather than just collected by researcher, by looking "…for patterns of social domination, hierarchy, and social privilege [the researcher] examines the power that holds patterns in place, [and] how people accept or struggle against them" (Agar 1996, p.27). Cultures being studied are therefore represented with such critical elements at the forefront.

### 3.2.4 The use of critical ethnography as a methodology for this thesis

In undertaking this study I have attempted to elicit an understanding of the factors by which the practice of nurses are constructed. By using critical ethnography as a methodology I believe I have been able to expose not only what nurses do, but the factors that shape practices. As I show in chapters five to eight, practices occur within a variety of cultures that nurses are both part of, and contribute to. These cultures are, in turn, shaped by socio-political factors. Using critical ethnography as a methodology allowed me to ask questions of what was occurring when I was on site, what the data meant, and why things occurred in the way they did. This was particularly helpful in considering complex relationships between nurses, consumers, and members of other health disciplines. It also helped make sense of how teams and wards viewed the purpose of inpatient treatment/care, and what nurses' practices should consequently be. A critical understanding of power relationships also partially helped explain why nurses responded to the shaping of practice in different ways; as I show in the next section, considering the data through a theoretical framing of both critical ethnography and particular works of Pierre Bourdieu further supported an understanding of why nurses responded differently to dominant cultural beliefs, and in turn produced different practices with suicidal consumers.

Researchers using critical ethnography cannot but take a philosophical stance on the research, and in understanding and writing about culture. Accordingly, Quantz (1992) considers it tautologous to even question whether critical ethnographers impose their values on research. He suggests that the key issue for critical ethnographers is to make explicit the implications of these values in research. In outlining the research question at the centre of this study in chapter one I showed that my observations as a nursing lecturer, anecdotal information from colleagues in mental health practice, and my own previous research experiences had led me to the research question. I am aware that I have always valued the place of building therapeutic relationships with consumers (including suicidal ones) in practice, to make them feel supported and to sometimes allow this relationship to be the basis of some psychological work with them. This value is important to acknowledge, as it did have the potential to influence both the way in which I gathered data (for example, by possibly privileging some interview questions over others, or to interpret some practices as 'better' or 'worse' than others). My own value base also may have affected the way that I interpreted collected data, for very similar reasons.

My initial hunch was that practice would have been largely shaped by a combination of fears about the consequences if a consumer completed a suicide whilst in an inpatient unit, and the privileged position of psychiatry and psychiatrists to determine the treatment for this group of consumers. I suspected that these two issues would be fundamental in creating ward cultures, and these in turn would be constructing elements of nursing practice. In chapter four I show that these hunches led to some initial interpretations of the data that I latter dismissed. This is not to say that critical ethnography was the wrong choice of methodology; on the contrary I am convinced that it was a very useful one. Instead, as I show in the next chapter, remaining cognisant of the risks of a singular viewpoint and following the tenets of good data analysis led to a consideration of power issues in a different way.

I have woven reflections on the interrelationship between the research interpretations and my own values system through this study. I have attempted to ameliorate the effects of these values by taking the advice of Emersen et al. (1995) who suggest that research findings must be grounded in data. As Thomas (1993) notes:

> … there is difference between values of the researcher and assuming the research itself has values. The lesson for critical ethnographers is profound, but not complicated: We let the data speak to us, we do not prejudge or impose our preferred meanings, and we make sure that we do not say *is* when we mean *ought*. (p.22, original author's emphasis)

Reflexive ethnography still cannot help but privilege the writer (Denzin & Lincoln 2002), as the writer ultimately produces the finished product. This position is similar to Moore's (1994), who suggests that "the anthropological self… is one made up through projection and interjection" (p.6). With this in mind, throughout this thesis I have used the pronoun 'I', as well as giving some comment on the experience of the research. In doing so, I have attempted to acknowledge my own position as an interlocutor in the research experience and recognise that my positioning is important where it has relevance to the data, and in the process of writing a thesis. In this study I attempt to research in a manner consistent with critical ethnography, and to write in a reflexive way. I have, however, attempted to strike a balance in the rest of this thesis between demonstrating my position as a researcher without overstating this. As Marcus and Fischer (1986) note:

> There is a tendency to dwell on the experience of fieldwork and its problems. The pleasure in relating fieldwork experience can be overplayed, to a point of exhibitionism, especially by writers who come to see reflexive meditation as not only the means but the point of writing ethnography (p.42).

The research question underpinning this study was "how is nursing practice with suicidal consumers in acute mental health inpatient units constructed?" The methodology of critical ethnography has supported an examination of ward and team cultures, a consideration of the complex role of power within and external to cultures, and how nurses accept or struggle against power. In the next section I show how selected works of Pierre Bourdieu (1977; 1979/1984; 1990; 1997/2000;

1998; 2001) provide a theoretical framework that is consistent with the principles of critical ethnography, and assist in a deeper understanding of how nursing practice is constructed.

## 3.3 Theoretical interpretation using selected works of Pierre Bourdieu

### 3.3.1 Introduction to this section

The analysis of research data, especially qualitative data, usually requires a theoretical framework to assist in explicating what the data means. The issue of ‘why’ practice is constructed in certain ways draws heavily on practice theory, in particular the works of Pierre Bourdieu (1977; 1979/1984; 1990; 1997/2000; 1998; 2001). This section outlines this work, and how it is be used in this thesis. I have given some brief examples from this thesis alongside some of Bourdieu’s concepts. This is done only to be indicative, rather than intimating that the concepts will be used separately. On the contrary, it is a more complete practice theory that helps make sense of the data in the discussion chapter. I also show how Bourdieu’s works are consistent with critical ethnography in eliciting understandings of the role of power in creating and reproducing cultures, and structural inequalities that create dispositions towards power. The concept of dispositions is key in Bourdieu’s work, as it indicates both why individuals or groups behave in particular ways, and how they act (Bourdieu 1977).

My understanding of Bourdieu’s works has been heavily influenced by readings of secondary sources that both summarise and explicate his theories. While I have read the original Bourdieu texts (in the English translations) I use throughout the thesis, my understanding was guided by the secondary sources I have also identified. As a novice researcher (and someone relatively new to reading social theory), these latter sources were very helping in being able to use Bourdieu’s works to better understand the data I gathered. However the theoretical conceptualisation is, necessarily, an interpretation (mine) of interpretations of Bourdieu.

Bourdieu’s works can be seen as a theory of practice, where theoretical reflexivity and research practice are combined in the production of bodies of work (Webb et al. 2002). Bourdieu considers that the locality of social research is constituted through the behaviours of people within the history of that group (Bourdieu 1990), making Bourdieu’s theoretical work an appropriate reference through which to analyse what constructs practice. Although the complexity of Bourdieu’s work makes summary difficult (Swartz 1997), this section outlines some of his main theoretical concepts in order to position these in a way that is useful in understanding their use in the later chapters of this thesis.

### 3.3.2 Bourdieu’s theories used in this thesis: An overview

Pierre Bourdieu produced an influential body of work of cultural theory from ethnographic and sociological work in Kabylia, Algeria and, more latterly, in France. Bourdieu’s research across an eclectic range of interests led to a formulation of theory examining the relationship between power and social structures, culture and the actions of individual agents (people) and groups. For Bourdieu (1977; 1990), the acquisition of power is central to all social life. It can be seen in the accumulation, or attempts at accumulation, of cultural symbols and practices, and is intrinsically enmeshed in the accumulations of different types of capital (discussed later in this chapter) for “the struggle for social distinction” (Swartz 1997 p.6). Bourdieu’s writings consider what practices are and, in particular, the way that “social structure tends to perpetuate itself” (Bourdieu 1998, p.19), often reproducing subjects and subjectivity. Bourdieu’s works reveal an “underlying preoccupation ... [with] the question of how stratified social systems of hierarchy and domination persist and reproduce inter-generationally without powerful resistance and without the conscious recognition of their members” (Swartz 1997 p.6), and as such is consistent with the principles of critical ethnography. Bourdieu explored this phenomenon by examining how “cultural resources, processes and institutions hold individuals and groups in competitive and self-perpetuating hierarchies of domination” (Swartz 1997, p.6). In short, Bourdieu was interested in how reproduction of practice occurs.

Bourdieu’s work focuses on the social structures that encourage reproduction, and as such have been criticised for being determinist and not recognising the place of the agency of individuals (King 2000). Bourdieu argues against such criticisms and suggests that practices of individual agents are not mechanistic responses (Bourdieu 1977) and similarly, the structures that influence responses are “not immutable” (Bourdieu 1998, p.32). Nevertheless, Bourdieu considers that the actions of actors are not the product of a ‘free will’.  As Swartz (1997, pp.8-9) states:

> He [Bourdieu] argues against conceptualizing [sic] human actions as a direct, unmediated response to external factors, whether they are identified as micro-structures of interactions or macro-level cultural, social, or economic factors. Nor does Bourdieu see action as the simple outgrowth from internal factors, such as conscious intentions and calculation, as posited by voluntarist and rational-actor models of human action. For Bourdieu, explanations that highlight either the macro or the micro dimension to the exclusion of the other simply perpetuate the classic subjective/objective antinomy. Bourdieu wants to transcend this dichotomy by conceptualizing [sic] action so that micro and macro, voluntarist and determinalist dimensions of human activity are integrated into a single conceptual movement rather than isolated as mutually exclusive forms of explanation. He thus proposes a structural theory of practice that connects action to culture, structure and power.

Bourdieu sees strengths in both objectivism and subjectivism as ways of explaining social practices, yet was critical of either as a useful totalising theory. The most understood theory of objectivism is structuralism (Webb et al. 2002), and has been practiced in almost all social sciences. In structuralism “the view [is] that the world is organised according to structure-rules, systems and forms-and these make meaning possible (Webb et al. 2002, p.xv). Bourdieu (1990) considers structuralism useful in eliciting an understanding of how structures affect individuals, and the way those individuals then experience the world. This concept is useful when I later consider the way that *some* (but not all) groups of nurses in this study experienced working with suicidal consumers.  Additionally, structuralism is useful in considering that ideas and objects only have meaning because of their relationship to each other, rather than having meaning intrinsic in themselves (Webb et al. 2002). I draw on this concept when describing the possible meaning of some of the cultural markers within wards.

Whilst Bourdieu (1990) considers structuralism useful when considering a deterministic dimension to social practice, he also suggests that structuralism did not provide an explanation of the various ways in which agents inhabit such structures, nor offer explanation for how some avoid or circumvent structures in change. Further, structuralism in itself, in Bourdieu's opinion, is unable to offer an explanation for how changes occur over time. Subjectivity is the notion that social reality is created by competent agents who construct their world through artful practice in everyday life (Webb et al. 2002, p.32). Bourdieu (1990) rejects a pure understanding of subjectivity, where agents are considered free to negotiate their way in the social world. Instead he saw a middle ground between subjectivity and objectivity, where individuals' actions are ameliorated by external structures. Bourdieu views subjectivism as useful in the consideration of the ways in which agents circumvent the structures imposed on them, for example the way agents act in the face of rules and laws, spoken and unwritten. He does not consider that people are dupes who mindlessly succumb to the wills of external structures. In other words the notion of subjectivity was useful in explaining the practical, everyday ways in which people cope in the world. In this 'middle ground' individuals' actions are seen as neither a pure product of structure, nor the stemming from free-will. This issue, central to Bourdieu's work, is articulated by Swartz (1997):

> A central issue sets the agenda for Bourdieu's theory of practice. How is action regulated; how does action follow regular statistical patterns without being the product of obedience to rules, norms or conscious intention? How do regular patterns of conduct occur over time without being the product either of some abstract external structure or of subjective intention? How can one take into account both the observed regularities of social action, which most frequently are visible only to the social scientist who takes the time and effort to calculate them, and the experiential reality of free, purposeful, reasoning human actors who carry out their everyday actions practically, without full awareness of or conscious reflection on structures? Moreover, how does one scientifically model practice without projecting the formal characteristics of the model onto the informal and dispositional dynamics of most every day practices? Bourdieu tries to find a scientific language that does justice to these conceptual dilemmas. Two key concepts permit Bourdieu to do this: habitus and field. (p.95)

Eliciting an understanding of how practice comes about, central to Bourdieu's work, is consistent with critical ethnography. In the latter, examinations of the complexities of power relationships within cultures are central to understanding why individuals practice in particular ways. Bourdieu extends these understandings of power within cultures to show how these are operationalised. The mechanisms for this are discussed in the next sections.

### 3.3.3 Bourdieu's concept of Habitus

Habitus is one of Bourdieu's foremost theoretical constructs. This attempts to explain how individuals "become themselves" (Webb et al. 2002 p.xii). Individuals are not purely the product of structure, nor do they entirely have a free will. Rather they are born into existing social systems that are located by the historical positioning of structures. Those structures are internalised by individuals and become part of the way attitudes and dispositions are learnt. Habitus "derives from the predominantly unconscious internalization [sic], particularly during early childhood—of objective chances that are common to members of a social class or status group" (Swartz 1997, p.104). Although the habitus of an individual can evolve and change, the world is mediated through categories formulated by socialisation, and actions are likely to be reproductive.

Habitus is a construct that attempts to explain dispositions to action of individuals. Bourdieu (1979/1984) describes habitus as:

> The structures constitutive of a particular type of environment (e.g. the material conditions of existence characteristic of a class condition) produce habitus, systems of durable, transposable dispositions, structured structures predisposed to as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively "regulated" and "regular" without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of the conductor. (p.72)

Habitus moulds the actions of actors to act within ways that pre-existing opportunities are perpetuated (Bourdieu 1977; 1990). Future actions by individuals are heavily influenced by past experiences, which were in turn influenced by structures present at that time. Rejecting a purely free-willed actor model of social practice, Bourdieu (1990) suggests that “unlike scientific estimations, which are corrected after each experiment according to rigorous rules of calculation, the anticipations of the habitus, practical hypotheses based on past experience, give disproportionate weight to past experiences” (p.54).

Habitus lays a foundation for future actions of an individual by eliminating the possibilities of choice that individual might make. Bourdieu (1990) argues that determinism and freedom of choice are regulated by “dispositions durably inculcated by the possibilities and impossibilities, freedoms and necessities, opportunities and prohibitions inscribed in the objective conditions” (p.54). These dispositions are “objectively compatible with these conditions and in a sense pre-adapted to their demands” (Bourdieu 1990, p.54). Individuals may have ‘choices’ in ways of acting in particular situations. However, these choices are limited by the past experiences of that individual (which are influenced by structures) and by current structures in which that individual operates. Therefore individuals’ actions are moderated and the most improbable practices (for that individual) are excluded, meaning that habitus is generative of future dispositions. This process is likely to occur without the conscious knowledge of the individual.

In chapter eight, I consider how the individual habitus of nurses (and of nursing as a group) meant that they were more likely to have been disposed to ‘allow’ the structuring influences on their beliefs about suicide and what practice should be, than nurses who resisted dominant views (and practiced differently). As I noted earlier in this chapter, critical ethnography allows a consideration of how individuals or groups practice in ways consistent with the dominant culture, or struggle against domination (Agar 1996). Bourdieu shows how this can occur when structural inequalities create dispositions that make it harder for an individual to consider actions outside of what they know, something that can be described as a false consciousness or ‘illusio’. Such views are often ‘unconscious’, ‘self-evident’ processes that allowed nurses to take a ‘common-sense’ view of what practice should be. Taken for granted, embodied views are what Bourdieu (1990) called ‘doxa’, which were seen as a product of individuals' habitus. In turn, doxa allows individuals to have a ‘feel for the game’ that means that they can easily practice comfortably in certain ways. These concepts are vital when I later explore why some nurses considered their practice to be the only feasible approach, whilst others undertook practice in very different ways.

### 3.3.4 Bourdieu’s concept of Field

Bourdieu’s concept of field is intrinsically connected with habitus, as fields are the place where individuals’ habitus are played out in social actions. Within the field, people struggle for power and control. The social field many be a defined physical area; however it more commonly transcends physical boundaries. An example of a field is the discipline of suicidology, where there are a series of orthodoxies about what constitutes common or taken for granted understandings. As such, Bourdieu’s concept of field may differ from the ethnographic field, such as the four sites for this study, which are bound physical areas where data is collected.

Society, in Bourdieu’s view, is merely a summation of fields. Bourdieu (1998) described this when stating:

> …what I mean when I describe the global social space as a field, that is, both as a field of forces, whose necessity is imposed on agents who are engaged in it, and as a field of struggles within which agents confront each other, with differentiated means and ends according to their position in the structure of the field of forces, thus contributing to the conserving or transforming of its structure. (p.32)

Such confrontations between agents (individuals) for control of power occur in fields that are denoted by “arenas of production, circulation, and appropriation of goods, services, knowledge, status, and the competitive positions held by actors in their struggle to accumulate and monopolize [sic] these different kinds of capital” (Swartz 1997, p.117). As such fields are relational, where individuals or groups “exist and subsist in and through difference; that is, they occupy relative positions in a space of relations which, although invisible and always difficult to show empirically, is the most real reality” (Bourdieu 1998, p.31). Because of this Bourdieu considers that social scientists should not construct social classes, but rather consider (and research) the spaces (fields) in which conflict occurs. Researchers, therefore, should "… seek out underlying and invisible relations that shape action rather than the properties given in commonsense categories" (Swartz 1997, p.119). The field is the place where these relationships of conflict can be examined by the researcher. Bourdieu (1998) is also cognisant of research and research process in themselves being fields of conflict, and as such drew attention for the need for reflexive practice.

Although the concept of a field may be suggestive of clear boundaries, the contrary is in fact true. The conflicts between defining of fields by actors within fields are a point of interest for Bourdieu (1998). For example, in a study such as this, the conflicts are around what is or isn't defined as suicide, or suicidal behaviours, and who controls such decisions, may have been a point of research. Bourdieu considered the concept of field to be superior to that say of institution, because the former suggests conflict whereas the latter (falsely) suggests consensus (Swartz 1997). Bourdieu (1990) considers fields to be arenas where individuals play out struggles for resources in the form of capital, which can be in the form of economic, cultural, scientific or religious capital. Different persons and groups attempt to be legitimised and gain resources in the form of further capital. The amounts and types of capital determine positions of subordination and domination in the field (Bourdieu 1990). Individuals or groups use field strategies of either of what Bourdieu calls 'conservation', 'succession', and 'subversion'. Conservation is utilised by those who are dominant and seek to maintain the status quo, whereas succession refers to strategies of those attempting to access dominant positions. A third group are those who have little expectation of access to dominance, and who use strategies of subversion (Bourdieu 1990). Such strategies may be subtle but are influenced by person's habitus, and are linked with existing and desired capital, and can be seen when examining fields of power.

Critical ethnography privileges an examination of power relationships within cultures as a focus of research. Using Bourdieu's works in this thesis allows an examination of the processes of how power affects ward and team cultures and nursing practices, and how (as I discuss in chapter eight) these are often reproduced. Reproduction of power and elites is, according to Swartz (1997), a unifying theme in all of Bourdieu’s works. Reproduction re-instills, without challenging the status-quo, power in individuals and groups, and contributes to a dominance of particular ideas. The processes of reproduction both in understandings of consumers’ suicidality in inpatient mental health units and the nursing practices that are related (or, less often, are in opposition to) are ones that are explored in the discussion chapters later in this thesis.

### 3.3.5 Bourdieu’s concept of Capital

Tied to the concepts of habitus and field is a third theoretical notion, that of ‘capital’. As noted in the last section, capital is closely enmeshed with the idea of field. Within fields various persons or groups vie for positioning both by using capital and by gaining it. Capital is a notion of ‘accumulated labour’ (Bourdieu 1979/1984) similar to the Marxist concept of the same name. Capital symbolises power “over the accumulated product of past labour ... and thereby over the mechanisms which tend to ensure the production of a particular category of goods and thus over a set of revenues and profits” (Bourdieu 1991, p. 230). Although Bourdieu uses, in this instance, economic explanations for capital, he differs from Marx by not limiting the concept to that of economics. Swartz sums these explanations up when stating:

> Labour can be embodied in a wide variety of forms though Bourdieu …generally speaks of four generic types of capital: economic capital (money and property), cultural capital (cultural goods and services including educational credentials), social capital (acquaintances and networks), and symbolic capital (legitimation) His concept of capital, unlike that of Marx, does not distinguish types of work specific to capitalism. Bourdieu treats capital as power relations founded on quantitative differences in amount of labor (sic) they embody. His concept cannot therefore distinguish capitalist from non-capitalist forms of labour. (Swartz 1997 pp.74-75)

The capital of individuals or groups does not necessarily remain static, as these persons or groups may compete for advances in capital. Additionally, the relative strength of capital is influenced by that capital’s volume and structure (Bourdieu 1998). Different types of capital are also not necessarily equal. Rather Bourdieu considered that economic capital and cultural capital are usually the most sought after in Western societies, with a struggle between the relative worth of these being ongoing.

The acquisition and maintenance of relativities of capital between individuals and groups is a fundamental concept in Bourdieu’s (1998) view of social behaviours. These practices are primarily about relationships of power. However power needs legitimising in the field, which Bourdieu sees this occurring through *symbolic capital*. Bourdieu (1998) states “symbolic capital is any property (any form of capital whether physical, economic, cultural or social) when it is perceived by social agents endowed with categories of perception which cause them to know it and to recognize it, and to give it value” (p.47). Such symbolism is, of course, bound by context, for what is perceived as being of value in one situation may not hold true in another. Within a context, those who claim and/or are seen to hold these properties have more symbolic capital than others, and therefore likely more power.

Symbolic capital provides a means by which individuals or groups can hold dominant positions within a field (Bourdieu 1990). The notion of symbolic capital is a useful way of examining individual practices with suicidal people, for, as I later show, it helps identify how groups of clinicians maintain legitimised roles in the wards. Bourdieu considers such domination to be a *symbolic violence* that occurred through a process of *misrecognition* by those upon whom such violence is exercised. Those in subordinate positions may come to think of such positioning as normal because their placement within the world means that they are enmeshed in symbolism that suggests that this is a ‘natural order of things’ (Webb et al. 2002). Bourdieu’s concept of *illusio* is another way symbolic violence can be allowed. Bourdieu (1991) describes *illusio* as “the primordial investment in social games” (p.48). People, in Bourdieu’s view, get ‘caught up’ in these ‘games’, and see ‘games’ as having an inherent worth in itself. In practical terms, this may mean that an individual or group may lose sight of an objective view of practice with suicidal consumers, instead seeing that practice as being ‘the only way’.

### 3.3.6 Using methodology and theoretical framing in this thesis

The methodology of critical ethnography supports the exposition of the relationship between power, culture and practice. It also expressly identifies the need for the researcher to consider his/her role in the development of data. Critical ethnography largely underpins the methods of data collection and analysis (discussed in chapter four) and the production of the data described in chapters five to seven. The use of works of Pierre Bourdieu as a theoretical framework is consistent with the 'critical' element of the methodology, in that it allows a deeper understanding of the processes by which power creates cultures and practice, and how nurses' dispositions, relational to power and dominant cultures, come about. Chapter eight therefore continues a critical ethnographic stance that is extended by the theoretical framework.

The process of research written about in this thesis was not directly influenced by readings of Bourdieu's works, or related secondary sources, until after the completion of data collection. Rather, initial readings of data gathered were suggestive of Bourdieu's major concepts as being useful theoretical strands on which to found a consistent analytical and writing base for this thesis. Bourdieu's major concepts of habitus, field and capital are prevalent throughout subsequent chapters of this thesis as they representative theoretical constructs on which to examine the treatment/care of suicidal people in inpatient mental health units. These units both represent a physically defined space that can be defined as an ethnographic or social field; however field is more than physical localities, being formed by a socially defined space. Whilst unique in itself, the socialised space brought about by the treatment/care of suicidal consumers in inpatient units represents an intersection amongst many different fields. Similarly, the habitus of individuals and groups in that social space are multiple and complex.

Bourdieu's concepts of habitus, field, and capital are used as a conceptual practice theory framework to understand the processes behind how nursing practice is constructed. They are consistent with the use of critical ethnography as a methodology and allow a deeper understanding of how the 'critical' power element is operationalised and effects nursing practice with suicidal consumers. Using

Bourdieu’s works as a theoretical framework is particularly useful in understanding how practice is often reproduced in similar manners across a number of wards and teams. I use, for example, the idea of capital and its interaction with habitus and field to explain how some disciplinary groups dominate the construction of practice with suicidal consumers. This is not a simple process; rather it is one of an intersection of a number of social processes that create an understanding of what suicidality is and what should be done about it, in particular how nursing practice should respond. I also use these notions to consider why some nurses are complicit with this domination, while others are not.

As I earlier noted Bourdieu has been criticised for not giving due recognition to the place of agency in his work, and solely applying Bourdieu’s theories would have limited my ability to consider why some groups of nurses do not challenge the structures that construct their psychosocial relationships with consumers, even though they are sometimes fully aware of these. For this reason I use Moore’s (1994) considerations of the place of agency and the investment that individuals have with taking particular positions. Moore considers “identity and difference are not so much about categorical groupings as about processes of identification and differentiation” (p.4). Moore further suggests that individuals have agency to make choices and “are able to bring about a considerable amount of self-reflection to bear on the practices and discourses of day-to-day living” (p.6).

Although Moore’s position on agency appears, on the surface at least, to differ somewhat from Bourdieu, I do not use her work to contradict Bourdieu theoretically. Instead Moore’s work was useful once I had completed data analysis, as it allows a bridge of sorts to understand why some nurses in this study appeared to fully comprehend the choices they made in terms of positioning their practice alongside the dominant ward views. I use the idea of capital and its interaction with habitus and field to explain how some disciplinary groups dominate the construction of practice with suicidal consumers. Similarly I have drawn on the work of Sayer (2005), who engages and in some ways extends Bourdieu’s practice theory and suggests that individuals do not always act to advance themselves; at times people act in certain ways just to ‘get by’, something that is evident with some nurses in this thesis.

Bourdieu’s theory of practice suggests that humans, although having personal agency, generally act within constraints. My understanding is that much of his work on practice theory focused on how these constraints worked to often reproduce dominance. The place of individuals’ agency in practicing outside of constraints was less well articulated in his works. In the data and discussion chapters I show how nursing practice was constructed by a number of factors that sometimes reproduced dominant ideas about suicidology and what nursing practice should be. However I also show that some nurses acted against this dominance and ‘resisted’ common beliefs to practice in different ways. I also discuss how nursing practice was different in some areas even when faced with very similar constraining forces. I have drawn heavily on Bourdieu’s works to understand how constraining forces are interpreted by different groups of nurses. Key to this understanding is the way in which nurses relate to factors that construct practice. These dispositional relationships are constructing factors in practices, and are involved in helping reinforce the culture in which practice sits, or, in some instances, transform the culture.

## 3.4 Conclusion

This chapter has outlined the methodological and theoretical frameworks of this thesis. I have shown the philosophical underpinnings of critical ethnography and why this was used to examine the culture of wards and teams, especially in the way in which power worked. I have also outlined some of the practice theory of Pierre Bourdieu, and shown how this extends an understanding of the data gathered through the methodology as it allows explication of the complex ways in which practice is constructed. These issues are picked up again in chapter eight. In the next chapter (chapter four) I describe the methods by which I gathered and analysed the data in this study.

# Chapter Four: Methods

## 4.1 Introduction

This study asks the research question “how is nursing practice with suicidal consumers in acute mental health inpatient units constructed”? This chapter details the methods used to gather and interpret the data that answers the research question. I structure this chapter by describing processes of entry to the field, data gathering, ethical issues and data analysis, and finish the chapter by identifying how rigour was maintained in all steps of the research process. While these steps are important, critical ethnography assumes an analysis of power issues that affect cultures, and the place of the researcher in interpreting data to a critical epistemology, rather than merely reporting data. I therefore weave in considerations of how power issues were elicited and reflections on my own place in data gathering and interpretation throughout the chapter.

## 4.2 Entry to the field

### 4.2.1 Introduction to this section

Entry to the field is a vital phase in ethnographic research. In this study, the process included preliminary and subsequent meetings with stakeholders. These included Māori, consumer groups, and management and clinicians of acute mental health hospitals. Accessing these stakeholders was vital, both because of an ethical imperative to make the study safe to participants and, on a practical level, to have ‘gatekeepers’ (people who could grant access to physical areas and to potential participants). This section describes how these meetings were brokered, and issues that arose from them.

### 4.2.2 Research with Māori

Health research undertaken in New Zealand is expected to be undertaken in a consultative manner with Māori to ensure the outcomes benefit them, and to be consistent with the principles of the Treaty of Waitangi (Health Research Council 2010). Articles Two and Three of the Treaty are especially pertinent to health research. Article two documents the tino rangatiratanga (control) of Māori resources by Māori. These resources include taonga (treasures), such as language. Article Three ensures fair share of resources, in this instance equity in health resources.

I initially met with representatives of the host University's Māori research committee, who advised appropriate persons to contact for guidance. This led to a meeting with Desmond Ripi, who had previously produced a manuscript of advice for persons working with suicidal Māori (Ripi 1998). Because my study focuses on practice I was advised that further consultation with specialist Māori groups working with acute mental health hospital consumers needed to occur. Initial hui (meetings) were undertaken with members of the Māori support team at the first hospital in this study. I was required to make minor changes needed to the research design. I was also offered support in my dealings with persons who identified as Māori in the research itself, and in the interpretation of results from the research if needed.

Whakamomori (suicide) may have different causes for Māori, an issue addressed in New Zealand policy on suicide (Hirini & Collings 2005). While the research was about the experiences of being recipients of practices rather than prior events, discussions had the potential to bring about feelings of shame for some (Hirini & Collings 2005). Therefore it was important that I was cognisant of this issue when interviewing Māori. I followed cultural advice to ameliorate these issues by offering participants interviews in te reo Māori (Māori language), through the use of paid interpreters and by having culturally appropriate support persons present.

The second site for the research was chosen after data collection was completed at the first, meaning that fundamentals of the research design had already been determined. At the outset of this study I was not certain that the research would require two participating hospitals. This meant that it was not possible to consult with Māori at the second site before the study design was formulated. However, once I knew that a second site would be used I followed the processes of consultation set down in policy at the second site. This meant that I consulted with the Māori support team at the second hospital, outlining the design study and purpose, and summarising what had occurred at the first site. One issue that arose from the second hui was that of researcher reciprocity when undertaking research with Māori. Some participants expressed concern that Māori had been over-researched with little tangible benefit to them, a concept that is recognised in New Zealand (Jahnke & Taiapa 2003). A process of negotiating followed these discussions, whereby it was agreed that I would offer a series of seminars on suicide, including the findings from this study, after the submission of this thesis.

### 4.2.3 Research with consumers

Mental health research design has historically been formulated without the presence of input from consumers (Peterson 1999), mirroring the exclusion of consumers as research participants because the presence of a mental illness was considered to preclude the ability to make informed choices, particularly in acute phases of illness (Koivisto et al. 2001). However it is now considered usual practice for health consumers to be involved in both research design that potentially directly affects consumers, and as research participants (Phillips 2006). In this study I attempted to liaise with consumer representatives and local mental health consumer groups during the research design phase. Peterson (1999) suggests that such a process not only allows the use of appropriate methodology, but is also likely to support the involvement of consumers as participants. There is no way of objectively knowing whether the number of consumer participants was influenced by the support of local consumer representatives. However the final number of interviewees and the processes by which these interviews occurred suggest that this influence was positive.

Meetings took place in the first city with the representatives of the local private mental health consumer organisation that contract services to the District Health Board (DHB). Discussions included the best methods to elicit research information in a manner that was as ‘non–threatening’ to consumers as possible. Some consumer group members suggested that individual interviews were appropriate, but requested additional support from the on-site consumer representative for any participants who identified this as a need. While no participants asked for this type of support, the consumer representative was aware of the interviews being conducted during field work, and discussed the research process during on-site consumer meetings in the hospital ward. Additionally, the consumer representative made himself available to be interviewed as a participant.

The second DHB directly employed consumer advisors at the time of undertaking the research. I met with both the coordinating consumer representative and the hospital ward consumer representative before the research question was formulated. Both reiterated the opinions of the first site consumer group, and suggested a similar process to interview consumers. During the data gathering phase a new consumer representative was employed to support consumers whilst in hospital. Although I emailed a copy of the research design and offered to discuss this with him by phone, I did not meet with him during this time due to his personal circumstances. However, other support was still available for consumer participants. Both sites' consumer representatives suggested a process for minimising risk to consumers during participant observations in the hospital wards. These are discussed later in this chapter.

#### 4.2.4 Contact with mental health services

Before entering the field (the hospital units) it was important that I negotiated with the mental health general managers of the two DHBs, who were effectively 'gatekeepers' for my entry to the hospitals. Polit et al. 2006 describe gatekeepers as persons who are protective of the field sites, and therefore require convincing that the ethical and practical aspects of the research are acceptable to the service and to clinicians and consumers within. Both mental health managers were supportive of the study in principle, but requested that I meet with senior clinicians before beginning field work to ensure they were aware of the research and to discuss concerns about the study before the data collection phase began. These meetings took place in the months leading to the research, and were very productive. This was, in part, because I had a previous professional relationship with many of the clinicians. However, three concerns did arise from the meetings. First, many clinicians at the meetings had participated in previous research but considered that they had not been able to access results from these studies upon completion. Because of this I agreed that I would return to the hospitals, after submission of this thesis, to present seminars outlining final results. The second concern of clinicians was that consumers in the study would be potentially vulnerable to harm from the research process. At the time of undertaking this research consumers of mental health hospitals were generally regarded as a potentially vulnerable population (Koivisto et al. 2001). This was seen as being particularly true of suicidal persons who at times of high risk of suicide may not be able to make an informed choice to participate in research (Farrow & O'Brien 2002). Clinicians wanted clarification of the processes of minimising risk to consumers from the interview process. These processes were described earlier in this chapter. The third concern was that the type of study I was undertaking would inevitably lead to results suggesting some changes to practice. Whilst there was a general sense that such feedback would be welcomed by clinicians, there was concern that the publication of such information (for example, in journal articles) might appear as criticisms of the particular hospital. For this reason I agreed that both the hospital name and the city in which the study occurred would be removed from any final published report (such as this thesis).

Meetings with clinicians allowed me to recruit supportive persons from each ward who were prepared to act as liaison people during the research process. This was especially important given that I could not always be present on the hospital wards, especially when I needed to travel between them and my home city. These persons were helpful in identifying potential participants amongst consumer groups and introducing me to key clinicians (usually a psychiatrist or psychiatric registrar and/or a registered nurse) who had worked with suicidal consumers. The initial meetings also allowed me to understand the overt structure of the hospitals and the wards. Each hospital consisted of three wards; two 'open' ones and an Intensive Care Unit (ICU). The ICU was, I was told, a small ward that remained locked at all times. Consumers in ICU were under civil committal (the MHA), meaning they were to receive treatment as determined by the psychiatrist in charge and could not freely leave. Consumers were sometimes admitted from the community directly to the ICU, or were transferred from the open wards if they were thought to need being kept in a locked environment for their own safety, the safety of others, or needed intensive one-to-one nursing care. The practice of nurses in the ICU environment was not the focus of my study, and I determined that I would not enter this environment during data collection phase. I was, however, aware of the presence of the ICU as I was told that on occasions suicidal consumers were transferred there if there was such a high concern for their safety that they could not be ‘managed’ on one of the open wards.

Before beginning the study I was given a brief tour of each of the open wards in both hospitals. I was interested in the layout of the wards, both to gain an initial impression of the spaces occupied by clinicians and consumers and to consider where I would physically be present during the data collection phases of the study. To enter the wards a visitor (or clinician or consumer) had to first pass through a ‘welcome’ area that was staffed by a non-clinician. This person or persons effectively was able to see all people who came or went from the wards, and permission to enter had to be obtained from this staff member.

The first hospital was built in a way that clinicians could observe consumers at most times. There were two wards running off a centralised ‘patient lounge’. This was a single room with armchairs and couches, and a television that appeared to be continuously on in daylight hours. This lounge had a small ‘nurses’ station’ joined to it, which had windows that looked over the patient lounge. Some of these windows were covered up from the inside with newspaper, so that consumers could not see in. This room remained locked with clinicians having the keys to access this. Running off this lounge were corridors that led to the offices of the charge nurse and medical staff, and an occupational therapy room, all of which were inaccessible to consumers without the presence of a clinician. Leading off each corridor were a number of bedrooms, segregated by gender, most of which housed two consumers. There were also a small number of assessment rooms that ran off the corridors, which were usually in use during week-day daylight hours. My overall impression of the two wards in the first hospital was that it was run-down, with holes in walls, dirty furniture, noisy and lacked privacy. My impression of this did not change during the data collection phase of this study.

The first unit (the mental health facility comprising two open wards and the ICU, along with administrative rooms) was re-located during the term of my study, and was replaced by a new purpose-built facility. There were a number of changes to design from the former building. The reception area appeared to be less of a screening area for visitors or persons leaving the ward. Each of the wards had separate lounges with televisions, but also had extra lounges that were deemed ‘quiet zones’ where consumers could be in a relatively noise free area. Nurses’ rooms were not located overlooking any of these lounges, but were in a central area accessible to consumers, if they chose to go there.

All consumer bedrooms were single, and had lockable doors for consumer privacy. These could be over-ridden by clinicians only in the event of an emergency. I also noticed that there were significantly more interview rooms available, and that after the move these were more often free for nurses to meet privately with consumers. My overall impression was that the new ward was significantly quieter, and that there was much more space for privacy. The second hospital was built on much the same lines. Because of this I will not re-describe these.

I asked hospital managers about the staffing structure of each ward before I started data collection, to ascertain which clinicians and managers I needed to contact in order to gain local permission and ‘buy-in’ to start data collection. I noted at the time the similarity of responses by each manager. I was advised by the manager of each service that there was a similar structure in each ward and, despite being in a different city, each hospital. I was told that each hospital had a clinical head who was a psychiatrist. This clinician was not necessarily involved in everyday clinical decisions for all consumers; instead he or she was available for consultation about the treatment/care of individual consumers if the management of that person was proving difficult.

Each ward had two teams consisting (usually) of a consultant psychiatrist, a psychiatric registrar on a six month rotation at the ward, and a house surgeon on a three-month rotation.  I was also told that there was a larger contingent (varying slightly between each ward and hospital) of registered nurses who undertook the day-to-day ‘care’ of consumers and managed the ward. At that time I did not ask what ‘care’ or 'management' meant, as this was, of course, part of the focus of the study.

One of the hospitals in the study only employed registered nurses. I was told that this was based on a belief that only registered nurses had the requisite skills training and education to manage and support consumers when in an acutely unwell state. The other hospital did have a number of enrolled nurses and nurse aides. Each hospital also had a number of other professional clinicians who worked across wards, including occupational therapists, social workers and physiotherapists. The data collection phase of this study allowed me to gather interesting data on the ways these allied professionals work with suicidal consumers. Whilst it is likely that I will publish this data in separate papers at a future date, I have not included this data in this thesis except when such data offers pertinent commentary on how nurses' practice with suicidal consumers was constructed.

## 4.3 Data Collection

### 4.3.1 Introduction to this section

This section describes the processes by which I gathered data, and issues that arose from this process. I initially discuss the time spent in the field, before describing each of the data collection methods individually.

### 4.3.2 Time in the field

Field work on the first site was completed before I entered the second site. This was a deliberate strategy, partly based on practical needs of traveling to the locations from my home city.  The decision to complete data collection at the first site was, however, primarily directed by the need to ensure data saturation and to establish key areas of research interest. Agar (1996) describes this process as a funneling of focus of research interests by structuring participant observations from the general to the specific. A total of 62 days were spent on site at the first hospital. These mostly occurred in two blocks of time, each of five weeks. The remainder occurred in periods of two to four days at various times over a fourteen month period. The time spent varied from a minimum of two hours up to eight hours, although most days I attended for short blocks before leaving the unit (for example, to write field notes) and returned later. I attended the wards at a variety of times to see if there were any differences in the way practice was undertaken.

The second hospital required less on site time because the research had become more focused at this point. I was more aware of the type of data that was required to answer the research question, and could more quickly identify where my presence was required to achieve this. I therefore spent a total 25 days in the second hospital. Most of this time was Monday to Friday between 7am and 11pm. Unfortunately, I was unable to attend the unit after 11pm at night. The absence of participant observation at night is a potential limitation in the final results of this thesis. However, I attempted to minimise this limitation by discussing practices of this time period with registered nurse and consumer interviewees.

On the first day at each ward I attended clinician and consumer meetings to explain my presence, and the research I was conducting. My attendance at meetings raised some questions about the process, which I was able to address. It also afforded me the opportunity to stress issues of participation as outlined in the next section, and distribute participant information sheets throughout a number of places in the unit (such as consumer lounges, staff rooms, and nurses' stations). I also placed posters on the walls of each unit, which identified my role as a researcher and the purpose of the research.

One of the reasons I spent so much time in the field was to maximise the likelihood that I would be able to identify the most important issues that contributed to the construction of nursing practice. This meant a careful use of data collection and analysis methods in order to understand the 'critical' components of wards and team cultures and how these impacted on nursing practice with suicidal consumers. I was aware that power issues, including the way nurses interacted with these, would likely be complex. I discuss some of the 'critical' method issues as this chapter progresses.

### 4.3.3 Participant observation

Participant observation is a useful research technique because it "locates both self (the researcher) and other in the same temporal order" (Pratt 1986, p.33). This differs from other methods commonly employed in ethnography (such as structured interviews) that rely on recollection of events. Instead the researcher and participants are both present in the same time, allowing the researcher first hand to see and hear what occurs. Participant observation is, like other methods of data gathering, reliant on the subjective interpretation of the researcher. The researcher’s sense, especially in the privileging of visual and oral data (Wolcott 1999), are the tools by which information is gained, in the same way that a survey might gather information. Researcher reflexivity is therefore of paramount importance. In this study I needed to be aware that my professional background as a mental health nurse could potentially influence the data gathering process. At times this was advantageous. For example, I was permitted to enter the staff tearoom, and some consumers allowed me to interview them because they considered that my clinical experience allowed me some understanding of what they were going through. However, my professional position as a nurse was also detrimental to the research process. I noted that, at times, I was invited into the nurses’ station to join other nurses, an action that may have been observed by consumers. I took time to advise consumers that I was not in the role of nurse but as a researcher. I particularly emphasised that I was not in a position to either be involved in decision-making (such as whether they could have leave from the ward) with them; nor was I going to be reporting on what they said or did to the clinical team (with the stated exception of an imminent safety issue). Clarifying my role was important when arranging interviews with consumers (discussed in the next section) where I went through a process of reassuring consumer interviewees of the confidentiality of the information they gave.

An additional conflict was present in the participant observation stage where my role as a researcher with a nursing background became apparent. As noted, this was advantageous with other nurses, although I found myself minimising my own role as a PhD student researcher. Agar (1996) considers that the processes of participant observation require researchers to, at times, “act the fool” (p.120). In some ways this was true of the current research where I considered it important that I ‘walk a line’ between being seen as a competent professional researcher, and someone who was not positioning themselves to criticise practice. The use of humour, I believe, aided this process. In contrast, I often found that there were instances where other clinicians, in particular medical practitioners, were inquisitive about the research when they established it was at a PhD level. On two occasions I was asked to leave multi-disciplinary team meetings by a consultant psychiatrist, despite another clinician introducing me and my researcher role. On one of these occasions the psychiatrist allowed me to stay after I explained the research. The second psychiatrist, however, questioned both the need for the research and validity of ethnographic research techniques, considering the results to be ‘theoretical nonsense’ (field notes). The psychiatrist advised me that the treatment/care of suicidal consumers was one of treating the underlying psychiatric illness with medication, and keeping consumers from themselves until the medication worked. My impression was that this belief in treatment and management meant that any other interventions were redundant as they would not alter the course of treatment and effect. This, I was told, was ‘scientific’ evidence of causation and treatment, whereas ethnographic research was, I was told, subjective and irrelevant (field notes). Although I dearly wanted to argue this point, I quickly resolved to consider this a viewpoint that the psychiatrist was entitled to, and, as per the ethics agreement I had made before beginning the research, I left the meeting.

Before entering the field I determined that my role would mainly be as a ‘complete observer’. This position means the researcher takes no part in the practices under observation (Mulhall 2003). For some researchers such a stance may be reflective of an ontological positivist positioning that suggests that involvement in the field may ‘contaminate’ data. However, researcher involvement in fieldwork is consistent with the more naturalistic paradigm in most ethnographies. My decision was based upon pragmatic rather than philosophical reasoning, because I wanted to minimise the possibility that I would be viewed by consumers as a *de facto* staff member. Despite my original intention, I did participate in some groups. This included occupational therapy groups, where participation was an expectation of any group member. I am aware that being a participant can lead to a different *kind* of data; nevertheless the experiences of being able to observe the group and the role of occupational therapists added a valuable contribution to this study.

I found the process of non-participant observation reasonably straightforward at some times, but very difficult at others. At times consumers have a structured routine and I found that I was able to observe more easily when these were occurring. I was, for example, asked by consumers and/or clinicians to attend consumer interviews, to go on walks around the hospital grounds with consumers and clinicians, and to attend clinician or consumer meetings. At other times I found I could relate to the sense of boredom expressed to me by a number of consumers, especially at times when there was little structure. I found that my role as an observer was more difficult, both in terms of physically locating myself in an unobtrusive but useful viewing space, and being able to explain why I was there. I was acutely aware of appearing somewhat voyeuristic, which of course, to a degree, I was. I found that being in the wards to undertake interviews in some ways ameliorated this problem, as it ‘legitimised’ my presence.

My presence on the acute inpatient unit did lead to approaches from individual consumers, health professionals, and visitors to the unit. Specific information (for example, verbatim quotes) given at these times by such individuals were not recorded, except in instances where informed consent was later given. While I could not capture these comments verbatim in such instance, I could refer to the gist of these if the particular person later agreed to be formally interviewed. At other times I only recorded processes of events, rather than an individual’s personal information.

A challenge for the ethnographic researcher in the field is to accurately record data in the form of field notes whilst remaining physically present (van Maanen 1988), but there appears to be little consensus as to what field notes should actually consist of. They may include details of what the researcher observes about specific activities, but can also include thoughts and feelings of the researcher (Emersen et al. 1995). Emersen and colleagues call these “intuitive asides” (p.100). I used both short and longer field notes, ranging from the jottings of brief ideas to commentaries on the perceived culture as a whole. I avoided efforts to find themes that the researcher notices during observations, instead heeding Emersen et al’s caution that using in-field categories without the benefit of reflexivity can bring about ethnocentric interpretations of data seen through the eyes of the researcher’s (often) dominant culture. In my case I was conscious of my own values and beliefs about practice, and wanted to avoid instant categorisation. This was particularly important given the ‘critical’ component of the methodology I employed. Participant observation allowed me access to an understanding of power issues between staff and consumers that were not straightforward. My early, somewhat naïve considerations of these led to some simplistic conclusions. The lengthy time in the field, the processes of research supervision and triangulation of data (especially interviews) afforded me the opportunity to re-visit the conclusions and the process by which I came to them, after which I avoided using in-field categorisations. Data triangulation was a particularly useful process as it allowed me an opportunity to critically 'test' findings from one data source for congruency from others.

Agar (1996) is concerned that writing notes in-field means a potential to miss gathering valuable data while immersed in writing. The alternative of writing field notes at a later time is equally problematic in that the recall of the researcher is needed. Agar suggests that field notes then be limited to only two things: ideas that need to be followed up in interviews and ideas that need to be further observed. In my field work I followed a similar model to that suggested by Agar, keeping field notes focussed on these two areas. In this way I attempted to maximise the time spent in the environment without missing valuable data collecting opportunities, but later adding to these. This afforded the opportunity for reflexivity when considering data, and ameliorating the potential for accidental typographies. My observations took place in a variety of situations within the hospital environment. These included being present in staff and consumer meetings; individual consumer-clinician interviews; daily group activities for consumers; clinician/consumer outings (usually consisting of walks around the local environment); various consumer lounges; nurses' stations; and multiple informal discussions with various clinicians, consumers, and visitors to the inpatient environment. My initial hunch was that field notes would be difficult to write because of the potential interest of some consumers, who, because of the acuity of mental ill health at the time, may have found a researcher writing notes to be threatening. However, the reality proved different, with the only expressed concerns coming from clinicians. This occurred on two occasions on the third day of field work. After this I decided that it was better to leave the site temporarily and dictate field-notes in a nearby locale.

A second form of data collection in participant observation is personal diaries. Agar (1996) suggests these are "…the reactions of the ethnographer to the field setting and the informants, the general sense of how the research is going, feelings of detachment and involvement, and so on" (p.163). The information recorded in a personal diary has the dual ability to assist in researcher reflexivity, and also to be used in the writing of the results by making the role of the researcher more explicit. I have interwoven accounts from my personal diary throughout the discussion chapters. These were particularly useful later in considering the 'critical' cultural issues that I earlier discussed. By using a diary system I was able to consider pertinent events of observational periods and reflect upon the complex ways in which nurses responded to ward and team cultures, including their responses to power. These diaries were useful prompts in interviews when nurses, other clinicians and consumers discussed the ways in which they saw power being manifested. In some instances the absence of participants' reflections on power issues was useful data when contrasted with other interviews or with diaries.

### 4.3.4 Interviews

Semi-structured interviews are useful for a number of reasons pertinent to this study. First, there is a tendency for a high response rate to requests for face-to-face interviews (Polit et al. 2006). This was particularly important in gaining interviewees in the consumer group, who are often difficult to gain as participants in research (Breeze & Repper 1998; Koivisto et al. 2001). Second, it seemed likely that face-to-face interviews would allow probing and clarification of issues that were unclear. Third, semi-structured interviews allowed for important questions to be asked, while still encouraging participant issues to be aired.

By using semi-structured interviews I was attempting to gain the benefits of structured interviews and unstructured interviews, whilst ameliorating the limitations of each. Structured interviews allow the researcher to ask questions in a similar manner to each interviewee, and to avoid the temptation (at least within the interview itself) to interpret the response from the interviewee (Fontana & Frey 2000). This was important, as I needed to ask particular questions. I was also able to formulate new areas of inquiry, including issues of power and nurses' responses to it, from previous interviews and areas of interest that had occurred in concurrent participant observation. I was aware of my familiarity with the hospital mental health environment, and the terminology used by clinicians. A risk with this was that I could assume shared understanding with interviewees. The ability to ask similar questions yet use unstructured further questions to clarify answers was the strength of the interviews in this research.

All interviews were audio-taped and later transcribed. Interviews with nurses offered some useful insights into what they considered constructed their practice. However a number of interviewees were surprised I asked questions about this, instead explaining what they actually did. Many were also taken aback that by me asking questions about how practice was constructed. My interpretation of this is that, for some, dispositions toward the ward culture and to practice was unconscious. This absence of reflection about constructing influences was notable data, as I was able to compare it to interviews where nurses spoke about constructing factors in great detail.

I conducted consumer interviews in the hospital wards. The focus of the interviews was the way in which individual interviewees saw how practice is constructed for suicidal people. Reflection on my own researcher diaries suggests that at times key issues may have been missed by me in the interviews. Nevertheless, the interviews do reveal significant data that represent both, as Sarap (1996, cited in Fontana & Frey 2000) suggests, ‘the story’ of nursing practice with suicidal consumers, and the ‘discourse’ of how the interviewee was aware of this knowledge. This content and the process of knowing are significant data that are discussed throughout the discussion chapters later in this study.

A total of 75 interviews were conducted in the two sites, comprising 40 at the first hospital and 35 at the second. Of these, 24 were with consumers, 36 were with registered nurses, four were with occupational therapists, two were with social workers, eight were with medical practitioners (four consultant psychiatrists and four psychiatric registrars), one with a consumer advocate. This number of interviews is of course not insignificant. There were a number of reasons for this (i) as I have already noted, the interviews ‘legitimised’ my presence on wards during observational phases of the research; (ii) some clinicians (especially nurses) requested interviews with me, and I thought that refusal could mean omitting potential useful data; and (iii) I wanted it known that I was still conducting interviews, as I was attempting to gain interviews with nurses until I reached data saturation.

I also met with Māori cultural advisors for each hospital. On both occasions I was advised that meeting informally was more culturally appropriate than formal interviews. Because of this I did not seek formal informed consent from all persons, and therefore, have not used verbatim quotes from these meetings as research data. However, participants were happy to offer advice regarding both the research process, and give generalised feedback about issues that are important in hospital practice with suicidal Māori. Such information I recorded in field notes at the time of the discussions, and have used where appropriate in discussion chapters in this study. I was only able to interview one nurse and one consumer who identified as Māori, and this dearth is a potential limitation of the data.

Clinicians were aware of the times that consumers were being interviewed. Although the content of these interviews was confidential, clinicians and consumers alike were informed that any perceived increase in risk of suicide or harm to others would result in termination of the interview, with this risk immediately communicated to appropriate hospital clinicians. This was iterated at staff and consumer meetings, and reinforced verbally at the beginning of interviews, as well as being noted on the Consent Form (see Appendix vi). One interview was halted by me because of the perceived increase in risk to a consumer. In this interview a consumer disclosed to me a desire to attempt suicide within 24 hours. I therefore stopped the interview and advised the nurse who was assigned to that patient. Later I was unable to gain consent to either re-interview this person or use the parts of the interview that were recorded, and therefore this interview was discarded.

### 4.3.5 Written document analysis

Written document analysis was a third form of data gathered used in this study. Records can be distinguished from other forms of written texts such as documents (Hodder 2000). The former are recorded with the intent of establishing that a “formal transaction” (Hodder 2000, p. 703) has occurred, whilst the latter are designed for personal usage. I was interested in exploring written policies, procedures and other directions about suicide practice, as well as the ways in which practice was structured and described in consumers’ clinical notes. Document analysis, when considered alongside interview and observational data, allows an understanding of “how everyday experiences are coordinated” (Walby 2013, p.141), or what Smith (1984, p. 65) calls “the ideological currency” of cultures. Smith cautions that written documents cannot be understood outside of their organisational context, but when I viewed these alongside other data sources the written records proved useful in understanding the relationship between ward or team cultures and nursing practice.

Permission was given by 23 consumer interviewees to view their clinical files. While no data about specific consumer’s treatment/care was extracted, the records were particularly helpful in determining how practice was described, and what was considered important by nurses and other clinicians. I also took note of what sort of information was not included in files, as these absences gave clues to both treatment/care priorities and ways in which professional and institutional power was operationalised. I have discussed these in the data and discussion chapters later in this thesis.

## 4.4 Ethical issues

Like all research, this study attempted to balance the potential benefits of completed research with the risk to participants of the research being undertaken (Health Research Council 2005). The principle of non-maleficence in research was particularly important, in order to limit risk to consumers. Risk of harm to consumers was minimised by (i) the process of participant selection; (ii) the focus of questioning on nurses’ practices rather than the individual’s suicidal stressors; (iii) primary nurses and other clinicians being aware of both where and when interviews took place; (iv) the location of the interviewee within an environment designed to minimise his/her risk (that is, within acute mental health wards); (v) the overt decision to contact appropriate inpatient clinicians immediately if the researcher or consumer perceived an increase in suicide risk; and (vi) the ability of the consumer, staff, management, or the researcher to terminate interviews if this process increased suicide risk, or was significantly distressing for any party.

*The New Zealand Health and Disability Code of Rights* (Health and Disability Commissioner 1996) explicitly decrees that all health consumers have the right to be involved in research. However, clinicians could prevent consumer participation in the project if they considered that the process was detrimental to the health of the consumer. Knowing what might cause psychological harm to an individual in an interview is more difficult to determine than potential physical risks (Koivisto et al. 2001; Usher & Holmes 1997). Fortunately my clinical background as a registered nurse and my previous research experience meant that I had familiarity in interviewing and supporting suicidal people. In addition, consumer interviewees had the option of having support people present in the interviews, although none chose to exercise this. Nurse and other clinicians also faced potential psychological harm if they perceived that their practices were being questioned. The risk of such harm was probably greater in the participant observation periods of the research process, as individual clinicians could choose not to be interviewed. I determined in my ethics application that I would attempt to minimise any risk in the study by explaining the purpose and the process of the research, along with information and processes of assuring anonymity of individuals and institutions.

A second significant ethical consideration in this research was the ability of consumers to give informed consent to take part in interviews or to allow me to analyse their clinical notes. People with mental illnesses have historically been regarded as unable to give consent to participation in research (Koivisto et al. 2001). However, more contemporary researchers consider it important that consumers at least have the opportunity to express their opinions in the research forum (Koivisto et al. 2001; Peterson 1999; Usher & Holmes 1997), a position with which I concur. The inclusion criteria for consumer interviews involved screening by a consumer’s’ primary clinicians (most often a registered nurse) of suitable participants who met the criteria, including the consumer's ability to be able to give informed consent at the time of interview. I was therefore reliant on the good will of clinicians to undertake this screening, meaning that other potential participants were not approached to take part. Usher and Holmes (1997) note that mental health consumers may want to take part in research studies despite the objections of overly-paternalistic caregivers. However, I believed that the process of gaining informed consent with a potentially vulnerable sample meant that the benefits of this process outweighed the exclusion of potentially useful informants. Any consumers who were considered eligible for inclusion in the study as an interviewee were given an overview of the study by their primary clinician. I was aware that decisions regarding informed consent are often expected to be made at the very times when consumers are in stressful situations; in this instance when a consumer of a mental health hospital, and having been recently at risk of suicide. At such times consumers may also be subject to 'information overload', meaning their ability to make an informed consent to enter research may be compromised. Therefore I determined to allow at least 24 hours for any consumer to consider the request for interview, even in situations where a consumer immediately agreed for the interview to take place.

The process for obtaining non-consumer interviewees was more straightforward. I decided (after discussions with groups of stakeholders identified in the next section) to attend staff meetings advising of the research, and to leave participant information sheets at accessible places around the hospital wards. I would then use a convenience sample of the first available persons who met the inclusion criteria (being an employee of the mental health hospital service of the DHB). I hoped (a hope that was borne out) that some interviewees would approach other clinicians, suggesting they offer themselves as interviewees. This process is termed 'snow-balling' (Polit et al. 2006).

Gaining informed consent from all persons present in participant observation situations is not easily achievable. I determined to ask for verbal consent in some situations (for example in multi-disciplinary team meetings). The continuous nature of participant observation in busy wards meant that it would not be feasible to ask for consent in all situations. The style of open observations that I used meant that my role as a researcher and the focus of the research was as clear as possible. For instance, at clinician and consumer meetings I decided to iterate that any persons who felt uncomfortable with my presence at times could ask that I leave.

This research received ethical approval from my own place of work, the university in which I was originally enrolled, and the two regional Health Research Committees. Copies of these approvals are shown in appendices at the end of this thesis.

## 4.5 Data Analysis

I have previously shown that data in this study came from undertaking participant observation and semi-structured interviews, and viewing written clinical and other records. Data from the latter two sources was recorded in various written and spoken formats, including research diaries, written field-notes, and dictated verbal field notes. These were transcribed into a standard format, along with data from interviews, by paid transcribers. Thorne (2000) concisely sums up the purpose of analysis in ethnography when stating:

> Ethnographic analysis uses an iterative process in which cultural ideas that arise during active involvement "in the field" are transformed, translated, or represented in a written document. It involves sifting and sorting through pieces of data to detect and interpret thematic categorisations, search for inconsistencies and contradictions, and generate conclusions about *what is happening and why* (p. 69, my emphasis).

I began data analysis from the first day in the field, making notes and asking a number of questions about these, using a framework suggested by Spradley (1979). The framework helped me consider (i) what had I seen, read and been told about what occurred; (ii) in what situations these practices occurred; (iii) whether there where similarities and discrepancies in practices between nurses, wards, and hospitals, beyond differences in clinical presentation of consumers (iv) who determined particular practices (v) what were participants saying that influenced nursing practice with suicidal consumers, and (vi) what did I see, hear or read that indicated how that practice was constructed. During the data collection phase I also pieced together my field notes with data from interviews and from record analyses.

This process continued until data collection at both hospitals had finished. I found this was a challenging process because the transcribed interviews offered more written information than the field, diary and written record notes.

On-going analysis of data was undertaken in a structured way by using ‘paper and pen’ techniques to form both verbal and visual representations of the organising categories in the data, and the relationships between these domains. This process occurred through the well-known technique of data immersion (Spradley 1979) which required me to read transcripts and listen to audiotapes on multiple occasions.  After initially analysing the data manually I used Nvivo (a qualitative software package) to undertake a secondary search of the data, and to build up better thematic representations of how the parts of the data interfaced with each other. I therefore located themes in the data to identify these cultures.

This data analysis process was informed by both Spradley (1979) and selected works of Bourdieu (1977; 1979/1984; 1990; 1997/2000; 1998; 2001).  I slightly altered Spradley’s (1979) framework to (i) examine how conflict was dealt with and the risks inherent in these practices; (ii) look for cultural contradictions within wards and between wards; (iii) explore informal techniques of social control; (iv) observe how nurses managed inter-personal relationships; (v) understand how nurses acquired and maintained social status, (vi) understand how nurses solved problems (vii) understand what nurses understood ‘good practice’ to be and (viii) identify how barriers and enablers to practice were perceived. I also asked questions of the data such as “what are nurses doing here?”; “who decides these actions?”; “what are the effects of these actions on nurses and nursing?” and, “what are the effects of these actions on consumers?” Commensurate with the *critical* component of critical ethnography this framework placed an emphasis on the impact of power, gender, and history in formulating an understanding of the current culture(s) that I observed. The data clearly indicated issues that shaped nursing practice, including evidence of differing dominant understandings of the cause of suicidal thinking and the expected practice of nursing with suicidal consumers. Alongside this there was evidence of power relationships that partially shaped nursing practices. However these relationships were ambiguous, and there were clear indications that nurses did not all interact with the dominant culture in the same way. By simultaneously considering these processes from a Bourdieusian perspective I was able to identify how differing nursing dispositions towards dominant cultures created different types of practices, and, in turn, either assisted in reproducing the dominant culture, or in transforming it. The use of both Spradley (1979) and Bourdieu (1977; 1979/1984; 1990; 1997/2000; 1998; 2001) helped elicit an understanding of the complexities of the construction of practice; I consider these in depth in chapter eight, and what they might mean for future practice, education and research in chapter nine.

The analysis of dispositions was limited by the methods I used to gather data. Readings of data suggested that nurses responded to ward cultures in different ways, and that their dispositions may have borne some relationship with why nurses practiced in certain ways. This meant that I re-analysed interviews by considering what the data said about their practices and about their dispositions to look for patterns. There were a number of limitations to such an analysis including (i) I was not able to use observational data to examine what individual nurses did (ii) interview data relied on self-reporting of practice (iii) dispositional demographic data was limited because I had not considered I would be undertaking such an analysis, and (iv) self-reported dispositional data was reliant on 'luck' either through me asking a related question or the participant offering it him/herself. Fortunately this was a regular occurrence. Despite these limitations some rich dispositional data was obtained.

## 4.6 Rigour

### 4.6.1 Introduction

The demonstration of rigour in data collection and interpretation is vital in research. This section focuses on the rigour of this study. I have taken the advice of Polit et al. (2006) in using standard terminology to allow an examination of rigour in qualitative research using the headings of credibility, dependability, confirmability, and transferability.

### 4.6.2 Credibility

I have previously shown that I spent a considerable amount of time in the field, a process known as *prolonged engagement* (Polit et al. 2006). This allowed me to have an in-depth understanding of what was occurring and why. I was particularly keen not to observe ‘one-off’, out of the ordinary occurrences and view them as normal. Similarly I continued *persistent observation* on aspects of the study. A second form of credibility is *triangulation,* which refers to the notion of creating redundancy in data collection methods by using multiple sources to confirm information (LeCompte & Schensul 1999). This in turn can create a stable basis from which to examine the findings from a source that might be considered ‘unreliable’. Triangulation is more than confirmatory. Agar (1996) suggests that ambiguity and difference in research findings aids the researcher to get beneath the social consciousness of participants to examine material and epistemological reasons for what occurs. I have, therefore, attempted to provide descriptive and interpretive accounts of the sources for data to show the ‘confirmability’ of findings. Commensurate with critical ethnography, I have at times juxtaposed data to compare and contrast systemic, interpersonal and intrapersonal ambiguity to explore the contextual factors that influence the construction of care for suicidal people in the inpatient environment.

I did not undertake member checks (a solicitation of participants’ reactions to data analysis) (Polit et al. 2006). I decided not to do this at the outset of the study, because I believed as a critical ethnographer I needed to firstly consider the data from sources that may have been contradictory to some participants’ beliefs, and secondly, I was in a privileged position of being able to view information from multiple data sources. I did undertake de-briefings with my original supervisor whilst in the field, the focus of which was to search for meaning in what was occurring in the emergent data. I believe that the process of triangulating and constant, ongoing analysis did allow me to search for disconfirming evidence. I have shown how my initial analyses may have accidentally ignored non-confirmatory data, but I believe I have ameliorated that with a rigorous, subsequent analysis and multiple discussions with my thesis supervisors.

The last type of confirmability, ‘researcher credibility’, has been addressed in the first section where I have described my own research, teaching, and clinical background.

### 4.6.3 Dependability and Confirmability

The nature of a PhD thesis means that I was the sole instrument of data collection. I have attempted to ameliorate the reality of this fact by including documented information in this thesis on the process of data collection and analysis.

### 4.6.4 Transferability

Transferability usually refers to how well the data can be utilised in other settings. The research focus in this study is about nursing practice within New Zealand. Transferability is, of course, often limited in any qualitative study, but I believe using four sites of data collection has ameliorated this to some extent. I am, however, aware that caution should be taken with this as there are approximately nineteen such sites in New Zealand. I cannot claim that the data findings are relevant to all of them. I am also aware that time has passed since data collection and publication of this thesis. I cannot know the relevance of these findings if changes have occurred.

One form of transferability, *thick description* (Geertz 1973), generally refers to providing descriptive data pertaining to the environment in which the research took place, including the involvement of the researcher as well as that of the environment and participants. Thick description acts as a form of translation for readers of the text that were not present in the field to understand some of the intricacies involved behind the process of data gathering. Such a definition of thick description can be misleading in its apparent simplicity, as on one level it can appear to be, as the name suggests, a description of ‘what is’. However, throughout this text this thick description is intertwined with a discursive text showing reflexivity, acknowledging my presence as the author of this textual representation.

## 4.7 Conclusion

In this chapter I have identified and discussed process issues that allowed for safe and, I believe, effective gathering and interpreting of data. I have shown how the methods used are consistent with critical ethnography, and how I attempted to gather and interpret data that privileged a ‘critical’ approach while remaining true to the data set. I have also briefly identified how the Bourdieusian framework added a layer of analysis that shows (as I discuss in chapter eight) how ‘critical’ elements of power construct nursing practice with suicidal consumers in complex ways. The processes undertaken, including the substantial consideration of a large data set, means that the data described in the next three chapters is an accurate and considered representation of what constructs nursing practice with suicidal consumers.

# Chapter Five: The construction of nursing practice in a bio-medical/risk culture

## 5.1 Introduction

This chapter is the first of three where I use the data to describe two factors that construct nursing practice with suicidal consumers. The first of these is the ward or team culture, in particular predominant views about the cause of suicidality and the consequent expected inpatient treatment/care. The second interrelated factor I discuss is the way differing groups of nurses responded to the culture, even when in the same ward or team.

In undertaking this research I did not attempt to find out how dominant ward or team cultures came to be, as my focus when gathering data was on the construction of nursing practice. Although this was perhaps a missed opportunity, there is some evidence about the development of ward/team culture, and I have included those examples when they occur. More relevantly, I show how nurses' practice within the dominant culture often acts to help reproduce it.

In all four wards two teams of clinicians worked together, usually providing treatment/care for consumers based on a consumers' usual place of residence. To aid clarity I have called each ward either 'A', 'B', 'C' or 'D'. Wards 'A' and 'B' were next door to each other in one city, while wards 'C' and 'D' were within the same building in a different urban centre. This chapter and the next show how:

- In wards A, C and in one team within ward D, suicidality was seen as resulting from a bio-medical cause, with a related view that a minimisation of the risk of suicide could be obtained by the use of coercive, restrictive practices with consumers. I have termed nursing practice that was largely consistent with this culture 'bio-medical/risk', although not all nurses agreed with the dominant viewpoint. Other nurses actively practiced in different ways, and I have termed these nurses as 'resisters' of the dominant practice. I discuss the data that shows why nurses responded to the dominant culture in different ways, as this response is a significant factor in the construction of practice.

- In the second team in ward D suicidality was seen as being the result of psychological distress, and practice was uniformly consistent with this. In chapter six I discuss the construction of nursing practice within this team, through the ward culture and the dispositions of nurses. I also show that bio-medical understandings of suicide and practice also had a role in constructing practice, even though this was not the perceived ethos of the team.
- In ward B there were competing understandings of what practice should be. There had been an attempt to introduce an applied Dialectical Behavioural therapy (DBT) model, but this change of culture had not completely occurred. I discuss how an absence of a unified ward culture meant that different nursing practices were constructed, and these were largely constructed through the dispositions of groups of nurses, but were still relational to bio-medical understandings of suicide and practice.

This chapter focuses on wards A, C, and the half of ward D which had similar cultural perspective on suicide practice (called ‘bio-medical/risk wards/teams’ herein). I show that bio-medicine and risk were significant factors in the construction of practice, but that these factors were interpreted in different ways by groups of nurses and produced differing practices.

## 5.2 Bio-medicine as a constructing element of ward culture

### 5.2.1 Introduction to this section

The prevailing ward culture about suicidality in the bio-medical/risk wards or teams was that suicidal thoughts indicated the presence of a mental illness; in other words, to be suicidal, a consumer had to be mentally ill. The corollary to this way of thinking was that the treatment of the medical event (the mental illness) would almost certainly remove a consumer’s suicidal feelings. By extension this meant that treatment/care needed to focus on diagnosis and medical treatment (usually through medications) of the underlying mental illness, while attempting to minimise the risk of attempted suicide through containment measures.

At the beginning of the study I suspected that medical doctors' positions of power meant that their viewpoints would dominate cultures and consequent practices, including those of nurses. While medical authority did reinforce the ward/team culture (as did nurses, as I later show) it appears that many medical staff felt their practice was also heavily directed by the bio-medical/risk culture. One considered this issue at length:

> "Medical explanations do hold sway [about suicide]. It's very very difficult, as I do believe in psychiatric diagnoses, and many [consumers] who are suicidal have a psychiatric diagnosis. And we should treat it. But the whole pressure on treating people rapidly in acute units means that we have to treat with medications. And it's our [medical doctors] ultimate responsibility to determine risk — well perhaps not wholly, as we rely heavily on nursing observations — but to make risk decisions. So all the notes are skewed to writing about medical treatment and risk amelioration. I'm not at all convinced it's even that helpful, or sometimes [risk minimisation practices] makes people worse. But we all have to work within this rushed medical system. It's far from ideal." (Psychiatric Registrar 3)

I was surprised by the different views that psychiatrists and registrars had about the bio-medical culture on the wards. Some registrars I interviewed expressed a frustration that their practice was, as one registrar stated "limited to prescribing med[s] and making decisions about keeping them [suicidal consumers] safe" (Psychiatric Registrar 2). This interviewee described how his personal belief was that the multiple 'real-life' issues that face suicidal consumers are devalued by a medical cultural model of practice, and that a focus on containment could lead to a break-down of (in this instance) the relationship between doctors and consumers. I was not able to interview many registrars, so it is not possible to state whether this was a widely held view; however the frustration shown by this interviewee gives rise to a consideration that sometimes doctors are compelled to practice within a particular ethos with limited individual ability to effect change in that culture.

The belief about the relationship between suicidality and mental illness was not always verbalised. Some participants (nurses and other clinicians) expressed surprise that I even asked what they thought caused suicidal thoughts in consumers. One nurse responded:

> "Oh, that's an odd question. It's [suicidality] of course because of the mental illness. Treat that and by and large the suicidal thoughts and that go." (Nurse 7)

This viewpoint was reinforced in clinical notes and in team meetings on the best treatment for individual suicidal consumers. Although issues from consumers' lives that negatively affected them were identified, the fact that a consumer was suicidal meant that the consumer was now considered mentally ill. The presence of the diagnosed mental illness either took primacy in intervention on the ward, or was the sole focus of treatment. In the rest of this section I show how the cultural beliefs about the relationship between three specific medical diagnoses, suicidality and nursing practice was conceptualised and shaped practice. In the following section I examine the place of risk in shaping ward/team cultures, and the risk actions of nurses specifically.

### 5.2.2 Suicidality and mental illness

The responsibility for determining medical diagnoses fell with consultant psychiatrists (or sometimes, in their absence, psychiatric registrars). Psychiatric consultants or registrars interpreted the suicidal thoughts and feelings disclosed by a suicidal consumer, along with a large amount of other information such as consumers' history of mental illness, their life events, and information given by family, to determine mental illness diagnoses. Similarly, information given by nursing and other clinicians about disclosed thoughts and feelings and perceived behaviours of consumers were interpreted by the consultant or registrar and formulated into medical diagnoses. A similar process occurred with determining risk, where the consultant or registrar (or, as I show later, the house surgeon) interpreted information and determined levels of perceived risk. The diagnosis and risk assessment were relayed to other clinicians and noted in clinical notes; from these plans of treatment and risk containment came about.

Consumers were given an initial assessment by an admitting psychiatrist when first on the ward. Much of these assessments focused on gaining an initial view of the medical diagnosis of the consumer and determining levels of risk of suicide and what precautions needed to be taken. Consumers were asked their viewpoints, but on almost all occasions I was present the psychiatrist determined an initial medication regime and what levels of risk containment would occur. Although other clinicians (including nurses) were present at the interview, they were largely silent. Their viewpoints were rarely asked for, and their input into decisions not elicited, despite the (usual) containment practices being ones that would have to be put into action by nurses. As one nurse noted:

> "When a [consumer] is admitted they are assessed by the consultant. The nursing staff and the community team sit in too, but the doctor decides whether [the consumer] is safe enough to be in the open ward, [whether to] contain the environment, sometimes Special Observations." (Nurse 9)

On-going medical diagnosis, determination of risk and ‘prescribing’ of containment were formulated by medical clinicians (including house surgeons) in follow up interviews with consumers. These were held on anything from a daily to a weekly basis. I was able, with the consent of consumers, to sit in in on a number of these. I was struck by the rapidity in which they occurred (for example, there was often only a ten minute or so warning given to the consumer) and the number of people present. My impression, after attending a number of these meetings, was that they were, again, a way for psychiatrists to quickly gather diagnostic and risk assessment data from consumers. This was confirmed to me in an informal discussion with a psychiatrist after such a meeting, who told me that time constraints on their daily work meant they have to be focused on a constant process of determining psychiatric diagnosis, updating medical (especially medications) treatment, and assessing consumers’ levels of risk (field notes).

Consumers found these meetings to be quite intimidating, partly due the sheer number of clinicians and other staff present. One consumer advisor noted:

> "There has to be a certain number of people… there’s got to be a nurse, there’s got to be the consultant and the registrar, and then you have the person’s nurse… [but] it is

> difficult for patients [sic] to disclose and talk with them all there, yet patients [sic] don't really get time to talk to the doctor or their nurse on [their] own." (Consumer Advisor 3)

There was a sense of irony for some consumers as they considered that they were expected to disclose suicidal thoughts and feelings when they had not been afforded the opportunity to do this on a one to one basis:

> "I found it quite disturbing really, I'm the sort of person that takes a while to get to know somebody and with the doctors here it was sort of… they had training doctors too, I found that was a bit personal… they were sitting in. One time I was asked whether I wanted a training doctor to sit in and I said "no", but other times they were there anyway." (Consumer 3)

Consumers often felt a lack of control in these meetings, with a sense that their personal information was being interpreted through bio-medical and risk frameworks, which in turn, were being used to determine consumers' choices. One noted:

> "I found the doctors difficult…just that I didn't see them often and [yet I] felt like they were controlling my life…They just want to know what is your illness? Will you do this? Are you safe?" (Consumer 5)

Multi-disciplinary team meetings (MDT) were regularly held (without the consumer present) to discuss the consumer's progress. There was a significant focus on medical management of consumers and on consumer risk levels and containment processes. At times this included instructions from the psychiatrists to increase or decrease levels of observation. It was again significant that a nursing 'voice' was generally absent. There were exceptions to this, notably from experienced nurses; however the focus on medical diagnosis, risk, and subsequent management meant that nursing practice was largely directed by the consultant psychiatrist.

I was struck by the continued 'taken for granted' relationship between suicidality, mental illness and the need for medical treatment at the MDT meetings. I have earlier described (on page 64) an incident where a psychiatrist considered that my research question was redundant. Although I was initially taken aback by the psychiatrist's response, my reflection on this is that the psychiatrist's (and many of the other clinicians on the ward) belief system, and the subsequent culture of the ward was so 'taken for granted', that my research would logically seem pointless.

Nursing staff readily identified that the ward or team culture about *any* practice was strongly influenced by the thinking of the consultant psychiatrist, and that this in turn, influenced what they could or couldn't do with suicidal consumers. The psychiatrists I interviewed were well aware of the power that they held as the catalysts of a practice, although most discussed their desire for including other staff in decision-making. They expressed a need for collaborative decision making about practice with other staff, but considered that they were ultimately responsible for the decisions made through the authority that was vested in their position as Consultant Psychiatrist or Psychiatric Registrar.

I saw many examples of nursing practice being shaped by bio-medical understanding of suicidality. One such example occurred in an MDT meeting. A psychiatrist was discussing his view that electro-convulsive therapy (ECT) was needed as a treatment for a consumer with a diagnosis of major depression who remained depressed and suicidal despite anti-depressant medication treatment. The consumer's nurse spoke up and suggested that perhaps the consumer remained depressed because of his social circumstances. The consumer apparently had recently received a diagnosis of a non-life threatening physical illness and had endured a relationship break-up. The nurse suggested that the consumer was making slow but significant progress and was beginning to engage with the nurse and a colleague. He agreed that the consumer remained at risk of suicide but was being more open about discussing this and considering alternatives. However the psychiatrist dismissed this viewpoint, instead commenting that the depression should have lifted by this time, and it was cruel of the nurse to suggest leaving the consumer "like this". No-one else in the MDT spoke up, despite other senior nurses and members of other disciplines being present, and ECT was prescribed and a second psychiatrist's opinion was sought (as is legally necessary under the MHA). The consumer received ECT treatment against his will (field notes). This example suggests that a bio-medical view of suicide dominated decision-making and shaped treatment decisions to such an extent that debate about the need (or not) for an invasive procedure was shut down.

I also noted other situations where nurses' (and other non-medical clinicians') suggestions about non-medical reasons for a consumer's suicidality were dismissed. Psychiatric registrars were, as I have already noted, not immune to their practice being shaped by a bio-medical view of suicidality. I observed, for instance, a registrar being publically criticised by a consultant for suggesting that a consumer of Asian descent be referred to a cultural specialist for assessment before his medications were increased (field notes).

The bio-medical shaping of practice also occurred in less obvious ways. Nursing notes were expected to be written in a way that highlighted consumers' psychiatric symptomology (along with their risk), and nursing hand-over (where nurses summarise consumer issues for the next shift) emphasised issues and treatment (along with containment practices) that nurses were expected to know or carry out. I observed criticism of two different nurses for writing notes that did not prioritise these and/or contained views of social issues that may have been affecting a consumer's suicidality (field notes).

### 5.2.3 Major Depressive Episodes and suicidality

Major depressive episodes (MDEs) were very often seen to be the *cause* of suicidal thoughts and behaviours. As a consequence, treatment of the underlying mental illness was considered by many clinicians to be the best way to reduce suicidal thoughts. The primary way of treating the mental illness was through medications, although there was some support for the use of psychological interventions as an adjunct treatment. However, consumers who were in the midst of a MDE were considered too unwell to have psychological intervention to explore the underlying suicidality, with such treatment expected to occur after discharge from the inpatient unit. One psychologist noted:

> "Standard treatment for depression would be medication … I might get involved with a bit of CBT [Cognitive Behavioural Therapy] but not normally… people would be

> normally significantly depressed and not necessarily be appropriate to treat with CBT in an inpatient unit." (Clinical Psychologist 1)

Treatment with medications was seen as the main way of reducing suicidality:

> "[By] treating the depression, [we can] treat the suicide thoughts." (Consultant Psychiatrist 2)

Some consumers with suicidal ideation were referred to the inpatient clinical psychologist, either by the consumer’s nurse or, more usually, their psychiatrist. On occasions the clinical psychologist suggested that their input was needed regarding a particular consumer. Because suicidal thinking was generally considered as part of a mental illness, psychological input was usually aimed at ameliorating symptoms of that mental illness. Although suicidal ideas were sometimes addressed, interviewees advised that such thinking was considered likely to lessen once the mental illness had been treated. One psychologist explained it:

> "I don’t see that many [suicidal consumers]. …they have medication for sleep disturbance or encouragement to hang in there, to get through that period, that it's [suicidal thoughts] not going to last and those sorts of supportive care. But that informal ‘hang in there’ type of support doesn’t usually come from psychologists, it’s more the other staff like the nurses." (Clinical Psychologist 2)

The strong association of suicidality with MDEs manifested itself, as shown by the previous interviewee, in a perceived need to treat the depression with medications. Along with this was a ward cultural belief that there was an equal responsibility to assess immediate risk of a consumer attempting suicide, and to stop this occurring. As one nurse noted:

> "Medications and stopping them trying [to suicide]…that’s the bulk of the job. Yes we give general support and we look at things like housing, but the main bits are getting them the right meds and keeping them safe as they are depressed and in no state to make a rational decision." (Nurse 12)

Some consumer interviewees found a medical explanation of suicidality was partially helpful. Two consumers showed this when they stated:

> "…knowing it was the depression meant it (the suicidal thoughts) wasn't me." (Consumer 22)

> "I couldn't control the feelings [of suicidality]. But the medicine has helped and because it's the depression, I'll keep taking it [to stop suicidal thoughts]." (Consumer 6)

However, there was a general sense that the diagnosis itself didn't explain away the suicidal feelings. Three consumers commented on this:

> "Ok, I have depression, I accept that, but the real stuff is still there when I go [home]." (Consumer 7)

> "...my advice [to staff] is, don't keep ignoring the reasons I felt like this [suicidal]...it's not *just* illness." (Consumer 3. Interviewees' emphasis)

> "...the staff have been good, but it's bullshit to say that its [suicidal feelings] disease…they don't know the real things that have happened, because they don't ask." (Consumer 21)

In addition, many consumer interviewees discussed how a focus on medical diagnosis reinforced a sense that they were 'sick', were unable to have control in their lives, and that their real life issue that led to suicidal feelings were irrelevant.

### 5.2.4 Psychosis and suicidality

A second group of consumers identified as being suicidal were those persons who were psychotic. As with consumers with MDEs, suicidal thoughts in the midst of psychotic episodes were uniformly seen as secondary to the psychosis, and the treatment of psychosis was seen as vital in reducing suicide. The corollary to this was that many nurses considered that consumers would not be suicidal once the psychotic episode had been medically treated. This perceived association between psychiatric diagnosis and nursing practice was iterated by a nurse when stating:

> **Nurse:** The diagnosis is vital. While we are dealing with people's problems, if they are psychotic for example we aren't going to talk about suicide with them [except] to find out risk. It is pointless.
>
> **TF:** What about when they are not psychotic? Would you ask then?
>
> **Nurse:** No, well we might if there was a concern, and we ask to ensure they aren't initially. But later, no. The psychosis caused the suicidal thoughts, so there is no point. (Nurse 14)

Like consumers with a diagnosis of MDE, psychotic consumers were seen to need assessment of risk to ensure that they did not attempt suicide. This issue was discussed in an MDT meeting, when the case of a consumer who was experiencing intermittent auditory hallucinations to leap off a building was discussed. The psychiatrist chairing this meeting advised other clinicians that all consumers who were psychotic should be assessed for suicidal feelings and thoughts, and should also be considered at risk of suicide even if they were not disclosing such thoughts or feelings. This association between psychosis and high assessed risk of suicide was supported by some clinical notes that I read (field notes).

### 5.2.5 Borderline Personality Disorder and suicidality

Chronicity of suicidal thoughts was often seen as another medical diagnostic symptom. Consumers who had continued thoughts of suicide were often diagnosed as having a borderline personality disorder (BPD). While the chronicity of suicidal thoughts and feelings was seen to be legitimate, the on-going presence of suicidality was seen as a confirmation of the diagnosis. When assessing risk the psychiatrists generally considered current risk, with a recognition that risk could increase. However this risk was generally seen as contextual and fleeting. Some consumers with a diagnosis of BPD were admitted to the wards during 'after hours' admissions. One psychiatrist explained it this way:

> "[Consumers} with BPD really only get admitted in the weekends. It is either because they are seen as suicidal, and there is a junior admitting registrar who is nervous, or as part of their on-going plans…these plans see hospital as respite. It's not really the place for them. They get worse, staff here hate it…" (Consultant Psychiatrist 2)

This interviewee expressed a sense that acute inpatient wards were not correct places for consumers with a diagnosis of BPD and reflected a prevailing ward or team cultural belief that acute suicidality for people with a diagnosis of BPD was only time-limited, and therefore admission was not needed. Whilst continued acute suicidality was a sign of mental illness, chronicity of suicide was often a symptom of an axis two (usually BPD) diagnosis, which was seen as non-treatable through medical means (such as medications) and therefore such consumers should not be present on the ward. The consternation caused by an association between chronicity of suicidal thoughts and the diagnosis of BPD is significant. One psychiatrist affirmed this:

> "They [consumers with a diagnosis of BPD] are seen, in general at least here, as misbehaving consumers, as if there would be a control for the behaviour if they would only make themselves stop doing it [having suicidal thoughts]." (Consultant Psychiatrist 2)

There was disagreement between staff about whether someone with a diagnosis of BPD could be at acute risk of suicide. An example of this was when a nurse's suggestion that a consumer with a diagnosis of BPD was at risk of suicide was met with derision by some. Comments included "she is just a PD [personality disorder], she is not really suicidal" and "she will always be suicidal, the fact she is just shows she is a PD" (field notes). Similarly, consumers who did not have a diagnosis of BPD, but had previously been suicidal with or without attempts, were informally labelled as having BPD by nurses. One psychiatrist commented on this association:

> "… one of the things that a lot of people who present with suicidality have difficulties with human connections and I mean they [suicidal consumers] get labelled with borderline personality, a lot of them [when this may not be the formal diagnosis]." (Consultant Psychiatrist 1)

A psychologist supported such a notion when stating:

> "If they [suicidal consumers] continue to threaten suicide… [nurses] are very cynical of people who threaten suicide …" (Psychologist 2)

It is quite possible that clinicians' general viewpoints about people with a diagnosis of BPD may have influenced some of the data, and a consideration of how nurses view such people is outside the remits of this thesis. Nevertheless the data does say something about the cultural understandings how suicidal people are expected to behave. Suicidal consumers were meant to 'respond' to treatment/care; without such a response, suspicions were cast that the consumer was neither truly 'suicidal', nor were they really 'mentally unwell'.

### 5.2.6 Suicidality as irrationality

Consumers who were considered 'truly' suicidal were also seen as irrational, as the deliberate ending of life was almost always viewed as an illogical, extreme response to stressors. The act of thinking about suicide was usually considered evidence of irrational thinking as part of a mental illness. One psychiatrist discussed this as follows:

> "To be suicidal is to be irrational. While we understand, and try to get the patient [sic] to understand what was occurring for them to get these thoughts, the thinking itself is skewed. In the moment it makes sense for them to suicide, but when treated they see it is not rational. And we know it is not rational, which is how we justify stopping them, using anything at our disposal." (Consultant Psychiatrist 2)

Irrational thinking, even without the presence of a mental illness, was seen in itself to be a justification for medication treatment and coercive interventions to keep a consumer safe. The same psychiatrist gave an example of this as follows:

> "We had a guy [in the ward] who I did not think met the criteria for a mental illness. He did not show other symptoms, but he had tried to kill himself because of a shameful thing he had done. While he was not mentally unwell, the idea that killing himself was a logical way out was flawed, so we did give him some medication to calm him down, and we kept him here on ward limits [where a consumer is not given clinical permission to leave the ward] until we were able to get people from his community in to talk to him. As I said he was not sick, but he was irrational, was stressed, and that irrationality manifested itself in wanting to end his life." (Consultant Psychiatrist 4)

### 5.2.7 Summary of this section

A bio-medical explanatory model of suicide and expected consumer responses to treatment/care was evident within ward/team cultures. I am not suggesting that there is not a relationship between bio-medicine and suicidality, nor am I implying that psychiatric illnesses should not be treated to assist consumers reduce their suicidal impulses. However the culture of the primacy of bio-medicine (and, as I show in the next section, risk) results in certain ontological understandings constructing practice. Medical practice, although not the focus of this study, appears to be constructed in a similar way, and there were strong interview clues from doctors that they felt their practice was restricted by the bio-medical culture. Nevertheless the ward culture of a bio-medical view of suicidality was manifested largely (but not solely) through medical authority, and disciplined nursing to practice in a way consistent with a bio-medical view of suicidality. As such the culture of bio-medicine is one element in constructing nursing practice with suicidal consumers in these wards or teams.

## 5.3 Risk and containment as a constructing element of ward culture

Intersecting with a bio-medical view of suicidality causation and requisite actions was a culture of the need to reduce the risk of a consumer attempting suicide by identifying risk through risk assessments, and containing the risk by the use of actions such as containment on the ward or nursing observations. Although I am not suggesting that risk identification and amelioration is not important, I do wish to identify four issues with this approach: (i) that the ward culture of the absolute priority of risk assessment and risk containment dominated views on what could be done with suicidal consumers, and the expected responses of team members to enact assessment and containment beyond any other action (except for bio-medical assessment and treatment), (ii) that containment was seen as the main way of ameliorating risk (iii) that attempting non-containment interventions was not considered to be feasible (as they would increase risk), and (iv) risk was thought of in absolutes, with consumers largely seen as ‘at risk/suicidal’ (and needing coercive interventions) or ‘not at risk/not suicidal’ (and needing to ‘take responsibility’/not needing therapeutic support from staff).

While a culture of risk was, as I will show, associated with bio-medical views of suicidality and reinforced by medical staff, many doctors also felt their practices were themselves shaped by a risk culture. A psychiatric registrar expressed frustration with the ward culture when noting, in a resigned tone:

> "Really there is nothing else done in most instance[s], apart from keeping them safe [on the ward] until discharge." (Psychiatric Registrar 2)

There was also a strongly held view that there was an external public perception that inpatient wards were meant to provide safety from suicide through the risk elimination practices of clinicians. Clinicians of all disciplines spoke of this perception within interviews and in informal discussions that began in MDT meetings, sparked by my presence. The following two examples highlight this:

> "We are under constant pressure here because the public perception is that we somehow magically keep people safe. When someone is suicidal, if they really wanted to, they could kill themselves here, despite our best preventions. And they can kill themselves when they leave. It is what I would do if it were me and I was intent on suicide. I would say “oh yes I am safe, thank you very much” until I left and then I would do it. But the public and the media expect us to keep everyone safe, and, yes, maybe we sometimes are more restrictive than we would like to be because of that fear that we will be blamed if it goes wrong, if there is a completed suicide, that it us who will be in front of the coroner, that the media will be naming me. So those fears become part of our culture and way of doing things. I am not saying we should not restrict certain patients [sic], but maybe we do it more than we have to." (Consultant Psychiatrist 2)

> In a discussion in an MDT today I was asked about my presence. This sparked a big discussion about how people do not understand their work. How the public expectation is to treat and lock the doors [to the unit]. In retrospect it is not surprising, but I was surprised at how quickly I had tapped into their feelings that lay perspectives of care influence a restrictive culture. (field notes)

A focus on clinical risk was evident in MDT meetings. As I have already noted these meetings were largely driven by medical staff. Consumers were described in terms of their diagnosis, need for medications, and perceived risk (usually described as being ‘high’, ‘medium’ or ‘low’ risk of attempting suicide), and the actions (usually nursing) that stemmed from the perceived risk. On two separate occasions I observed a consumer’s primary nurse attempting to consider risk more fully. In the first observation a nurse suggested that while a particular consumer’s risk was ‘high’, that being subject to special observations was making the consumer “more paranoid and upset” (field notes; the quotes are a summary of my observation rather than verbatim). The nurse instead suggested that she intensify her time spent with the consumer, so that a consistency of nursing and support was given without the obtrusiveness of different staff following the consumer. The consultant psychiatrist quickly dismissed this suggestion, asking “will you take responsibility for her if she does it” [attempts suicide], turned away from the nurse, and said “no, observations are the only way [to maintain safety]” (field notes).

A second, somewhat similar observation also was indicative of a risk culture and the way this was reinforced. A nurse, who had initially sat silently in the MDT meeting while a consumer’s diagnosis, medication treatment and risk level was being discussed, spoke up and suggested that the consumer’s risk level could be ameliorated by allowing a home visit (and also suggested other benefits of this) as the inpatient environment was somewhat oppressive and tedious for the consumer. The consultant rolled his eyes and, in a slightly raised voice, indicated that the environment was “not meant to be homely; it’s about being safe”. The nurse visibly slumped back in her chair and was quiet for the rest of the meeting (field notes),

The view on risk appeared to be closely associated with a view of suicidal consumers as being mentally unwell, and therefore unable to contribute to decision-making about their own safety. Instead decisions appeared to be made largely for them. One nurse, who had previously practiced in the United Kingdom, expressed frustration with what he saw to be a risk adverse ward culture:

> **Nurse:** There is such a narrow way of seeing people and risk. It is like risk is this thing that sits out there, sits like this monster to be battled. Risk isn’t like that, it is in a context. Sometimes we make people worse by the things we do to them, we make them more at

> risk. We make them more unsafe. There is just so little understanding that by us taking risks we help people in the long term
>
> **TF:** Can you give me an example of that?
>
> **Nurse:** Yea, yea definitely. Like a guy I was nursing a few weeks ago. He was a young guy, really fit. You could see him getting wound up here. Not like he was going to hurt someone, just himself. He was more and more agitated, and I wanted to just get him out, give him some space. But the doctor here is from [name of an eastern European country]. They just don't see risk the same way. So he was like "no, no, he is at high risk of suicide", keep him on obs [ervations]. And what happens, he goes to the toilet, tries to cut himself with a razor another patient [sic] gave him. And the nurse doing the obs gets in trouble for not following him into the toilet. Now maybe he should, but the context of understanding that the focus on risk just as a "yes he is at risk, no he is not" is way too simplistic. What was missing was the therapeutic aspect of us thinking "what is most likely to be of benefit overall". It is about risk being God, about find the [risk] level and max[imise] the containment. It's just the culture of this bloody place. (Nurse 2)

It appeared to me that risk was part of a general ward culture (as was the pre-dominance of bio-medicine) as some clinicians suggested in interviews that non-suicidal people were subject to a similar framing of risk and risk containment. However just 'being suicidal' was enough for a consumer to be considered high risk. In formal and informal discussions with various clinicians I was advised that suicidality was in itself 'irrational', meaning that suicidal consumers could not make rational decisions about their safety (field notes). However a reduction in suicidality meant that (through medical treatment) rationality had returned, and consumers could be given 'responsibility' for their own safety again. The ward culture seemed to perpetuate a view that suicidality was dichotomous; a consumer was either actively suicidal or they were not. Similarly, an actively suicidal consumer was at risk and needed containment before (and usually instead of) any other consideration of what might reduce their suicidality; a consumer who was not suicidal could take responsibility for their own safety often meaning the consumer could be discharged, even if the consumer or his/her family member thought this was not the right course of action. This dichotomous view of suicidality/risk in the ward or team culture was evident. All the wards I studied during this research faced considerable pressure on balancing the need for inpatient treatment of current consumers, and the waiting list of consumers who needed to be admitted. To facilitate this, current consumers were often discharged, or temporarily transferred to other mental health service locations to sleep the night. Almost always consumers who had been suicidal but were now considered ‘low risk’ were the ones to be moved or discharged. One doctor described the situation:

> "Every single afternoon [or] evening patients [sic] have to be moved out of their rooms to sleep somewhere else because there’s not enough rooms… [staff] try to assess first, the risk and what the patients want, but in the end they have no choice and we have to choose who we think is less at risk and damn the consequences, so while it may be safe [consumers are low risk of suicide] they don’t get any attention [from staff]". (Psychiatric Registrar 2)

The same registrar recounted an exemplar about a consumer who had to be moved:

> "…we had one [a consumer who was moved overnight] a month ago, two months ago, a patient [sic] who seemed less suicidal and we had to move him to [name of a drug and alcohol unit] …and then he got very upset…he attempted to kill himself, a very serious attempt. With all the best will in the world we assessed him and thought he was the least risk [of all the consumers on the ward] and we were pressured and he didn’t say anything, but this being moved and feeling that he wasn’t important just fed into [the consumer’s sense of rejection] and it just led to the attempt…and um which I think wouldn’t have happened if he could have stayed here." (Psychiatric Registrar 2)

A psychologist summed up the reality of the limited resources of an inpatient unit as follows:

> "… life and death issues… are balanced against the pressure to get the people out the door." (Psychologist 1)

Resource demands had a very real impact on the ability of clinicians to provide treatment/care; however the fact that suicidal consumers were dichotomously seen as suicidal or not, the emphasis on this risk over any notion of the potential therapeutic impact of the inpatient environment on suicidal consumers, and that they were often the first to be moved, suggests that a risk and containment view of treatment/practice prevailed. Significantly, nurses were expected to operationalise risk minimisation through nursing interventions. One suggested:

> "Yes that’s our job [risk containment, my term]. Along with making sure they [suicidal consumers] get their meds, we make sure that they don’t go off and do anything. The medical staff do the first-up [risk] assessment and we do them every shift and write them in the notes. And as a team we decide things like can they have leave [off the ward], do they need obs[ervations]. But in a nutshell if we go through a shift and make sure they get their meds and keep them alive, then our job is done." (Nurse 7)

## 5.4 Nursing practices within a bio-medical/risk culture

### 5.4.1 Introduction to this section

This section outlines nursing practices within bio-medical/risk ward and teams, and shows that these practices were largely consistent with the dominant culture. I initially describe the processes by which nursing practice was shaped by the culture. I then show how nurses undertook therapeutic work with consumers, and how risk assessment and risk containment practices occurred. I end the section with a brief description of a group of nurses who practiced in a very different way from the ward or team culture. I have called these nurses ‘resisters’ for reasons I shall later describe.

### 5.4.2 Processes that aligned nurses with the dominant culture

Many processes were significant in aligning nurses with the dominant ward or team culture, and ensuring that nursing practices were consistent with a bio-medical risk view of care/treatment of suicidal consumers. These included documentation in consumer files, nursing handover, and structured documentation sheets. Most consumer files that I saw did not have a specific nursing plan of treatment/care. Instead management plans, written by the consultant psychiatrist or the psychiatric registrar, listed interventions for action by the multi-disciplinary team, including nurses. These plans related to consumers’ psychiatric diagnoses and indicated that pharmacological treatment and risk prevention were a priority. In the minority of instances nurses wrote nursing care plans in suicidal consumers’ notes, mostly focused on the safety of consumers, and were prescriptive about the need for nurses to, for example, maintain observations. Notably, few care plans highlighted nursing involvement with psychosocial needs of consumers.

Nursing handover notes about suicidal consumers also emphasised the psychiatric diagnosis and the risk management practices needed to prevent suicide. I was surprised how little time or attention was given to the issues that led to consumers becoming suicidal. In retrospect my surprise was unfounded when the suicidality was primarily considered to be part of the mental illness.  A nurse described how practical aspects of nursing care with suicidal consumers were directed by the psychiatrists in the medical wards:

> "…it [nursing practice] is based on what the doctors say, a lot of it.  … whether they're [suicidal consumers] going to be on a Special (observation], or what medication they're going to take…[but] we're the ones that have to give the medication out and if someone needs an injection then we're the ones that have to do it, so we're sort of directed by the doctors what happens." (Nurse 30)

On some wards nurses were given structured sheets of paper with pre-determined areas for completion to both give hand-over information and to note these down. These forms had titles that indicated the priorities of psychiatric diagnosis, medications, levels of observations or other containment (such as 'ward limits') and the consumer's current level of risk. Nurses were expected to follow this format in doing handover and to complete them for later reference. A similar format was expected of nurses at MDT meetings. Although more detail was given, nurses were expected to attend these and give brief information in that format to the MDT. This format was, to me, both representative of what was expected of nurses and acted as a way to discipline them to practice in a bio-medical/risk way. Notably this disciplining came from other nurses as well as medical staff.

### 5.4.3 Therapeutic work with consumers

The bio-medical/risk culture impacted on what was, and what was not, seen as legitimate nursing therapeutic work with consumers. Almost all nurses described the main focus of their role to be the gaining of a rapport and having an on-going therapeutic relationship with suicidal consumers. I was therefore initially surprised to hear that talking to suicidal consumers about their suicidality was considered to be the antithesis of best practice. There was a widely held view that talking to suicidal consumers about their suicidality was very problematic:

> "Why would you talk to them about the idea of suicide? We are here to keep them [consumers] safe, not encourage such thoughts. Talking about it will just get them to dwell on it, to deepen such a thought, at a time when their thinking is off-kilter." (Nurse 11)

Some nurses iterated the opinion that discussions of suicidal thoughts and feelings were not part of their role. Others extended this notion, suggesting that such discussions were not the function of hospital treatment/care:

> "Well it's almost an unwritten policy that as we are an acute unit its meds and beds, then we don't do anything therapeutic...if it is [needed], then it's the psychologist [that does the therapeutic work]." (Nurse 16)

There was also a belief that discussing suicidality was likely to worsen the consumers' suicide risk. This belief was enacted in many situations I saw, as the following field note reflects:

> "Today [I] saw an example that I have seen many times; a patient [sic] was distressed and approached her [primary] nurse and said she wanted to talk about what had occurred before she entered the ward and what her being suicidal meant to her and her family. The nurse told her that she should discuss this with her doctor next time she saw him." (field notes)

Clinicians from other disciplinary groups echoed the notion that only psychiatrists and psychologists should discuss consumers' suicidal thoughts and feelings. I observed one interaction in a staff meeting where the psychiatrist present strongly advised a new graduate nursing staff member that her role was not to discuss suicidal thoughts and feelings with a consumer lest this undermine the therapy being done with the particular psychiatrist (field notes). I was unable to interview the psychiatrist for this research project. However, other staff told me, in informal discussions, that this was not an unusual situation, and this was also reiterated in some consumer notes. This experience was echoed by consumer interviewees, with many describing a perception that nurses actively avoided discussing consumers' suicidal thoughts and feelings. Even those who had encountered supportive nurses were aware of many individuals who did not discuss such issues. I asked the following consumer interviewee whether she thought staff members were active or open to such discussions. She replied:

> "Not all. Some seemed to avoid asking about it [suicidal thoughts and feelings], instead chatted about general things, the weather and so on. Others asked quite bluntly [about suicide risk only] I thought." (Consumer 12)

I did observe nurses advising consumers that they could seek them out if they needed to talk (although, as I have noted, as long as the discussion was not about suicidality). Some nurses did this as an adjunct to finding time to talk with consumers. Others, at times, left such interactions up to the "discretion of the patient [sic]" (Nurse 32). However, almost all consumer interviewees emphasised the need for nurses to actively seek them out during the day to talk, rather than being left to find the staff member if needed. Most interviewees considered nurses too busy to approach, and thought they would be considered 'demanding' if they did so:

> "I've seen consumers sitting up in the foyer area just there in tears for 10 to 15 minutes before their nurse has been able to get to them or do anything for them because they've been so busy with another consumer or doing something else. I mean that poor person sat there and bawl their eyes [cry] out waiting to talk to someone but there would be no one there. Other nurses have just said "oh well your nurse will be here in a few minutes" and turned their back on [them]." (Consumer 15)

The consumer advisor of two inpatient units contrasted the approach of clinicians approaching consumers with that of consumers having to physically attend the staff offices (in this case the nurses' station) to ask for this time:

> **Consumer Advisor -** I'd like the staff to get out that, I call it the begging bowl. The nurse station there and they're sitting there, people have to come up there and beg for things, and that gets used a lot; the begging bowl, that's a term that gets used a lot round here.
>
> **TF -** Can you tell me more about that?
>
> **Consumer Advisor -** Well it's just my idea, because I just said 'shake the bowl', and people have to go up there to beg if they want something, to me it's demeaning, I think staff should be, as far as possible, out on the ward, and some do, and some don't, some do, some are out on the ward all the time, and I can name them. (Consumer Advisor)

Consumer interviewees described how such an approach increased the sense of shame they felt, because being ignored increased the concurrent sense of worthlessness that they had. The underlying shame and worthlessness was in part caused by 'failing' to attempt or complete suicide, at having been suicidal, and partly because they considered that they carried a stigma of being a 'suicidal person'. Consumers discussed their own self-image of being 'weak', because they had resorted to suicidal thoughts and/or attempts. Many considered that others would perceive them in such a way as well. This sense of shame exacerbated difficulties discussing emotional issues. Many consumers maintained a sense of ambivalence about future suicide, considering this a potentially valid option for the future if life continued to be intolerable. Although most expressed a desire to talk about such feelings, they struggled to approach nurses because of the sense of shame that they felt. In short, they felt that they were not deserving of nurses' attention. One interviewee told me that the main reason he allowed himself to be interviewed was a hope that the findings of this study would show that nurses should spend time talking to consumers about their suicidal thoughts and feelings:

> "It is important that you tell them [nurses] that talking to people is the most important. And making them feel wanted and valued as humans. It is so hard to talk, to deal with the shame, but tell them [nurses] to approach us, to show us we are worth talking to." (Consumer 22)

As I noted, nurses considered that the focus of inpatient nursing with suicidal consumers was having a therapeutic relationship, but it appears that nurses and consumers had different views on what this is. Consumers wanted active approaches from nurses and to be able to discuss their suicidality when needed, yet there was a prevailing nursing view that seemed to be aligned with cultural expectations that nurses discussed general issues but avoided discussions around suicide. In addition consumers were expected to approach nurses when they needed something. Nurses approached consumers to attend to practical matters such as assisting them to attend MDTs or family meetings, give medications or advise consumers of meal times. I show in the next section that accurate risk assessment was similarly thought to be able to occur within the context of brief discussions. I was aware that nurses appeared to be busy attending to a myriad of other tasks, but little time appeared to be spent talking to suicidal consumers. This may have been because they were genuinely busy, but other nurses on the ward ('resisters') were notable for being with consumers much of the time. It appeared to me that, while time constraints were a real issue on the inpatient ward or teams, the little time spent, and the absence of allowing consumers to discuss issues around suicidality, was a primarily an alignment with cultural beliefs that 'therapeutic relationships' meant general support and doing things for a consumer, with suicidality a topic not to be approached in any depth (field notes).

### 5.4.4 Risk assessment practices

Nurses' practice was significantly impacted by the bio-medical/risk culture which saw risk identification as a priority and as the domain of medicine. Although nurses were usually expected to provide risk information, they usually had no authority to rate risk. An example of this was the formulation of a policy in two wards that allowed house surgeons (first year doctors with minimal mental health experience) to formally assess consumers for suicidality and risk of violence to other people. Only 'senior' nurses, in pairs, could make a similar assessment (field notes). In practice this meant that house surgeons were often delegated the task. Nurses were often unable to locate another senior nurse to undertake the assessment with them. Others did not try, as they considered it:

> "Insulting, really insulting. We are senior. I have been here for over ten years, and with all due respect to the house surgeons, they don't have experience in psychiatry. What do they know about risk? Just don't bother [doing assessments]. It's just insulting." (Nurse 18)

The emphasis on risk assessment undertaken by medical clinicians further undermined nursing authority to make assessment of risk of suicide. This was especially apparent on weekends. A number of clinicians discussed consumers who had not been granted leave before a weekend because of the risk of suicide. However in some instances this risk, according to assessment by nurses, had changed, and nurses therefore considered that 'leave' should be granted:

> "They [the on-call registrars] have got more sort of power than us in decision making. If a consumer wants weekend leave they [the on-call registrar] just come in you know? …months go by between their visits and then they're gone again and the next ones come in…they're making all these decisions...We know the people (the consumers) better than them, but we are unable to make decisions about when they [consumers] can have leave. It's ridiculous." (Nurse 11)

The formalising of risk assessment policy on the two wards was one indicator of the ward culture of nurses not being involved in risk assessment. In the other ward nurses were expected to assess, report and record risk. The few occasions I saw this occur I was struck by how they were conducted. I noted this in the following field notes:

> [T]he [risk] assessments seem to be brief and cursory. The nurse went up to [consumer] and asked things like "how is [sic] those suicide feelings today? Are you safe? Can you promise me that?" The consumer barely had time to answer. I wondered if that was just a follow up, maybe I had misinterpreted, but the [consumer] confirmed in the interview I did with her today that that was the only time she spoke to the nurse, and yet it was documented in clinical notes as "risk of suicide low as stated by patient [sic]." (field notes)

I asked about this style of assessment in many interviews. Most nurses confirmed that this was the way risk assessment was undertaken on the ward. This approach was seen as compatible with the notion that any further depth to questions would mean entering into a conversation about suicidality that, as shown previously, is not seen as the role of nursing. This approach was seen by some to be good practice for three reasons. First, it was thought to both minimise the likelihood that ‘inappropriate’ conversations about suicide would occur. Second, it was thought that this style of assessment would also provide accurate information about risk very quickly. Indeed many nurses advised me in interviews that consumers would always disclose true suicidality. Third, brief risk assessments were thought to be a way of minimising the likelihood that consumers would delve into suicidal thoughts and increase their suicidal thinking by talking about it. Similarly, some interviewees considered that this brief risk assessment approach was either consciously or unconsciously undertaken by nurses because it aligned with the bio-medical/risk culture on the ward. A small number of interviewees suggested that the ability to verbalise and write risk and pathology in medical diagnostic terms was highly valued and validated by medical staff and some other nursing staff. I observed many occasions where there appeared to be a compulsion for nurses to give risk information very succinctly to their colleagues (for example in handover) or in face to face conversations with doctors. New graduate nursing interviewees and student nurses on placement commented on this in interviews.

### 5.4.5 Risk minimisation practices

Nursing practice in the bio-medical wards and teams was shaped by dominant cultural views of consumers’ risk of suicide as being something to be identified and minimised through containment. Even in instances where nurses were allowed to undertake risk assessment, it was medical staff who often had the authority to direct nursing risk containment practices (field notes). Containment practices occurred in many ways, as I show in the rest of this section.

A significant minority of consumers had ‘voluntarily’ (not subject to the MHA) admissions to the units. Despite the voluntary status of these consumers, many files contained ‘prescriptions’ from admitting medical practitioners directing nurses to invoke section 111 of the MHA (a registered nurse's power to ‘hold’ a consumer in an emergency, until assessment by a doctor) if these consumers were to try to leave the ward. I mentioned this to interviewees, but few were concerned about this practice; instead many saw this as a necessary way to contain risk of suicidal acts occurring. One interviewee suggested:

> "[It is ] a common-sense solution; it allows patients [sic] to not have the stigma of the act but it means we know that they aren't  really able to choose to leave. We have to stop them." (Nurse 6)

There appeared to be a belief that suicidal consumers could not be rational enough to make a decision to be admitted to the ward, or to leave of their own volition. Although I found this practice problematic, I was aware that I had previously formulated my own views on this in a published article with colleagues (Farrow et al. 2002). I was open about this in interviews, but almost all nurses disagreed with the view that voluntary admission with the implicit threat of section 111 was problematic. Instead there seemed to be two views that dictated practice: (i) that voluntary admission avoided the stigma of a consumer being placed under compulsory admission, and (ii) that 'safety-first' containment was a priority, and that allowing consumers to engage with this notion was a practical solution to ensuring containment occurred.

A second containment practice directed by medical clinicians for nurses to enact was preventing some consumers from leaving ward environs. Those consumers, considered to be a 'medium' or 'high' risk of suicide were not able to leave the ward unless approved by the consultant psychiatrist or registrar. In some instances this meant that nurses attempted to negotiate for leave for a consumer whom they thought at a low risk. Generally though, nurses either agreed with the conservative leave measures instigated by the psychiatrist, or advocated for less restriction. However, there appeared to be an inconsistency between the expectations of some nurses to undertake risk assessment, and their ability to do anything with risk findings apart from reporting and documenting these. Two nurses noted this:

> "I've had consumers request to have time out from the ward, and I have explored how safe they are [undertaken a risk assessment] and found they are low risk. [But] going out and having that ability to demonstrate that to the doctor is different. It's [the risk assessment] been overridden by doctors." (Nurse 12)

> "It seems that here our job is to tell doctors what we find, but we have to do it in such a way that it is recognised...it has to be in psychiatric terms... We have to give a risk level. We ask consumers about their risk you know. The irony is we have to find this out, we know a lot about it [risk levels] but we can't, we don't have much say in what a consumer can or can't do. It is really ironic. We spend so much time doing it, then arguing with the doctor about leave. So much of our [nurses'] time is taken up. It is just a waste." (Nurse 13)

Another way in which significant nursing time was used to contain suicidal consumers, at the direction of medical staff, was the use of 'observations'. There was variation about who could end such an observation, with two of the wards needing this to be a written order from a medical doctor, and the others allowing a senior nurse to order this in writing in the consumer's notes. Nurse interviewees expressed frustration about their inability to start and end observations. However, there were also concerns that nurses and the institution would be vulnerable to criticism if a suicide occurred and there was not a medical signature authorising the observations:

> "Yeah I guess the institution protocol... the problem is if you bend a rule you may not cover the area of the rule so you're really caught between a rock and a hard place." (Clinical Psychologist 2)

There was a marked difference in the practice of nurses undertaking the observations. Some appeared to use this as an opportunity to engage in conversation with the consumer. Others spent most of their time in silence. At times this may have been appropriate, as this is what the consumer wanted or needed at that particular time. In most instances consumer interviewees reported that they would have welcomed some verbal communication. The absence of nurses' communication had the effect of making observations seem intrusive:

> "I was being followed everywhere I went. Sometimes it was ok as the person talked to me and that was fine, I didn't want to say much, I was just too depressed but she checked I was there… I tried to explain to them, well embarrassing things like I can't go to the toilet with someone watching but they just ignored me and did it." (Consumer 4)

The same consumer contrasted this with a minority of nurses who operated differently:

> "… the others were good, I understand that it maybe was necessary as I was a danger to myself, but they gave me a little space. And they talked. Not too much but I knew, well they seemed like they were interested which meant a lot." (Consumer 4)

The difference in the perception of the helpfulness for consumers appeared to be whether they could talk about current issues with the nurses undertaking the observations. However nurses noted that the very act of observations meant that as nurses they were busy and unable to spend time with the consumers they were working with. This view was supported by the following two interviewees:

> "Well, it's like when we have to run around and do checks that the doctor orders, it prevents discussion of [consumers'] feelings both because they see it as focusing on risk and because you are then so busy that you don't have time to talk." (Nurse 12)

> "Being able to listen to them, what the consumer is saying, validating their feelings and getting trust going and a relationship, that's what the most important thing is with suicidal [consumers]. That's why it's so important to have one to one nursing instead of people on Obs [observations]." (Nurse 13)

Another nursing practice was sometimes used to determine containment decisions. Consumers were asked to verbally agree to 'guarantee their safety' and to contact a nurse if they felt they were likely to act on their suicidal urges. If a consumer could make this 'guarantee', then they were thought to be at a low risk of acting on suicidal urges. The contrary was also deemed true, with an inability to give a guarantee seen as indicating a high level of risk:

> "If it [suicide risk] is rising and they cannot guarantee their safety [it indicates] they might do something untoward." (Nurse 4)

The presence of 'guarantees of safety' was noted in clinical notes and was part of discussions between nurses and other clinicians. It appeared that the refusal or inability to guarantee safety was sometimes seen as pivotal in decisions that lead to containment activities, especially refusal for short term leave off the ward and the beginning of observations. Similarly, a guarantee of safety meant that such containment activities would either cease or not be instigated. There was also awareness that consumers guarantees of safety were required by some medical staff, who, some nurses considered, directed their practice:

> "…we have people guaranteeing safety but it depends on the doctor. Some insist on [them]." (Nurse 5)

Not all nurses supported the idea of guarantees of safety, but were aware there was a perceived pressure for nurses to undertake them and record the outcome in clinical notes:

> "...some people write that in the notes; "guarantee your safety", so I presume that's what they're asking if they're saying that in the notes. And that's like… it's like for how long? Is it for that five minute period that you were talking to them or is it going to be happening in an hour? When I come on is it still that they're… or are they doing it to cover their arse so that if someone reads the notes if the person's killed themselves, they've written that." (Nurse 12)

Some interviewees considered that guarantees of safety were useful in differentiating a diagnosis of a MDE from a BPD:

> "… to me if somebody says they're suicidal and won't contract their safety then to say they're suicidal "I have these intrusive thoughts" and that "I'm not going to act on them in the hospital", that means that they have a personality disorder…if they are truly suicidal then they will admit it and say they can't guarantee (not to suicide)...if they guarantee their safety it means that they are suicidal but not at current high risk [of attempting suicide]." (Nurse 2)

My hunch at the outset of the study was that guarantees of safety would be used and that they would be seen as a therapeutic tool that helped nurses gain a rapport with suicidal consumers. This hunch was partially based on the findings from a study I conducted on the use of 'no-suicide contracts' (another name for 'guarantees of safety') with suicidal consumers in community crisis situation (Farrow et al. 2002). However, no nurses in the medical wards commented on what they considered the therapeutic value of guarantees of safety, with its value seen in its perceived ability to aid in risk and psychiatric diagnosis. During the study I also suspected that 'resisters' would be less likely to use guarantees of safety and/or be more likely than other nurses to see them as problematic. However, this was not the case.

## 5.5 Dispositions as a constructing element of nursing practice

### 5.5.1 Introduction

I have shown that the wards and teams under discussion had a culture of perceiving suicidality as a bio-medical/risk event. However, not all nurses responded to the culture in the same way. Many (although not all) interviewees explained that their beliefs about suicide had changed since working in the acute wards. Some disclosed this early in the interviews, whilst others had not considered this in the past. This was well articulated by one interviewee, who approached me two days after interviewing him. He told me he had given a lot of thought to the interview and his own thinking about suicide, and realised in retrospect that he now had very different views than when he was a student nurse (field notes). His consideration led me to think more deeply about the dominant culture and *why* nurses absorbed this, and I deliberately asked questions about this in subsequent interviews.

One group of nurses considered it self-evident that the 'factual' relationship between suicidality and mental illness should shape their practice. A second group of nurses were very aware of the dominance of the bio-medical/risk view of suicidality and considered it problematic. Despite this consideration, this group of nurses still practiced in alignment with the dominant culture. I start this section by identifying these two groups of nurses' dispositions through their views about the causation of suicidality, issues about the stress related to working with suicidal consumers, and their previous exposure to bio-medical/risk and other ways of working with suicidal people. By identifying these dispositions I show how nurses' dispositions can have a constructing influence on practice, even when there is an inconsistency between dispositions and what nurses do. Later in this section I discuss a third group of nurses who partially resisted the dominant bio-medical/risk culture, particularly in the way they undertook inter-personal therapeutic work with consumers. I both show how the ways in which they practiced and consider how their dispositions led them to work differently than the first two groups of nurses.

### 5.5.2 Views on suicidality causation

Consistent with the dominant culture, the first group of nurses believed that mental illness *caused* suicidal thoughts. For these nurses the presence of a mental illness precluded the ability of consumers' rational decision making, with the very thought or act of suicide being irrational. As two nurses stated:

> "Why would you kill yourself? You can't make things better that way, no matter how bad life is. It [suicide] is just so final." [Nurse 27)

> "I'm employed to stop people committing suicide and I will do everything in my power whilst I'm at work to stop people doing that. They almost always have real life stuff, it manifests in mental illness, they [suicidal consumers] lose their ability to make a rational choice. Hey, maybe a small minority could make a rational choice, but then they are probably the ones who don't have a mental illness. If they don't, they get discharged, after that it's up to them. It's sad, but it's their choice. And while they are here and have the diagnosis, then we must help them by putting safeguards on, treating them with meds and that, and constraining them to the unit. I can live with that; it's my job. It's the moral thing to do." (Nurse 2)

Interviewees in the second group of nurses had a different view of suicidality. In their view, the right to commit suicide, if in a rational state of mind, was dependent on the personal circumstances of a consumer. Most considered that there needed to be both an extreme magnitude of misery in the consumer's life, and that this misery had to be chronic without a likelihood of being relieved. For most, misery would have to be caused by chronic physical pain, or terminal illness. One nurse suggested:

> "…. the jury's still out on that one [rational suicide]. Probably for me too. I've had situations where, heaven forbid; thankfully people have come into the unit because they've re-established hope. Perhaps it's been a chemical imbalance their medication's helped, they've gone on to lead awesomely productive lives. But I've also cared for people who have been in the grips of neurological degenerative diseases that have come

> into the unit and perhaps they’ve attempted suicide, their reason for doing it is that they’re actually still motor wise are still capable of doing it, that’s a much more difficult area." (Nurse 6)

Although these interviewees did not consider the mental illness caused the suicidality in consumers, the presence of mental illness meant that suicidal consumers were not able to rationally decide whether to suicide or not. Part of their nursing role was therefore to intervene, because a suicidal consumer might make a different choice when not mentally unwell (reflective interview notes). However, other nurses viewed the relationship between suicide and mental illness as non-linear. While almost all mentioned research evidence showing a high percentage of suicidal persons have a diagnosable mental illness, many suggested that mental illness was not necessarily causative of suicidal thinking; instead that was considered an individual response. However some suggested that because suicidal thinking is a symptom of mental illness, and therefore any diagnosis of mental illness in suicidal people was tautologous. One nurse put it:

> "… the only way you could classify them [suicidal consumers] as mentally disordered is because they want to kill themselves, but in actual fact they will be able to give you very rational reasons about the thoughts and the processes that they’ve gone through to come to that what they see as a rational decision. Yes they may have a mental illness diagnosed, but you almost always will get that diagnosis if you mention suicide. It’s a catch 22." (Nurse 6)

Interviewees in the second group of nurses revealed a disparity between the individual views of suicide that some nurses held, and what the articulated nursing practice should be. As an example, a number of nurses told me that they believed that the decision to suicide or not was a question for an individual nurse to determine, from his or her own moral basis, as long as the consumer was able to rationally make this decision.

> "I think people have the right to decide what they’d like to do with their lives, I mean that’s one extreme decision, but yes, there are a number of people I’ve either come across or have heard of second hand who have been in that position where they’ve clearly thought things through and they, yes… it appears to be a rational decision." (Nurse 12)

### 5.5.3 The stress of working with suicidal consumers

Almost all interviewees in the first and second group of nurses found working with suicidal consumers stressful. The following interviewees explained:

> "It's a big responsibility…caring for those [suicidal] people, [it] is quite difficult [if] you don't have that much experience …" (Nurse 7)

> "For me personally it [dealing with suicidal consumers] means high anxiety levels, it means accountability; it means high vigilance and maintaining [a consumer's] life…" (Nurse 1)

The stress nurses (and other clinicians) felt was exacerbated by the emotive and cognitive responses it brought up in them, with many empathising with the difficulties in suicidal consumers' lives. One interviewee discussed this difficulty:

> **Nurse:** That becomes quite scary you know. It becomes much easier just to, you know, think they [consumers] are unwell, or worse blame them. You sometimes get that that phewww [feeling]. You spend too much time listening to them and you empathise too much. It brings up all sorts of thing.

> **TF:** Can you tell me more about 'all sorts of things'?

> **Nurse:** [laughs humourlessly] well 'maybe I should kill myself, my life isn't great too'. Or other patients [sic], maybe we should help or allow them…no it's just too scary to allow contemplation. (Nurse 2)

Whilst most nurses found nursing suicidal consumers stressful, it appears that those that closely aligned with the bio-medical/risk culture found solace in believing that the inpatient treatment/care approach was the only option available. One stated:

> "Yes it is [stressful] but I can sleep at night knowing that we do everything possible. They have a mental illness that we treat. We do the best with the [risk] assessments and to keep them here [on the ward] but at the end of the day if they really want to kill themselves, they will. So, yea, we are doing the best [nursing] work we can, we make sure we keep a really close eye on them and stop them from leaving and we make sure they take their meds. What more can you expect. That I show I sleep at night (Nurse 27)

In contrast, nurses in the second group appeared to feel more stress as they considered themselves helpless to intervene in some consumers' lives. Some cast doubts on the validity of risk assessments, and instead considered that brief risk assessments were a way of decreasing anxiety for themselves:

> **Nurse:** There's a lot of anxiety about that and I think, um, because of that perhaps we are admitting a lot of people into hospital who are suicidal, and it's sometimes scary with the responsibility...it is easier to ignore their issues and to focus on the risk, then we can show what we have done properly if something goes wrong, and we don't have to get into all the "what lead[s] you to being here" stuff". Some people do it well anyway, still do all the [risk] assessments and stuff, but still, you know, truly *talk* [interviewee's emphasis] to people, but for others doing risk is a way out [of talking because] they are scared.
>
> **TF:** Are you saying the risk assessment allays anxiety somehow?
>
> **Nurse:** Exactly. That's exactly it. We hate them [risk assessments] on one level. But we can show what we do. Not for the coroner [if suicide occurs] although that is part of it, but because we can be like "professional face" and do assessments, but never actually talk to the person about the real problem. In my opinion it all comes down to be[ing] scared about talking about death, and suicide, and you know, what if they are right, what if it [life] really isn't worth living…(Nurse 5)

One of the research challenges I faced was to attempt to extricate individuals' underlying beliefs and fears. Some, such as this nurse interviewee, attempted to articulate the reasons why the bio-medical/risk approach had appeal in reducing anxiety:

> "We [nurses] are actually scared of them killing themselves. Not because we will be blamed but because we have to face up to our own mortality and the fact we are so helpless in the face of someone else's mortality. We have few tools to stop them, we hold them and we treat them with meds, and that does seem to help for some [consumers]. But I wonder what happens after discharge, do we really *really* [nurse's emphasis] help? I sometime think we act in this way to reduce our own anxiety, so we are doing something, anything…"(Nurse 23)

The sense of responsibility was also influenced by external expectations that the inpatient environment would afford consumers both safety from suicide, and medical treatment for the causes. Although this research did not examine public perceptions of suicide and suicide care, many staff cited media articles that had been critical of inpatient care after a consumer suicide. Some bemoaned a lack of public understanding of the complexities of causes of suicide, and suggested that suicide treatment/care authority was manifested in doctors because of this:

> "[The public expect mental health staff to] protect [consumers] from bad things that do happen, that we have no control over, and put all our faith into the medical profession to save them [suicidal consumers] …and that's why [medical staff] get paid so well as the public have to put them on a pedestal to maintain our belief that somebody could [do] something about this [preventing people from suicide]…so from a sociological perspective [doctors] are really important, not necessarily because [they] are doctors, but because [they] represent an elite system… that we can make things [suicide problems] go away." (Nurse 2)

This interviewee articulated a view that there was an expectation that treatment/care of suicidal consumers is generally seen as being about the elimination of suicidal feelings in individuals and preventing suicide attempts from occurring. This viewpoint was seen as another cause of stress for nurses who were expected to carry out the societal expectation; something that appeared to be operationalised in the form of the medical culture. This cause of stress was echoed in nurses' concerns about possible repercussions for nurses in the event of a consumer completing suicide. Many discussed external inquiries into other mental health units. In these instances clinician decision-making had been questioned after a discharged consumer had proceeded to kill others and then committed suicide:

> "Some of that anxiety is obviously about the fact that the patient [sic] could in fact act on suicidal thoughts and ideas to completion to in fact kill themselves. I think there's a fair bit of anxiety around nursing a suicidal patient since the [name removed for confidentiality] inquiry … There is some anxiety around the risk assessment because of what can happen, i.e., the person could kill themselves and I think… repercussions on

> your career and our jobs so I think it’s all anxiety around the suicidal person, and I think some anxiety around the risk assessment." (Nurse 5)

The example given by this interviewee was mentioned in a number of interviews and had also been discussed when I was gathering observational data. This is unsurprising as the inquiry had been undertaken within the preceding six months. The interviews with nurses contained many instances of such apparent incongruities between personal beliefs and nursing practices. As one nurse succinctly put it:

> "It is easier to go along with the ward [culture] and allow risk assessment to be done by doctors. It goes against the grain, but why fight it. Let them [psychiatrists] take responsibility. That way I can sleep at night." (Nurse 14)

### 5.5.4 Previous exposure to non-bio-medical/risk ways of practicing

There was a disparity in the exposure different nurses had to non-bio-medical/risk ways of practicing. Most of the first group of nurses had little formal education in suicide, apart from hospital or polytechnic based teaching in the distant past. Interviewees described this as being focused on demographic and statistical information, rather than what practice could or should actually be. This type of education was described by one nurse:

> "In our [undergraduate] training we never really discussed it [suicide care practice]. We were taught demographics [of suicide] but there was never a clear position, you know, what is nursing’s role in all this. Are we jailers? Should we talk to people? If so how? We just learn on the job." (Nurse 21)

Others had more recently been graduates of polytechnic or university undergraduate program. There appeared to be a variation in these programs content around suicide, with some reflecting the stance already mentioned; others appear to have had a focus on therapeutic work that could be done with consumers, albeit at an introductory level. Some nurses had received post-graduate education in formal suicide papers, which appeared to consider risk assessment skills with a focus on skills of engagement and some consideration of the purpose of risk management. There were also differing experiences of *in vivo* learning. Many nurses had not experienced working in anything but a similar culture. Others though, had worked in wards or teams where suicidality was understood differently, and the focus of nursing practice followed a different cultural model. One nurse described her experience:

> "I did work in another ward, [illegible comment] actually when I was overseas. It taught me a lot. The work with consumers was meant to be about engaging with them. The whole job as s[p]ending time with them and doing therapeutic things. It was not always talking; sometimes it was just doing activities with them. But we encouraged them to discuss their feelings. And you know what, we didn't have suicides. The whole fear here and focus on keeping people locked in is just a myth – there are other ways –and I miss that way of working." (Nurse 12)

### 5.5.5 Resisters: practice as a different kind of therapeutic work

The first and second group of nurses appeared to have different dispositions to working with suicidal consumers, yet both groups practiced in alignment with bio-medical/risk culture. In contrast, a third group of nurses practiced in ways very different from the ward or team culture. I have called these nurses "resisters", a term I picked up in reading about practice culture theory (Ortner 2006). Unfortunately I did not realise the implications of the process of resisting until I had finished data collection, and therefore did not have the opportunity to discuss this with nurses. It is possible that I do not know the extent to which some nurses actively resisted the bio-medical/risk view of practice with suicidal consumers; however the numbers of interviews I conducted (that is, I interviewed a good proportion of nursing staff on each ward) leads me to be reasonably confident that 'resisters' were in the minority. Certainly they were clear about the need to act in a way they thought important, but felt unable to change the practice of others, or to be open about how they practiced, as one interviewee showed:

> "I practice in a way true to what I believe. It is not the way the ward has it. I write notes in a way that subtly shows what I do, like I say about how the person is, give more context, but in the main I just write about risk, about symptoms…the same way I deal with the psychiatrists. I know they want to know 'is this person safe', what's the risk level, what's the pathology, so I give them what they want to hear. But I don't work that way with [consumers]." (Nurse 34)

Resisters also believed that part of their role was to allow suicidal consumers to express their current thinking and feelings around suicidality, including reflecting on events that had led up to them becoming suicidal or making an actual suicide attempt. In this view, engagement with suicidal consumers was the essence of practice. Engagement was seen as a two-stepped approach, whereby, in the first instance, consumers were encouraged to discuss how they felt, or were responded to if they approached or disclosed to nurses how they felt. Nurses would discuss these feelings and thoughts, and sometimes offer reassurance. A second approach was to, in the words of one nurse, 'actively challenge' some of the thinking. The following reflections summarise these approaches:

> "I saw… today where the patient [sic] was talking about wanting to be dead. The nurse was saying "that must be a strange and distressing feeling" or something like that… but the nurse was also asking the consumer to imagine what it would be like, and challenged some of her responses, like "would you really see the look on others faces?", "what might the future be like if you changed some of these things", it was gentle but seemed to me to be useful as she [the consumer] was thinking about it. It seems to be about the nurse using timing [of when she discussed issues] and the [consumer] having trust in the nurse. The nurse also spent time with her [the consumer] and then talked about planning for the current day; it wasn't like she was just left. My impression was this was really useful for the consumer and was reflective and empathetic, used their relationship to allow gentle challenging, and to help anchor her [the consumer] into her day." (field notes)

I was fortunate in being able to interview both the consumer and the nurse discussed in the reflective notes. The consumer interviewee was one who identified some nurses as being helpful and others as less so. I asked her about the interaction I observed and asked if this is an example of what she meant, or whether I had misunderstood. She replied:

> "Oh yes that's it exactly. She [nurse' name] talks to me all the time. I have told her more than I've told my family. Or other nurses who didn't want to know. She [the nurse] allows me to think about how I am, she kind of gives hope. But it's not ra ra everything will be ok. She is realistic. But she doesn't let me get away with crap. She kind of guides, I guess. Yea that's it, guides me into thinking about my thinking. Does that make sense?...Yea it's really *really* [interviewee's emphasis] helpful. And she helps me get

> through each day, each one is better, yea, I reckon it's the most helpful thing I've had here… (Consumer 8)

The nurse told me in some detail about her approach to working with suicidal consumers, including 'Consumer 8':

> **Nurse:** It's really important that they feel valued as human beings, that their feelings and the things that led them to being here is valued. That we don't judge them. It's not for us to say whether being suicidal or not is an appropriate response. We are all different. Maybe in their shoes I'd do the same or worse. But it's important we empathise. So that's the first thing. But we also have to help them see that there are alternatives. So on the moment when they say for instance, that they would be better off dead, I don't invalidate that feeling. But I try to help them see that it is an over-whelming, totally natural feeling, and one they may have had for ages, so they can't see any alternative. But I try to help them see alternative paths. That's what giving hope is. [It is] not telling them everything is rosy, because that is false. But it is challenging some of their ideas and helping them see alternatives. And sometimes [suicidal] people  get ideas that have logic to them but are not logical
>
> **TF:** Can you tell me more about that?
>
> **Nurse:** Where they might for example say that they want to be at peace, and I might gently challenge them to think what being at peace would be like. I try especially to work with their belief system about after life, so if say it was someone Christian I'd have one approach, an atheist another, but it's all about finding this out and helping them consider other possibilities, to challenge gently inconsistencies. All gently of course. (Nurse 12)

I asked later in the interview about how this approach sat with the rest of the ward staff:

> "Well to tell you the truth I don't tell about the approach. It's not the done thing here. Here it's like we talked about before [earlier in the interview] where nurses are not seen as being the ones to talk about suicide with patients [sic]. In reality no one does in my opinion. Unless we are asking about risk. But the stuff I do, I don't tell anyone else, I don't record it [in the notes]. I like the other nurses here, I really do, but sometimes I get pissed off as I get poo-poohed for working the way I do, I know it's like "oh there she

> goes with her touchy feely way" but I have learnt to ignore them. Its water off a duck's back as I know this is what patients [sic] need. I just feel for the other ones [consumers] who largely get ignored. Don't get me wrong, the others [nurses] are by and large caring. It's just the approach here. Talking about suicide is just not the done thing." (Nurse 12)

My impression of the issues raised by this interviewee (and other nurse interviewees who practiced in similar ways) is that they were well aware of the dominance of bio-medical/risk views of suicidality, yet offered some resistance to that dominance in their therapeutic approach with consumers. Nevertheless it was notable that the results from this therapeutic approach were not documented in clinical notes; in fact the approach and the outcomes were largely hidden. Other parts of resisters practice, such as risk containment practices, were aligned with the dominant culture, even though resisters expressed frustration with it:

> "Yes I still have to do observations even though I don't agree with them. I have to follow the doctor's plans and keep people on the ward when I don't believe it is in the patient's [sic] interest. In part it is because you have to follow a team plan… it is also because you as a nurse *just have to* [interviewee's emphasis]. There is only so much you can do before you are pushed out [of a job on the team or ward]." (Nurse 12)

It appears that resisting was seen as possible while it remained hidden from perusal, such as in inter-personal discussion with consumers. However resisting either remained hidden from scrutiny in notes, and nurses did not actively resist the culture when their practice was more clearly able to be seen, such as in containment activities. My impression was that nurses did so as they considered themselves subject to possible negative ramification, such as dismissal, if they did otherwise.

As I have noted I only realised the importance of the difference of the practice of resisters after I had finished data collection. Therefore some caution needs to be taken with the interpretation of the relationship between resisters' dispositions and their practice, although the data, as it stands does begin to identify some differences between resisters and nurses in the other two groups. I have already noted that resisters referred to a strong sense of the need to 'do the right thing' in their practice. Many nurses in the second group of nurses commented to me that their personal views on suicide did not impact directly on their practice, as these were subsumed by the need to practice in alignment with the dominant culture. In contrast resisters considered that their personal morality was integral to their practice. Some referred to strong cultural/religious viewpoints obtained in families of origin. One nurse gave me an example when I asked how she ‘stayed true’ to practicing in the way she did:

> "…my background. I was bought up with a strict Christian faith. We were taught you always treat people well, that our role on earth is to help others. I have put that in a professional context and I don’t mean preaching or anything [laughs] but it does mean supporting people, listening to them, helping them to find better ways than suicide." (Nurse 34)

Other resisters appear to have learnt about other ways of working through experiences of work on other wards. One nurse who had recently arrived from the United Kingdom commented:

> "There [on the previous ward] it was all about talking to patients [sic]. It was seen as *the* job [interviewee’s emphasis]. It is vital. They need a sense of connection, coaching to help them through the tough time. A sense that they matter, and that there is hope. We can really only do that by talking. I cannot and will not work in a way where it is about lock them up and then ignore them. While I have to toe the party line in doing observations and all that, my job is to talk to patients [sic]. Otherwise I am not being a nurse. And it works, you get better outcomes, everyone is better off." (Nurse 12)

### 5.5.6 Summary of this section

In chapter four I described the difficulties in eliciting information about dispositions and practice when this was an unconscious process. Nevertheless many nurses offered insights into this area and there does seem to be indications that nursing dispositions are as much a constructing factor in practice as the dominant culture is. I return to the relationship between the dominant culture and nursing dispositions in chapter eight.

## 5.6 Conclusion

In this chapter I have examined the way that discourses of bio-medicine and risk have constructed nursing practice. Practices are largely consistent with the culture, although some nurses resist and practice in different ways. In the last section I have shown how nursing dispositions are a second constructing factor of, and suggest that dispositions are relational to the culture. I continue an examination of culture and dispositions in the next chapter, in which I look at nursing in a different culture.

# Chapter Six: Practice in a culture of psychological work

## 6.1 Introduction

This chapter focuses on the findings from one team within a ward that had two distinct cultures. One team within the ward operated from a suicide as a bio-medical/risk event culture, with nursing practice predominantly aligned with this. However, in the other half of the ward the dominant understanding of suicidality causation was consumers’ psychological distress, and practice was almost uniformly consistent with this belief. In this chapter I discuss the latter team, and show how the dominant cultural view of suicidality impacted on nursing practice. I also describe the ways in which nurses’ dispositions towards the cultural beliefs reinforced both practice and the culture.

## 6.2 Psychological understandings of suicidality as a team culture

### 6.2.1 Understandings of suicidality

Ward “D” had a clear split in the philosophical underpinnings of what caused suicidality, and what the consequent inpatient treatment/care of suicidal consumers should be. The teams were headed by a consultant psychiatrist who held a differing view of the meaning of mental illness and, of relevance for this study, suicide. One believed, as described in the previous chapter, that suicidality was the result of mental illness; the treatment of the mental illness, in this view, would reduce suicidality. In contrast, the second psychiatrist believed that suicidal thoughts stemmed from unresolved psychological issues individual to each consumer. The psychological explanatory model of suicide that underpinned practice was not explained to me as a whole. Instead I was told various parts of the belief system, which were often presented by clinicians as a contrast to what they saw as the ‘wrong’ way of treatment/caring for suicidal consumers in the other team. I only realised this once I re-analysed data, and so I didn’t have the opportunity to ask clinicians to give a total (in their view) causal explanation. However it was clear to me that there was a consistent, dominant explanatory model of suicidality that clinicians felt very strongly was the ‘correct’ one, with a subsequent ‘right’ way of practicing.

Many interviewees pointed to a tension within the ward that was apparent to me in interviews and during observational periods. Clinicians from both teams took time to tell me about the reasons why their team’s way of practicing was the ‘correct’ one, and why the other team’s practices were problematic. It was noticeable that those in the ‘psychological’ team felt most vehement about this. My interpretation was that their way of working was seen as a deliberate move away from the ‘norm’, whilst the other team appeared to be less conscious in this approach. In fact their way of explaining suicidality and the model of practice that stemmed from this was, like the wards described in the previous chapter, sometimes taken for granted. The consultant psychiatrist of the former team described how a psychological understanding of suicidality was vital to good consumer outcomes in inpatient treatment. This was done by comparing the psychological teams’ views to those of the other team:

> "I believe that we must first gain and maintain psycho-therapeutic relationships with patients [sic]. Once we have that alliance we can work with them to work out what’s going on — why they are suicidal. Suicide is as much a psychological process as a medical one. My colleague [the psychiatrist leader of the medical second team] believes suicide is mental illness through and through. Therefore his team work that way. It’s [for the second team] about medication and risk prevention. I don’t mean to knock them, but it’s a cause of tension. We just operate differently. Yes we have two different models of operation on this ward." (Consultant Psychiatrist 3)

A registrar who worked with the consultant explained how this belief underpinned the ward culture of practice with suicidal consumers. In this culture, inpatient care was seen as providing a sense of security for suicidal consumers and helping them to have a sense of human connection. He explained this as follows:

> "...most [suicidal] people, they feel safe once they’re in a hospital environment, a change of environment, in a sense of containment that provides feeling of being safe and nurtured. That is not to say we focus on holding them on the ward. Actually we do

> sometimes [but] we try to avoid that if we can. It takes away their sense of self control even more, and in a sense infantilises them, which is the worst thing we can do when someone is suicidal. ...the other I guess the other really important thing is for people to actually feel they have human connections [with clinicians] in that place because in the unit it's the connections that make life worth continuing...and give them a reason a sense that there is something out there other than the hell inside them that makes them keep going." (Psychiatric Registrar 3)

I was told in many interviews and in informal conversations that 'providing safety' was meant "as providing asylum like the old sense of the word" (Nurse 14). In this view inpatient treatment/care was aimed at consumers feeling secure in the physical environment and in having "non-judgmental understanding" (Nurse 14) provided by trained clinicians. Nurse interviewees stressed that 'security' rarely meant containing consumers against their will. While this did happen on occasions, this was seen as being counter-productive in the treatment/care of consumers. This contrasted with practices that arose from a bio-medical/risk, where containment was central to risk management.

In this explanatory model, suicidality was most often (although not always) viewed as a consequence of a series of events in a consumer's life that led to them becoming suicidal. Sometimes this meant the person became 'mentally unwell' and had a psychiatric diagnosis, most often of a MDE.  However the psychiatric illness was described as a manifestation of the life events, rather than causative as seen often in the medical view of suicidality. On some occasions a person's suicidality might be as a consequence of distorted psychotic thinking, but there was a consideration that the psychotic thinking might at least have psychological root, rather than a purely organic one. Diagnoses of BPD were seen as "legitimate" (Nurse 14), but again the reasons why people had this diagnosis were seen to be based on life causes, rather than on physical pathology. Referring to treatment/care in the other team on the ward, a psychologist suggested:

> "One of the things that a lot of people who present with suicidality have difficulties with human connections and…they get labelled with borderline personality, a lot of them, they get re-labelled so quickly and informally just because they are suicidal, even if they

> don’t fit the categories, [yet] one of the biggest problems with that group of people have is relatedness, so that consistency of relatedness in the caring unit is really important for those [suicidal consumers]. People who are suicidal are depressed people ...for them a lot of what they experience is a loss of self-worth, self-esteem that is as a set of feeling able to be with people just because you feel so bad about yourself. You know it’s really important for those people that they feel comforted and cared for you know when they’re in hospital. Otherwise it [hospital] becomes another part of a demeaning diminishing experience which they don’t need particularly." (Psychologist 3)

The ‘re-labelling’ referred to by the interviewee was a phenomenon I discussed in the previous chapter, whereby consumers who did not fit the diagnostic category of BPD were informally diagnosed with this label in some circumstances. The interviewee’s view was one I heard many times in the psychological ward. The second point made by the interviewee was that the purpose of inpatient treatment/care was primarily to help suicidal consumers regain human connections, which differed from the central purposes of treatment/care within the bio-medical/risk cultures.

### 6.2.2 Psychological support as treatment/care

In addition to the differences in the views of the nature of suicidality, the two teams differed in their approaches to treatment/care. In the psychological team the treatment of any psychiatric diagnosis with medications was viewed as a concurrent approach with therapy, which differed from the primacy of medication usage in the other team. In the psychological team assisting consumers to understand the reason why they were suicidal was seen to only be achievable through talking therapies. Most often talking therapies were seen as the role of the consultant psychiatrist, psychiatric registrar, or the clinical psychologist. Sometimes the assessment of an individual’s life events and their reaction to it resulted in active psychological treatment through therapy by one of the aforementioned clinicians. In other instances the brevity of time in acute inpatient care meant that active psychological treatment was undertaken in community settings. The giving of hope was seen to be a role of both treatment within therapy, and as a practice of nursing. Similarly, assisting suicidal consumers to consider alternatives to suicide was seen as both necessary within therapy, and on a day-to-day basis by nurses.

Most clinical notes that I read reflected the overall team approach to treatment/care. Although psychiatric diagnoses and clarity about decisions around medication treatment were evident in files, descriptions about the therapy undertaken were also prominent. Progress was documented, and a contemporary daily plan, consistent with this progress, was made for nurses to follow. This included interventions that supported the plan if the consumer was distressed and/or seen to be at risk of suicide at that time, and approaches that nursing staff had made about what had worked (or not) to ameliorate suicidal feelings. The updated plan also included approaches to coaching consumers to look at ways in which they might deal with distress in the future. An example of this was partially copied by me into my field notes (with permission from the consumer):

> … continues to have supportive therapy every two days. Focus remains on helping [the consumer] understand her triggers. She [consumer] notes she has tightness of chest when thinking about [the life issues that led to suicide attempt] and negative cognitions. Coaching of ways to deal with this occurs. Plan is to continue to have supportive nursing input and reinforce breathing techniques, using her own lavender oil, using positive imaging strategies [these were previously described in earlier notes]. Still needs encouragement and coaching to use these consistently… (field notes)

Most files had similar notes written. Although documentation of therapy was less consistent when there was an outside therapist involved, the general highlighting of such sessions reinforced the primary focus of treatment/care. In addition it acted as part of the basis of the nursing practice consistent with a psychological approach that I discuss later in this chapter. This contrasted with the documented plans for consumers under the treatment/care of the other team, which privileged the identification of psychiatric phenomena, medication treatment, and risk categorisation that often did not provide a context for understanding how that category had been derived.

### 6.2.3 Understanding risk

The differences between the psychological and the bio-medical/risk cultures was also evident in understandings of risk. In the psychological culture risk assessment was seen to be part of therapy, rather than a ‘stand-alone’ process. Although I did not observe this happening (as I did not sit in on therapy sessions), I was advised by a number of clinicians that an understanding of the risk of suicide (or harm to others) of any suicidal individual came, in the main, from understandings that came about within the therapy sessions. These were, I was told, discussed between the therapist (the psychiatrist or psychologist) and the consumer, and ways of ameliorating this risk whilst in the inpatient unit were negotiated between the therapist and the consumer.

> "It is in the part of the process of therapy. Risk is part of therapy, not something different. It should always be seen as something the patient is experiencing in the psychological process, not as a discrete entity. Therefore it is important it [risk assessment] is treated as part of that [psych-therapeutic] process. It is important that if I am the one doing therapy, then I am the one unpicking, unpacking if you like, risk with the patient [sic]." (Psychiatrist 3)

Risk management was also viewed differently between the two cultures within the ward. As discussed previously, a bio-medical/risk culture was strongly linked with coercive restrictions. However within the psychological culture risk management was seen by clinicians as a process of engagement with consumers to jointly reduce the likelihood of adverse outcomes. While coercive restrictions were sometimes placed on suicidal consumers, the attention to supporting consumers with active therapy, active daily support, opportunities to talk about their feelings (including their suicidality) when needed, and offering hope were seen as ways of reducing risk. These were all roles in which nurses were involved. In a minority of cases, suicide was thought to be seen by consumers as the only possible option to end their psychological suffering. In such circumstances clinicians were seen as having a moral responsibility to intervene to maximise the likelihood of preventing suicidal actions. This did not necessarily mean nurses or other clinicians taking coercive actions. Instead, coercive actions were often considered counter-productive. Suicidality was viewed as a form of psychological distress, and those experiencing this were thought to be looking for a way out from this, rather than wanting to die. Coercive actions were sometimes seen as adding to stress, meaning (in this view) that for many consumers coercive treatment/care could actually increase the risk of a consumer attempting suicide. A psychologist gave an example of this:

> "It turned out this person had a big secret that he was holding inside [that] was contributing to his risk of suicide. [He] was at such a high level of stress that it only took a small thing [referring to a consideration of keeping the consumer on the ward against his will] to push him to that point where he would be at a higher risk." (Psychologist 2)

The cultural understanding of the way risk was assessed and attended to was explained to me by the consultant psychiatrist of the team:

> **Psychiatrist:** Understanding risk is about helping the patient [sic] understand themselves. When they understand that, and we help them see there is future, hope, they will improve. This may often take medications as well, but it’s not just them. We discuss their risk together, the patient [sic] and us, we work out together how suicidal they are, how much risk they are. We work out together what we do to lessen that risk.
>
> **TF:** Do you mean that you negotiate ways of risk amelioration?
>
> **Psychiatrist:** Yes exactly. Like for instance we know some patients [sic] react badly to observations. In most cases we would not put them on them. But we would negotiate another way of helping them to be safe. Some, not many in my experience, but some [consumers] like the security of having someone with them 24 hours. In this case we would do that. (Consultant Psychiatrist 3)

Integral to understanding and ameliorating risk were that (i) there had to be mutual trust between a clinician and a consumer before a consumer would disclose how safe or not they really felt; (ii) that risk was contextual and could be ameliorated by the environment, including the ability of a consumer to discuss how they felt with staff; (iii) that without this trust that risk assessment could not be seen as accurate and that consumers might not disclose risk truthfully if they considered there would be adverse outcomes, such as the curtailing of freedom and (iv) that there had to be ‘therapeutic risk taking’ (a term that I heard on a number of occasions), whereby sometimes allowing greater physical freedom could decrease risk, whilst the converse was also true - that increasing restrictions in physical liberties could make consumers feel more at risk. The consultant psychiatrist stated:

> "You know how are they going to trust us if we don't trust them? And so… we've got to develop that trust with the person... we have to give them some space and shared decision making so that they can learn to trust themselves [again]. I know it's all a philosophical debate really but if we trust them and they can trust us and they can share things, then you get better outcomes, a better, truer understanding of risk. It's all a facade, a game otherwise." (Consultant Psychiatrist 3)

The interviewees in the psychological team often compared their cultural beliefs and practices with the other team on the ward, and with perceived societal expectations of inpatient treatment/care of suicidal consumers. One nurse summed this up:

> "The others [other team] see us as mavericks as we don't work from a medical model. Yet we think of them as being the ones being out of kilter. How is it that 'watch 'em, treat 'em, stop them leaving' helps the poor old patient? [sic]. How are they any better off than when they came in? I think – we think, that approach makes them worse. It is maybe what Joe Public expects, but it doesn't work. Yes medication can be great, don't get me wrong. But do we really teach patients anything with that approach? Do we help them to be resilient next time they are really down? No. I feel proud of what we do here [in this team] but I despair for patients who receive that [bio-medical/risk] approach." (Nurse 14)

The team were also criticised by members of the other team in the ward. My field notes reflect this:

> …lots of snarky comments today from clinicians about the [psychological] team. How their soft approach was fluffy, how someone would die. (field notes)

Unfortunately, I did not think to question how this team came to operate so differently from the other team in the ward. I made an error of assumption during field work that the ward culture was brought about by the charisma and medical authority of the consultant psychiatrist. However the ability of this team to function so differently in the face of external criticism needed a more complex explanation. Two processes explain this: nurses' dispositions that made them supportive of the approach, and the disciplining approach, although subtle, led to nurses with different dispositions leaving (or attempting to leave) the team. I discuss these two factors later in this chapter.

## 6.3 Nursing practice in a psychological culture: practice as therapeutic work

### 6.3.1 Therapeutic work: an overview

Nursing work in the psychological team was almost uniformly consistent with the prevailing culture. Nurse interviewees from the psychological team consistently described their practice as being underpinned by therapeutic relationships. The following discussion has been reproduced at some length as it both summarises nursing therapeutic work and demonstrates a clarity about what nursing work with suicidal consumers was within this team:

> **Nurse:** It [practice] is the therapeutic aspect first and foremost. It's about the relationship with them [consumers] which gives them a sense of safety, that someone cares, that someone's there to listen to them, to support them.
>
> **TF:** Can you give me an example of a time you did that?
>
> **Nurse:** Well I think every time we work is an example. As well as general spending time, which in itself is important, it's about being there when things get on top of them. Not to physically stop them, although that might be the last resort, but to talk to them, help them through the distressing feelings. It's about reminding them of the work and the progress they are making, about understanding the cause of their distress, how they can prevent it. So yeah, it's helping the[m] connect when they are at their worst, connect with another person, about helping them through the mini crises, about really reinforcing the psycho-therapeutic work they are doing

> **TF:** Can I clarify, do you mean the psycho-therapeutic work they are doing here with the psychologist?
>
> **Nurse:** Yeah sometimes, Sometimes with [name of consultant psychiatrist], occasionally the registrar. Often our stays here are too short for longer therapy, but they do short-term stuff that can be picked up in the community or yea, the community psychologist comes in. but yea we work to that plan I do think our work is therapeutic, but it's like a master plan.
>
> **TF:** By 'we' do you mean nurses?
>
> **Nurse:** Yeah nurses. We do support, we do crisis intervention and we do reinforcement of the psychological treatment. And we pick things up, like what the patient might be thinking at that time. Things that pop up. We don't just ignore it. We discuss it, but always with a view to recording and discussing it with whoever is doing the therapy so they can pick it up with the patient in their next [therapy] session. (Nurse 4)

My observations of nursing interactions and interviews with nurses and consumers suggest that therapeutic relationships were seen as having two inter-related roles. These were to (i) daily therapeutic work, and (ii) to consider consumers' risk assessment and management within the therapeutic relationship. I discuss these individually.

### 6.3.2 Daily therapeutic work

Nurses' therapeutic work appeared to fall into four over-lapping categories: (i) 'informal' discussions and activities undertaken together that offered general support to consumers and had a purpose of helping them feel connected with others; (ii) discussions that encouraged consumers to be able to identify and discuss issues that the consumer identified or that may have come up in the course of discussion between the consumer and nurse; (iii) discussions that were aimed at supporting consumers to further consider issues, that may have been discussed in therapy sessions and were signaled on treatment/care plans as being areas that required further daily support, and (iv) reinforcing approaches learnt in therapy.

General support was often given through ‘informal’ discussions, which contrasted with the pre-set times for therapy with the psychiatrist or psychologist. The importance of informal contact was highlighted by nurses as a way of building up therapeutic relationships and to support the aims of therapy. My field notes hold many examples of where I observed nurses engaged in conversation with consumers in ‘non-formal’ settings, such as sitting on the ward entrance steps drinking tea together, talking in the consumer’s bedroom or the general lounges, or in the midst of other activities, such as playing table-tennis together. Many consumer interviewees described seemingly mundane, informal moments with nurses as being key to their treatment/care. The following example was typical of such events:

> "She [the interviewee’s nurse] went out …and showed me the whole place [the ward and grounds] and sat there with me… and went away and got me a coffee and made me coffee just the way I like it and basically just sat there with me and made sure that I was ok and if I had any problems that she was there to help me through them all." (Consumer 22)

Consumers were aware that formal therapy was undertaken by the psychologist or psychiatrist in the team or from a clinician external to the team, but many interviewees described times that they needed support and the ability to talk to trusted others between therapy sessions. One told me:

> "I had a really good experience on this ward when there was a brand new nurse [for this consumer] on and [even though] she’d been a nurse for years… I’d never met her and I was really, really anxious and suicidal. I kind of expressed to her that ‘I’m anxious’ and then she must have seen or looked in my face or something to have like ‘oh’ and she was like 'oh do you want to talk?' and I was kind of like ‘oh no, no, no, [because] you’re just going off to tea’ and then she kind of just dropped everything and said ‘oh no if you want to talk I’ll talk; you know we can talk now’. And it was like it really validated what was going on and even if she hadn’t been able to talk right now it was like she’d kind of picked up that … I sort of trusted her after that and we immediately developed a relationship because I thought, well, she’s willing to kind of like back track from her position, maybe then [she is someone who will] take that time out to figure out what was going on for me." (Consumer 14)

Being present with consumers appeared to allow them to identify and discuss issues that were important to them without needing to wait until their formal therapy sessions. In addition discussions sometimes led to a consumer disclosing information or feelings about suicide or other life events to the nurse. In the psychological team culture such moments were considered to be vital for the nurse to engage in discussion with the consumer, and later document and share the outcome of these with the MDT. A nurse gave an example of using such an example to help a currently suicidal consumer:

> "I was looking after a guy who was suicidal who took a massive overdose after his wife told him she was leaving you know. And its grief and what… they're feeling. He was really embarrassed when I talked to him about it but even so he didn't want to talk about it and when I sort of pushed a bit and [talked about] the grief process and what he'd been through and you know and that other people have done similar things or thought or felt similar things then he decided to talk about it. Talking about it allowed him, allowed us to look at his life, and the more he opened up the more he was able to think of things and get perspective and to think of other ways he could deal with the situation. That the situation was awful and feeling despondent is normal, but there are other [than suicide] actions [that could be taken], you know?" (Nurse 14)

The nurse interviewee further explained that the information from this discussion was documented in the notes and discussed with the psychologist and the rest of the MDT, so that the issues identified could be further discussed in therapy.

Active therapeutic discussions were seen by nurse and consumer interviewees as consistent with the work that was being undertaken with therapy, and the discussions with nurses were seen as a way to further reinforce or elaborate upon issues that came out of therapy sessions.  One consumer explained:

> **Consumer:** She [the psychologist, explained in therapy that] it's totally natural [to have suicidal thoughts]; it's [how] the human body works and gives you a definite reason or an educated reason as to why you're having the [suicidal] thoughts that you're having and the reason behind it. The psychologist [helped me to understand] how you're feeling, your emotions and think about why do I feel guilty or why do I feel this way or whatever.

> The psychologist can then turn around these around and help me turn those thoughts around so I can understand them. And when I had those thoughts the nurse talked to me about them and took the same approach and again it was helping me to understand and to deal with them
>
> **TF:** So, it sounds like the consistency in approach between the nurse and psychologist helped?
>
> **Consumer:** Oh yes yes, definitely. Like it was reinforced. The psychologist helped me to understand that I can tackle the bad thoughts, and the nurse just sat with me for as long as I needed and just went over the same things again. It was brilliant. Couldn't ask for more. (Consumer 21)

I observed many examples of nurses using planned cognitive approaches to helping consumers manage immediate distress. It was apparent that these approaches were directly linked to the therapy that consumers were undertaking with the inpatient psychiatrist or psychologist. It is not my intention to fully describe what this therapy entailed, however it was clear from interviews and from consumer notes that some of the therapy was aimed at consumers identifying the causes of suicidality and cognitive and behavioural strategies to cope with the feelings of suicidality. It was evident that the describing of these strategies in some detail in the notes, and the discussing of these in team meetings, meant that nurses were able to reinforce and support consumers to use these strategies in a way that was consistent with the overall plan. I had noted an example of this in my field notes:

> [The] file described the background to the problems that [name omitted] had and the way the psychiatrist was working with her. [The psychiatrist] had stated she had got [the consumer] to describe her thinking when the stressors were there, and what things worked. She also taught her some techniques that were physical such as breathing techniques, and some ways of changing her thinking to the more positive. There was a whole lot of other detail but basically the idea was that there was a plan and this was to be reinforced. I saw this happen when the nurse was talking to her [the consumer] and she [the consumer] was saying about how stressed she was a[s] she had a court appearance and the suicidal thoughts were increasing. The nurse took her to a quiet place, I did not see this part, but it was in the notes later. She said in the notes that she got

> [consumer's name] to practice the breathing and relaxation techniques and to talk through and practice the other way of thinking. It seems like there are lots of bits. Working on the physical relaxation, helping and reinforcing the practice, staying with her [the consumer] until she was ok, re-assessing risk, making a short term plan of how [consumer's name] will get through the next unit of time, documenting all of this in the notes. I am surprised…by the level of detail [of documentation] and the constant reference to the plan and to the seeing the risk as so much in the context. I hear over and over that this works. (field notes)

It was also clear that consumer interviewees found that this approach works, as explained by the following two interviewees:

> "[When] I was feeling down and worse yesterday and not seeing the doctor for a few days the nurse talked to me. She kept really calm and told me over and over that I could do things that helped, that I was able to help my thinking. Her just being there, spending time with a cuppa and talking me through it. Yep, that's what makes the difference." (Consumer 14)

> "I was feeling out of control, like I wanted to try to suicide. She [a named nurse] knew what I was going through. She listened but didn't let me stay in that [suicidal] place. She kept helping me to do things I had learnt with the psychologist. It really helped. It helped in that moment and it helped as I am more confident. You know I will feel bad again, but I feel more confident that there are ways to help myself get out of that space instead of taking the pills [for an overdose]." (Consumer 12)

Nurses and consumers alike considered that the previous assessment and planning of techniques that helped a consumer to dampen distress or to support the learning of techniques to do this when necessary in the future was helpful. The physical techniques often appeared to me to be 'simple', such as the previously mentioned use of hand-massage or lavender oil. However I was repeatedly told by clinicians and consumers that these techniques worked if they were applied to individual consumers' preferences. Sometimes these techniques were not part of a previously identified preference, but were used on a 'trial and error' basis with consumers, and the success or failure of these were documented in clinical notes. I noted an example of this in my field notes:

> I saw a good simple example of intervening with a [consumer] today. The person was distressed, quite agitated and worried about some things that had led her to be suicidal and in the unit. The nurse seemed to quickly assess the situation. That the [consumer] was unable to go through the [cognitive] approach in the plan. The nurse said “Hey let’s just sit together and how about I give you a hand massage?” They went and sat outside and the nurse did this. I didn’t see what happened but later I spoke to the nurse and she told me that the [consumer] was too agitated to be able to relax or to think differently. The hand massage and being present seemed to help her relax into such a state that she was able to do some of the “thinking” techniques. Once again this was all in the notes after [at the end of the shift]. (field notes)

### 6.3.3 Risk assessment and amelioration as therapeutic work

Like therapeutic work, nurses’ assessment of the risk of suicide by consumers was notably different in the psychological team than the other team in the ward. In the former team, risk assessments were generally part of on-going conversations with consumers. My clinical experience of undertaking risk means that I am *au fait* with what is required in the content of a risk assessment. What struck me was that the questions about risk were woven into non-linear conversations that naturally (to me anyway) appeared to flow; in my view vital risk questions were not omitted through this technique. I failed to note in my field notes an example of this, but I was told by nurses that there was a belief that this approach would most likely make consumers feel they were having a discussion with an interested party rather than receiving a list of questions. Many nurses were concerned that an undue focus on risk of suicide in interactions with consumers could actually detract from discussions about thoughts and feelings of suicide, as these discussions might be interpreted by the consumer as being primarily about managing future risk, something that was echoed by consumer interviewees. Nurses, especially, and some consumers, commented on what they saw as the problematic nature of assessing risk without a concurrent understanding of what was described to me as the “changeable and contextual nature of the feelings of suicide”. (Nurse 17)

Nurses in the psychological team believed that consumers’ disclosure of suicidality was intricately linked to consumers’ trust that the purpose of risk assessment was based upon nurses’ genuine concern for them, and a desire to work collaboratively to ameliorate risk. A nurse told me:

> "For the [consumer] to discuss their issues when they’re suicidal without thinking that it will all be used against them to lock them up is vital…it’s about being honest that sometimes you need to take control for them but that mostly you understand that suicidal feelings are closely tied up with having ways of coping with the feelings psychologically and ways to minimise their risk in the short term. I mean we don’t do a risk assessment then leave them. That is rubbish and not helpful. It doesn’t even give us a real risk profile [of the consumer]. You look at what is currently happening, you look and work with them on the plan to help them with their psychological coping, you help them look at minimising the things that are making them suicidal in the immediate term. It might be helping them with something meaningful to distract, it might be focusing on small steps." (Nurse 22)

Nurse interviewees were critical of the idea that risk assessments could be contemplated as being separate from risk management:

> "We challenge even that [that risk assessment is separate from risk management]. We …begin to work on reducing the *components* [interviewee’s emphasis] of risk by some cognitive work around the meaning of the stressors that are on the person, helping them to see alternative ways of viewing the situation coming up with constructive alternatives. These are a continuation of the plan overall. That way everyone knows what is happening and no one does random [inaudible word] things." (Nurse 18)

Consumers also described the need to have the changeable nature of their feelings listened to, and how this was only able to be achieved by spending time and showing understanding of this. Three consumers, who had previously been nursed in either the other team on the ward or in another hospital, described how they had learnt approaches to hiding the true extent of their suicidality. These approaches including avoidance of one-on-one time with particular nurses, and minimising the reported risk of suicide by telling clinicians that they felt safe, when in fact they did not. I reflected on this at some length in my field notes:

> [I have been] fascinated by the difference on this ward between the two teams and the way they approach risk. The [psychological] team take a different approach. Some in the other ward do but it's not seen as the right thing where it's mostly brief assessment screening [sic]. Here it's seen, and I keep getting told by [consumers], that there is a relationship with assessment and outcomes [risk data] and what they do with management. To trust the nurse the consumer had to believe that the nurse cares about how they feel. That's done in lots of ways like doing what they say, but a vital part is about really believing and having empathy for their distress, and understanding that the distress is complex and changes and not easily categorised, that there needs to be a good exploration of what is making them distressed at that moment] and how the [consumer] can be supported and reinforced in their ability to deal with this, to cope with it psychologically, to use the techniques they are being taught. But also to help them minimise the fear, but breaking things into do-able blocks, by helping them with things to do. These may be as simple as distraction, but they might be helping them with their environment. [I] saw a nurse getting a [consumer] a piece of music… and a hottie [hot water bottle] as these were things that made them relax. Simple things but these seem to be related to ameliorating distress. These seem to minimise the suicidality. So its trust, then long detailed assessment through close talking, then the management, the sometimes simple things that seem to support the [treatment]plan, but understanding that it's not risk assessment and tell the doctor, its discussion and understanding that the management is completely part of the risk assessment, not something separate. (field notes)

The approach to risk assessment and management in the psychological team appeared to result in less coercive interventions being used when compared to the bio-medical/risk wards or teams. I did not attempt to measure this difference; however this view was supported by the staff in the psychological team. I had an informal discussion with two nurses and an occupational therapist during a lunch break, where they suggested that the way that suicide risk assessment and management occurred meant that risk amelioration occurred instantly if needed, by, as I have already described, doing things *with* the consumer, rather than the coercive practices that were seen as doing something *to* them. A second reason for the minimal (compared to bio-medical/risk wards or teams) use of overt coercive practices was that the notion of therapeutic risk taking within the MDT meant that some consumers were seen as having a higher risk of suicide if coercive actions were put in place; therefore such coercion did not occur.

As I have noted, risk assessment was conceptually viewed and practiced differently between the two teams in the ward. These differences signify the role culture has in constructing practice. In the bio-medical/risk culture nurses were expected to report risk features of consumers, with medical staff determining actions of nurses to contain risk. In contrast nursing practice in the psychological team saw risk in the following ways: (i) risk assessment was seen to need to occur as part of a conversational style of interaction, with ‘lists’ of risk questions considered to be unhelpful either to consumers or in getting accurate risk information; (ii) risk was generally conceptualised as something that occurred within a context, rather than being solely located within the individual consumer; (iii) risk was seen to be fluctuating; (iv) the verbal response from consumers about their risk was seen to be very dependent on the consumer having trust in the nurse to give an honest answer; (v) responses to risk (such as the imposition of restriction of movement) was seen to be influential on risk, in that excessive restrictions could actually increase a consumer's risk, and (vi) risk assessment and management were seen as one process, with a nurse’s understanding of current risk tied in with a need to support a consumer in using cognitive approaches learnt in ongoing therapy, and behavioural strategies identified with the consumer as part of a plan. Imposed risk management was generally only used once these cognitive and behavioural interventions had been exhausted or were shown not to work in particular instances.

## 6.4 Factors impacting on the therapeutic/psychological approach of nurses

As I have shown, nursing in the psychological team was largely consistent with the team culture. Despite this, there were a number of barriers to nurses working in this way. The presence of these barriers highlights that the psychological team, and nursing practice within it, functioned within a prevailing bio-medical/risk orthodoxy within the rest of the hospital. In contrast, there were a number of ways in which nurses' psychological work was reinforced within the team. I highlight the barriers and supports for psychological practice within this section.

While the need for consistency with the plan of treatment appeared to be supported by consumers, nurses and other clinicians, it was notable that nurses' roles in this were not always as well articulated in clinical notes. This contrasted with the clear psychological treatment plan and the work of other clinical team members. Nursing notes were similar in content and structure to the ones seen in medical wards, with an emphasis on describing mental status examinations, the daily events for the consumer (such as family visits), and reminders of appointments for nurses on the following shifts. I was surprised by the lack of description of the supportive work and psychological intervention that nurses undertook with suicidal consumers, when this was seen by nurses and other clinicians as the essence of their work. Unfortunately I failed to directly ask about this inconsistency in interviews. However a clue to this reason may have been provided by a nurse while commenting on the perceived societal view of expectations of inpatient treatment/care:

> "We have to be seen to conform with expectations to some degree, even if it is not the main emphasis, like in the way we write notes and prioritise risk status and medication compliance and other things that are not really the priority. They are important but not the focus…" (Nurse 4)

Although there were a number of barriers to psychological nursing practice, there were processes within the psychological team that reinforced psychological nursing with suicidal consumers. I summed these up in my field notes:

> In this team the contrast is great. It's like they know they are working differently. They talk about the therapeutic work in psychological terms with each other. They seem to be able to identify the steps in what they do. More than that they make time for it to work. They recognize the work of other nurses is legitimate. It's not like the other wards when a nurse is with someone sometimes it's like that nurse is skiving [sic]. This is more like they cover for each other, they see it [therapeutic work as legitimate]. (field notes)

Nurses who did not subscribe to the therapeutic/psychological approach appeared to be identified by other nurses and subjected to disciplinary actions to get them to work in a manner consistent with the ward culture. One nurse described this as follows:

> "Oh yea, we do occasionally get bureau nurses [nurses who do not consistently work in the ward, but attend in the absence of a regular ward nurse] who don’t like the way we work. We don’t ask for them again, instead we insist on the ones that do. And most don’t tend to come here who don’t like our approach. We have had the occasional one, but we are like shape up or ship out. It’s not as harsh as that. We try to support them, get them to change the way they practice. Coach and mentor. But ultimately if someone is really stuck in a medical way we gently ostracise them. Sounds terrible I know, I mean we give them every opportunity to stay and change, and we want people to, but in the end it’s for the good of the patient [sic], the good of the team. We get them to go." (Nurse 4)

## 6.5 Nursing dispositions and the construction of practice

As I discussed in chapter five, nursing dispositions appear to be an important factor in the construction of practice. In the bio-medical/risk wards there were discernible divergences in belief about the relationship between causation of suicidality and the subsequent focus of inpatient treatment/care, and sometimes, resistance to the dominant culture. In contrast, nursing practice in the psychological team was consistent with the culture. This section examines the dispositions of nurses in the psychological team in order to identify the relationship between these and the prevailing culture, and how they together constructed nursing practice.

It is possible that nurses who did not subscribe to a psychological focus of nursing did not often remain working within the team for long. I was told that the psychological focus of practice was well known outside of the ward, and that nurses and other clinicians went there because it fitted their own belief systems. I was not able to know if this was ‘true’, beyond the described perceptions. However it was evident that nurses that I interviewed were almost uniformly supportive of the way that the team practiced and the role of nursing within the team. Nurses also believed that that consumers received good treatment/care and had positive outcomes because of the overarching model of practice. Similarly many nurses were equally as vehement that other models (such as that used in the other team in the ward) were ‘wrong’ and led to poorer outcomes. These beliefs about suicide and practice were markedly consistent within the psychological team. These were summarised within my field notes:

> They [nursing beliefs] are emerging; it seems that viewing consumers as individuals with individual needs is a priority. While diagnosis is legitimate, the relationship with this and suicide[ality] is seen as individual and therefore the intervention is less similar. It is so different from the other [“medical”} wards and the other team. This [team] does not value control and having to know what box someone fits into. But on the other hand structure is valued; it’s not *laissez faire*. They like having a clear plan made with the [consumer] based on his [sic] needs. They have [nursing] interventions based on what is happening but consistent with the plan, so no-one is off doing any random intervention… This is what I hear from nurses over and over. The importance of individuality of [consumers] and the clarity of decision making and what to do, and the paramouncy [sic] of the need to have an active therapeutic relationship with [consumers]. They are [both] team values and they are nursing values. (field notes)

There was significant support for both the explanatory model of suicidality and how this translated into structured practice roles. Some nurses suggested that they found working in the culture of the psychological team less stressful and more supportive than other wards. This meant that there was less conflict within the team and clarity around what the role of nursing was. This gave a sense that nurses had a role beyond reporting on symptomology for psychiatrists or imposing coercive interventions on consumers. A minority of nursing interviewees described this as having a nursing model to work from or a model of practice consistent with their nursing values, meaning that they were positively disposed towards the dominant culture. There was a strong sense that they were working in a manner that was safe, consumer focused, and was likely to have good outcomes. These areas were summarised by one interviewee as follows:

> "Working like this… almost everybody resonates with that, and the nurses, they're satisfied with their job; they go home feeling good about themselves. They haven't been a jailer for the day, they've been a healer, and that feels wonderful." (Nurse 32)

Other nurses also articulated a satisfaction with the way that this model of practice was a good ‘fit’ with their ideals; in other words there was again an alignment with their disposition towards what practice with suicidal consumers should be. Many interviewees described this as a resonance with their nursing philosophy that had been subjugated in other areas of practice. However one nurse summarised an absence of a disciplinary model of suicide care practice in the past:

> "In our training [w]e never really discussed it [inpatient practice with suicidal consumers]. We were taught demographics but there was never a clear position, you know. What is nursing’s role in all this? Are we jailers? Should we talk to people? If so, how? We just learn on the job. And on the job means whatever the psychiatrists view is. While we are in agreement with [name of consultant psychiatrist] I think we are happy with this philosophy because it works and is person-centred, holistic, like nurses are meant to do. But better than that, we now have a framework; we now have a way of knowing what we are meant to do." (Nurse 21)

I took from this and similar statements that nurses in this ward had a clearer model of practice in which to work within the psychological team. Informal discussions with nurses suggested the emphasis on engagement and mutually constructed risk sat well with both their personal understandings of suicide, and their philosophical underpinnings of practice. It appears that nurses within this team were positively pre-disposed to the cultural beliefs about suicidality causation, and the consequent expectation of nursing practice.

The limited demographic data suggests that almost all of the nurses in this ward had post-graduate education (including in suicidology for some), and many had been exposed to practice in non-bio-medical/risk wards in the past. Because of this nurses were already disposed to considering suicide from a psychological causation perspective, and to an expectation that a structured, psychological /therapeutic nursing approach was likely to get good consumer outcomes, fits with their ideals, and be a positive environment in which to work. Although the methods I used in this study mean that conclusions are tentative, my impression is that the positive dispositions towards the culture and to practice, coupled with the reinforcement of the culture and of practice within the team, meant that psychological culture and nursing practice were reinforced, even though a the rest of the hospital had a culture of bio-medicine/risk.

## 6.6 Conclusion

In the team described in this chapter, the cultural belief system around suicidality and what inpatient care should be was one of psychology, with psychological/therapeutic nursing practice consistent with this ethos a priority. Although this study has not attempted to measure outcomes of different types of practice, consumer interviewees spoke positively about being nursed by members of the psychological team. Nurses were almost uniformly supportive of the structured approach to practice and the role of nursing within this structure, and, unlike the bio-medical/risk wards, there appeared to not be any resisters to this way of practicing. It appears that nursing practices in this ward were constructed through the ward culture, supported by nursing dispositions. These in turn perpetuated the culture of the ward and the way of practicing with suicidal consumers. The next chapter looks at a culture in partial change, and how a lack of consistent understanding of practice contributed to the construction of nursing practices.

# Chapter Seven: Practice in a culture of partial change

## 7.1 Introduction

This chapter describes ‘Ward B’, a ward that had previously had a bio-medical/risk culture, but was in the midst of an attempt to change practice to align with an applied Dialectical Behaviour Therapy (DBT) model. DBT is a model of practice that is usually applied to working with consumers with a diagnosis of Borderline Personality Disorder (BPD), who often experience chronic suicidality. In ward B an attempt had been made to use DBT as a model of work with acutely suicidal consumers, but was not fully imbedded in practice. In this chapter I describe the culture of partial change, consider the evidence as to how this change had occurred, and show how the interpretations of the partial change in culture were played out in different types of nursing practice. The data suggests that the attempts to change to practice had somewhat ironically resulted in three differing types of nursing practices. I show that the absence of a ward or team cultural understanding of suicidality was a significant factor in the construction of nursing practice. It is not clear from research *within* the ward why three different types of practice had emerged; however comparison with data from the previous two chapters suggests that nursing dispositions were a significant factor constructing the data.

## 7.2 The attempt to change a culture

### 7.2.1 Introduction to this section

In this section I outline the previous culture in the ward, and explain the attempts to change practice with suicidal consumers to a model of applied DBT. I show what practice was meant to be like in this ‘new’ model, but explain that this had not completely taken effect. This then leads to the next section where I show how the lack of a complete uptake of DBT led to competing nursing practices.

### 7.2.2 The previous ward culture

I have shown in the previous two chapters that the bio-medical/risk wards and the psychological team in ward ‘D’ were philosophically and operationally very different in their approaches to practice with suicidal consumers. Key to the ward or team culture appeared to be the beliefs about the causation and best treatment of suicidality, and the way that these intersected with the dispositions of nurses and, consequently, were manifested in nursing practice. Ward B was very different. Initially I considered that rather than there being one or two cultures, there were a number of sub-cultures. This was because there were three main groupings of practice that nurses used, but, unlike the other bio-medical/risk ward or psychological team, none of these appeared to have primacy within the ward. However further examination of the data led me to believe that an attempted philosophical and practice change had led to an absence of an over-arching culture of what best treatment/care of suicidal consumers should be.

Anecdotally, ward ‘B’ had previously operated under a bio-medical/risk culture, in part driven by the previously held views of the consultant psychiatrist about the causation of suicidality. It was clear from interviews with nurses and allied health professionals who had worked in the ward for lengthy periods of time that the consultant psychiatrist held a great deal of professional power within the ward, a view supported by the physician himself. In interviews I was told a number of stories about how practice was previously constructed, as the following examples show:

> "He [the consultant psychiatrist] was well known for his approach. Medicate, hold ‘em [in the ward], discharge when they are ready, and only when ready. No messing around with talking therapy, that’s all the community’s [responsibility]. I’m not exaggerating—he was well known for it. The changes in philosophy have been stunning." (Psychiatric Registrar 4)

> "We [nurses] felt there was no choice. This was the way things were. If he said observations, it was observations. There was no talking to him about how these may be counter-productive to [consumers] or anything. He was definitely in charge, well

> he still is. But he was in charge and it was nurses' job to do his medical model work." (Nurse 15)

A common theme in interviews was that the consultant psychiatrist's beliefs about suicide causality aligned with those described in the bio-medical/risk wards and teams. The consultant had previously believed that the treatment for suicidality was predominantly one of treatment by medication, whilst ensuring consumers were limited in their movement in order to minimise the risk that they would attempt suicide. This was, like the other bio-medical/risk wards and teams, operationalised through nursing practices such as observations and restricting consumers in their movements within and beyond the ward. Decisions about risk, while informed by the observations of nursing staff, were considered by the consultant to be a role of medical clinicians. Nursing roles, in the consultants view, were to support the psychiatrist by observing and reporting consumers' psychiatric pathology, asking brief questions about risk each shift and reporting these, ensuring the medication compliance of consumers, and carrying out actions to ensure suicidal consumers remained safe.

I did not directly attempt to ask nurse interviewees about their belief systems about suicide and nursing practice before the changes to the ward culture. In retrospect this was an oversight on my behalf, as this may have proffered useful insights into nursing's part in the ward cultural change. My sense (although not directly supported by interview data) is that individual nurses held a range of beliefs about both suicidality and what nursing practice should be, but that, for most, actual practices aligned strongly with the ward medical culture.

### 7.2.3 Attempts to change the ward culture

A philosophical change in the consultant psychiatrist had led to an attempted change in ward culture. It appears that attendance at DBT training by the consultant psychiatrist, psychiatric registrar and some nursing staff had a profound impact on the beliefs about suicidality and requisite practice. In this training ward staff attended workshops in which they were exposed to the then latest research evidence in working with consumers with a diagnosis of BDP, along with clinical examples of the differences this had made in the lives of consumers receiving inpatient and community treatment, and the day to day increase in satisfaction in clinicians. This training was seen as a critical point at which the consultant psychiatrist's thinking about practice with suicidal consumers began to change. In particular, he emphasised that the way that the DBT model helped him re-consider approaches to managing risk of acutely suicidal consumers was pivotal:

> "I think the DBT training that I went through two years ago… that the managing of risk is best done with their giving them mainly power rather than my taking [of power] by my disempowering them. And I extrapolated that to other cases and other situations and asked the question `Is this person able to take the responsibility for themselves? [sic]'." (Consultant Psychiatrist 4)

I was told by various clinicians in Ward B that they saw the evidence for positive outcomes with consumers with a diagnosis of BPD from DBT based-work. The DBT model also helped clinicians better understand the purpose of self-harm (such as superficial wrist-cutting with knives or razors) and descriptions of emotional states (for example, 'wanting to die') as being understandable, adaptive responses, rather than being something that was 'manipulative' (in order 'to get attention' from clinicians) or needed clinicians to coercively intervene in order to prevent. Indeed the contrary was true. I was told:

> "The DBT model in here [the inpatient unit] means that it's a win-win for everyone. We still assess for acute risk [of suicide] of course, but now we don't focus on self-harm. We medically treat cuts and what-not if need be, but they are seen as a symptom of [the consumer's] distress, not something we have to get into stopping. Trying to stop just results in [a] stand-off. Instead we focus on the feelings behind what's going on. It's so much better for us, we are less stressed, we understand them better, we understand that they aren't trying to manipulate [nurses], we understand it's their distress. And of course it's better for the patient [sic]. And because it has a really strong evidence [base] and is an international model, and approved and everything, and we have had training, we can write it in the plan, the [consumers] know, they agree, it's so, so much better." (Nurse 3)

I was told that in the DBT model, chronic suicidal thoughts and self-harm have the purpose of decreasing distress in consumers. Attempts to coercively stop these attempts would therefore be counter-productive by increasing distress and creating a cycle of clinicians and consumers being at loggerheads. After the DBT training a year earlier the ward had significantly changed the focus of nursing work with consumers with a diagnosis of BPD. Rather than a focus on self-harm assessment and practices to prevent these, the focus of nursing was seen as supporting consumers to follow a plan of treatment/care designed to help consumers understand the purpose of their self-harm and look at other ways of reducing distress. The description I have given of the application of DBT applied in the acute setting is simplified, for to fully describe the theoretical underpinnings of such an approach would require reference to current research and theoretical textual writings on the topic. Moreover I am not attempting to comment on either the consistency of application or the efficacy of this approach in ward ‘B’. To re-state, I have briefly described this understanding (as told to me) in order to consider how a conceptualisation of understanding of the DBT model with chronic suicidality influenced an understanding of *acute* suicidality, and nursing practice with consumers who experienced this.

As I have already noted, the consultant psychiatrist held a large amount of vested power to determine the practice culture of the ward, including the day-to-day work of nursing with suicidal consumers. The interviews with him were enlightening in that they showed that he understood and accepted this power, as he believed:

> "… that’s what I do has to be the right thing. I set the clinical tone of the ward. I lead in the understanding of how things should be. It’s important that I do the right thing. In this instance [work with suicidal consumers] I have had to reflect after [DBT] training… a great deal of soul-searching. I was wrong before, but I’m very confident I am right now. I have had to change, and the ward had had to change." (Consultant Psychiatrist 4)

During the interview the consultant psychiatrist took pains to explain that the principles of DBT when working with consumers with a diagnosis of BPD, although in some ways new to him, were timely due to the frustrations he had had with previous practice. He gave one example:

> "I have an example in mind very clearly of a woman… We tried everything with medications and then we tried ECT and she had 12 treatments of ECT and she had secondary memory loss [from this]. Now she already had problems with her memory, and she got enraged with us for what we did. `How could you do this to me? It felt like I was being abused again.' She had a history of abuse, and she just hated us and everything we did. She was angry at us and I said "well OK, you go". She left the hospital, and the community tried to pick her up and engage with her, she just didn't trust `em any more, and one day she just went home and hung herself she just was so, I think, was so disempowered by what we did to her. In part, she had some serious psychopathology but we made it worse. We set her up and there is an example of someone where, had we discharged her much sooner, instead of throwing the kitchen sink at her, everything we could do involuntarily to try and sort of force her brain into submission, I think she'd still be alive." (Consultant Psychiatrist 4)

It appears that the timing of the completed suicide coincided with the DBT training, and the latter offered participants a belief that there were better ways of conducting inpatient treatment/care with chronically suicidal consumers. At the same time the principles taught in the DBT training were considered to be potentially useful in the treatment/care of *acutely* suicidal consumers.

### 7.2.4 How applied DBT was meant to occur as ward practices

Operationally, applied DBT principles were meant to translate into ward practices in a number of ways. First, treatment/care was meant to be non-coercive where possible. This was evident in an interview with the ward consultant psychiatrist:

> **Consultant Psychiatrist:** I feel like I have a sense of — I trust my own sense of clinical judgment of who is at high risk. But for others, the risk adverse things we do to them, I believe, makes them worse
>
> **TF:** Can you give me an example of 'making them worse'?

> **Consultant Psychiatrist:** Well we stop them going on leave, we follow them round with observations. We are telling them we don't trust them. And at the same time we make them promise not to kill themselves. Straight after we have said we don't trust them. It's absurd, a farce. All this does is give us [clinicians] a false sense of security, or a way we can 'dot the t's' in [the] files to say we have done everything. But it disempowers them and gives them messages they are not able to make decisions for themselves, at the very time they are most vulnerable. What we need to do, what we do now, is say to them, "I know you feel vulnerable. I want to help. I hear your pain. How can we help". And we do this by *negotiating* [interviewee's emphasis] things that help keep them safe, by listening to their distress, by supporting them when they are distressed, by coaching them well, helping them to work out better coping strategies than death. But what we don't do is pretend we are stopping them [from attempting suicide] in the name of safety by coercing them and taking any power they have away. What we do, we learnt this from DBT and I firmly believe this from all the evidence, is help keep them safe by helping them to help themselves. (Consultant Psychiatrist 4)

This shows that that the psychiatrist considered coercive practices to be problematic. Suicidality in non-psychotic consumers was understood to occur when other options to cope with particular life stressors were seen as absent. Further removing consumers' choices, and their ability to be able to make better choices, was seen as counter-productive in the longer-term. The consultant psychiatrist again suggested:

> "Can someone be left on their own, can we let them into the Open Unit and let them sit out on the deck on their own, and will they wander off into the woods and harm themselves? Do they need to be watched all the time, do they need to be in a locked set-up, do we need to put them in the Intensive Care Unit? That I find very problematic things to do for suicidal people, because often they're suicidal because they're feeling helpless and overwhelmed and usually there's something out in the world that's happened that they can't control — like split-up of a relationship or fired, getting fired from a job, you know, some front that they had no control over and so we take control away from them in response to that, seems like a kind of counter to it, so we try not to, to do that unless the only way to contain this person, their dangerousness in the short run is to give them that intense level of nursing support." (Consultant Psychiatrist 4)

Similarly, some nursing interviewees considered that the notion of providing coercive practice to maintain safety was fraught:

> "I don't think our goal should really keep somebody safe but rather to support them in their efforts to keep themselves safe. Because safety isn't something we impose very successfully. Where you can put someone in a room with nothing to hurt themselves with and get the sense that you're keeping them safe, but ah, you're taking away their dignity, and they can always run from one end of the room and bang their head on the wall on the other end of the room, so unless you tie them down as well, you just, you can't keep somebody safe." (Nurse 29)

A second expected translation of DBT principles into practice was in supporting consumers to self-determine their needs when feeling unsafe, which was seen as an important part in recovery from suicidal thoughts and/or attempts. Similarly some nursing interviewees viewed the evidence around completed suicides post-discharge from acute units as a possible indication that coercive models of inpatient treatment may actually make consumers worse. One nurse noted:

> "We should, but we don't, tie suicide to hospital when the suicide occurs after the person leaves the hospital. But in fact, when they were in the hospital we [previously] treated them in such a way that when they went out they were shattered and not, not, had no more skill than they had before, and uh, and so we set `em up, and they go out there bitter, with no skills at coping with the real stuff that led them to suicide, no skills at coping with the emotional distress except by suiciding [sic]. That’s what we always did [on the ward] but now we, at least some of us [nurses] do, we actively coach them, support them to make good decisions now and [in] the future. Our job has changed for the better. We now help, it’s the crux of our role, and [applied] DBT just gave us a means to validate what we do is right. That and the other evidence." (Nurse 15)

A third expected translation of applied DBT principles into practice was the supporting of suicidal consumers’ resilience:

> "We say, “I hope you don't [kill yourself]”. But you need to understand that there's not much we're going to be able to do to help you with, that unless you really do try and open your mind to the ideas that we're going to, that we're going to use.' There's a lot of DBT based strength [work] that goes on here. It helps them recognize that they can have their own inner resources to deal with distress in ways other than suicide. We do a lot of work to help them recognise this." (Nurse 33)

While the consultant psychiatrist and *some* other interviewees stressed that the applied DBT model could not be used when someone was psychotic, the principles were still seen as useful in helping consumers’ resilience:

> "There are a lot of suicidal people who are psychotic, who just are hearing voices, you know, or who are delusional because they think the Mafia is out to get them and they want to kill themselves before they get `hit'. You know, and for them, working with the beliefs and using medication becomes kind of the way to validate, you validate their fear but there's a lot of intervention to stop them. …So the medication [is used] as a rule, and I don't, I don't want to pretend it doesn't, but that's not the end of the story, that's the beginning. We now [after the consumer becomes non-psychotic] try and help them understand why, how they got so fearful, what you think that was all about. Next time that starts to happen what they should do. So it's the same notion of, `How can you protect yourself from the next wave of distress that you experience?' Well maybe you, maybe continuing to take the medication is the way to go, or coming up, ah, getting a network of support so when you get an early sign of problems you can call somebody up." (Consultant Psychiatrist 4)

The consultant psychiatrist and nursing supporters of the applied DBT model considered that the emphasis on therapeutic relationships, where clinicians both understand the emotional distress of consumers and support them to use ways of dealing with distress in the ‘here and now’, is a major focus of nursing practice and has utility in assisting acutely suicidal consumers to be resilient. This could involve therapeutic ‘talking’ or the use of physical input (such as going for a walk with the consumer or foot massages). I was told:

> "Yes the therapeutic relationship is vital. It’s useful in itself as suicidal [consumers] lose human connection. It’s one of the reasons they are suicidal. It may be the cause

> or it may be something that happens because of the stress. So the relationship with clinicians here models positive relationships based on trust. So it's doing good in of itself. But it's also a basis to do work. It's the basis to do coaching work, it's the basis to help intervene if they get distressed on the ward. And we don't just sit in there with a pen and paper. It's not therapy. We may do some things like simply go for a walk with them, whatever helps minimise their distress. We try and work that out in advance, "what works for you". It may be giving them a hand massage. It may be listening to a relaxation tape. It may be running them a bath." (Nurse 3)

A fourth expected translation of applied DBT principles into practice was an absence of clinical focus on the desire of consumers to self-harm. While acute suicidality had to be assessed and managed, chronic suicidal thoughts were seen as a symptom of distress. In a DBT model focused on working with BPD consumers and *chronic* ideas of self-harm, a focus on the act of self-harm itself was seen to be therapeutically counter-productive, could possibly increase the risk of or suicide, and could put the clinician and consumer in a place of opposition where the clinician considered him or herself obligated to try to prevent the self-harm. Similar principles guided the applied DBT model with *acutely* suicidal consumers. This required an understanding that consumers' suicidal thoughts and feelings often fluctuated, depending on circumstances. It was therefore seen as vital for clinicians to differentiate between the risk of immediate suicidal action, and fluctuating suicidal feelings. The latter might require intervention, but the intervention (such as talking with the clinician or undertaking some physical action) would likely lessen the risk. Coercive intervention might be necessary, but only if the other interventions were seen to be unsuccessful.

In summary, applied DBT principles were seen as applicable to working with acutely suicidal consumers. It was stressed to me in interviews that these principles were a guide to working with acutely suicidal consumers to actively do therapeutic work, including coaching, and to assess and help consumers manage risk in a more useful way. The consultant psychiatrist explained to me, on a number of occasions during the interview, that the change in focus did not mean that nurses (or other clinicians) should not undertake risk assessment. On the contrary the new consideration of ways of working was seen to make nurses more responsible for, and responsive to, risk assessment. Nurses were expected to be more aware of understanding an individual's fluctuating suicidality and helping the consumer manage this. If risk had increased to an extent where a consumer may need more nursing or medical input (or even coercive actions), this was meant to be clearly documented and discussed with the consultant psychiatrist or registrar. In turn, the consultant now expected to have nursing input into all risk assessments he undertook. He noted:

> "In the old way of working I carried a lot of that risk on my own. While nurses were expected to do risk assessments, it seemed that risk was seen as being something static. Like I would get told “so and so is saying they are feeling unsafe” and I would ask “so what are you doing about it, what have you tried?”, but it seemed that risk was my domain, and there seemed to be a helplessness with the nurses that they couldn’t do anything unless I told them. Maybe that was partly my fault, maybe I was too controlling, but certainly it was the case. It is not perfect yet. Not all nurses do it, but most of them do, most of them will cope with someone’s increasing risk, try things, work on the [consumer’s] strengths, help the consumer cope, rather than coming to me for permission to lock the doors or hold them on the ward. Now nurses discuss risk with me. Ultimately for someone we think at high risk the buck stops with me. But no longer do I do it in a vacuum. It [is with] the nursing staff who knew [consumers]." (Consultant Psychiatrist 4)

The issue of risk was also discussed by some nurses who had adopted the applied DBT model:

> "In the past it was just so frustrating. It seemed that the medical approach meant as soon as someone [a consumer] said the ‘S’ [suicide] word we were meant to panic and run to the doctor for what to do. The [applied DBT] approach means that it validates what we already knew. That talking to someone in the immediate term helps, trying other things like walks helps, that risk changes by doing something in the here and now. Risk isn’t something you distance yourself from. What we [nurses] do influences risk. As I said this way of working validates this and allows us to do what is just right." (Nurse 3)

The support from the consultant psychiatrist and some nurses for the applied DBT approach may suggest a change to the overall culture of the ward in working with suicidal consumers from one of a medical treatment of the acute suicidality of consumers with concurrent nursing actions, to one similar to the psychological culture and nursing practice described in the previous chapter. However this was not the case. While some nurses clearly aligned themselves with the applied DBT model, the culture was one of unshared interpretations. By this I mean that some nurses (and other clinicians) considered that they were following the new model, but appeared to interpret and practice this in different ways than the consultant described; others were unclear about what practice was meant to be, and a minority disagreed with it and considered it unsafe. I discuss these in the next section.

## 7.3 Nursing practice(s): Competing views

### 7.3.1 Introduction to this section

The support of the consultant psychiatrist and some nurses (for the sake of clarity I have called this group ‘applied DBT nurses’) for the applied DBT model was not universal on the ward. A second group of nurses also supported, at one level, the applied DBT model, but appeared to apply this to practice in some clearly different ways to the first group. It seemed that this difference was not a conscious one; rather it was one of interpretation. In particular they considered the role of nursing of suicidal consumers in acute wards to be one more akin to talking therapy with consumers. I will expand on this later in this section, but again, for the sake of clarity, I have labelled this group ‘therapy nurses’. A third group were more consciously opposed to the applied DBT model, considering it to be unsafe. These nurses worked very much in bio-medical/risk model; for this reason I have called this group ‘bio-medical/risk nurses’

### 7.3.2 Nursing as applied DBT

One group of nurses considered the ‘new’ way of thinking about practice to be largely aligned with their belief system about both the causation of suicidality and what nursing practice in inpatient unit should be. I have touched on this group in the previous section, as their views were similar to the consultant psychiatrist's in supporting the applied DBT model. Perhaps unsurprisingly, almost all of this group had attended the DBT training. Although they did not name their practice in the way nurses in team 'D' did, they considered that the therapeutic relationship underpinned good nursing:

> **Nurse:** The DBT training really confirmed what I believed in. I know it was [about] borderline [personality disordered] people, but the principles really made [name of consultant] think, and now he supports this kind of nursing work.
>
> **TF:** What about for you personally?
>
> **Nurse:** Yes I am totally committed to it. Before I used to practice mostly the same, but I felt I wasn't supported, it was like I was a maverick for thinking that you should really really listen to consumers about their experiences, that you should try to see suicide as a symptom not an illness, that you should not obsess about crazy things to try to stop them killing themselves, that the best way to keep someone safe is to get them to do it. Not leave them to themselves and say "it's your responsibility", but to work with them and look at their strengths and say "hey look you are here, you are alive" there is some part of you that wants to survive, and we can work together to look at how you can cope better. Sorry I'm raving (laughs) but I'm passionate about this and passionate that this is the right approach. (Nurse 29)

Like nurses in the psychological team in ward 'D', these nurses considered a therapeutic relationship between a nurse and a suicidal consumer to be helpful to the consumer in itself, and to be a basis from which work to support consumers to deal with current distress and to examine the ways that they approached the difficulties in their life:

> "I come from a CBT [cognitive behavioural therapy] type perspective as well, so I utilise CBT, so I kind of can see what's sort of going on for the person cognitively and what [thoughts] needs changing and how to help them, and I guess my main aim is to engage the person to start with, get some trust and some rapport, and then work from there to try and get them to look at what's going on in their life that makes them make choices about

> death instead of other options. And work so that they can look at better ways to cope. That’s how I kind of deal with it. But you need to be educated in this, or else all you do is ask questions like “are you going to kill yourself?” Like just reporting risk to the doctor." (Nurse 15).

The methodology used in this study did not always allow for an examination of the relationship between how individual nurses said they practiced and what I observed, so conclusions about groups of nurses within wards must remain tentative. Having said that it did seem that this group of nurses both stressed the importance of the supportive and coaching role they had, and were congruent in how they practiced. Similarly they emphasised, and from what I observed, practiced, a conversational style of risk assessment. The therapeutic work and intertwined risk assessment were akin to the way nurses practised in team ‘D’. Because of this close similarity, I will not repeat the details of this here.

I noted in the previous chapter that the manner in which the therapeutic and risk assessment practice was overt in team discussions, discussions with other nurses and medical and allied health professional staff. Similarly these nurses were able to work with consumers to manage risk through immediate therapeutic work and through the use of distraction techniques and other non-coercive physical interventions. The ‘applied DBT’ in ward B involved similar negotiated interventions with consumers, but it appeared that these and the supportive and coaching therapeutic work was not made overt in team discussions or nursing handovers, nor documented in notes.

Clinical notations from these nurses still appeared to focus on general day-to-day activities of consumers (including, for example, visits of family members, when medications were due), assessment of pathology, and risk assessments that largely described risk in brackets of ‘high’, ‘medium’ or ‘low’. Although some consumers were noted as being in the former categories, there was little in the way of coercive interventions that I saw in the biomedical wards or teams. Close or special observations were rarely used, and the ward remained unlocked all the time I was there. Little or no documentation was made about the immediate effects of nursing therapeutic work that was seen to ameliorate this risk. I asked some nurses about this lack of documentation. I was told:

> "Oh the risk assessments in notes are a rough guide. We know that the *real* work is done by working with [consumers; interviewee's emphasis] not doing this to them. We know if they are at real risk, and we discuss with [name of psychiatrist] or [registrar's name]. We know that obs[ervations] don't make any difference to risk. We do know that working with them [suicidal consumers] to find out how we can help minimise their risk makes the difference. If they are really really bad we can negotiate with the consultant or them for them to go to ICU but by and large we help them manage their immediate risk. … and yea, the notes, we have to write 'high' or 'medium' or whatever, it doesn't really mean anything." (Nurse 15)

I initially thought this was because therapeutic interactions were seen as the 'taken for granted' work of nursing; however surprisingly (for me at least) discussions about the outcomes of nurses' therapeutic work with consumers did take place between nurses and the consultant psychiatrist or the registrar on the ward. Clearly the consultant psychiatrist and psychiatric registrar did consider the therapeutic work, risk assessment and risk management of these nurses to be valid. I have already noted the consultant's beliefs about the nature of day-today support and coaching work, and it was evident that the interventions this group of nurses did to ameliorate risk was seen as valid. I observed this on a number of occasions:

> ..today [I] saw something that occurs a lot. A nurse was talking to [consultant psychiatrist] about the risk she saw posed by a consumer. This person had previously been admitted after a serious overdose and they [ward clinicians] I know were concerned about her. The nurse has been working with her closely and described some of the staged things she has done to help decrease her [consumer's] agitation and need to suicide. This included using a whole lot of support and more specifically using relaxation techniques and approaches when the stress was on, taking her back home to deal with some tricky home stuff. She now wanted to allow the consumer some time off the ward and at home, with her [the nurse] checking in. [The consultant psychiatrist] was concerned as the consumer had only that morning been distressed apparently, but the point is that the nurse described the risk factors and [the] benefits

> of going home, and the approaches of what has been done, and how her [the nurse's] supportive work had changed the risk *and* [my emphasis at the time] had seen the distress as a way that showed how the consumer was able to apply some of the techniques she had learned successfully. I looked at the notes later but none of this is described, only that she was at low risk and able to go home and was discussed with [name of doctor]. (field notes)

Nurses in the applied DBT group expressed satisfaction that the consultant and registrar both recognised the work that they did and how this affected risk. However there was a sense of frustration that on weekend on-call registrars, who usually did not know the consumers, would make decisions not to allow leave based on perceived risk without considering the views of nursing staff. I did discuss this informally with one on-call registrar. His answer was unequivocal; that he could only assess risk of consumers based on what was currently in the notes (field notes). I considered this in light of the 'resisters' in bio-medical/risk wards and teams that practiced in a similar manner and did not overtly discuss or document this. However the 'resisters' had felt unable to make clear their work with the psychiatrists on the ward. Aside from the noted frustrations about documentation and the more conservative risk approaches of on-call registrars, there was a view that there was support from the consultant psychiatrist and psychiatric registrar for nursing work to be focused on support and skill coaching. In part this was seen as recognition of the value of such work:

> "It feels like, it [the bio-medical/risk model] feels very unrewarding, you know, and so if you say, "stop that is not our goal, our goal is to allow the person to help them stay safe", then it becomes some service that we are offering to somebody, not something we're forcing down their throat." (Nurse 31)

Interviewees in this group of nurses also considered that the focus of the ward culture was in the process of changing and that there was an emphasis on practice that fitted in with their beliefs about how suicidal consumers should be treated for good outcomes. There was acknowledgement that the DBT training the team had been on had significantly affected the way the consultant perceived suicidality and consequent need for nurses and their practice. In particular they considered that the applied DBT model suggested that (i) coercion can make suicidal people worse (ii) that undue emphasis on suicidal actions and thoughts (beyond understanding risk) were not helpful, and (iii) that the *primary* role of nursing was to support and coach consumers to deal with suicidal thoughts. In addition they considered that nursing interventions could ameliorate risk, meaning that the differentiation between risk assessment and risk management was a false one; they were, in fact, considered part of the same thing.

However this group of nurses were also very concerned about the impact the change to practice was having. In particular there were concerns about the applied DBT model not having universal acceptability either within the ward, or with nurses on the ward next door:

> "It’s (the model) definitely not thought of highly by everyone here. Some stick to the old ways, doing risk assessment and just watching [consumers] from a distance, not really *being* [interviewee’s emphasis] with them. I think they don’t understand it. I think they are afraid of it. I don’t know, maybe they don’t feel they have the skills for it. There is deliberate resistance alright. Probably they think it’s unsafe. Yea, that’s what I’ve heard others [nurses on the ward] say, it’s unsafe." (Nurse 15)

> "I have done occasional shifts on [the ward next door in the same hospital]. They are like, “Oh he’s [name of the consultant psychiatrist] gone native, he’s forgotten what the job of inpatients is, just wait until something goes wrong,” that sort of thing. And the same thing gets directed at our nursing practice." (Nurse 31)

There was also some concern about the way that the model was understood by some nurses. The following excerpt from an interview with a nurse summarises the recognition of how the applied DBT model had been interpreted and hints at why it may have come about this way. It also describes one of the significant differences between the applied DBT nurses and the ‘therapy’ nurses. I elaborate on this further in the next section:

> **Nurse:** The new way of working is great. But you know it’s kind of been introduced by stealth. It hasn’t come in formally. No one’s written down anywhere that this is

what we should do. Mind you it wasn't written down before. But some still work in the old ways. And a few I could name think this is *carte blanche* license to spend their time doing therapy

**TF:** Can you tell me more about that?

**Nurse:** Well rather than supporting consumers to make ways of coping with the stressors they have, they see their time as booking them [consumers] in and saying that they will spend time with them doing short term [inaudible word on tape] therapy. It really worries me. It's a fine line I know, understanding and supporting and helping work out better ways, but the few I mentioned before are seeing that their main role is [to] delve into the person's past, to help them resolve their life issues.

**TF:** Where do you see the boundary between the way you and others work and the kind of therapy you just discussed?

**Nurse:** I guess what they are doing is what you would see on TV as the psychiatrist lying the person on the couch and doing psycho-analysis. Don't get me wrong. I totally think suicidal people need more than coaching to deal with stress and support and meds, but the in-depth stuff should be done by those trained in therapy, and most often once they have been discharged. It's usually on-going. Our stuff is to help them be safe now through support and helping with the times they are distressed and then getting them to understand better ways to deal with stress. Ours is here and now. (Nurse 29)

### 7.3.3 Nursing as therapy

As the last interviewee discussed, a small group of nurses considered one of the main roles of inpatient nursing with suicidal consumers to be undertaking therapy. Some described it as therapy, whilst others did not use this label, but appeared to be working in a similar way. It was evident the therapeutic work of nursing was perceived differently by the 'therapy' nurses. These nurses universally described the basis of nursing practice as the therapeutic relationship. Rather than a role intervening when consumers were suicidal and the coaching of skills to manage suicidal thoughts at future times, therapeutic work was seen to be about undertaking therapy. This was explained to me as follows:

> "I do intensive work with consumers. It is really important that they come to grips with why they are suicidal, not just what they can do about it. They need to be able to understand what in their life has brought them to this point. There are always underlying issues. It's not about pathology. Sure people get depressed, but depression is about life issues. DBT allows us to think about trauma in peoples' lives, and to help them understand how this trauma repeats itself in patterns of life behaviours. While DBT was designed for people with borderline personalities, the fact is the principles are still the same. People have maladaptive ways of dealing with life. Suicide is merely a symptom. So my job is to help them to understand this. Yes its therapy I do. Yes it could and maybe should be done outside [in the community] but in truth there aren't the resources, and you have to act while they [consumers] have the motivation. There is the nearness to the event [of being suicidal or making a suicide attempt] that makes them go 'hmmm', so you have to start now, not wait." (Nurse 19)

> "I know the ward is moving towards a DBT model, and it's a great thing. I used to practice similarly before but now I'm more open about it. They [suicidal consumers] want more than medications, more than support. They want someone to sit with them in a structured way and go over what's led them here. Not just recently, but their whole life. My job is to help them make changes. If I start to do this and it's going to be a huge thing then of course it's something I would see as needing a referral to a psychologist. But being in an acute unit allows me to do some pretty intense work with consumers." (Nurse 28)

The other significant difference in practice was the way risk was considered. In particular, this group of nurses undertook risk assessment in the same way most nurses did in the bio-medical/risk wards. I was initially surprised by this, as I had thought that the focus on therapy would have meant a conversational style assessment of risk, and a similar emphasis on ameliorating risk through nursing interventions. Again I emphasise that this was a small sub-group of nurses, so the findings are tentative. However the findings point to there being two parts to risk assessment. First, there seemed to be a belief that the therapeutic work being undertaken would be undermined by discussions of current risk:

> "I keep risk out of the therapy work. It would undermine it. I do risk assessment by a more casual chat and ask how they are, how the suicidal feelings are, when I see them. But not in the therapy, no." (Nurse 19)

Second, the therapeutic work at other times was considered to be a basis by which a trusting relationship was built up, and consumers would therefore be able to offer accurate information with brief questions. Interestingly, if this information showed a ‘high’ or ‘medium’ level of risk, nurses considered that the medical staff needed to arrange admission to ICU, rather than either coercive nursing practices or more intensive one-on-one nursing. One said:

> "Oh yes once I have asked that, if they seem at high risk, I get the doctor immediately. It’s their job to put risk strategies into place. We [nurses] may have to do them, but yes its nurses’ job to report, doctors’ jobs to then assess and see [i]f the assessment is accurate and put something in place." (Nurse 28)

As I have stressed the number of nurses operating in this way seemed to be small. I initially wondered if this was the practice of one or two individuals, but another nurse confirmed that there was a “sub-culture of practice as therapy” (Nurse 3). From what I could ascertain all of these nurses had between one and three years of clinical experience and had not practiced elsewhere. Not all of these nurses had attended the DBT training, but when I asked all were positive about the application of DBT to practice with acutely suicidal consumers. My tentative conclusion is that their interpretation of applied DBT was different than that of the first group.

### 7.3.4 Nursing as bio-medical/risk work

The third group of nurses in the ward believed practice should be very similar to that described in the bio-medical/risk chapter. While this group considered the basis of nursing to also be the therapeutic relationship, the range of beliefs about the causation of suicidality was similar to those in the medical wards; that is, that suicidality was a medical event caused by psychiatric illness. Similarly their approach to working with consumers was one of providing safety, ensuring medication compliance, and assessing for pathology and for risk through brief assessments. So similar was this to the medical wards that again I will not labour this point by giving similar examples. Nurses working in this model were very concerned in what they saw as the partial adoption of an applied DBT approach. Perhaps significantly, most of those who worked in the medical model had not attended DBT training, but were nevertheless critical of such an approach with consumers with a diagnosis of BPD. One nurse interviewee stated:

> "It's crazy and frankly it's dangerous. DBT was for borderlines [sic]. I have some concerns about that approach too, but to apply that with suicidal people is just asking for trouble. Where is the evidence that this works? We know suicidal folk have life issues, and we should be sympathetic. But inpatient is to keep them safe and to treat the illness. When their risk is low we discharge them and they can get counselling or whatever there. They are in no fit state to do anything else from what I have seen, not to make decisions for themselves [sic] about risk. We do that for them. We protect them while they need it then they say thank you and leave. If they are they shouldn't be here. I know this sounds blunt but they should not block up beds if they are ready to do counselling work." (Nurse 24)

The notion that the focus of inpatient nursing practice to a move away from what was described as "necessary coercion" (Nurse 20.) was seen as putting consumers and staff at risk if the consumer attempted suicide:

> "The idea that [consultant psychiatrists name] has that we don't forcibly keep people safe based on chronic suicidal [sic] would be laughable if it wasn't so scary. What happens when one of these people kill themselves after we have said 'Oh we can't make you do what you don't want, you don't have to stay on the ward or have medication to get better. The shit will hit the proverbial. The poor old [consumer] will be dead, and we [nurses] will lose our registration. I'm just not doing it. I am looking for a new job. In the meantime I'll do what I've always done." (Nurse 20)

Nurses in this model did not consider the coaching of skills to deal with suicidal thoughts to be nursing work; rather, this was seen as the job of outpatient psychologists. In interviews it was apparent that these nurses saw brief ‘questionnaire’ type risk assessment as being an appropriate focus on suicide without over-stepping professional boundaries, whilst they considered an applied DBT type approach steered away from this by being more informal:

> "It’s important that we ask risk questions, all of them, in the right order. Otherwise we miss things. It’s a pain, and the [consumers] know what you are going to ask, but they feel safe, and tell the truth. I explain why we ask. (Nurse 24).

There was some relief expressed at the retention of a structure of documentation that focused on risk categories, pathology, and clear instructions about the use of coercive practices to maintain safety:

> "I still write up assessments just as I always did. Everyone has to have a MSE, a risk assessment each shift, show what meds they took. The structure is the same, thank God. (Nurse 24)

While the three types of nursing practice had similarities, they were dissimilar in both understanding of causation of suicidality, and what the focus of direct nursing work with suicidal consumers should be. Interviewees in all groups were very well aware of the link between the DBT training that the consultant psychiatrist and some nursing and allied health professional clinicians went on and how this had affected the consultant’s views of what practice should be. It was apparent though that there was opposition to this way of thinking both within and external to the ward. It may have been because of this that despite moves to change the culture of practice, many of the important symbols of authenticity of practice (in documentation and much of the language) were still firmly bio-medical. I only considered this issue when analysing data, and unfortunately was not able to question why this was with clinicians. However in the next section I show some other evidence for why this ward was one undergoing a change of culture but with multiple nursing practices. This data gives clues to why this may have been the case, and is discussed at some length in the discussion chapter that follows.

## 7.4 Factors in practice construction

### 7.4.1 Introduction

The data indicates that two factors impacted on the construction of nursing practice. First, the way that a new cultural understanding of suicide had been introduced had resulted in an absence of a unified, over-arching culture of understanding suicidality and what practices should occur. Second, in the absence of this culture nursing dispositions largely appeared to lead nurses to work in one of the three practice styles I have identified. I discuss these two issues in turn.

### 7.4.2 A partial change of culture as a constructing factor of practice

It appears likely that the process by which the new model of practice was introduced was partly at issue. The DBT course was not attended by everyone, and it seems that the thinking around the translation of this to suicide practice was not widely discussed. This was evidenced in two interviews:

> **TF:** You mentioned others doing practice differently than the new model. Do you have ideas why this might be?
>
> **Nurse:** (after a pause). Good question. Yes I do have ideas. I attended the DBT course, and I do agree that it has application to working with other [acutely suicidal] consumers. So I am a fan. But there’s not consistent uptake, and I think that's partly because not everyone went; partly because the thinking behind the original DBT and how it should be done with suicidal [consumers] is not clear to everyone; but most of all I think because it has never been explicit. No one has ever said, "Oh now it’s the way we work here". It’s not written anywhere, it just came about after a few discussions. And probably nursing practice in psychiatry is like that anyway. The nitty-gritty is not described well, so everyone can do different things and no one is the wiser. (Nurse 3)
>
> "The way it was introduced… it was just a discussion with the ones who were there. I think its credit to [the consultant psychiatrist] that he had an epiphany and saw that this is a great way to work. But I think he just expected that overnight we would

> change. Because a lot of us work this way doesn’t mean we all do, and as I said earlier there are some weird practices here. I’m not sure he knows that." (Nurse 29)

While some nurses embraced the changes in the ways of thinking by the psychiatrist, it appears that this was not, as I have shown, clear to all. Rather it seems that the changes were described to nurses without their input. This created in some a sense of resentment that a new model had been imposed without consultation. What this model meant in practice was also not clear. In particular there were concerns that a way of practicing with consumers with chronic suicidality and a specific diagnosis of BPD was being translated into one with acute suicidality and a variety of diagnoses, something that I have already mentioned.

A second issue was one of incongruence between the ascribed new way of practice and the processes of documentation and formal discussions in handovers and MDTs, which largely remained bio-medical/risk orientated. One nurse noted:

> "I think the way we have to write things up is still a huge problem. The files are still so medical. There has been no leadership in changing these. So on one hand our work is meant to change, on the other it’s still all about illness and brief risk and meds." (Nurse 33)

I do not definitively know why this was the case, but this may have partially been because the consultant psychiatrist wanted the new practice to remain beyond the gaze of external persons. It may have also been an indication of the external dominance of bio-medical/risk as a structuring influence of practice, given that the team in the ward next door still operated under such a culture. Alternatively it may have just been because of a time lag in changing documentation processes. This seems less likely, as almost a year had passed since the DBT course had been attended.

It is possible that a confounding issue was an absence of clear nursing leadership in the ward. The previous charge nurse had been on long term sick-leave, and had been replaced by a temporary person. This nurse had, in turn left, and there had been two to three months where the position was filled by different nurses on a daily basis. When I was on the ward a new charge nurse had been appointed from the United Kingdom. This nurse had only arrived in New Zealand within the few weeks before me being on the ward, and it was my impression that she was still coming to terms with understanding New Zealand culture generally and the culture and structure of mental health practices in the local area. The variation in the availability of formalised nursing leadership was commented upon by other nurses:

> "I wonder if the reason it [applied DBT] hasn't completely taken hold is because there isn't a strong nursing leader. [Consultant psychiatrist] is a strong personality, and you have to be strong to stand up to him or to even help him understand where things are at for nurses. I think if [name of previous charge nurse] had been here we might have seen something different if she had embraced the model. She knew how to coach nurses to put things into practice, especially new nurses who need guidance." (Nurse 29)

It appears that the void in leadership also coincided with a significant staff turnover in the ward over the previous two years (field notes), with the result that most of the nurses were either within one to three years of graduation, with a small number who had remained working on the ward, but had not experienced working in other acute or other types of inpatient ward. In addition none of the nursing interviewees in this ward had had exposure to formal post-graduate education in suicidology or in risk assessment education from the district health board.

### 7.4.3 Nursing dispositions and the construction of practice

Notwithstanding the methodological limitations in examining dispositions that I identified in chapter four, there is some evidence of the relationship between nurses' dispositions and the way they practiced. As I have shown throughout this chapter, a number of nurses considered that the applied model of DBT allowed them to practice in a way consistent with how nurses wanted to practice. One nurse summed this up as follows:

> **Nurse:** I like the model [applied DBT] for a number of reasons. It sits [with] my outlook o[n] nursing. I became a nurse to help people, not to hold people down and make them do things. I have always been of the view that suicide is a complex thing and that our [nurse's] jobs are to help them learn ways of thinking that…help them think about the way they think, if that makes sense?
>
> **TF:** I have heard other nurses say similar things. Why do you think it is that some nurses are aligned with the new way of practice and others are not?
>
> **Nurse:** That’s a hard one. I know what you mean though [inaudible]. I can speak for myself. I have worked in [name of another New Zealand city] and they didn’t have the focus on illness as they used to here. It was more like the old therapeutic communities. The focus was on helping the patient, [sic] on them being in a place of refuge but doing therapeutic work with them. And it worked. There was not deaths. There wasn’t the fear around it…so working in this model [applied DBT] really for me is just another version of that. And yes I guess the training made sense to me, not just with self-harmers [sic] but with suicidal patients. It is just a way of allowing us [nurses] to do our therapeutic work without the emphasis on psychiatric diagnosis and keeping people locked up. (Nurse 29)

Other nurses also appeared to be happy with the movement to applied DBT in the ward, but as I have shown they saw this as an opportunity for them to conduct therapy. It appears that these nurses had undertaken post graduate training in therapies but had previously been frustrated by their lack of opportunity to practice it. I had an informal discussion with two such nurses in the tearoom of the ward, where they discussed the freedom to practice as they saw nursing should be. It appeared to me that their interpretation of DBT was that nurses should not be involved in coercive actions with consumers (field notes). While the data about the dispositions of this group of nurses was limited, it was commented on by other nurses. One expressed concern, and suggested that their understanding of DBT and the lack of exposure to non-bio-medical/risk ways of nursing disposed them to the way they practiced:

> "Yes there are others have taken the opportunity to do their own thing. Like the ward is their little practice fiefdom. Don't get me wrong. Therapy is important for patients [sic], but it's not the role of nursing in here. It's like they have decided DBT means we don't worry about anything like ward management or having a concern for patients. [It is like] they have no responsibilities in this area. There is only a small handful, two or three, but it is concerning. They have only worked in places that are medical, they don't know that nursing can be working with patients and doing therapeutic working without being fully fledged therapy." (Nurse 29)

The third group of nurses in this ward included those who continued practicing in a bio-medical/risk way. I have noted that some of them expressed concerns with the applied DBT model of working with suicidal consumers. It appears that these nurses were similar to most nurses I described in chapter five. A minority had received post graduate education in suicide, but most had not. More importantly, almost all of the nurses in this group that I interviewed indicated that had not worked in wards where a bio-medical/risk culture was not present. Some, like nurses in the bio-medical/risk wards in this thesis, disclosed the anxieties and fears that working with suicidal consumers bring about, similar to nurses in bio-medical/risk wards. However it does appear that such dispositions were, like those nurses created *in vivo* experiences through working in such cultures.

## 7.5 Conclusion

In this chapter I have shown how the consultant psychiatrist in Ward B, had attempted to change the culture of practice with suicidal people to an applied DBT model. However nursing practices did not always align to the new way of working, with some nurses taking the opportunity to see nursing practice as therapy, while others remained working in ways consistent with a bio-medical/risk culture. I have suggested that the constructing reasons for the varying practices came about because of the absence of an over-arching ward culture, and because of the dispositions of groups of nurses.

In some ways the limitations of the methodology of critical ethnography, and, more pertinently, the fact I did not realise some of these outcomes until data analysis, means that some of the answers to why practices emerged are tentative. However the strength of a multi-site ethnography means that a comparison of data from the three chapters does allow for a better understanding of what practice is, and especially, why it was constructed this way. The work of Bourdieu as a practice theorist is particularly helpful, and these considerations are discussed in the next chapter.

# Chapter Eight: Discussion

## 8.1 Introduction

The last three chapters described the culture of wards and teams that were included as sites of observation and data collection. The methodology of critical ethnography has aided an understanding of the ways in which dominant views on suicidality partially construct ward and team cultures, and how nurses responded to the various cultures to produce practice. This chapter extends the critical ethnographic examination of what constructs practice by using theory informed by Pierre Bourdieu (1977; 1979/1984; 1990; 1997/2000; 1998; 2001). As I showed in chapter three, using Bourdieu's works as a theoretical framework is consistent with the 'critical' component of critical ethnography, as it extends an understanding of the way that discourses, power and dispositions operate to produce practice and, often, reproduce cultures and power inequities.

This chapter explores and considers the dominant discourses that shape ward and team cultures, and partially construct nursing practice through discourses of bio-medicine and risk. As I stated in chapter two, I use the concept of discourses in a way consistent with Bourdieu (1991), whereby they are a way of ensuring the adoption and continuation of dominant ideas by making them seem 'normal' or 'taken-for-granted'. I also discuss five ways in which practice was constructed through dispositions: practice through passive alignment; practice through reluctant alignment; practice through deliberate non-alignment; practice through mis-alignment; and practice through deliberate alignment. I do not attempt to show what 'gold-standard' practice is, although I do comment on what these different dispositions may mean for nursing. Most importantly, I argue that the consideration of how nursing practice with suicidal consumers in acute inpatient units is constructed is not merely a theoretical exercise; rather, if there is a 'best' way of practicing, then nurses need to be able to practice in this way.

## 8.2 Interpretation issues

It is important to foreground this chapter with two points. First, in considering categories of dispositions created from the position of nurses' habitus to the field and imposition of capital, I have been cognisant of Sayer's (2005) argument that habitus does not always need to be activated. Instead he suggests:

> Most people are in the middle range of a continuum ranging from conscious reflexes to rational deliberation and choice. Our responses to the world are mostly at the level of dispositions, feelings and embodied skills. When we are in a familiar context, these dispositions give us a 'feel for the game', an ability to cope and go on effectively without conscious deliberation and planning. (p.25)

This is important for this study as I am aware from the data that individual nurses did not always rigidly conform to the five categories I identified; some likely moved between them depending on contextual factors, and may well have changed if, for example, they moved wards. What I am instead trying to point out is that these groupings did exist. Second, I am acutely aware that my position as a researcher in this study privileges my interpretation of data. Some interpretations were reliant on fine analysis of interview tapes and transcripts, especially when considering what was absent in interviews. In particular, the first group of nurses I discuss in this chapter (those I have labelled as having practice constructed by passive alignment), often did not consider the relationship between their practice and the dominant culture of the ward/team unless I asked. This is salient when considered against responses from nurses in other categories. In this context, saliency is a term that addresses the significance given to statements in interviews by interviewees, rather than, for example, the number of times a concept is discussed (Buetow 2010). I have had to consider how much my own views on nursing and practice with suicidal consumers has effected this interpretation, for it is certainly possible that the absence of comments does not necessarily mean that a conscious consideration of this relationship was absent in these nurses. In Bourdieusian terms, it may be that this is an imbued, sub-conscious disposition arising from habitus, but it may not necessarily be one of alignment.

Later in this chapter I argue that nursing dispositions are vital in constructing nursing practice, for these are relational to the culture of the ward or team in which practice occurred. Similarly, the culture of the ‘psychological’ team and the ward where practice was in ‘partial change’ were both heavily influenced by external bio-medical and risk understandings of suicidality. I argue that these concepts are discourses that influence both ward or team culture and nursing practice, even if they are not the dominant culture *within* the ward or team. I showed in the literature review chapter (chapter two) of this thesis that bio-medical views of suicidality are one of three dominant discourses. However the influence of bio-medical understandings of suicidality and of risk were profound in all the types of nursing I later describe, and for that reason I start the next section with an examination of these understandings.

## 8.3 Bio-medicine and risk and the construction of practice

### 8.3.1 Introduction

In chapter two I showed that there are three dominant discourses (sociological, psychological and bio-medical) that inform western understandings of suicide. McManus (2004) suggests that, in New Zealand, bio-medicine has been replaced by risk as the predominant discourse of suicide; however the data gathered in this thesis indicates that discourses of suicide as a bio-medical event and of risk are both significant factors in constructing nursing practice with suicidal consumers in inpatient wards. This section examines how these discourses dominate ward and team cultures and the practice of nurses. I follow this, in the next section, by considering how nursing dispositions interact with these discourses to produce different practices.

### 8.3.2 Bio-medical understandings as a constructing factor of nursing practice

A bio-medical discourse of suicide seen within bio-medical/risk wards. This section explores how such a discourse can create a cultural expectation of treatment/care, including the practice of nurses with suicidal consumers.

The data in this thesis suggests that a bio-medical view of suicide positions a suicidal consumer in a vulnerable position, as his/her thinking is considered irrational and as part of mental illness. Both of these, in a bio-medical discourse, justify treatment and coercive practices from nurses. Serious faults in a suicidal consumer's logic *may* justify coercive intervention; however the presence of mental illness doesn't necessarily cause a consumer to have factual errors in their logic (Cosculluela 1995). While New Zealand research indicates that consumers of mental health services can have their experience of coercion reduced when they are able to express their views and have these views taken seriously in decision-making (McKenna et al. 2001), the placement of suicide within a bio-medical discourse means that consumers are *a priori* considered mentally unwell and irrational by their presence in an acute ward. Practice can therefore be *done to* consumers, as their decisions concerning their own safety will be based on irrationality, justifying coercive nursing practices.

In the literature review (chapter two) I gave a brief overview of the way 'western' views of suicide have dominated the way suicidal people have been treated within communities. Of particular relevance to this thesis is how bio-medical understandings of suicidality dominate 'mainstream' treatment/care, even in the face of other compelling data that suggests that suicidality is an individualised, complex issue. Minois (1999) suggests that a bio-medical view of suicidality is a modern phenomenon that is a dominant discursive understanding that sees suicidality as intrinsically 'wrong' and therefore needing to be treated through medical intervention. The 'wrong-ness' of suicide and its association with bio-medicine eliminates the possibility that suicide may either be the actions of a rational individual, or have other causation other than bio-medical ones, and therefore justifies consequent bio-medical interventions, even against the will of a consumer. A bio-medical discourse underpins some New Zealand policy initiatives to reduce suicide rates which identify the treatment of mental disorder as a priority (MoH 2008). Similarly, New Zealand guidelines (published in 2003 but still contemporary) prioritise the need to treat mental illness of suicidal consumers in inpatient units. The guidelines state:

> Underlying mental illnesses/psychological difficulties should be treated vigorously. Targeting of specific symptoms, such as anxiety, agitation and insomnia, should be considered. This may include both psychopharmacological and psychological interventions and should be introduced as early as possible in the person's admission. (NZGG/MoH 2003 p.27)

Although 'psychological difficulties' are specifically mentioned, these are framed as illness symptoms requiring treatment. As I have noted, the evidence for the need to treat suicidal consumers' underlying medical illness is compelling; however, as the analysis of data in chapter five (the bio-medical/risk wards) showed, the influence of a bio-medical discourse locates suicidality as a bio-medical problem, rather than a multi-factorial one. Because of this, suicidal consumers are put in a position where they are subject to medical assessments that interpret their suicidality as irrational and as part of mental illness, from which stem expectations of the need to treat and contain the suicidality (Orentlicher 2001).

Mainstream services have a delegated responsibility to reduce the risk of suicide attempts and to treat the disorders that are seen as causing the events (MoH 2008). The expert treatment of mental illness is delegated to the profession of psychiatry, and the locale for coercive treatment is the inpatient unit. I wish to reiterate that I am not suggesting that clinicians are arbiters of indiscriminate coercive treatment of suicidal consumers, just as I am not suggesting that inpatient treatment is controlling *per se*. However the data from this study suggests that the location of inpatient mental health units as places of treatment for suicidal consumers cannot help but be strongly influenced by societal views of suicide as an irrational event that should be prevented. Consumers who are suicidal or have previously attempted suicide have low social and symbolic capital, meaning that their needs (especially those of 'engagement') are seen as less relevant than bio-medical treatment and a need to reduce risk of suicidal actions.

The data in this study suggests that psychiatrists have high symbolic capital in hospital treatment/care, although this appeared to be at least partially linked to their constancy (or not) in applying bio-medical principles in treatment. Psychiatry's capital to enact bio-medical discourses around suicide can be viewed as an example of what Cutcliffe and Happell (2009) argue is “invisible power’” (pp.116-125) to “provide the power for [mental health] practitioners to act in particular ways, to exercise control” (p.121). However psychiatrists were also subject to a bio-medical discourse; as I showed in chapter seven, a psychiatrist who changed his practice was subject to symbolic violence.

Crossley (2004) considers that ‘being mentally ill’ “is both a social position and a socially shaped disposition or habitus, no matter what other organic and psychological states it may also entail” (p.162). The locating of suicide within a bio-medical discourse carries potential long term disadvantage (in the receiving of a ‘mental illness’ diagnoses), and in inpatient experiences for some suicidal consumers, as shown in this study. For example, some consumers identified the distress caused by being ignored by nurses, yet being subject to coercion based on perceived risk. The juxtaposition of consumers being ignored and being seen as ‘risky’ was supported as what Bourdieu (1990) considered doxa, or taken for granted ‘best practice’. Other ways of communicating and considering risk were not considered best practice in bio-medical/risk wards and teams. Nurses were subject to the controlling influence of a bio-medical discourse to practice in a congruent, bio-medical way. Nurses were well aware, for example, that they needed to discuss consumers’ suicidality in the form of symptomology and of risk in team meetings. Bio-medical/risk framing of practice was also enforced through the use of written notes, handover and reporting structures that privileged diagnosis, risk, and the coercive interventions that nurses were expected to take. Written discussion of any psycho-therapeutic interventions nurses undertook were, according to interviews and two observational instances, dismissed by instructions that nurses not to write such interventions.

Many nurses knew that if they wished to be ‘heard’ by doctors they needed to speak a medicalised language that was a form of doxa, or ‘taken for granted’ and normalised. Bourdieu (1991) suggests:

> the *normalised* language is capable of functioning outside the constraints and without the assistance of the situation, and is suitable for transmitting and decoding by any sender and receiver, who may know nothing of one another. Hence, it concurs with the

> demands of bureaucratic predictability and calculability… (p. 48, original author's emphasis).

Such a normalised, medicalised language was a short-hand for discussing symptomology and risk of consumers, and suggested an *a priori* view that suicidal consumers were medically unwell, at risk, and in need of coercive practice to treat illness and minimise risk. Such normalised language also serves another purpose. Bourdieu (1991) notes:

> The competence adequate to produce sentences that are likely to be understood may be quite inadequate to produce sentences that are likely to be *listened* to, likely to be recognized as acceptable in all the situations there is occasion to speak…Speakers lacking the legitimate competence are *de facto* excluded from the social domains in which this competence is required, or are condemned to silence (p.55, original author's emphasis).

In other words, the language of bio-medicine/risk also served to legitimise nurses who worked in a bio-medical/risk way as knowledgeable clinicians, reinforcing their status. I showed in chapter three that symbolic violence is a form of 'soft' domination that requires groups to comply with the dominant group. As I showed in chapter five, some nurses were tacit in their alignment with the dominant culture, while others felt they had little choice but be compliant. Either way these nurses were subject to symbolic violence, "the violence which is exercised upon a social agent with his or her complicity" (Bourdieu & Wacquant 1992, p.167). In contrast nurses who did not structure their conversations in expected ways were subjected to forms of disciplining; effectively not conforming to dialogues of assessment and treatment was met with overt or covert dismissal of their wants, or were seen as problematic.

### 8.3.3 Risk as a constructing factor of the inpatient culture

A second discourse, 'risk', was a significant factor in creating ward/team cultures, and in turn, the construction of nursing practice with suicidal consumers. This was particularly evident in the expectation that nurses provide containment practices for consumers who were suicidal. In this section I argue that a risk discourse around suicide has a role in the construction of nursing practice. This occurs through the intersection of a lay public expectation that inpatient units provide safety from completed suicide, and New Zealand policies determine that inpatient practice primarily focusses on suicide prevention practices through risk recognition and containment.

The perception of the expectations of a lay public is consistent with theoretical literature on risk. Lupton (1999b), drawing on the work of Mary Douglas, argues that "the difference that is commonly observed between 'expert' and 'lay' judgements of risk is founded not in the fact that lay people cannot think in terms of probabilities…but rather that other concerns are brought to bear in the ways they judge risk" (p.37). The nurse participants in this thesis suggest that a public view of suicide has a bearing on their daily practice, as the public see being suicidal as being at risk, and risk has negative connotations (Fox 1999). As I have already suggested, the expectation that 'abnormalities' of mental illness, including suicide, be contained drives a societal expectation of containment of suicidal consumers. Lupton (1999a) suggests "to be designated as 'at risk'… is to be positioned within a network of factors drawn from the observations of others. The implication of this rationalised discourse again is that risk is ultimately controllable, as long as expert [clinician] knowledge can be properly brought to bear upon it" (pp. 4-5), and for nurses in bio-medical/risk teams and wards, to prevent suicide attempts by controlling risk through coercive practices.

New Zealand policy in preventing suicide is underpinned by a risk discourse as well as a bio-medical one. Fox (1999) argues that an actuarial understanding of risk suggests that identification of those at risk is possible, and that is certainly what occurs in New Zealand suicide prevention policies, which target community initiatives at those actuarially more likely to attempt suicide (Associate Minister of Health, 2013). Individuals who are suicidal can be assessed by clinicians within a formal district health board structure, who also determine decisions on whether to hospitalise individuals or not. Hospitalisation is meant, as a priority, to reduce the risk of suicide of consumers. However an outcome of the discourse of risk was that risk interventions follow, as the presence of risk itself, rather than disease, is grounds for treatment (Shim et al. 2006). Although understandable, the clinical emphasis on preventing suicidal consumers from attempting suicide is strongly shaped by an understanding of risk assessment and risk containment. This view is clear in New Zealand guidelines which state:

> People in imminent danger of suicide require a structured environment with clinically trained staff. Although inpatient admission reduces risk, it does not provide absolute protection. Sometimes people will attempt and complete suicide despite being in inpatient care, most commonly within the first week of their admission. Therefore staff need to be particularly vigilant, especially when the person is not well known… The level and frequency of support and observation should reflect the person's changing level of suicide risk. Close supervision is required for people who are assessed as being at high risk for suicide. (NZGG/MoH 2003, p.27)

While an emphasis on safety of suicidal consumers may appear axiomatic, the data shows that in bio-medical/risk cultures this is privileged before other nursing practices, and assumes a stance that practices such as observation as being efficacious at preventing suicide, and, by implication, non-coercive practices are not. This is perhaps not surprising, as assessing and minimising risk in individual consumers is a value-laden task that, within a risk discourse, is the responsibility of clinicians. Crowe and Carlyle (2003), writing within the New Zealand context, consider that:

> …[psychiatric] diagnoses are moral judgements of how close to normal a person's behaviour is. These moral judgements incorporate the concept of risk because inherent in a diagnosis is its prognosis. The risk is situated with the person diagnosed as mentally disordered but because that person is already regarded as somehow socially deviant (i.e., not normal) the blame for any potential risk lies with individual clinicians who have a social responsibility for ensuring public safety inherent in their position (p 21).

The focus on identifying risk as a priority also impacted on the practices of nurses in this study, who were expected to report on risk without the benefit of a structured model of risk assessment. While structured risk assessment cannot predict whether a particular individual will attempt the act (Sullivan et al. 2005), it can assist in helping clinicians work with consumers to identify areas of concern and to prioritise interventions based on a detailed understanding of a consumer's historical and current problems (Shea 2011). In the absence of a structured model of risk assessment, nurses within bio-medical/risk wards/teams were either unable to undertake risk assessment, or were expected to conduct these in a brief way. The prevalent risk discourse appeared to consider risk assessment as being based upon ‘common-sense’ predications (Fox 1999) reliant on nurses' past experience or the responses of consumers.

### 8.3.4 Nursing practice as partially constructed by a bio-medical/risk culture

Nursing practice in the bio-medical/risk cultures was partially constructed by the structuring influence of inpatient wards and teams, reinforced by the symbolic capital of psychiatrists. They were also subjected to symbolic violence when they did not conform to the expectations of practice. I say *partially* deliberately, as in the next section I show how nurses various habitus interacted with the field and capital to produce differing practices. In the bio-medical/risk wards and teams, nursing practice with suicidal consumers was meant to support the assessment and treatment of medical symptoms of consumers, and ensure containment of the risk of suicide. This occurred through identifying, documenting and describing psychiatric symptoms, and ensuring that treatment is carried out, something seen in another study of mental health nursing practice (Cleary & Edwards 1999). The expected practice was described in some policies which identified what nursing practice should be, but in the main this was taught to nurses *in vivo* by other nurses, who effectively reinforced notions of ‘proper’ practice by teaching newer nurses what to do, and the use of symbolic violence towards nurses (especially ‘resisters’) who did not conform.

### 8.3.5 Summary of this section

In this section I have shown the discourses of bio-medical understandings of suicidality, and of risk, play a significant part in producing the field of a bio-medical/risk culture in an inpatient unit or team. Psychiatry has a delegated responsibility to enforce a medical treatment and containment of suicide, although many doctors themselves feel ‘trapped’ by such an expectation. Symbolic capital and violence towards nurses (including from other nurses) reinforces the expectation that practice is made up of gathering and reporting of symptoms of pathology and risk, enforcing treatment, and enacting risk reduction practices.

## 8.4 Nurses' dispositions as constructing factors

### 8.4.1 Introduction

Despite the constructing influence of bio-medicine and risk, nurses did not all respond to this culture in a similar way. Some nurses’ practice was aligned with the cultural expectations; others complied with expected practices reluctantly, while a third group actively resisted and practiced in a different way. The differences in responses to dominant cultures is not entirely unexpected, as individuals and groups respond to power in different ways (Agar 1996). Differences can be explained by an examination of dispositions. Bourdieu (1990) suggests that dispositions come from the habitus but are also relational to others within a wider field. The rest of this section will examine the three groups of nurses who responded in different ways, and suggest that it is the place of habitus, and how this related to the wider culture, that was the final ingredient in constructing different practices in a bio-medical/risk ward or team.

### 8.4.2 Passive alignment and the construction of practice

The first group of nurses is one I have termed ‘passive aligners’, meaning that their disposition towards the prevailing culture was aligned, but was either largely unconscious or ‘taken for granted’. As I noted in chapter five, these nurses were either surprised when I asked about the bio-medical/risk culture that other nurses had described, or did not consider that such a culture existed. On the contrary, they viewed the way the ward ran and their own practice to be ‘normal’, and beyond the need for consideration. This is an example of doxa, or that which is taken for granted (Bourdieu 1977). There are two intersecting explanations for this (i) that this positioning was because of personal gain through recognition from others, or (ii) that a more complex relationship with the habitus and the wider field imbued them with this position.

It is likely that this group of nurses was subject to what can be seen as a “soft form of domination” (Sayer 2005, p.16). This suggests that these nurses gained rewards for compliance with the culture, through recognition from their peers who worked in similar ways, and from the psychiatrists as ‘doing the right thing’ in their practice. Nurses who were passive aligners did appear to be recognised for their ability to, for example, report psychiatric symptomology and risk in a way consistent with the dominant culture, although it is unclear whether this was seen by these nurses as a reward or not. Similarly nurses who did not act in this way were the recipients of symbolic violence from both psychiatrists and other nurses, who, for example, criticised any practice that did not privilege bio-medical/risk actions, or would not engage with clinical discussions that were not framed within a bio-medical/risk language.

Soft domination and an imbued understanding of how symbolic violence affected those who did not align with the dominant culture gives a partial explanation of how practice was constructed for passive aligners; however it does not explain why they responded in ways that other groups did not. This response *can* be understood through an explanation that passive aligners were imbued with the dispositions of the wider field that were unconscious and part of a habitus formed *in vivo*. While most nurses in this study suggested they had put aside their pre-existing beliefs and morality about suicidality, passive aligners differed from other nurses in that they generally had not been exposed to other ways of thinking about suicidality through education or experience within wards that had different cultures. Their habitus exposure to understanding suicidality, and ways to practice with suicidal consumers, was almost exclusively learnt *in vivo* in wards that had bio-medical/risk cultures. The data, taken together, suggests that passive aligners had an imbued model of practice learnt within bio-medical/risk contexts that allowed a 'non-complex' frame of reference for understanding suicidality and for responding in practice. This framing had the benefit of reducing the potential discomfort of working in what other nurses considered to be morally ambiguous and sometimes stressful situations.

A bio-medical understanding also appears to have aided this group of nurses to have a sense of security by offering a framework that appears to be objective and 'common-sense'. Providing treatment/care for suicidal people can be stressful and can make clinicians of any discipline feel powerless to prevent suicidal acts (Berg & Halberg 2000; Maris et al. 2000; McAllister et al. 2002; McLaughlin 2007). Suicidal consumers can make clinicians feel rejected (Goldblatt 1994), and their past experiences invariably play a part in treatment of current suicidal consumers

(Alexander et al. 2000; Rothes et al. 2013). It is estimated that in any one year 84% of nurses in inpatient will witness mild self-harm, 57% severe self-harm and 68% a suicide attempt (Nijman et al. 2005). While nurses may consider it ‘part of the job’ (O’Donovan & Gijbels 2006), other studies suggest that nurses can be anxious working with suicidal consumers, as they feel powerless to prevent consumers’ suicide attempts (Wilstrand et al. 2007). Similarly Aldridge (1998) considers that part of clinicians’ negative emotions towards suicidal consumers is based on the notion that consumers enter an informal treatment covenant with clinicians, whereby consumers are expected to do everything to get well. Ongoing suicidal acts and thinking, in Aldridge’s view, break that covenant. The theme of the anxiety of working with suicidal consumers was common with many nurses in this study; however it is poignant that passive aligners did not discuss this. Bourdieu (1998) states that habitus “… makes distinctions between what is good and what is bad, between what is right and what is wrong…” (p.8), and it appears that a habitus inculcated *in vivo* and passively aligned with the bio-medical/risk culture allows a relatively straightforward moral framework. I suggest that the imbued dispositions from bio-medical/risk culture allowed a straightforward understanding of suicidality and requisite nursing practice responses that minimised the need for consideration of the complexities of individuals’ suicidality and therefore reduced the potential anxiety in passive aligners.

Passive aligners appeared to genuinely believe that their nursing practice helped consumers; as a corollary to this, passive aligners expected that consumers should respond to medical treatment positively. While there was initial tolerance of suicidal thinking or acts of suicide in individual consumers, those who remained suicidal after treatment with medication were pejoratively labelled as having a BPD. Although discussing therapy rather than nursing, Maris et al. (2000) consider the iatrogenic effect of treatment of suicidal consumers can include “… a range of aversive reactions (thoughts, feelings, behaviors [sic] that are manifested in clinicians…” (p. 512). They suggest that working with suicidal consumers can be rejecting for the clinician and that:

> Negative therapist attitudes toward suicidal patients [sic] are also observable in the pejorative labelling attributed to difficult-to-treat patients. Suicidal patients [sic] are

> often seen, for example, as “manipulative”, suggesting they are devious and indirect in attempting to control others and/or outcomes, rather than more simply deficient in skills to be in better control (Maris et al. 2000, p.513).

Similarly, Shea (2011) suggests:

> …many emotional currents dart beneath this chill [of suicide]: fear, grief, anger, puzzlement, and even condemnation. When unrecognised, these feelings can drag an unwary clinician into a sea of counter transferential responses and unproductive interventions. The potentially dangerous undertow, beneath this sea, can pull us away from the very people who most need our help; acutely suicidal patients [sic] (p. 42).

The easily accessible, non-complex frame of understanding of suicidality and expected nursing responses appears not to allow for ambiguity in understanding suicidality as an individual experience that needs individualised responses. This framework of understanding allows dichotomous thinking that consumers were either truly suicidal (and in need of inpatient treatment/care) or they were not. In the latter case it appears that the pejorative labelling of consumers who did not follow a trajectory of treatment responses suggested by a bio-medical understanding may have been a response to passive aligners’ expectation that such consumers should not have been receiving inpatient treatment. It is not possible to conclusively know this, for the paradox of gathering data about imbued understandings of practice was that they were not easily articulated by nurses.

Overall it does seem that passive aligners were subject to the structuring influences of the field and the shaping actions of soft domination and of potential symbolic violence if they acted differently. What made passive aligners different from other nurses was that their disposition towards the dominant culture was imbued through habitus exposure through almost total *in vivo* learning, meaning that alternative understandings of suicidality or of ways of practice were not likely to occur.

### 8.4.3 Practice constructed by reluctant alignment

While passive aligners were unconsciously imbued with bio-medical/risk understandings of suicidality and requisite nursing practice, other nurses considered this problematic. Some resisted the constructing influence of the culture on their practice, and actively attempted to work with suicidal consumers in a different way. I discuss these ‘deliberate non-aligners’ in the next section. A third group of nurses appeared equally aware of the way that the dominant culture influenced nursing practice, but felt less able to enact practice change that opposed the constructing influence. I have named this group of nurses ‘reluctant aligners’. These nurses were well aware of the influence of the discourse that constructed the culture and the influence of the culture on their own practice, but felt unable to change their practice. I consider the place of these nurses’ habitus in understanding why nurses were able to understand this, yet nurses did not feel able to practice differently

The ‘reluctant aligners’ were largely made up of two discrete groups of nurses. The first were experienced nurses who had attended post-graduate nursing or other health-related education, that had exposed them to the possibility of working with suicidal consumers in a different way to that determined by a bio-medical/risk culture. The second group included nurses who had graduated from undergraduate training within the previous two years. These nurses were frustrated with the limited possibilities of nursing within the dominant culture, but considered they were unprepared to be able to nurse in different ways.

Reluctant aligners who were experienced nurses appeared to develop views on suicidality and how nursing with suicidal consumers could be practiced within an *in vivo* experience. However these nurses had a secondary habitus developed through exposure to different ways of viewing the field, either through post-graduate education or through experience in working in non-bio-medical/risk cultures. Carlyle et al. (2012) found that “postgraduate nursing study does influence the use of underpinning framework models and conceptualisation of possible interventions, if not the actual implementation of these in everyday nursing work” (p.228). It appears that exposure to other kinds of cultures and nursing practices may have enabled nurses to consider nursing differently, even if they felt unable to enact changes. The second group of nurses were more recent graduates of schools of nursing who had developed an understanding through their education that nursing could, and should be undertaken differently. Like the first group, however, they did not feel they had a framework of practice that allowed them to practice differently. In addition, they considered they had not been taught the skills of what do with suicidal consumers, beyond critiquing what others did. It may be that this group of nurses was more consciously unskilled in this area; it is unclear whether other groups in this study felt similarly, as this did not come up in interviews. Other studies support the notion that even experienced nurses feel unprepared with the communication skills needed to work with suicidal consumers (McAllister et al. 2002; McLaughlin 2007).

Dispositions towards suicidality and suicidal consumers were markedly different in reluctant aligners when compared to aligners who were passive. Rather than an imbued understanding that saw suicidality as a bio-medical event that needed treatment with a corollary that those ‘not truly suicidal’ should not be in inpatient units, reluctant aligners considered suicidality as the result of a multitude of individual circumstances, and that the focus of nursing treatment/care should be to support individuals to increase their resilience to suicidal thoughts in the short-term. While supporting medication treatment was seen as part of nursing work, physical restrictions on consumers were considered to be useful only in extreme circumstances. Despite these beliefs, reluctant aligners felt unable to practice in such ways. The place of the habitus gives clues to how some nurses came to understand the field and practice, but it does not show why they felt unable to reconstitute practice as deliberate non-aligners (resisters) did. The answer appears to lie in two starkly different notions. The first is that this group of nurses appears to have been subject to symbolic violence when they acted in a manner inconsistent with the ward culture. I was surprised to hear stories in interviews of the comments made by other clinicians that denigrated their practice. They, in short, felt they were unable to practice differently for fear of the negative consequences. Undoubtedly the symbolic violence experienced by these nurses is in the forefront of their consciousness. Indeed, reluctant aligner interviewees discussed at length the way they considered practice to be limited by the ward or team culture. However the impact of this structuring force still does not explain why some nurses aligned reluctantly, whilst others, as I show in the next section, actively resisted and practiced in a different way.

The second explanation for this difference between passive and reluctant aligners appears to be that reluctant aligners' ability to practice differently was limited. Their exposure to education or practice in other models supported them to consider suicidality and nursing practice in ways outside the structuring influence of the discourses. Although they had seen different ways of practicing, or been exposed to theories of how practice could be different, they had not been exposed to understanding how to make change occur. The structuring influence of the discourses and symbolic violence should not be underestimated, and in the absence of a way of bringing about a change to the culture of the ward, it was difficult for reluctant aligners to sustain changes in their personal practice. Sayer (2005) extends Bourdieu's (1984) analysis of practice theory by suggesting that individuals do not solely act for advantage of economic social and cultural capital; rather that some of the struggles are about 'how to live'. Reluctant aligners were, it seems, often merely making their own daily work tolerable, rather than being in conflict with the dominant culture and experiencing symbolic violence (as resisters often did). Sayer (2005) further suggests that "people may work for organisations for decades and become thoroughly habituated to them, yet while they have a feel for the game they can still experience conflict between how they feel they ought to act and are allowed to act…" (p.41). Reluctant aligners did feel conflicted, but it seems they considered they could at least make it tolerable for consumers by easing them through their inpatient experience by being supportive to them. As Sayer notes "how people treat each other is of extraordinary importance… it can make the difference between misery and happiness" (p. 12).

Like passive aligners, the discourses influenced both the shaping of a bio-medical/risk culture and, in turn, nursing practice. For reluctant aligners though, there was a sense of frustration both that their nursing practice was limited by this culture, and that consumers were not, in their view, getting the care that they needed. These findings are similar to other studies of nursing in similar wards (Berg & Hallberg 2000; Ramberg & Waserman 2003). Just what this care should be was not well articulated, beyond noting that it should be based upon a ‘therapeutic relationship’. The difficulty in articulating what was meant by a ‘therapeutic relationship’ or indeed an alternate model of practice is perhaps unsurprising. Studies suggest most mental health nurses are unable to state their model of practice (McAlister & Moyle 2008), or that they consider that there are many models of practice in place in their work places (Nolan et al. 2007; O’Donovan 2007). Similarly, Carlyle and Crowe (2012) found that mental health nurses aspired to a psychodynamic approach to nursing, but considered that they were thwarted in this approach by a strong bio-medical model in place. Murtagh (2008) found similar frustrations in New Zealand nurses attempting to give care to suicidal consumers in inpatient wards. Whilst useful, these studies relied on various forms of self-reporting of nurses who described what they saw as a useful model of practice and the overarching barriers to this practice being played out. The experience of reluctant aligners suggests that mere knowledge of possibilities or models of practice is not enough for sustained changes to occur, for the pull of discourses and dominant capital is almost indomitable without other changes occurring, as the following sections show.

### 8.4.4 Practice constructed by deliberate non-alignment

A third group of nurses had a differing relational aspect to the prevailing bio-medical/risk culture. Rather than passively align or reluctantly accept the constructing element of the field on practice, deliberate-non-aligners resisted and practiced in a different way. This section examines the habitus of this group in order to understand this difference. Deliberate non-aligners had, it seems, an attunement to the field that allowed them to know in some detail how nurses were expected to behave. This is what Bourdieu called illusio, or a “feel for the game” (Bourdieu 1998, p. 76). But so too did reluctant aligners. Deliberate non-aligners were frustrated by this control of practice and what it meant for practice, but again, so did reluctant aligners. So what made them resist dominance when reluctant aligners didn’t? A simple answer could suggest mere freedom of choice- decisions made by deliberate non-aligners that reluctant aligners decided was not for them. However Bourdieu (1990) argues that freedom of choice is regulated by “dispositions durably inculcated by the possibilities and impossibilities, freedoms and necessities, opportunities and prohibitions inscribed in the objective conditions" (p.54). Habitus moulds actions, in this instance, that of nurses, to act within ways that pre-existing opportunities are perpetuated (Swartz 1997). Acting in a heterodoxical way is, then, more than individual choice. Moore (1994) cites Holloway's (1984) notion of 'investment', suggesting that people invest in actions within pre-existing opportunities, much like Bourdieu's idea of habitus. Moore (1994) considers that:

> …if we imagine that individuals take up certain subject positions because of the way in which those positions provide pleasure, satisfaction or reward on the individual or personal level, we must also recognise that the individual satisfactions have power and meaning only in the context of various institutionalised discourses and practices. (p. 65).

All nurses, no matter their disposition, take up subject positions that have reward. Deliberate non-aligners considered that they were 'doing the right thing'. Moore (1994) suggests that taking up particular subject positions is not about individualised self-identity; rather it is about inter-subjectivity, a relationship to others. For these nurses, relationships with other like-minded clinicians and with consumers, with whom they empathised, were of vital import. In addition to the stated importance of relationships, it appears that deliberately non-aligned nursing self-identity was tied to practicing in the way that they did. Moore cautions that the historical contextualisation of discourses means that not all subject positions are equal, with some positions carrying more social reward than others. Subject positioning is not one of consciousness, rather investment shows emotional and subconscious reasons for subject position. Moore states:

> In this context fantasy, in the sense of ideas about the kind of person one would like to be seen to be by others, clearly has a role to play. This explains why concepts such as reputation are connected not just to self-representations and social evaluations of self, but to the potential for power and agency which a good reputation offers. (p.66)

The dispositional difference between the positive self-view of deliberate non-aligners and reluctant aligners was evident within close readings of the interview data. Yet this difference in self-view still does not explain why some nurses choose to deliberately non-align with the dominant culture, while others aligned with much reluctance. The answer appears to be within two differing groupings of experiences that shaped deliberate non-aligners' habitus to such an extent they felt committed to practice in heterodoxic ways, even when this practice meant they were, at times, subject to symbolic violence from other clinicians, including nurses. The first of these was an experience that appears different from other nurses in this study. Instead of their personal views on suicide and care of suicidal consumers being subsumed by a secondary habitus imbued *in vivo*, some deliberate non-aligners suggested that their early development played a part in how they saw suicidality and practice. In particular these interviewees discussed the place of religion and a sense that their religious faith endured despite the prevailing culture. Their responses to what they saw as inequities in how consumers were treated and in how nurses were allowed to practice were often felt as frustration, an emotional sense that something was wrong. Sayer (2005) suggests that "emotional responses to the inequalities and struggles of the social field and how people negotiate them are to be taken seriously both because they matter to people, and because they generally reveal something about their situation and welfare" (p.37). This group of nurses appeared to be interested in the plight of consumers and of nurses, although the latter was important as nurses' practice affected consumers, rather than a concern for power for nursing *per se*.

The second group of deliberate non-aligners was nurses whose habitus was developed within the field, much like passive and reluctant aligners. Unlike these latter two groups, deliberate non-aligners appear to have experienced strong mentoring from a nurse (or group of nurses) who convinced them that nursing was a political activity, and that practice needed to be different for the sake of consumers and for nursing. My sense was that this *in vivo* learning was formative, as it allowed deliberate non-aligners to both understand the social position of nurses and consumers within the field, and to understand how resistance to this could occur.  Like the first group of deliberate non-aligners, these nurses' imbued habitus gave them an emotional as well as intellectual commitment to resistance.

Sayer (2005) argues that the concept of 'commitments' should be viewed alongside that of investment as it implies something stronger, more serious, and having an emotional component. This certainly appears to be the case for deliberate non-aligners. Bourdieu (1994) considers that individuals are only changeable when they are politicised from without (such as I noted through the influence of education) or when going to a different part of the field (such as people educated overseas or exposed to new ideas as in the psychological ward). Nevertheless the second group of nurses changed with*in* the field. As Sayer (2005) suggests, “it is possible for actors to not only deliberate on their situation and what they have become, but to strive to change their habitus” (p.30). However, the data suggests that there needs to be a unique series of circumstances in place for that change to occur.

### 8.4.5 The construction of practice in contested fields

The bio-medical/risk culture of many of the wards and teams in this study were created through the intersecting of dominant views on suicidality; the wards/teams were representative manifestations of these constructing influences where practice was created. Whilst there were contesting practices *within* the field of the inpatient unit/team, there was little direct challenge for control of the acute unit field itself. The other wards in this study were contested, and it was clear that attempts to create new cultures and different nursing practices were affected by the dominance of the discourse of bio-medical views of suicidality and of risk, which acted as strong anchor to change. This was evidenced by the split in culture within one ward, and the pull of the bio-medical/risk culture on practice in the ‘partial change ward’. It was also evident medical capital alone was not enough to completely change the field. The psychological team’s approach to working with suicidal consumers was considered heterodoxical to the bio-medical/risk view of suicidality and expected inpatient treatment. Much like nurses who resisted the dominant ward culture, psychiatrists who resisted the discourses were subjected to symbolic violence from their psychiatrist peers and from other clinicians. Although this thesis is focused on nursing, the evidence that psychiatrists, despite their strong capital to influence practice, are subjected to the same structuring influences of the discourses that nurses experience is significant.

A limitation of this thesis is that I did not always inquire in any detail as to how cultures had changed. This failure to ask has meant that possible rich data about nurses’ roles in constructing ward environments was missed. Nevertheless the comments made in interviews with psychiatrists and nurses in the psychological team and in the ‘partial change’ ward hint at the main difference between the attempts at change in these two areas. Changes in each area did not appear to be as a result of a coordinated strategy; rather changes had occurred over periods of time. Nurses in the psychological team had been drawn to the thinking and practice of the consultant psychiatrist, and the support given to them to be able to practice in a way they considered ‘right’. It appears that the psychiatrist and nurses had then co-constructed the operationalising of the team’s practice, including nursing practice. In contrast, attempts at practice change in the ‘partial change’ ward appear to have been instigated by the consultant psychiatrist alone, with the result that practice became fragmented. Indeed most nurses remained working within a bio-medical understanding of suicidality. As I have noted, it appears that that psychiatrists’ capital alone is not enough to change practice when the practice aspired to seems heterodoxical. Although my interview limitations meant the data is not conclusive, the contrast between the effects of attempts to change understandings of suicidality and subsequent practices is at least indicative that practice change in the face of such strong discourses needs to be made through partnerships between clinicians. The data, taken together, also suggests that the imbued bio-medical/risk culture acts as a de facto model of nursing practice with suicidal consumers. For changes to occur, a viable alternative needs to be in place, much like the changes to nursing practice in the psychological ward.

### 8.4.6 Practice constructed by deliberate alignment

Interviews with nurses working in the psychological team pointed to how they had been able to change practice to align with the views of the consultant psychiatrist, and even co-constructed the culture (the field) within their team. I have named these nurses ‘deliberate aligners’, because their practice was consciously consistent with the team culture and the view of the consultant psychiatrist. It appears that many nurses chose to work within the psychological team, which hints at them having a disposition to practice in this way. I discuss what these dispositions might be later in this section. Alongside this it seems that the psychological team itself appeared to be a form of habitus, for some nurses considered that the practice within this team allowed them to consider practice in a way that showed positive results for consumers. This positive feedback had, for some, a significant constructing and reproducing effect on their practice. This was manifested in a number of ways.

The theoretical understanding of suicidality as a process that did not deny that the importance of a bio-medical view of causation was important. However, suicidality was seen as the result of a number of processes that differed depending on the individual. A psychological understanding of individuals' experiences was seen as vital. Similarly, the place of risk in this model was not negated, but rather was seen as a more dynamic process that required the involvement of consumers themselves in determining risk, rather than risk understandings being solely located within the expert knowledge of clinicians. Nurses were cognisant of the way a discourse of bio-medicine/risk impacted on wards and teams, yet appeared to feel confident that the psychological model of practice allowed a more complex understanding of the place of bio-medicine without negating it. This created a sense of safety for nurses, whereby they considered that if a serious incident (such as a completed suicide) occurred, their practice would stand the test of external investigation because it was consistent with the ward culture and it still showed through note-writing an extended discussion of symptomology and risk, even though it extended both of these concepts.

Importantly, nurses considered that the nursing role was clear within the team. Although hierarchical processes still occurred, nurses considered that their role was valuable and was more than mere reporting to doctors, or imposing coercive actions on consumers at the bidding of the psychiatrist. Instead it appeared to me that nurses articulated what they considered to be an active component of the therapeutic relationships they had with suicidal consumers. The relationship was seen as important in itself, and was seen to be supportive of consumers who were viewed as disconnected, something that aligns with Shneidman's (1997) theory that suicidal people experience *psychache*, something seen in other studies (Cutcliffe & Stevenson 2007; Dunne et al. 2000; Lindgren et al. 2004; McLaughlin 1999; Samuelsson et al. 2000). It was also apparent that nurses' therapeutic work supported consumers to consider, for example, their responses to stress, consistent with the psychological one-on-one work consumers had with psychologists or psychiatrists within or external to the ward. These interventions are similar to ones purported to be vital to practices designed to therapeutically assist suicidal consumers in more recent mental health nursing texts that challenge a bio-medical/risk practice model (Cutcliffe & Stevenson 2007; McLaughlin 2007). Nurses also considered that the communication role was a vital intervention at times of escalation of consumers' worries, and was supplemented by physical interventions to help consumers regain a sense of calm. Taken together, it appears that nursing within the psychological team had allowed for the development of a model of practice that 'made sense' to nurses, despite the external pressure influence from the other ward team to practice within the orthodox bio-medical/risk model of practice.

It appears, furthermore, that the habitus of the nurses pre-disposed them to align with the psychological model. Almost all had undertaken some form of post-graduate education, and many indicated that they had practiced in such ways before the creation of the psychological team. My suspicion is that these nurses would have been deliberate non-aligners in a bio-medical/risk team or ward, as their habitus had given them what Bourdieu (1979/1984) calls "meaningful practices and meaning-making perceptions" (p.170). The meaning-making practices were, like those of resisters/deliberate non-aligners, within their own practice, but their own perceptions of influences allowed them to consider the constructing influences of bio-medicine/risk, and, in turn, pre-disposed them to being open to working within a new field.

The psychological team created a field in which their practice was consistent with the dominant model. More than that, nurses' habitus, aligned with that of the psychiatrist, changed the field. In his later works Bourdieu (1997/2000) proposes that the interplay of capital and habitus *can* change field. The changes to the field were predicated both on the authority of the psychiatrist, and on the alignment of nurses.

### 8.4.7 Practice constructed by mis-alignment

In the 'partial change' ward, the field of the bounded space of the inpatient unit was a contested space. As with the psychological team, the new philosophy of practice was driven by a psychiatrist, but was heterodoxical to the discourses of bio-medicine and risk. Unlike the psychological team, the attempts at changing practice within the ward did not result in a unified space; rather the field was contested from within by some nurses and other clinicians, including registrars, and from without by clinicians in the other ward in the hospital. Included in this are nurses who I have named ‘mis-aligners” who interpreted the field in a different way than was intended by the new model of practice, and, because of their dispositions through habitus, practiced in a very different way.

There were a number of factors that impacted on the division within the ward. First was that the psychiatrist had himself previously been a proponent of the bio-medical/risk culture, imbued with a habitus from within similar fields of a bio-medical/risk control of the inpatient treatment of suicidal consumers. His own experiences that led to a conscious re-consideration of the place of psychiatry in the treatment of consumers, including suicidal consumers, were led by a personal experience and by training in a new model of working. My suspicion is that without the personal experience (which I cannot name) the training by itself wouldn’t have been enough to formulate a change in position. What is important is that this change was seen as so different from his previous way of working it was considered unusual. Coupled with his personal experience, which was well known to staff members, he was considered by many to have ‘gone native’ in his attempts to work in a way of minimal restriction with consumers. It is unclear whether it was the change in itself, or the move to a heterodoxical position that led to an undermining of his symbolic capital both within and external to the ward. My suspicion is that it was both. A second issue that destabilised the field and made it open to power challenges was that the ‘new’ model of practice was, at the time, not known as a way of working with suicidal consumers; rather it was (and arguably still is) seen as a model of working with consumers with a diagnosis of BPD who were often chronically suicidal. As I have shown, there was considerable opposition from many clinicians about having such consumers on the ward for respite treatment; in some cases this opposition was openly hostile, something seen in a recent doctoral study of nursing practice in Australian mental health inpatient wards (Palmer 2012).

The model of DBT was seen as both unclear in terms of what nurses were meant to do and was removed from an imbued understanding that a bio-medical/risk model allowed. For some nurses, working in such a structure with the removal of the usual options for safety (for example the use of observations) was considered unsafe for consumers and for themselves. I am not attempting to argue whether coercive interventions such as observations or no-suicide contracts are valid in reducing incidents such as self-harm; however it was apparent that many nurses did not feel prepared to offer nursing in a different way. Whilst some had attended DBT training, the broader application of this to working with suicidal consumers was not explicit. Similarly disciplinary structuring influences were still bio-medical/risk orientated (such as policies and note writing structures). In effect many nurses felt they were expected to perform in an unclear model, without training, and with a structural emphasis on bio-medicine.

Before I started research on this ward I had heard tales of how the ward had changed and, especially, how the psychiatrist practiced differently. My naïve assumption was that some nurses would have taken the opportunity to work in a new model of practice, one that was somewhat aligned with what was my own view of what good practice may be, somewhere aligned with recovery and working in partnership with consumers. Instead I was very surprised to find that nurses were undertaking forms of therapy. In retrospect this was perhaps understandable for two reasons. First, this group of nurses had all undertaken post-graduate studies in specific therapies. However there appeared to be little place for nurses to undertake pure therapy within the inpatient ward. There appeared to be a high sense of frustration with this. A second, related issue was that within the DBT model on the ward there was a lack of clarity about what nurses' (and other clinicians') roles were. Larkin and Callaghan (2005) caution that when health professionals perceive their role to not be understood by others it can lead to unclear lines of responsibility and accountability; this certainly appeared to be the case. Other nurses notably either returned to working within a known bio-medical/risk framework, or did not change practice at all. Bourdieu (1984) contends that older, established persons in the field attempt to conserve practices, and this appears to be the case with this sub-group. Bourdieu (2001) notes:

> The passions of the dominated habitus (whether dominated in terms of gender, ethnicity, culture or language) - a somaticized social relationship, a social law converted into an embodied law - are not of the kind that can be suspended by a simple effort of will, founded on a liberatory awakening of consciousness. If it is quite illusory to believe that symbolic violence can be overcome with weapons of consciousness and will alone, this is because the effect and conditions of its efficacy are durably and deeply embodied in the form of dispositions. (p. 39)

Although some of these nurses had undertaken post-graduate education, it seems that this alone was not enough to change practice in the absence of a clear model. Importantly, the absence of a clear model appeared to bring about anxieties in nurses and return them to a model they knew well. Although a bio-medical/risk understanding may not be considered a nursing model *per se*, it is clear that this is often the default way of practice within cultures that demand it.

## 8.5 Conclusion

This study has answered the research question “how is nursing practice with suicidal consumers in acute mental health inpatient units constructed?” I have shown that nursing practice is constructed through an interplay between two major factors: (i) discourses of bio-medicine and risk, which are in turn reinforced through symbolic capital, and, (ii) nurses’ dispositions, through their habitus. It is clear from the data that the culture of wards and teams is a place of competing fields; these fields are in turn influenced by discourses of bio-medical understandings of suicidality, and of risk, even in wards or teams that did not have a bio-medical/risk culture. Most ward cultures were directly constructed by these discourses, and expected nursing practice was reinforced by capital and symbolic violence towards nurses who did not practice in that way and consumers who did not behave accordingly. When nurses’ habitus are formulated *in vivo*, it is perhaps unsurprising that they are imbued with culture and carry it into practice. However many nurses had developed understandings of suicidality and nursing practice through secondary habitus, and either felt discomfort or enacted practice in underground resisting ways. When the discourses are not in alignment with the view of psychiatrists then wards becomes a place of contest and psychiatrists themselves become subject to symbolic violence. The effect of this, if aligned with other changes, meant that practice became fragmented. However when fields of power align with nursing habitus, change can occur.

In the next, final chapter, I consider how knowing how nursing practice is constructed in acute mental health units can assist in future planning of research, education, and practice formulation.

# Chapter Nine: Conclusion and recommendations

## 9.1 Introduction

These thesis was designed to answer the research question ‘How is nursing practice with suicidal consumers in acute mental health inpatient units constructed?’, and had two aims:

(i) to identify the contextual factors that influence nursing practice with suicidal consumers in acute mental health inpatient units, and

(ii) to describe how these factors construct practice.

I have met the aims of the this study and have shown that that discourses of bio-medicine (as an understanding of suicidality causation and expected treatment/care that stemmed from that understanding) and risk (as the elimination of suicidal thinking and practices) are significant constructing factors of nursing practice. These factors are in turn reinforced through symbolic capital. Nurses’ dispositions, through their habitus, are a second constructing factor as they consciously or unconsciously interpret the field and produce practice. The identification of the influence of bio-medicine/risk in constructing ward/team cultures and nursing practice does not imply that bio-medicine and risk are not useful factors in nursing practice or for good outcomes for consumers. However the dominance of bio-medicine and risk as intersecting discourses does restrict other ways of working with consumers. The findings show that any practice change needs a number of inter-related factors to occur, including education, a clear understanding of the outcomes of nursing practice, guidelines that reflect what consumers want, articulation of what therapeutic practice is and how this can be relayed and documented in ward situations, and relationships with medical staff and other clinicians to consider what the purpose of inpatient work is. This is no mean list, but the research indications are that all need to be attended to in order to make sustained cultural changes. In this chapter I therefore discuss the implications of the findings of this study on nursing practice, future research, and nursing education. This study, like all research, has limitations, and I finish this chapter by identifying these.

## 9.2 Implications of findings

### 9.2.1 Implications for practice

The practice implications stemming from this thesis are twofold. First, implications about nurses' influence over general ward cultures and their own practice, and second, specific practice issues. I discuss both in this section.

The most significant implications for practice finding is how practice is constructed. Although this is not surprising, given that it is the question at the heart of this thesis, the findings indicate that nurses are involved in reproduction of cultures. I have earlier indicated that my hunch going into data collection was that medical staff would hold significant power to influence cultures; however it is clear that nurses can (accidently or otherwise) be part of reproducing cultures that they are often critical of. On a more positive note it is clear that nurses can be involved in culture change. I do not wish to over-simplify this by making a trite statement that nurses should undertake individual tasks.

The results from this study indicate that risk assessment is a key area of practice needing attention. Although all wards in the study undertook risk assessment, there were marked differences in the ways this occurred. I did not undertake a detailed examination of risk assessment *per se*, but it was clear that the usage of terminology, the writing of risk assessment in clinical notes, and the assigning of responsibility for undertaking assessment are all areas that need clarification. The New Zealand guidelines on suicide care in inpatient units state that "a key difficulty in the assessment of risk of suicide is the arbitrary nature of assigning risk as low, moderate or high' (NZGG/MoH 2003, p.21). This terminology was seen on all wards, but the details of how this assessment was occasioned, and the details of the suicidal person's assessment, were inconsistent in detail. Some clinicians contextualised this information, whilst others used the categories in a more arbitrary way.

Two wards considered that two senior nursing clinicians could undertake risk assessment, whereas a house surgeon (usually in the first year of qualification post medical education) could undertake this assessment in the other two wards. The other wards appeared to have inconsistent practices around this authority. Some clinicians told me this could be a senior nursing role, whilst others said this was a medical domain. The task of *formal* risk assessment is one that should be undertaken by senior clinicians (NZGG/MoH 2003). This indicates that nurses (or other clinicians) could undertake this. The usage of house surgeons appears to contradict the notion of seniority, and also caused resentment with some other staff. Such usage also appears to be problematic due to house surgeons having little experience in risk assessment, and having little contact time with patients previously.

All of the wards in the study used observations, although some deliberately used these less often. Like risk assessment, there was inconsistency between wards about who was responsible for observation. Operationally, observations were often undertaken by clinicians who were employed ‘casually’ on the wards, suggesting that observations are considered a less valuable use of regular nursing time than other roles. One ward, on occasions, used nursing students in the role of ‘observers’. There was also an inconsistency between wards about which clinicians could terminate or ‘lessen’ the time periods between observations. This varied between being a strictly medical practice, to being one that senior nurses could alter, a situation noted in an Australian study (Horsfall & Cleary 2000).

Guidelines on suicide treatment/care specifically address observations, stating:

> It is vital to review regularly the mental state of the individuals under such close observation. This should be done formally at the nursing handover at the end of each shift. Senior nursing and psychiatric staff should review the level of observation at least daily when the overall management plan is reviewed. The levels of observation and changes to this should be documented separately in the clinical notes, with counter-signatures from senior staff and the responsible clinician. The documentation will include date, time and signature, level of observation, stop date and role of each person signing. Changes to closer levels of observation may be initiated by any senior clinical

> team member. Reduction of the level of observation must be approved by two senior members of the clinical team. (MoH/NZGG 2003 p.27)

There appears little utility in having only medical staff being able to have the levels of observation altered, and it is recommended that this practice change to that of the MoH/NZGG recommendations. Equally, the value of observations needs attention. The results of this study show that suicide is anxiety provoking for many clinicians. Barre and Evans (2002) suggest that an unconscious part of observations may be that an anxiety-provoking part of dealing with suicidal people is dealt with by delegating out observations to other staff. I suggest that observations be undertaken by regular ward registered nurses where possible, given that this time can be used to support a suicidal consumer. It is vital that inexperienced persons (including student nurses) are not given this responsibility.

### 9.2.2 Implications for future research

The methodology in this study has allowed a comparison between wards and teams. I suggest that this is advantageous as other ethnographic studies into nursing practice with suicidal consumers usually only have the benefit of a single site. This study asked “how is nursing practice with suicidal consumers in acute mental health inpatient units constructed”. While the findings have answered the research question, further research needs to be undertaken to see whether the findings are relevant for other locations, especially outside of New Zealand. I suggest that any such studies incorporate methods that allow them to examine the relationship between dispositions of nurses and practice. In addition the methodology and the theoretical framework appear to offer a useful way of understanding culture, including cultural changes, in other areas of nursing outside of mental health.

There is a dearth of evidence showing the relationship between nursing practices and consumer outcomes (Cutcliffe 2014). Proving causation is methodologically problematic, but without the development of robust evidence about what makes a difference, then nursing actions that are suggested within policy guidelines (such as the NZGG/MoH 2003) are likely to remain focused on evidence that does exist (such as for observations). Quantitative research is needed to show outcomes from nursing practice, especially that of therapeutic interpersonal work. While a ‘trial’ of such work is not feasible, it is possible to consider wards, such as the ‘psychological ward’ in this study, and compare outcomes compared to a ward that is driven by a bio-medical/risk culture.

Also difficult methodologically is a need to assess whether inpatient suicide treatment affects outcomes post-discharge. Consumers in this study, particularly those that were in wards with a bio-medical/risk culture, suggested that the treatment/care they received would have a direct bearing on whether they would contact mental health services in the future. More ominously, a minority stated that the effects of the care they had received made them feel worse than before admission. Obviously the methodology employed in my study did not allow for assessment (beyond indication) of causation, especially if events occur in the future. There is evidence that the period post-discharge is a high risk time for recent inpatients (Appleby et al. 1999; Cutcliffe et al. 2014; McKenzie & Wurr 2001) but currently it is difficult to determine whether the suicide rate in this period is due to the population already being high risk, or whether inpatient iatrogenic effects are present.

In the chapter four I noted the invisibility of the treatment/care of Māori in the study. This area is ripe for research. Issues surrounding suicidality, for Māori, cannot be considered the same as for non-Māori (NZGG/MoH 2003). The provision of Māori inpatient support services is now an expectation within inpatient services. The effectiveness of these services on outcomes for Māori needs evaluation, using methodologies that are cognisant of the need for involvement of Māori from outset (Health Research Council 2010).

### 9.2.3 Implications for education

I am unaware of any study that examines the suicide component of education in the mental health disciplines (in particular psychiatry, nursing, social work, occupational therapy, psychology and mental health support work) in New Zealand. However, anecdotal evidence suggests that the components of these vary enormously, and that suicidology competes with multiple other topics; although the evidence is somewhat dated, this situation is similar to one previously seen in Australia (Hazell et al. 1999). I showed in chapter two that a brief review of contemporary texts commonly employed in nursing curricula in New Zealand nursing education as part of this study showed that sections on practice with suicidal consumers was focused mainly on bio-psychosocial causation and epidemiological data, with engagement and other interventions only receiving cursory mention. These findings match an older study in the United States of America (Coppola and Strohmetz 2002). Although the research is again somewhat dated, it not surprising that the latest evidence I found shows that front-line workers learn about suicidology *in vivo* (Meehan & Boating 1997).

Attitudes about suicide treatment/care are located within the fields of bio-medicine and risk, and within nurses' habitus. Education is a secondary habitus, and it would be simplistic to suggest that changes to education would change nurses' attitudes to suicide and suicide care completely. Nevertheless, there are indications that suicide education can ameliorate these. Samuelsson and Asberg (2002), for example, studied attitudes of clinicians' pre and post a training programme in suicide prevention. While they found a change to positive attitudes to suicidal persons overall, it is unclear whether these results were translated into practice. One study of 'training for trainers' in suicide intervention resulted in implementation of a wide range of preventative activities in intervention clinics (Ramberg & Wasserman 2004). However, the results from my study indicate that educational components about suicide require a focus on attitudes, for it is from these that suicide treatment/care practices stem. Rothe et al.'s (2013) research with clinicians echo some of the findings in this thesis. They suggest:

> It is important awareness that risk assessment process cannot be made by a simple identification and compilation of risk factors. In order to be reliable, this assessment has to be made in the therapeutic and relational context of confidence. (p.8)

My findings suggest that suicide education cannot just focus on demographics or risk assessment as a technical skill. It has to instead address the concerns that nurses have about working with suicidal consumers, and help establish how nurses can practice in a way that is therapeutic

## 9.3 Limitations

### 9.3.1 Introduction

Like all research studies, this thesis has limitations. In this section I identify these in terms of two areas: (i) the limitations of the methodology employed, and (ii) the limitations of the data. I discuss each in turn.

### 9.3.2 Limitations of methodology

Critical ethnography was a useful and appropriate methodology to answer the research question “how is nursing practice with suicidal consumers in acute mental health inpatient units constructed?” As I have shown, this study examined ward and team cultures and how these partially construct practice. This has elicited an understanding of the complex ways in which power is dispersed and imbued into practice through dispositions. However critical ethnography, on its own, did not show how nurses dispositions towards ward and team cultures come about. This came about through a later examination of data using selected works of Pierre Bourdieu (1977; 1979/1984; 1990; 1997/2000; 1998; 2001). Bourdieu’s works are consistent with the methodology of critical ethnography, and added to the overall findings from this research.

Interviews with informants were a necessary part of gathering data. However, I had to both respect the opinions that came from such interviews, yet ask questions as an informed spectator. This spectator view both objectified the research, but also required a subjective interpretation that was and is my own. Although these were rigorous in application, they undoubtedly were reliant on the formulation of a relationship with participants and were respectful of participants’ viewpoints. This, coupled with my own experience as a mental health nurse and academic, clearly meant that an element of subjectivity was involved in the process.

The undertaking of ethnography also meant that data gathering was contingent on me as a ‘tool’ for finding information. Therefore my choices of where to be and how to act must have affected information gathered. In particular, I was aware that I was unable to be in multiple locales at one time, and that I potentially missed seeing other informing situations. The choice to have multiple wards in the study also potentially diluted the data. I do believe that the hundreds of hours spent on the wards allowed for data saturation. However it is possible that, as Denzin (1997) warned, multiple sites did not mean better data. The ethical requirements of being able to interview consumers during admission (as opposed to, for instance, interviewing them at home post-discharge) was another potential limitation. It is possible that consumers may have had a different viewpoint if they were able to reflect back on their time in the wards.

The final data-gathering limitation was the inability to use participant observation or interviews within the intensive care units attached to the inpatient units. This limitation was made because of the possible intrusiveness of a researcher within a small environment when consumers were possibly acutely vulnerable. As far as I am aware no ethnographic study of mental health intensive care units has been undertaken, a situation that appears similar in other countries (Crowhurst & Bowers 2002). Some interviewees did spend time in the intensive care unit, with the primary aim of 'containment' because of clinician fears that they would leave the unit and act on suicidal urges. However this data, while informing consumer experiences, was largely absent from interviews. This is possibly because I did not specifically ask about this. This absence may have deprived the study of valuable viewpoints.

### 9.3.3 Limitations of data

Specific treatment/care of Māori consumers is not overt in this study. This absence, in itself, could be interpreted as data; with the question asked 'why is Māori care invisible'? However, I believe that such an interpretation would not be grounded in data, and instead consider the treatment/care of Māori is an area worthy of study in its own right.

In chapter five I have discussed issues related to the data that indicates the relationship between nursing dispositions and outcomes. In establishing the data gathering methods used in this study I did not envisage a relationship between dispositions and outcomes. If I had I would have gathered more thorough demographic data and deliberately asked more questions about nurses' backgrounds and views within interviews. I am convinced that while the methods used were a study limitation, the data is robust enough to make the interpretations that I have.

## 9.4 Conclusion

In this study I have shown what constructs nursing practice with suicidal consumers in acute mental health inpatient units. The findings indicate that significant constructing factors are (i) dominant ward cultures influenced by discourses of bio-medical understandings of suicidality and risk and, (ii) dispositions of nurses. These findings are not insignificant. I have suggested in this final chapter that consideration needs to be given to providing evidence of nursing practice and consumer outcomes so that ‘gold-standard’ practice can be established. There are a number of areas that need to be addressed in order to effect change at a both ward cultural level and nursing dispositions. I suggest that changes, although not without significant challenges, need to occur in order to support best outcomes for consumers and to help inpatient nursing to reach its potential.

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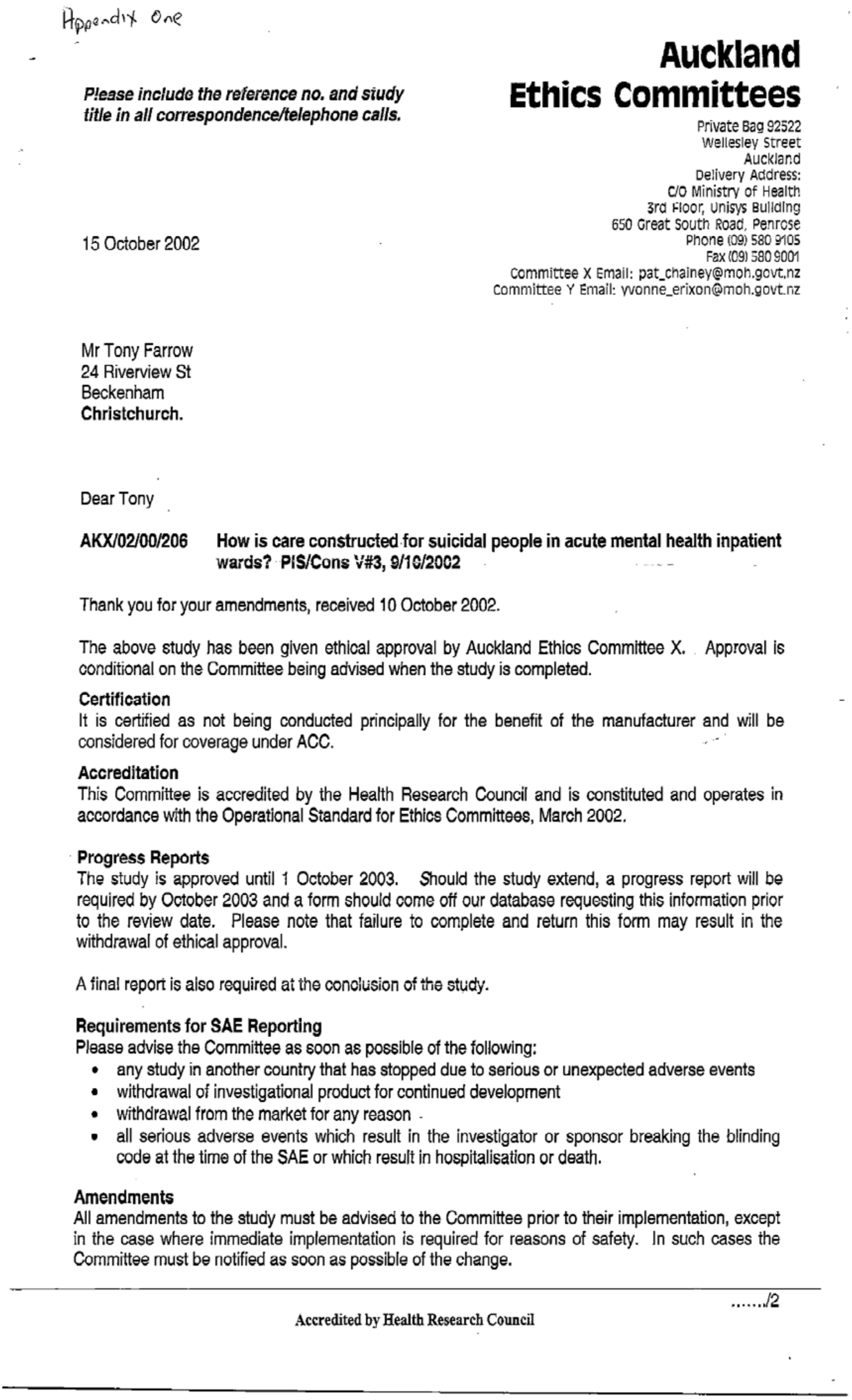


Appendix One

*Please include the reference no. and study title in all correspondence/telephone calls.*

**Auckland**
**Ethics Committees**
Private Bag 92522
Wellesley Street
Auckland
Delivery Address:
C/O Ministry of Health
3rd Floor, Unisys Building
650 Great South Road, Penrose
Phone (09) 580 9105
Fax (09) 580 9001
Committee X Email: pat_chainey@moh.govt.nz
Committee Y Email: yvonne_erixon@moh.govt.nz

15 October 2002

Mr Tony Farrow
24 Riverview St
Beckenham
**Christchurch.**

Dear Tony

**AKX/02/00/206 How is care constructed for suicidal people in acute mental health inpatient wards? PIS/Cons V#3, 9/10/2002**

Thank you for your amendments, received 10 October 2002.

The above study has been given ethical approval by Auckland Ethics Committee X. Approval is conditional on the Committee being advised when the study is completed.

**Certification**
It is certified as not being conducted principally for the benefit of the manufacturer and will be considered for coverage under ACC.

**Accreditation**
This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

**Progress Reports**
The study is approved until 1 October 2003. Should the study extend, a progress report will be required by October 2003 and a form should come off our database requesting this information prior to the review date. Please note that failure to complete and return this form may result in the withdrawal of ethical approval.

A final report is also required at the conclusion of the study.

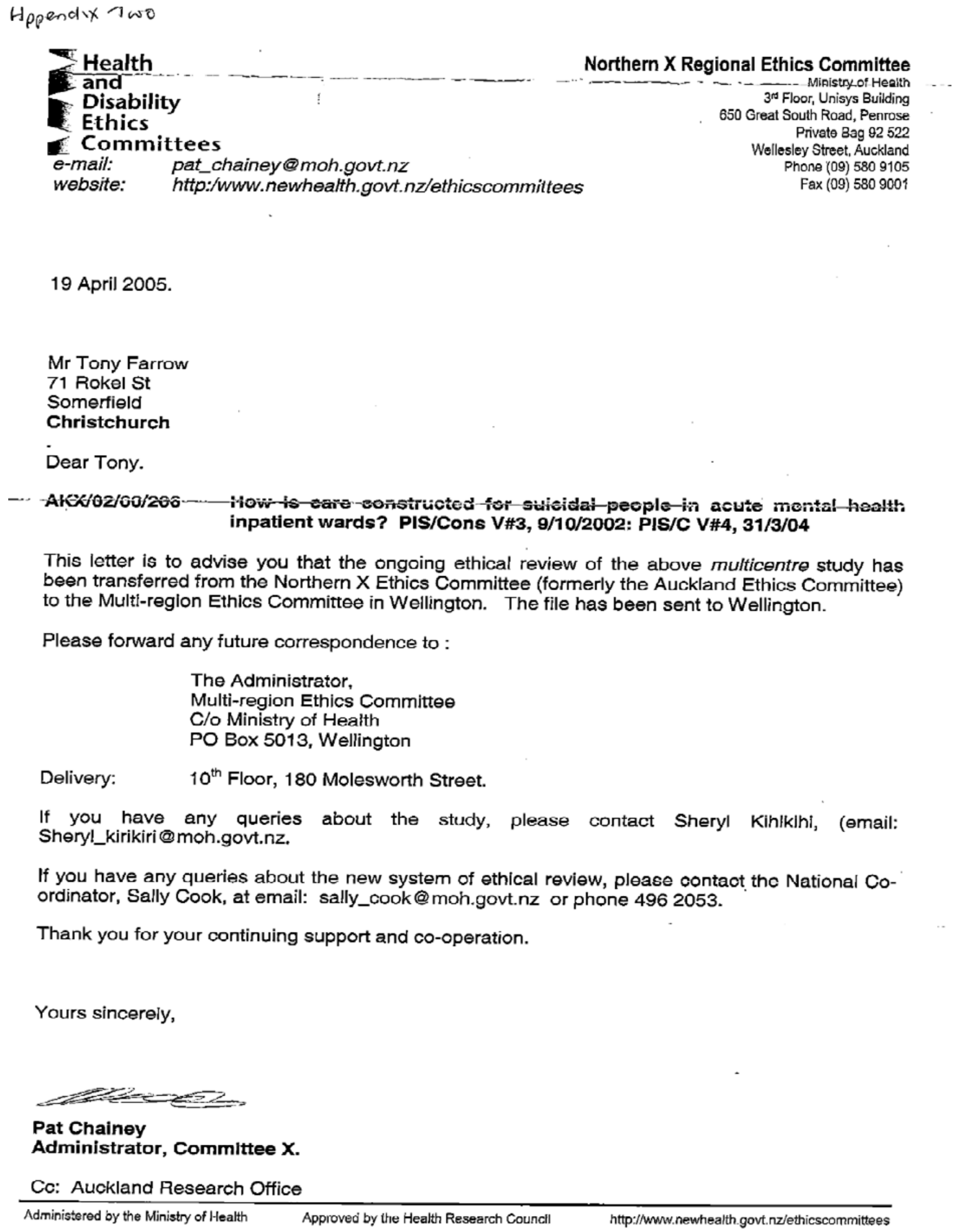
**Requirements for SAE Reporting**
Please advise the Committee as soon as possible of the following:

- any study in another country that has stopped due to serious or unexpected adverse events
- withdrawal of investigational product for continued development
- withdrawal from the market for any reason
- all serious adverse events which result in the investigator or sponsor breaking the blinding code at the time of the SAE or which result in hospitalisation or death.

**Amendments**
All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

……/2

**Accredited by Health Research Council**



Appendix Two

**Health and Disability Ethics Committees**

e-mail: *pat_chainey@moh.govt.nz*
website: *http:/www.newhealth.govt.nz/ethicscommittees*

**Northern X Regional Ethics Committee**
Ministry of Health
3rd Floor, Unisys Building
650 Great South Road, Penrose
Private Bag 92 522
Wellesley Street, Auckland
Phone (09) 580 9105
Fax (09) 580 9001

19 April 2005.

Mr Tony Farrow
71 Rokel St
Somerfield
**Christchurch**

Dear Tony.

**AKX/02/00/266 How is care constructed for suicidal people in acute mental health inpatient wards? PIS/Cons V#3, 9/10/2002: PIS/C V#4, 31/3/04**

This letter is to advise you that the ongoing ethical review of the above *multicentre* study has been transferred from the Northern X Ethics Committee (formerly the Auckland Ethics Committee) to the Multi-region Ethics Committee in Wellington. The file has been sent to Wellington.

Please forward any future correspondence to :

The Administrator,
Multi-region Ethics Committee
C/o Ministry of Health
PO Box 5013, Wellington

Delivery: 10th Floor, 180 Molesworth Street.

If you have any queries about the study, please contact Sheryl Kihikihi, (email: Sheryl_kirikiri@moh.govt.nz.

If you have any queries about the new system of ethical review, please contact the National Co-ordinator, Sally Cook, at email: sally_cook@moh.govt.nz or phone 496 2053.

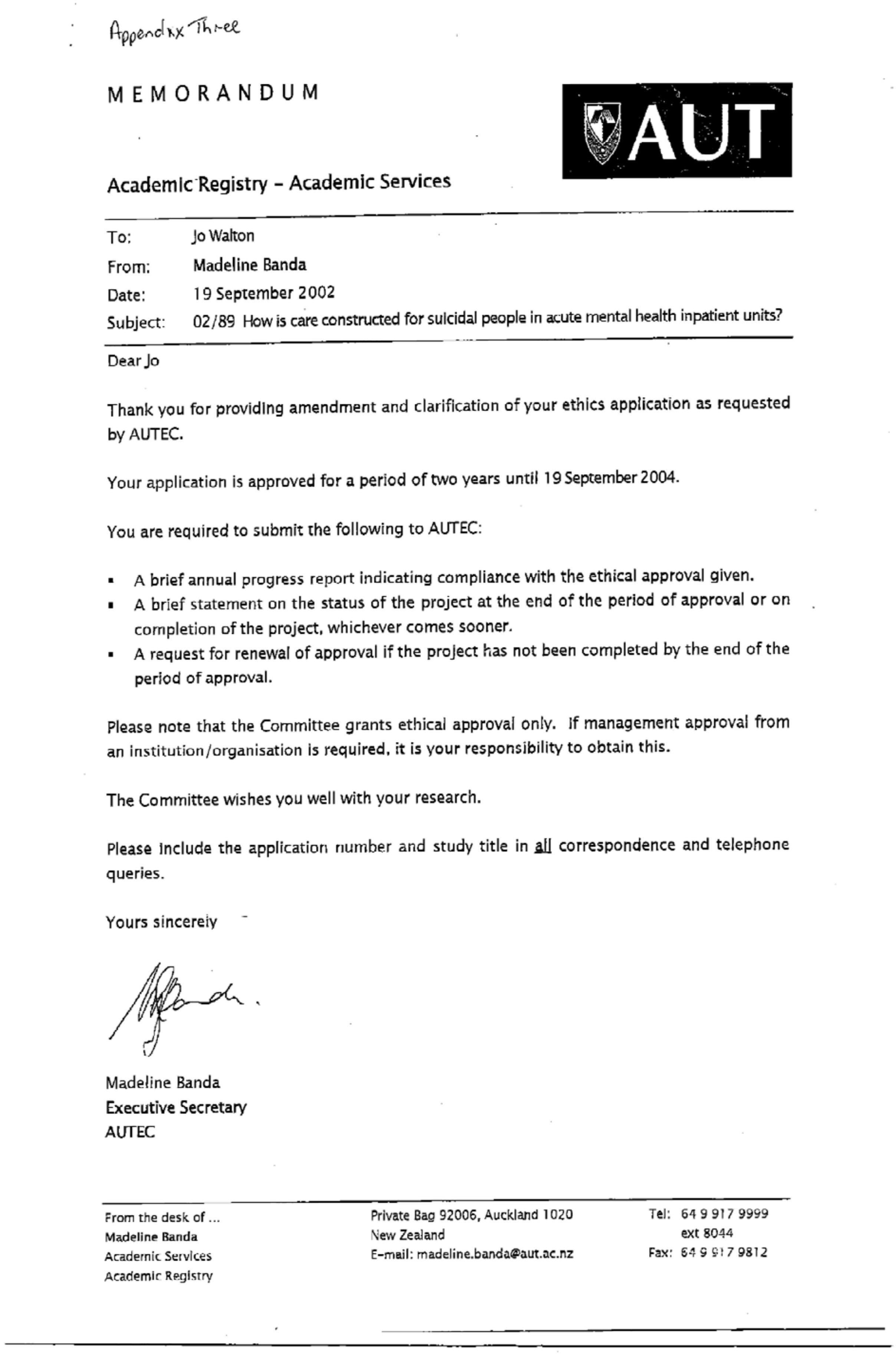
Thank you for your continuing support and co-operation.

Yours sincerely,

**Pat Chainey**
**Administrator, Committee X.**

Cc: Auckland Research Office

Administered by the Ministry of Health Approved by the Health Research Council http://www.newhealth.govt.nz/ethicscommittees



Appendix Three

MEMORANDUM

**Academic Registry – Academic Services**

To: Jo Walton

From: Madeline Banda

Date: 19 September 2002

Subject: 02/89 How is care constructed for suicidal people in acute mental health inpatient units?

Dear Jo

Thank you for providing amendment and clarification of your ethics application as requested by AUTEC.

Your application is approved for a period of two years until 19 September 2004.

You are required to submit the following to AUTEC:

- A brief annual progress report indicating compliance with the ethical approval given.
- A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.
- A request for renewal of approval if the project has not been completed by the end of the period of approval.

Please note that the Committee grants ethical approval only. If management approval from an institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research.

Please include the application number and study title in all correspondence and telephone queries.

Yours sincerely

Madeline Banda
**Executive Secretary**
AUTEC

From the desk of ...
Madeline Banda
Academic Services
Academic Registry

Private Bag 92006, Auckland 1020
New Zealand
E-mail: madeline.banda@aut.ac.nz

Tel: 64 9 917 9999
ext 8044
Fax: 64 9 917 9812

Appendix Four

# Participant Information Sheet

**Project Title** How is care constructed for suicidal people in acute mental health inpatient wards?

This research is being conducted as part of a Doctor of Philosophy (PhD) study by Tony Farrow.

**Invitation** You are invited to be part of this study. This will involve you being interviewed by Tony Farrow, the lead investigator in this project. It may be that you will be asked to be interviewed on more than one occasion. However you can refuse this if you wish.

The questions will be around your experiences of caring for suicidal people whilst a clinician on this or other inpatient units. You can choose not to answer any specific questions(s). You can withdraw from the study at any time.

You are very welcome to have a support person with you during the interview(s).

The interviews will probably last between half an hour to one hour. The interviews will be tape-recorded, if you agree. The interviews are confidential i.e. no information will be passed on to anyone else.

## What is the purpose of the study?

The purpose of the study is to explore how suicidal people are cared for in an inpatient setting, and what factors cause care to be conducted in these ways. It is hoped that this study will be a step in improving care for people when they are suicidal in inpatient units.

## How was a person chosen to be asked to be part of the study?

Anyone who is a full-time staff member of this unit is offered the opportunity to join.

## Can I join the study?

You are very welcome to join the study. You just need to advise Tony Farrow of this, either in person, by phoning 9408503, or by email farrowt@cpit.ac.nz

## What happens in the study?

You may have noticed Tony Farrow on the unit. He is conducting the study by observing how suicidal people are cared for, reading written records on the unit, and interviewing both patients and staff. Permission for reading written records has been obtained from management of the mental health division of the Canterbury District Health Board; however individual patient records will only be accessed if written consent is obtained from that patient. Tony will also be undertaking similar tasks at some other inpatient units around the country. Once these are completed, the results will be analysed, and published as part of his PhD study. These results will later be published in journals and at conferences. Neither you nor the inpatient unit will be identified anywhere in the publications.

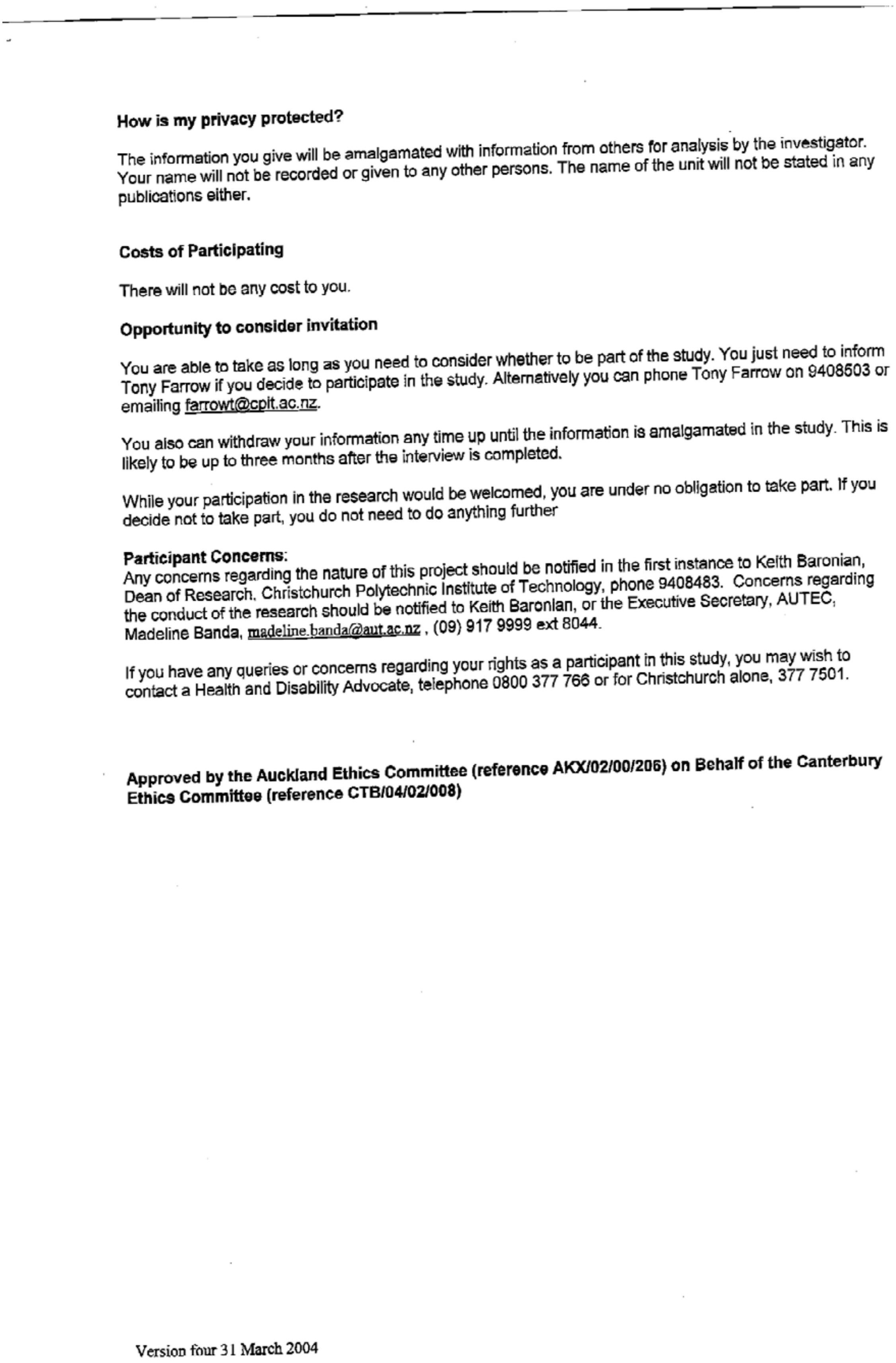
## What are the discomforts and risks?

It is possible that talking about your experiences of caring for suicidal people may make you feel uncomfortable. You may stop the interviews at any time. You are also very welcome to have a support person present with you.

## What are the benefits?

As mentioned above, it is hoped that your participation, along with the participation of others, will be one step in improving services for suicidal people.

Version four 31 March 2004



**How is my privacy protected?**

The information you give will be amalgamated with information from others for analysis by the investigator. Your name will not be recorded or given to any other persons. The name of the unit will not be stated in any publications either.

**Costs of Participating**

There will not be any cost to you.

**Opportunity to consider invitation**

You are able to take as long as you need to consider whether to be part of the study. You just need to inform Tony Farrow if you decide to participate in the study. Alternatively you can phone Tony Farrow on 9408503 or emailing farrowt@cpit.ac.nz.

You also can withdraw your information any time up until the information is amalgamated in the study. This is likely to be up to three months after the interview is completed.

While your participation in the research would be welcomed, you are under no obligation to take part. If you decide not to take part, you do not need to do anything further

**Participant Concerns:**
Any concerns regarding the nature of this project should be notified in the first instance to Keith Baronian, Dean of Research, Christchurch Polytechnic Institute of Technology, phone 9408483. Concerns regarding the conduct of the research should be notified to Keith Baronian, or the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz , (09) 917 9999 ext 8044.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate, telephone 0800 377 766 or for Christchurch alone, 377 7501.

**Approved by the Auckland Ethics Committee (reference AKX/02/00/206) on Behalf of the Canterbury Ethics Committee (reference CTB/04/02/008)**

Version four 31 March 2004

Appendix Five

AUT

# Participant Information Sheet

**Project Title** How is care constructed for suicidal people in acute mental health inpatient wards?

This research is being conducted as part of a Doctor of Philosophy (PhD) study by Tony Farrow.

**Invitation** You are invited to be part of this study. This will involve you being interviewed by Tony Farrow, the lead researcher in this project. It may be that you will be asked to be interviewed on more than one occasion. However you can refuse this if you wish. You may withdraw from the study at any time. You will not be asked to participate in interviews once you have been discharged from the inpatient unit.

The questions will be around your experiences of care whilst you have been suicidal in the inpatient unit. You can choose not to answer any specific questions if you wish.

You are very welcome to have a support person with you during the interview(s).

The interviews will probably last between half an hour to one hour. The interviews will be tape-recorded, if you agree. The interviews are confidential i.e. no information will be passed on to anyone else. The only acceptation to this would be if you were thought to be at risk of suicide or harm to others, in which case staff would be advised immediately.

You may also choose to allow Tony Farrow to read your clinical files. Permission for accessing clinical files has been gained from management of the mental health division of the Canterbury District Health Board. However Tony Farrow will not access your clinical files without your permission. If you do agree to this, Tony will read these to try to understand the ways in which your cares have been recorded. No personal information about you will be written down or discussed with anyone else. Refusal to allow access to your clinical files will not exclude you being able to choose to being interviewed for the study.

### What is the purpose of the study?

The purpose of the study is to explore how suicidal people are cared for in an inpatient setting, and why the care is carried out in these ways. It is hoped that this study will be a step in improving care for people when they are suicidal in inpatient units.

### How was a person chosen to be asked to be part of the study?

Anyone who is an inpatient of the mental health unit, was admitted because of suicidal thoughts, or has become suicidal whilst on the unit and is thought capable of agreeing to enter the study, was offered the opportunity to join.

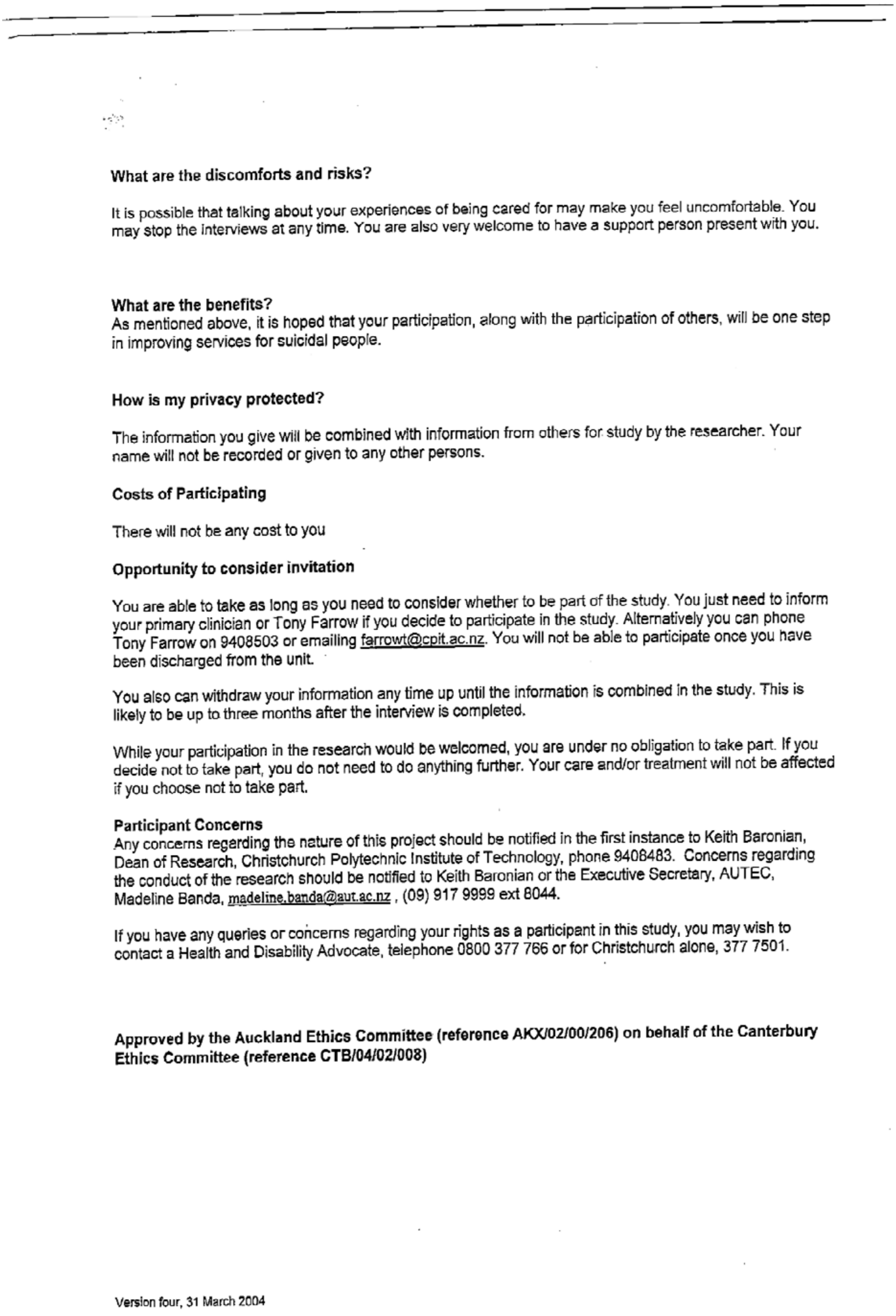
### Can I join the study?

You are very welcome to join the study. However, for your safety, approval will also need to be given by your nurse or doctor. This is to try to ensure that you will be safe during the study.

### What happens in the study?

You may have noticed Tony Farrow on the unit. He is conducting the study by observing how suicidal people are cared for, reading written records on the unit, and interviewing both patients and staff. Once these are completed, the results will be studied, and published as part of his PhD study. These results will later be published in journals and at conferences. Your name will not be written anywhere in the publications. Likewise the name of the unit won't be stated either.

Version four, 31 March 2004



**What are the discomforts and risks?**

It is possible that talking about your experiences of being cared for may make you feel uncomfortable. You may stop the interviews at any time. You are also very welcome to have a support person present with you.

**What are the benefits?**
As mentioned above, it is hoped that your participation, along with the participation of others, will be one step in improving services for suicidal people.

**How is my privacy protected?**

The information you give will be combined with information from others for study by the researcher. Your name will not be recorded or given to any other persons.

**Costs of Participating**

There will not be any cost to you

**Opportunity to consider invitation**

You are able to take as long as you need to consider whether to be part of the study. You just need to inform your primary clinician or Tony Farrow if you decide to participate in the study. Alternatively you can phone Tony Farrow on 9408503 or emailing farrowt@cpit.ac.nz. You will not be able to participate once you have been discharged from the unit.

You also can withdraw your information any time up until the information is combined in the study. This is likely to be up to three months after the interview is completed.

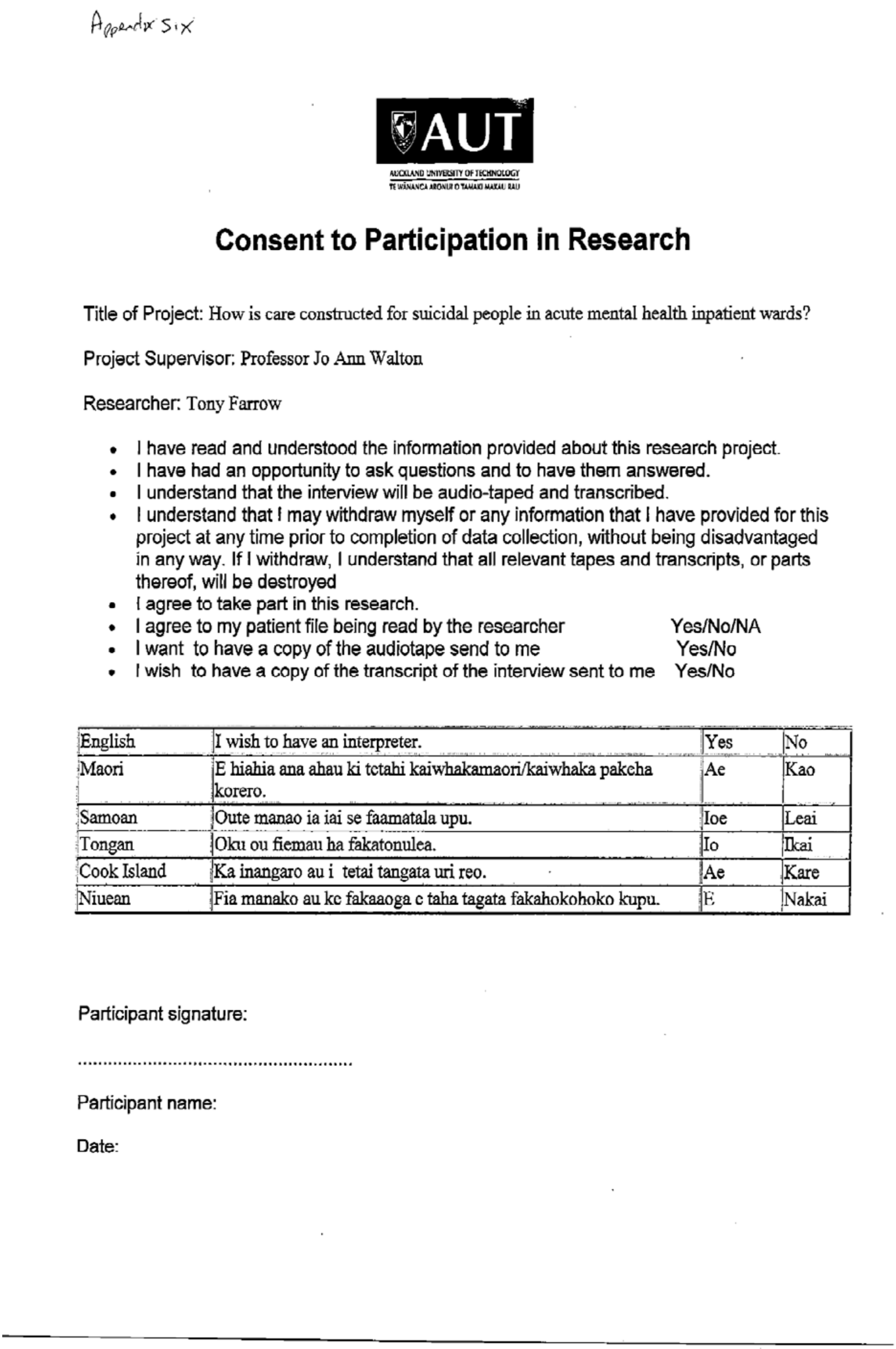
While your participation in the research would be welcomed, you are under no obligation to take part. If you decide not to take part, you do not need to do anything further. Your care and/or treatment will not be affected if you choose not to take part.

**Participant Concerns**
Any concerns regarding the nature of this project should be notified in the first instance to Keith Baronian, Dean of Research, Christchurch Polytechnic Institute of Technology, phone 9408483. Concerns regarding the conduct of the research should be notified to Keith Baronian or the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz , (09) 917 9999 ext 8044.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate, telephone 0800 377 766 or for Christchurch alone, 377 7501.

**Approved by the Auckland Ethics Committee (reference AKX/02/00/206) on behalf of the Canterbury Ethics Committee (reference CTB/04/02/008)**

Version four, 31 March 2004



Appendix six

AUT
AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

# Consent to Participation in Research

Title of Project: How is care constructed for suicidal people in acute mental health inpatient wards?

Project Supervisor: Professor Jo Ann Walton

Researcher: Tony Farrow

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed
- I agree to take part in this research.
- I agree to my patient file being read by the researcher Yes/No/NA
- I want to have a copy of the audiotape send to me Yes/No
- I wish to have a copy of the transcript of the interview sent to me Yes/No

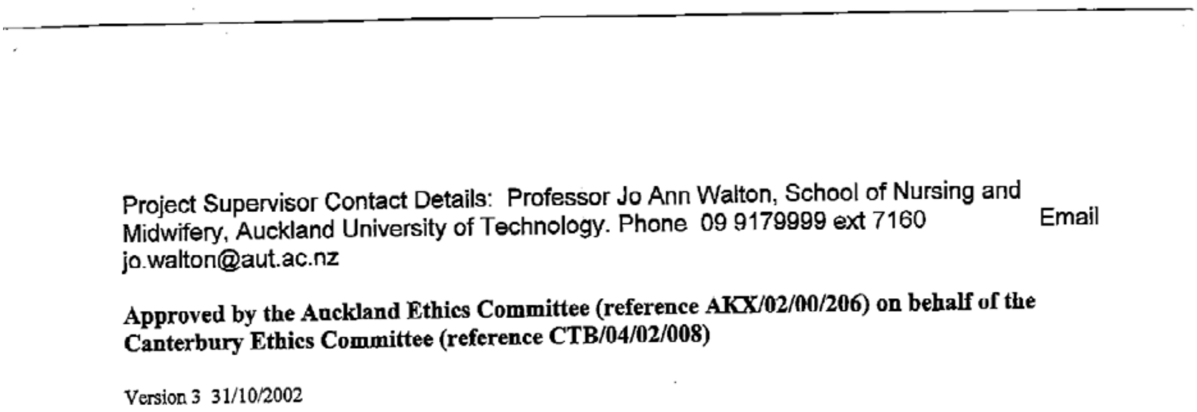
| | | | |
|---|---|---|---|
| English | I wish to have an interpreter. | Yes | No |
| Maori | E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero. | Ae | Kao |
| Samoan | Oute manao ia iai se faamatala upu. | Ioe | Leai |
| Tongan | Oku ou fiemau ha fakatonulea. | Io | Ikai |
| Cook Island | Ka inangaro au i tetai tangata uri reo. | Ae | Kare |
| Niuean | Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu. | E | Nakai |

Participant signature:

.......................................................

Participant name:

Date:



Project Supervisor Contact Details: Professor Jo Ann Walton, School of Nursing and Midwifery, Auckland University of Technology. Phone 09 9179999 ext 7160 Email jo.walton@aut.ac.nz

**Approved by the Auckland Ethics Committee (reference AKX/02/00/206) on behalf of the Canterbury Ethics Committee (reference CTB/04/02/008)**

Version 3 31/10/2002