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Aroha Mai:
Nurses, Nursing and
Mental Illness

Jacqueline Dianne Kidd

A thesis submitted in fulfilment of the requirements
for the degree of Doctor of Philosophy, The University
of Auckland, 2008
**Abstract**

This research takes an autoethnographical approach to exploring the connections between being a nurse, doing nursing work, and experiencing a mental illness.

Data is comprised of autoethnographical stories from 18 nurses. Drawing on Lyotard’s (1988) postmodern philosophy of ‘regimes of phrases’ and ‘genres of discourse,’ the nurses’ stories yielded three motifs: Nursing, Tangata Whaiora (people seeking wellness) and Bullying. Motifs are recurring topical, emotional and contextual patterns which have been created in this research by means of the formation of collective stories from the content of the nurses’ stories, artwork, fictional vignettes and poetry.

Interpretation of the motifs was undertaken by identifying and exploring connected or dissenting aspects within and between the motifs. Using Fine’s (1994) notion of hyphenated lives, the spaces between these aspects were conceptualised as hyphens. The Nursing motif revealed a hyphen between the notion of the nurses as selfless and tireless carers, and the mastery requirements of professionalism. The nurses’ hope for caring, belonging, expertise and ‘goodness’ were also features of the nursing motif. The Tangata Whaiora motif revealed the hyphen between being a compliant patient and a self-determined person seeking wellness, and also foreshadowed the notion that the nursing identity does not ‘permit’ the dual identities of nurse and tangata whaiora.

This research has found that nurses who have experienced, or are vulnerable to, mental illness negotiate a nexus of hyphens between societal, professional and personal expectations of the nurse. Ongoing unsuccessful negotiation of their identities is exhausting and leads to enduring distress. At times, negotiation is not possible and the nurse is immobilised in a differend of silence and injustice. At such times, the only resolution possible for the nurse is to leave the nursing profession. Bullying surfaced as a feature of the hyphen between the nursing and tangata whaiora identities, as well as being a part of each identity as colonising, silencing and/or discriminatory acts.

Successful negotiation between and among the nursing and tangata whaiora hyphens requires a radical restructuring of the nursing image and culture across the education, workplace and personal/clinical areas. Three strategies are proposed for the discipline of nursing to achieve this change: transformatory education, a conscientisation programme, and mandatory emancipatory clinical supervision.
Dedication

This work is dedicated to an extraordinary group of nurses;

Alice, Morrie, Rachel, Anne, Julie, 64, Ellie, Jayne, Mary, Gemini, Josephine,
Elizabeth, Chloe, Helen, Jenny, North Island Bunny, Vicky, and Michelle.

Also,

To those nurses who volunteered to take part in the research but were, for my
reasons or yours, unable to be there

And

To the nurses who have written, phoned and talked to me since I began this
research, to tell their stories and to support me as I told this one.

Kia tau te rangimarie

(Let peace be upon us, even in the face of difficulty)
Acknowledgments

Completing a doctorate is a selfish endeavour. This thesis embodies the contributions of many people whose presence in its pages are implicit and enriching.

I have been fortunate and wise in my choice of academic supervisors. My work with Dr. Mary Finlayson has demonstrated the delicate, skilled art of simultaneously supporting and challenging, and has enabled me to find a path that encompasses passion, creativity, and the highest of academic standards. I count myself very lucky to have been accepted as one of her students. Dr. Peter Adams has generously shared his knowledge, experiences and resources, and has immeasurably enriched this project. Thank you, both.

My most extraordinary family have been an integral part of this research journey. Tracy, you combine spirit, determination, love and humour in your life and your career. You are an inspiration to me. For your courage and boundary pushing, Elin, you constantly surprise and delight me. I have to thank you for a steady supply of coke zero and distractions whether I needed them or not – even from London. Caitlin and Drew, no longer children and no longer shorter than me! Your contributions to this research have been important to me; your music, patience, jokes and your own achievements at school have made it possible for me to work hard and hopefully make you proud of me. The four of you challenge me to be the best I can be.

My mother has gone beyond the maternal ‘rules’ of being interested in your daughter’s work, and has read and commented on my vignettes as the work progressed. Most impressively, though, she has edited The Whole Thing. Thanks Mum! (Any remaining errors are my responsibility, and are probably because I didn’t listen to her.)

The last acknowledgment goes to Tony, not because he is least important, but because he is the foundation from which I have been able to engage with this work and stay (relatively) intact. It takes a strong, special man to not only endure, but to actively encourage the changes that are involved in a project like this. For the meals, the housework, the conversations and the constant love, thank you is not enough. Perhaps dinner and a movie? I have the time!
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Chapter one: Beginnings

I would really love to see a group of nurses with mental illness out there, visible, showing their colleagues that they are normal and should be treated like people. But there is a chicken and egg situation, where the nurses who have mental illnesses are scared to step out and tell people because they will be treated badly, and a lack of knowledge and acceptance among nurses in general because there is no-one brave enough to step out and tell others!

Jayne

This is an autoethnographical study of nurses who have experienced a mental illness while they were in clinical practice. The research draws on eighteen independently written autoethnographical stories from nurses who have negotiated life with a mental illness and, through them, explores the way being a nurse or doing nursing work can affect one’s mental health and it recommends strategies for reducing the impact of mental illness on nurses.

Autoethnography (auto – told from the first person and ethno – located in the culture of nursing) is grounded in postmodern and feminist approaches to research, using storytelling as a method for obtaining and interpreting emotional and social data, and presenting findings to the research
audience that evoke in them a desire to effect change (Ellis, 1997, 2004; Ellis & Bochner, 2000, 2006). The overt inclusion of emotion and emotionality is a unique feature of this approach, rendering it particularly relevant for research in the mental health arena (K. Foster, McAllister, & O'Brien, 2005, 2006; S. White, 2003).

The idea of this research began with my autoethnographical story of working as a mental health nurse, written as a part of the course requirements for a postgraduate nursing paper. That story has been updated and is presented on page three, tracing the development of my research topic through my personal and professional experiences. The story also provides information about my identities as researcher, nurse, woman and Māori, illustrating the underlying values that pervade the research project and are explored as the thesis progresses.

The decision about what to write in these first few pages is a complex one. The research was not tidily chronological, but involved continuous talking, thinking, reading and writing, looking outward, imagining forward, reflecting inward, and rotating backward in a circular pattern that denied the identification of a clear starting point. Historical positioning, theory, the nurses’ stories, my own story and the literature all vied for place, each of them holding vital information that needed to be read before a full understanding of the project could be reached. Attaining enough clarity in the beginning of the thesis for comprehension, while not pre-empting the outcomes, was a tense process. Adding to the complexity, writing a thesis from an autoethnographical standpoint has disrupted some academic traditions by, for example, writing in the first person, using storying (including vignettes of poetry and fiction) to capture and present nuances in the interpretation of data, positioning the nurses’ stories in their entirety throughout the thesis, and the feminist use of first names when referring to other researchers and authors in the text. While these disruptions provide opportunities for enhancing the depth and intricacy of the thesis, they also require more difficult decisions about how to achieve and present that depth.
I have adopted an approach that synthesises some of my later learning for inclusion in this chapter, particularly regarding the situatedness of nurses who have experienced mental illness, to signal the overall direction of the text. Within the overall document structure, the content of the thesis moves from my personal, historical story as a starting point, broadens to include the nurses’ stories, broadens further as the nurses’ stories indicate the need to examine literature, and then interprets the findings from the stories and literature within the larger contexts of nursing and New Zealand society. The research then narrows back to my autoethnographical reflections about the meaning of the project and its impact on me. These writing techniques give the reassurance of a coherent, tidy text, although this is a perception that is challenged throughout the balance of the thesis.

My story occupies the next section of the thesis. It is positioned thus because it traces my practical, emotional, and academic experiences that have resulted in this particular research project being conducted in this particular way. In the remainder of this chapter, the need for this research and the way mental illness has been defined herein is discussed. This is followed by a description and explanation of the way the thesis has been crafted, including the use of fonts and asterisks for layering voices into the text, its naming, and the structure of the chapters.

**Coming to the research question**

**My story**

*I have been a mental health nurse for more than 15 years and have found great satisfaction and joy from my work. During that time I have also been stressed, bullied, silenced, exhausted and burned out, as have many of my colleagues. At times, it has seemed as though emotional distress is the norm for nurses.*

*As I write this, I am approaching the end of my PhD journey. My data is collected and I have more than half of my thesis written. I should be concentrating on deepening my*
understanding and knitting up any loose ends. Instead I am remembering being in the ‘hot seat’ in a mental health team meeting.

I was one of eight Kaioranga Hauora Māori (Māori mental health workers) working in an urban area. Our Kaiwhakahaere (team leader) had refused to allow me to be employed as a nurse, and kept a tight rein on the team. Every Monday afternoon we had a team meeting, for over three hours. Our office had a glass wall and partially glassed ceiling, overlooking a car park. It was usually very hot. In each meeting, a staff member would be in what the team unofficially called the ‘hot seat.’ It was often me, because I never learned to keep my mouth shut! I would question and challenge, and believe that I had the right to determine my practice. I would be shouted at, laughed at, told to be quiet, ridiculed and scorned. Oh, I was stubborn. The torture would usually end when I cried, and to my shame and fury, I usually did cry. I also ate. My team mates and I would work our way through vast amounts of chocolate, lollies, bread, cakes and fizzy drink as we swallowed our words and tried to chemically change our feelings. During my two year stay in that team my weight ballooned to the point where a size 24 t-shirt was tight. I had quiet support and camaraderie from within the team and I offered the same in turn, yet none of us ever spoke out. Nor did anyone ever get up and leave those meetings. I still feel shame for having stayed there for so long, and have only recently noticed the irony of being violently colonised personally as a result of wanting desperately to work to decolonise my own people through my professional skills\(^1\). Now, many years later, I can see the parallels and can bring them into my life and make meaning of them.

I am someone whose life spans the European notions of professionalism, individuality and self responsibility, and simultaneously the Māori concepts of interdependence and life as a spiritual journey. This is a painful duality – the beauty of the Māori culture and

\(^1\) Colonisation is discussed further on page 50.
the ugliness of poverty, a beautiful language that I am not fluent in, a feeling of being pulled apart by being both European and Māori. I have European features and postgraduate education, which can put me at odds with many Māori, and a heartfelt Māori belief in the world that creates a barrier to understanding with many Europeans. This dichotomy is echoed, not only in my stories of being bullied into silence in the Māori mental health team, but also in this research. It is echoed in stories of nursing and stories of mental illness, as well as in stories of cultural colonisation.

I came to this research project with perceptible but unexplored personal values that would not be shaken, about not predefining the way the nurses would portray their experiences; the importance of narrative as a way to transmit information; about my need to see the nurses’ stories uncensored and complete in the thesis; and being unable to reconcile objectivity with my need to honour the nurses and their stories. It has not been until this late stage in the research that I have been able to connect the personal with the academic, to ‘come out’ as a newly aware, bruised and defiant person who is resolute about not inflicting those hurts on anyone else. And also to claim my heritage of the narrative, finally understanding my bone-deep need for and respect of stories. The autoethnographical approach has provided me with an authenticated method to engage in academic research that fitted with my cultural and personal imperatives.

At a meeting with other mental health nurses recently, we shared ‘war stories’ about close calls and scary times in our practice. I talked about a several-hours-long interaction with a nervous man who, at the conclusion of our session, pulled an 18 inch knife out of his rucksack, handed it to me and announced that he had decided to trust me. Another person threatened to ‘come after’ me and my family because I had passed on information to his psychiatrist about an intended violent crime. I still feel my
heartbeat fast and my stomach shrivel when I think of him. I push those thoughts out of
my head as quickly as I can, otherwise I break out in a sweat and become nauseous. A
colleague recalled negotiating with a man who had brought a gun onto the ward.
Another nurse had several months off work after being punched in the head by a
woman who had waited behind the kitchen door for her. Yet we all vehemently dispute
media representations of mentally ill people as violent. We all say that these events are
few and far between, and we are right. But each violent event, whether from a colleague
or a client, leaves its mark. And sometimes, it seems, the deeper the scar, the less we
talk about them. I didn’t share my experiences of the hot seat, eating, or of being so
terrified I could barely breathe.

After I left the Māori team, I worked in an acute psychiatric unit. I remember having a
conversation with a colleague about being tired. We were understaffed as a result of
winter-time staff illness, so we were all working long shifts with complex patient loads. I
was having nightmares and waking several times through the night to attend to people
who I believed were in need of attention, while she claimed to ‘sleep like a baby’ every
night. Although I recognised that I was in need of a break from nursing work, I thought
that she was the more unwell of the two of us. Working in our acute environment with a
high staff turnover made feeling distressed a logical consequence for the nurses on the
ward.

Later in my career, when I worked in an emergency service, I was experienced enough
to be entrusted with the care of nurses who were patients of the mental health service.
They tended to have temporary clinical files, sometimes even unlabeled manila folders,
rather than full files. Noms de plume were used in place of the nurse’s own name, and
only carefully selected senior staff were permitted to know the full client history and
treatment. The care I was able to provide was inadequate. I knew that. We negotiated
constantly between protecting the nurse from exposure to colleagues and accessing the most effective services, which required a level of exposure through referrals and funding applications. At the time I did not question the need for secrecy, although I often felt grateful that I did not have to make the choices imposed on those nurses and their families. Now, of course, I see myself as silencing the nurses’ stories through my misguided attempts to help. I can excuse myself, be kind to myself, on the grounds of insufficient self awareness and following institutional norms. But, again, I am ashamed. I didn’t know – yet I should have known.

The issues of stress, burnout and secrecy emerged in my personal life and academic studies when I was undertaking post graduate study, and carried through into my Master of Nursing research. I was working in the clinical practice settings described above, so I lived in, and also theoretically explored, the tensions involved in being a mental health nurse. I identified a series of seemingly incompatible requirements for nurses to balance such as empowering people who have experienced mental illness, and keeping them under control for the comfort of the community (Kidd, 2002). I kept the issues at a slight distance, acknowledging that I had some experience of stress and burnout, but maintaining the illusion that it was an ‘issue’ that I had ‘dealt with’, and that was transformed through my academic research into ‘useful’ knowledge.

That research ignited the fire for this PhD research. I became passionately concerned for the fate of nurses who have experienced a mental illness and must negotiate the inevitable tensions involved in caring for people as well as coping with their own illness issues, often in secret. I wondered about the connection between the stress of being a nurse and the development of a mental illness. I became conscious of my own mental health as I negotiated uncomfortable or contradictory aspects of my job. I also noticed colleagues who were unhappy or clearly unwell, and took mental note of my actions and
reactions when I worked with them. I pondered the implications of the way nurses with mental illness were treated when they became patients in the mental health service.

Recovery as a philosophy of mental health care came into service documents in 1998 (Mental Health Commission, 1998), and into common use in the early 2000s, which served to crystallise some of the questions I had begun to formulate about being a nurse and having mental illness.

I had moved away from the clinical setting and was working as a lecturer in an undergraduate nursing programme when I decided to undertake doctoral study. I had continued to read about and think about the pressures of being a nurse and the implications for mental health. I wrote in my journal:

I have a huge sense of unease about the whole subject of nurses and mental illness. I feel like I could open a can of worms and then not know what to do with them! On the one hand, what if I’m wrong, and it’s only me who has this feeling? But what if I’m right and don’t do anything about it? (Research journal, 2003)

I talked to colleagues and friends about the issue, and reassured myself that they believed there was a worthwhile research project to be done on the subject of nurses and mental illness. Some colleagues shared stories about their own experiences, either nursing other nurses or experiencing mental illness themselves. As I worked with undergraduate students in their mental health paper it also became clear that the problem was not confined to nurses who were already in the workforce. As a school we struggled with the realities of enrolling nursing students who have, or had previously experienced, mental illnesses. A colleague despaired one day:

What are we doing? We ask these students to tick a box [on their application forms] to tell us that they have mental health issues, and then we either sit back and wait for them to fail, or we support them so much that in the end when they pass the course they have no faith in themselves as nurses (Personal communication, Robyn Boladeras, 21 August 2003).

The pervasive nature of the connection between being a nurse and having a mental illness seemed to confront me on an almost daily basis. I developed a conviction that
this research needed to be done, and that I was well positioned to do it. In discussions with an advisor who later became my academic supervisor, I slowly began to unpick the seemingly enmeshed aspects of the questions that were haunting me.

The need for this research

My own experiences and anecdotal evidence from nurse colleagues arising from my discussions with them suggested that research in this area would be a valuable addition to nursing knowledge. Upon searching databases CINAHL, psycINFO, EBSCOhost and ProQuest, I discovered that there is no identifiable published research that directly addresses the question of nurses who have experienced a mental illness. However, personal accounts of mental illness written by nurses appear in the literature at times (Grant, 2006; Manchester, 2004; McNeil, 2006). These provide insight into the individual lives of those nurses, although no attempt is made to analyse or find meaning in the stories other than that which is offered by the authors. I am aware of two nurses who have recently completed research into this general area: Terry Joyce conducted a Foucauldian discourse analysis of the workplace experiences of nurses who have a mental illness (personal communication, T. Joyce, 30 June 2006), and Kim Foster took an autoethnographical approach to exploring the experiences of the adult children of parents with psychosis (personal communication, K. Foster, 29 June 2006). Neither of these researchers has published their findings at the time of writing.

Nurses and mental illness

In 2004 there were 34,660 registered nurses and midwives in clinical practice in New Zealand (New Zealand Health Information Service, 2004). Applying the prevalence statistics suggested by Oakley-Browne, Wells and Scott (2006), and assuming that the nursing workforce statistics have not significantly altered since 2004 (which is the date of the latest statistical information
about the nursing workforce), 16,151 nurses may experience a mental disorder\textsuperscript{2} at some point in their lives, and 6,932 nurses may be experiencing a diagnosable mental disorder this year. However there is a body of literature that suggests nurses are over-represented in statistics for depression or other mental disorder. There are clearly researched links between job stress, workplace aggression and role conflict with psychiatric disorders in nurses, particularly regarding the impact such illnesses have on the healthcare organisation as a result of staffing turnover and sick leave (Andrea, Kant, Beurskens, Metsemakers, & van Schayck, 2003; Baba, Galperin, & Lituchy, 1999; J. Carson, Fagin, Brown, Leary, & Bartlett, 1997; Firth & Britton, 1989; Lam, 2002; Lam, Ross, Cass, Quine, & Lazarus, 1999; Montgomery & Haynes, 2001; Muscroft & Hicks, 1998; Weinberg & Creed, 2000; Yang, Pan, & Yang, 2004). In many of these research reports, mental illness is referred to casually as a by-product of nursing job stress, without any attention being paid to what that actually means for the nurses who are affected in their personal and professional lives.

\textit{Mental illness, clinical practice and impairment}

I was unable to find any research-based literature about the effects of mental illness on nursing practice other than that which focused on impairment, and even then the researchers conflated mental illness with substance misuse (Blair, 2002; Swenson & Foster, 1993). The focus throughout such research is on the actions of nurses who misuse substances, with only minimal mention of nurses who have a mental illness. Swenson and Foster (1993) record in their findings significant discrimination by employers against those with a mental illness, with mental illness causing more limitations on practice, dismissals or non-employment than either substance misuse or physically impaired nurses. They do not comment on this discrimination in their discussion, however, or draw any conclusions about its impact.

\textsuperscript{2} I have differentiated between the terms ‘mental disorder’ and ‘mental illness’ according to their use in the literature. A discussion of the way the terms are applied in this thesis is found on page 13.
In New Zealand, issues of impaired practice are ruled by law, the Health Practitioners Competency Assurance Act (New Zealand Government, 2003), and administered by the Nursing Council of New Zealand (Nursing Council), the statutory authority that governs the practice of nurses through the establishment and monitoring of standards to safeguard the public and the nursing profession (Nursing Council of New Zealand, 2004). Anyone may report impaired practice to the Nursing Council, and employers are required to report any nurse who has been dismissed or resigned as a result of practising below the required standards of competence (Nursing Council of New Zealand, 2006b).

The standards for practice are partially enforced by the requirement for all registered nurses to hold a current competency based practising certificate (Nursing Council of New Zealand, 2005). Of particular interest for the nurses in this study is Question 10 of the application for a practising certificate, which reads “do you have a mental or physical condition that means that you are unable to perform the functions required for the practice of nursing?” (Nursing Council of New Zealand, 2006a, p.2). An affirmative answer to this question requires the applicant to write an explanation to the Registrar; there is no information on the application form or in the accompanying notes that indicates what happens after the letter is received.

Once impairment is suspected or established, the Nursing Council of New Zealand Health Committee undertakes a monitoring process and recommends appropriate action (Nursing Council of New Zealand, 2006b). During the year January 2006 – December 2006, 20 nurses were notified to the Nursing Council under Section 45 of the Health Practitioners Competence Assurance Act 2003 as being suspected of having a mental illness, resulting in four nurses having conditions attached to their practice. Three of the nurses have had no further action taken, four are unwell so no action will be taken until they are well, seven are awaiting a meeting with the Health Committee and two are not practising nurses (personal communication, Marion Clark, Registrar for NCNZ, 22 February 2007).
The disparity in the likely number of nurses experiencing a mental illness and the number who were investigated raises many questions about what is happening for nurses. One explanation is that few nurses are experiencing impairment as a result of mental illness, or nurses may be being managed and supported to maintain safe levels of practice despite some impairment. Alternatively, significant impairment may be under-reported as a result of the hidden nature of mental illness, the lack of involvement in each other’s lives, the tendency of nurses to protect each other, the perception of the Nursing Council as punitive and the fear of ‘losing one’s badge’ (the colloquialism for being removed from the register of nurses for disciplinary reasons), the reporting process, the way in which nurses interpret impairment, and the overall mental health of nurses. These questions are not the focus of this research, although some answers are suggested throughout my interpretation of the nurses’ stories. Future research aimed at uncovering the extent and practical management of mental illness in nurses would provide valuable information for the profession and for the Nursing Council.

**Disclosing a mental illness**

The process of deciding whether to disclose a mental illness is complex, and is often located within the experience or expectation of stigma and discrimination and the anticipated response of the profession to a perception of impaired practice (Blair, 2002; Corrigan, 2005; Darbro, 2005; Johnstone, 2001; LaFrance, 2007; Vickers, 2000). Margaret Vickers (2003) notes that deciding how to handle information about an illness can be “breathtakingly difficult” (p.90) for the ill person who is choosing whether to display, disclose, tell, or lie. In a study of people with chronic, unseen illnesses, she found that the decision about whether to disclose a mental illness to colleagues and managers is complicated not only by stigma and discrimination, but also by an uncertainty about what help is available and how to access it, and/or the potential for being or feeling rejected and marginalised when anticipated help is not forthcoming.
Nonetheless, the negative experiences of disclosing a mental illness are not universal. Some literature records people, including nurses, finding acceptance and reassurance from disclosing their illness, along with the relief of being authentic with others; a position that is clearly present for Kathy and Susie (Leibrich, 1999) and for many others (Grant, 2006; Jago, 2002; Lapsley, Nikora, & Black, 2002; Ralph, 2002; Vickers, 2000). The ramifications, both positive and negative, of disclosing mental illness in the workplace are discussed further as the thesis progresses.

**The aim of the research**

This research addresses the lack of attention previously given to the impact of mental illness on nurses, focusing entirely on the experiences of nurses who have had mental illness and exploring the relationship between being a nurse, doing nursing work, and having a mental illness. Finally, this research extrapolates strategies that the nursing profession might employ in order to prevent or reduce the distress of nurses experiencing mental illness as a result of phenomena related to their chosen career.

**Defining mental illness**

Mental illness is a term that appears to be well understood and is in common use in New Zealand. During the recruitment phase of the research I invited responses from ‘nurses with a mental illness,’ but I did not prescribe how the nurses identified that they had a mental illness. In particular, I did not require psychiatric diagnosis as a prerequisite for participation. While I did not locate mental illness completely according to the psychiatric discourse, nor did I dismiss the right of the nurses to locate their experiences therein. The experiences the nurses write of are not limited to diagnosed psychiatric disorder, or to receiving psychiatric care, although some participants chose to acknowledge a diagnosis and/or are under the care of a psychiatrist. My choice of terminology located ‘mental illness’ as denoting a contextual view of mental distress (Barker et al., 1998) that was defined by the nurses.
The psychiatric discourse is pervasive, and is the subject of considerable interpretation as the thesis progresses. While not pre-empting that discussion, it is timely to note that there is an apparent understanding that psychiatry is beyond criticism and therefore “if we are not actively pro-psychiatry then we must, perforce, be anti-psychiatry” (Barker & Buchanan-Barker, 2006, p.621). This research adopts neither of those positions. Mental illness is positioned here as being able to draw on both pro- and anti-psychiatry definitions, and those which are defined as being neither of these, for example people who locate themselves by an emancipatory frame and decline to be defined by their proximity or resistance to the psychiatric discourse. ‘Mental disorder’ is a term which is seen primarily in the psychiatric literature, and is utilised herein only when discussing literature that specifically employs the term.

* * *

Regrettably I required, in the recruitment letter, that the nurse should have accessed treatment as a result of their mental illness. I defined ‘treatment’ as any assistance received by the nurse, including medication, talking therapies, natural therapies or spiritual therapies. At the time of planning the research, I felt that it was necessary to ensure that the nurses’ mental illness was not of such insignificance that it would resolve itself without external assistance. In retrospect, this qualification acted to locate the nurses within the medical discourse. I was surprised and dismayed to discover that I had imposed this upon the nurses. If I were designing the research today, I would not add that proviso to the recruitment letter, but would recognise and trust the nurses’ self identification as the most important defining act in the research. All of the 18 nurses in the study, as well as those who withdrew, had accessed treatment as I defined it. I do not know how many nurses my condition of treatment may have excluded, or how their stories would have changed the course of the research.

* * *

3 See the recruitment letter in Appendix Two.
This non-definitive position is supported by research that has explored the experiences of women who have been depressed, which found that the women could draw on biomedical understandings to explain their distress and manage stigma associated with it, while also acknowledging that they needed to look to alternative ways of knowing to find meaning and hope (LaFrance, 2007; Schreiber & Hartrick, 2002)

**What’s in a name?**


* * *

Language in relation to mental illness is contradictory and confusing. The first National Nutters’ conference has just been held in New Zealand (Like Minds Like Mine Project, 2007b), with organisers claiming the right to determine the language that attempts to define them. Kathryn Church (1995) sets out a matrix of the terminology of mental illness that was in use in Canada at the time of her research, noting that ‘patient’ and ‘illness’ are rooted in pathology, ‘client’ in rehabilitation, while ‘consumer’ or ‘survivor’ emerge from self-help arenas. The political landscape in New Zealand has altered in the last 12 years, necessitating a change in the language to describe it. My suggested formulation looks like this:
Phil Barker and Poppy Buchanan-Barker (2004; 2005) locate their writing and teaching within an emancipatory frame, declining to engage in illness discourses, referring instead to a ‘person’ who is distressed. I have chosen to use ‘Tangata Whaiora’ in this thesis on the occasions when the nurses discuss issues that relate to their illness and recovery in addition to its use as the title of the second motif.

Where they are not discussing illness, my language has been focused on the ‘nursing’ identity as one that is prized by the nurses and is located outside of the language of illness and impairment. That decision is one that I have revisited frequently throughout the writing process.

* * *

Has my language located and locked the nurses into being singularly defined as a nurse? Why did I do that? What will happen if I change language now, partway through the research? None of the nurses commented on it when they read the motifs . . . maybe they didn’t notice, or maybe they were just being nice? What hidden paths have I followed, unknowing? So I wonder. About
whether I have marginalised people like Helen, Ellie, and Jenny, who have all left nursing

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* * *

I am unable to resolve this issue to my satisfaction because of the individuality of each of the people who have participated in the research. To honour the context of one is to disregard it for others. For convenience and ease of reading, and because the research called for ‘nurses’ stories’ I will retain the term ‘nurse’ when I refer to all the research participants. Similarly, I resort to abbreviating ‘his or hers’ to a generic feminine, with apologies to Morrie (the only man who has shared his story here) and to men who read my work. Sometimes, although I have the best of intentions, I have chosen to write in the most expedient and comfortable way.

Crafting the thesis

In their critical reading of key postmodern theorists, Steven Best and Douglas Kellner summarise postmodernism as rejecting the single truth asserted through metanarratives and “assumptions of social coherence and notions of causality in favour of multiplicity, plurality, fragmentation, and indeterminacy” (1991, p.4). Autoethnographical research, which is grounded in postmodernism, therefore does not expect coherence or agreement among the nurses, nor a neatly plausible conclusion. It locates the entire research project, including the nurses’ and my stories, as partial, time and context dependent depictions of experience. This is also reflected through the process of a locally situated ‘interpretation’ of the data, rather than a more overarching ‘analysis’ (Denzin & Lincoln, 2005). The way the research is located presents challenges, as writing an academic text is usually chronological and linear in form, and maintains an omniscient “God’s eye view” researcher voice (S. Harding, 1993, p49) as its means of conveying knowledge. This approach is problematized in autoethnographical research, provoking a crisis of re-presentation.
The postmodern crisis of re-presentation

Donna Haraway (1989) evokes the image of rigor-mortis as she likens the work of the taxidermist to the act of scientific inquiry. She notes that both act to freeze a moment in time and re-create it as a fact and that by recognising the power of the act, it is possible to see the irony in freezing the moment of death and re-creating it as life. Similarly, Chow (1999, p.41) refers to research as a process whereby “links to the pungency of life are broken and life is squeezed out from our research findings.” Haraway and Chow contest the relevance of research that captures a moment in time and represents it as overarching truth. The term ‘represent’ is thus problematized. Rather than viewing it as a legitimate expression of a single truth, it is instead re-framed as ‘re-present’, an explicit acknowledgement that someone’s truth has been re-presented, possibly re-framed and certainly re-interpreted, and an implicit acknowledgement that truth is momentary, multi-voiced, fractal and contradictory. Presenting multiple, partial, sometimes contradictory voices in a written text is a dilemma that is commonly referred to by qualitative researchers as the ‘crisis of re-presentation’ (Arvay, 1998; Behar, 1996; Camden Pratt, 2002; Church, 1995; Clements, 1999; Ellis, 2004; Lincoln, 1997; Lincoln & Guba, 2000; Picart, 2002; Ronai, 1992; Tierney, 1997, 1999, 2002).

The crisis of re-presentation in this research is not grounded in the scientific/bad, autoethnographic/good discourse. Rather, it reflects my search for the most effective way to portray the nurses’ stories and the findings from my own critical interpretation to a relevant audience. As Ellis and Bochner (2000p, 748) note, the goal of autoethnographical research has moved “from description to communication,” signifying the purposeful involvement of the audience in the research text. A linear text that tidily presents and answers questions limits opportunities for audience engagement. The involvement of the audience opens up a potential conversation about and through the research and thereby necessitates an accompanying move in the way such research is re-presented.
In addressing the crisis of re-presentation for this research, I have identified several ‘voices’ through which the research is presented, reflected upon, emotionally experienced, critically interpreted and contextually located (Camden Pratt, 2002; Church, 2002; Ronai, 1992, 1996; Tillmann-Healy, 1996). Such voices include those of the eighteen nurses who are the research participants and my nursing colleagues. They also include my varied self(s) as the researcher, academic teacher, nurse, colleague, woman, and student.

Specifically, the voices present in this thesis include firstly, the unedited, autoethnographical stories and artwork of the nurses and excerpts at the beginning of each chapter. The positioning of these stories throughout the thesis aims to disrupt the tidiness of academic writing with their emotion and expectation of attention. Further disrupting the continuity of the thesis, these stories and excerpts are presented in a different font, with the right margins unjustified to signal the unpredictability and lack of uniformity of the lived life. The nurses’ voices are also heard, although through my researcher filter, as quotes throughout the thesis.

As the researcher I am an integral part of the research process, which assumes that there are multiple truths and that the findings from research are dependent upon the lenses through which the researcher views the data. Thus, my story forms an important part of the research as it provides elucidation of the lenses applied. This overt presence requires that the thesis is written from the position of ‘I’ (Behar, 1994; Church, 1995, 1997), so my primary academic voice is heard in the first person as I present and discuss my research project, critically interpret the organisational and cultural context of nurses who have experienced a mental illness, and reflexively construct an understanding of why nurses become ill. This is the voice that I have used in most of the thesis. It serves to locate the research as an individual endeavour and the conclusions as time and context bound.
My disengaged, passive voice is perceptible during the third phase of interpretation,\(^4\) when the extant literature is critically examined, and is used to maintain consistency with the material being reviewed. Excerpts from my research journal and reflections that occur as I write allow culturally situated glimpses of me in my identities as woman, student and mental health nurse. These additional perspectives sometimes contradict the rational critical voice. They appear throughout the text in italics, framed by asterisks.

In addition to the three researcher voices, I have also included my intuitive, creative and intimately involved voice in the vignettes and poetry that capture facets of the nurses’ stories and my interpretations that are difficult to portray in any other way\(^5\). Their purpose is to deepen my interpretation through metaphor, emotional evocation and resonance with the audience.

Finally, I have offered my story of mental distress, although this has contextualised my researcher identity and the research as a whole rather than contributing to the data that informs the research findings. This decision is contestable from within some autoethnographic approaches as I could be perceived to be withholding my presence (Bochner & Ellis, 1992) or could even be appropriating the methodology for use outside its parameters. However, the choice of an autoethnographical approach is grounded in the knowledge that I am a full member of the researched group and I am visible in the research (Ellis & Bochner, 2006)\(^6\).

In addition to containing multiple voices, this research includes the political intention of creating change across a range of settings\(^7\) and in doing so it aims to address multiple audiences, for example nurse colleagues, organisational and service level managers, and academics. Writing and performing/presenting different texts for different audiences is a solution that constitutes a plan for research dissemination and post-doctoral work. Another, more immediate, solution is to

\(^{4}\) The phases of interpretation are described on pages 74-86.
\(^{5}\) The use of fiction as a tool for analysis is discussed in Chapter Three
\(^{6}\) My relationship with the research and the nurses is discussed further on page 46.
\(^{7}\) This is a feature of autoethnographical research, and is discussed further on page 34.
present the range of voices within this single text by positioning each voice in such a way that they present a layered stream of thought.

**Structuring the text: a layered account**

In attending to my crisis of re-presentation in this thesis, I have constructed a layered account that is guided by Carol Rambo Ronai (1992) and Catherine Camden Pratt (2002). Carol Rambo Ronai (1992) layers her research account of being an erotic dancer to fund her way through graduate school. She writes from a position of ‘I’ and in the present tense when she describes her dancing and her academic role, but adopts the passive voice for theoretical discussion. She uses three asterisks:

*    *    *

... to denote “a shift to a different temporal/spatial/attitudinal realm” (Ronai, 1992, p.102). Her juxtaposition of three voices throughout her text creates the effect of three layers of knowledge – the dancer, the graduate student who is critically observing the dancer and is reflecting on the research and writing processes, and the academic who searches for and critically applies theoretical constructs.

Similarly, Catherine Camden Pratt (2002) layers her text as she reports her research into being the daughter of a mentally ill mother. Using different fonts, she writes of her childhood recollections, the focus group discussions and collages of research participants (of which she is one), her reflections and paintings as an academic, and the theoretical positioning of her research.

The aim of such layering is to expand the types of knowledge conveyed by research, so that rather than presenting a tidy, linear explanation of the topic, new and messy spaces are opened out for examination. These spaces invite the audience to construct their own interpretation of the writer’s text (Ronai, 1995). A layered account also provides a mechanism for deepening my
interpretation within the text, as the juxtaposition of voices illuminates contradictions, similarities and knowledge gaps (Richardson, 1994, 1997)\(^8\). Criticism of such techniques tends to focus on their self-referential nature and the lack of consistency of results due to the intensely personal nature of the interpretation (L. Anderson, 2006; Bochner & Ellis, 1992; Coffey, 1999; Delamont, 1997; Ellis & Bochner, 2000; K. Foster et al., 2006; Sparkes, 2000). Ensuring methodological quality\(^9\) is a universal requirement for researchers, and autoethnography is no exception to this. It does, however, challenge the dominant scientific discourse in that it refuses to privilege a single voice. Layered accounts value all types of knowledge and offer the audience the opportunity to hear multiple voices and to construct explanations of the research topic according to their own context.

I have layered this text by adopting the three asterisks to frame changes in voice. I have also used different fonts to illustrate different voices. This font, Times New Roman, justified, occupies most of the thesis as both the engaged and disengaged academic voices. *Times New Roman Italicised, unjustified*, denotes my reflective voice, *Arial Italicised, unjustified* denotes the nurses’ and my stories, and *Comic Sans MS, unjustified* is used for vignettes and poetry.

A final note about the way the thesis is structured relates to the absence of an early literature review. I have adopted the grounded theory approach to literature, meaning that I did not anticipate the content of the nurses’ stories but waited until the data were collected and could guide me to the relevant texts (Glaser & Strauss, 1967). The data collection process is described in Chapter Three, but it is timely to acknowledge that I wanted to be as free from preconceptions as is possible when I first met the nurse participants. The literature was critically reviewed as a part of the interpretation process of the research, and is therefore presented from Chapter Four onwards.

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\(^8\) Interpretation is discussed on page 84.

\(^9\) The qualities of good research are discussed on page 86.
Choosing a name: Aroha Mai

The thesis is named ‘Aroha Mai’, which is a term that literally means ‘love me’ and ‘sympathise with me’ (Ryan, 1989; Williams, 1992). There are deeper meanings to the phrase than those found in dictionaries, though. It also means ‘care for me.’ When the word ‘aroha’ is broken down, ‘aro’ means to be present and ‘ha’ is the word for breath, so further meanings for Aroha Mai are ‘be with me’ and ‘breathe with me.’ Aroha mai is used in contemporary Māori conversation as a term for ‘forgive me.’ These meanings are all intended in my naming of this thesis. The nurses who have shared their stories have done so with the stated intention of concern for future nurses, requests for understanding and compassion from other nurses and, for some of the nurses, a plea for forgiveness for ‘letting the side down’ by leaving nursing. These meanings are embodied in the research process as I have adopted an intimate methodology, autoethnography, which allowed me to ‘breathe with’ the nurses.

Thesis structure

Chapter One: Introduction – Introduces the research, its origins and the need for the research. At this early point I have foreshadowed some of the theoretical and methodological issues that are important for an informed reading of the thesis. These include postmodernism and the crisis of re-presentation. The crafting and naming of the thesis are also explained.

Chapter Two: Theoretical Map – A synthesis of the theoretical positions that inform and underpin the research. I have described this discussion as a theoretical map because the theoretical positions establish the framework of the research territory through which the thesis moves.

Chapter Three: Autoethnography as Method – Details of the autoethnographical research project are described and discussed. These include phases of research such as the nursing sample, negotiated stories as data collection, ethical issues, the factors that constitute good research, and
interpretive practises. The group of nurse participants is introduced and the makeup of the group is discussed against the backdrop of nursing demographics in New Zealand.

Chapter Four: The Nursing Motif and Chapter Five: The Tangata Whaiora Motif – Nursing and Tangata Whaiora are two ways in which the nurses described their identities throughout their stories, one as a nurse who has experienced a mental illness and the other as a person who has experienced a mental illness and is a nurse. These two motifs are evocatively designed, using images from one of the nurse participants, my own poetry or prose, as well as the nurses’ words to illuminate and illustrate the multifaceted power of the stories related by the nurses. They reflect the events each nurse chose to include, the emotion that is both contained within the stories and engendered through the stories, and the ‘mess’ that situates the stories in everyday life. The content of each motif leads into a critical review of the directly relevant literature.

Chapter Six: Hyphenated Lives – The motifs of Nursing and Tangata Whaiora and their attendant literature are drawn together in an interpretation of the complexity that constitutes the nurses’ lives. This chapter includes the Bullying motif, which is interpreted from within the context of the nurses’ hyphenated lives.

Chapter Seven: Nurses Seeking Wellness – The research findings from working the nurse-tangata whaiora hyphen are examined in light of other research and recommendations for reducing or preventing nursing distress are formulated.

Chapter Eight: Starting Anew – The research findings are revisited and reformulated into a visual model that incorporates the key experiences, hyphens and recommendations of the research. Strengths and limitations of an autoethnographical project are discussed, and further research is proposed to move this research into new spheres.

The background to this research has been presented in this chapter, along with the challenges in re-presenting it textually. In the next chapter a map of the key theoretical positions in the research is presented.
Helen’s story

I started my nursing training 30 years ago, but I can’t say I ever really felt like a nurse. I was 19 years old, and looking around for the best place to train. I believed that medicine was important – the greatest and the best! I chose to go to a private hospital, thinking it would give me the best experience. That training school was amalgamated, with others, into a larger training school at the end of my first year. In hindsight, it was probably better that way, because in the private hospital my duties were mostly to do with waiting on the patients “would you like cream or milk with that?” I am proud that I achieved a good pass in my second year, because it was a huge change, going from offering tea or coffee to being in charge of the drug round as the senior student.

I realize now, looking back, that I had little sense of how to relate to patients in the role of being a nurse.

I started my registered nursing life in a small private hospital, and lasted 3 months until I left nursing. This was a pattern I kept up throughout my 20’s. I felt conflicted within the role of nurse. But it provided me with a job, so I kept going back to it. In 10 years of doing nursing work, I didn’t stay longer than 6 months in a nursing position.

The more I got into doing the work of nursing, the more I felt deceived and let down. My belief in medicine was shaken by the things I saw, and the way I was treated which left me feeling very hurt and isolated.

My first real realisation of how damaging the nursing hierarchy was to us was, as a third year student, when a nurse from my class bawled out a first year nurse for a minor transgression. When I asked my classmate about it she was self-righteous in saying that she had been treated that way, so it was her right to do the same to those ‘below her’.
I have a family and personal history of mental illness, although I didn’t seek any treatment for my depression until I was in my 30’s. Perhaps that is a part of my sensitive antennae! I certainly associate my time as a nurse with feeling hurt, disrespected, disregarded and isolated. I believe that being treated like that is a part of the nursing culture – the hierarchy creates a climate of mistreatment and abuse of power. The doctors treated us like maids, but the way the senior staff treated other nurses was just as hurtful. The worst of it is that the patients are actually at the bottom of the hierarchy, and we were expected to lie to them at times, about their diagnosis and prognosis. It was deeply disturbing to me. I remember one nursing position in particular, that sums up my feelings about the nursing culture. It was in a long term spinal unit in Australia in the mid 1970’s. We had to wear starched veils with absolutely no hair showing, no jewellery, no sign of any individuality, and worst of all; no-one was permitted to be called by their first name. The patients, who we cared for every day for months and months, still had to call us by “Sister . . .,” and the nurses had to maintain these standards constantly – even in the tearoom, which was on the same floor as the ward! The ward was in a high-rise building with windows that barely opened, so we and the patients had no birdsong, no fresh air, and no earth. I became very depressed, and I remember that in that time I barely smiled. It came to a head there when the nursing supervisor caught me breaking the rules and bawled me out in front of everyone. I resigned, but the Charge Nurse there actually asked me to stay. I didn’t stay, but I think that was the first time I had a sense of being desirable in the hospital situation. On the whole, I had no sense of support in nursing, experienced no praise, and felt isolated.

Overall, I never fitted in nursing – never felt that commitment that said I would work all night after my shift, work without pay, do anything for anyone, be humble – that’s just not me. In fact I started to refer to nurses as “floral nighties,” referring to the strong image of Florence Nightingale doing good work. That kind of commitment is expected of nurses, and I couldn’t
give it. I never took on the nursing identity. In 1990, I started training in an area of health that values my independence, and I am a healthy person again. I give of myself in my work, lots more than I could as a nurse – but I am valued as a knowledgeable individual. I like who I am now, and what I do. I would never consider going back to nursing at all.

Rachel’s story

I did my RGON training first, then did my psych training to bridge to Comprehensive. I have done a post grad paper since then. I started work in a general area, doing med surg and geriatrics. It was there that I first became unwell. This last time I was working with babies, and have now moved into working almost fulltime in primary care.

20 years ago, I had glandular fever and was very depressed on top of it. I had virtually no support, and was expected to get on with it at work. My GP told me it was all in my head. I did try to go back to working just part days, but without any kind of consultation, I was put onto full time in a very heavy geriatric ward, then I was put onto 6 weeks of night shift. I wasn’t sleeping, and was trying to function on about 2 hours of sleep a day, if I was lucky. The weight just dropped off me, and I became hypotensive. I just about fell apart then. I changed my GP and my new one sent a letter saying that I was clinically depressed and wasn’t to be on night shift. My nurse leader at that time asked me “how long will you be depressed?”

This last time I became depressed has been a real contrast – very special. I’ve had so much support it has just blown me away.

I had a death in the immediate family, which is what tipped me over, I think. I had already been having counselling because of some abuse that had happened in my childhood and was starting to churn around in my head. After the death, I went into denial, insisting that I was coping fine
– and I was in the beginning, but then I fell apart. To make matters worse, I have a long-standing back injury that was causing me excruciating pain almost every day at one point.

I tried really hard to stay out of hospital, and took huge amounts of prescribed medication to keep on living at home. I did overdose on them once, but not seriously – something stopped me at the last minute. But I remember sitting in the kitchen one day with a craft knife in my hand, contemplating suicide. I knew then that I had to be admitted. When the CAT team assessed me, I honestly couldn’t remember when I had last slept. I was also having awful nightmares when I did manage to sleep. There was no bed for me in the unit, so I went into respite. Then I started an acute day programme, which was just excellent. I stayed there for about 6 months. It’s so easy to isolate when you feel awful. I live alone, and just didn’t want to get up. If it wasn’t for my cat demanding to be fed, I wouldn’t have done anything.

My manager has been incredibly supportive. She reassured me straight away that I would be “rehabbed” back into work, and that I could work part time. I also had support from my friends and church. Not so much from my family – they either have their own problems or they don’t want to face it. Having the spiritual support has meant that I am looking at my life from the whole aspect, which has been powerful in my recovery.

One of the first things I had to sort out after I became unwell is that it is OK not to be well. Then, that it is OK to ask for help. There is, I think, a feeling that “nurses shouldn’t” get unwell and need help. It’s not as obvious as it used to be, but there is still that stigma about mental illness. Accepting that depression is just as much an illness as anything else has been important. If I have to be on meds for the rest of my life, then so be it. It took me quite a while to think “Heck I’ve been very ill.” Part of my journey was trying to work out who I am, and giving up on trying to be the perfect person. In the past, nothing I did was 100% in my mind, and I ended up beating
myself up over it. Now I take one day at a time, and I’m much easier on myself. I know that I
don’t have to be clever at everything!

My psych worker and I worked out a care plan that gives details of my early warning signs and
triggers, with a time frame and what I can do at each stage. I’ve given copies to some of my
closest friends so they can help me. It’s been disconcerting, though, knowing that people were
keeping an eye on me! But a friend pointed out to me that I am allowed to have bad days, that
everyone has “blips!” One blip was that my wonderful counsellor died quite unexpectedly, and I
had to find a new source of support. When I did, though, I realised what a huge amount of work
I’d done and that I didn’t need to see anyone every week any more. I haven’t been back since
then, but I know that she is there if I need to talk to someone. Doing all that work, especially in a
short time frame, has left me feeling quite tired, but it is a good kind of tired.

My nurse manager worked out a plan with me to rehab back to work. I was off for at least 6
weeks, so it was important that I didn’t have to work a full shift at first. I talked to her before I
went back, and she suggested that I aim for 4 hour shifts to start with. She initiated this, and I
have to say that I have felt really valued through this process. The support I have received from
my workplace has given me a vital hand up throughout my recovery.

I know that this isn’t over – it never is. But, and I know it sounds corny, on the day I was
discharged I truly felt that this was the first day of the rest of my life. A friend commented a
while ago that I was “just like my old self,” but I’m not. I’m entirely new. I have also changed
my GP to a fantastic one, which is one of the best things I could have done.

I have changed jobs, now, to one in primary health. I wouldn’t have done that if my old
employers could have increased my hours to what I needed, financially. But ACC had, in their
wisdom, cut my entitlement and I needed the money. I haven’t specifically told my new
employers about the depression, but if it comes up I know I’ll be comfortable talking to them about it. I don’t have any worries about the Nursing Council declaration, either.

On the whole, I believe that things are slowly improving for nurses with mental illness, although it does depend on the DHB you are in, and your manager. There are people out there who understand, even though it can be hard to find them. I want nurses to know that there is a way out. We’re no less worthy just because we struggle with this sort of illness. For those who might read this who are Christian, this is a valid illness. We are OK. I have to believe that Christ knows how we feel. It is not a sign of weakness to go down this path. It is not a sign of weakness to need psych meds, even though you might need them for the rest of your life.
Chapter Two: Theoretical map

I started to refer to nurses as “floral nighties,” referring to the strong image of Florence Nightingale doing good work. That kind of commitment is expected of nurses, and I couldn’t give it. I never took on the nursing identity

Helen

This chapter presents a theoretical map which establishes the framework of the research territory through which the thesis moves. It is a synthesis of the theoretical positions that inform and underpin the research. These include the overall framework of the theory of autoethnography and its utilisation of storytelling as data and as a tool for interpretation and presentation of findings (Ellis, 1997, 2004; Ellis & Bochner, 1996), the use of Jean-François Lyotard’s work on regimes of phrases and genres (1984; 1988) to interpret the content and context of the nurses’ stories and the extant literature, and Michelle Fine’s (1994) identification of the hyphen as a means of negotiating the relationships within the research and also interpreting the relationships involved in being a nurse who has a mental illness.

Valuing and centring the stories of the nurses was a key imperative in this research. My cultural heritage of orality and (de)colonisation, combined with my professional values based on the recovery approach has intersected smoothly with this highly personal, sensitive research topic. I was particularly concerned that my impact as researcher upon the process and the participants
should be explicit, rendering the research transparent, yet would not take over the research focus (Oakley, 1981). Thus, the autoethnographical methodology has been appropriate from the inception of this project. The application of method has, however, been a process of exploring the inherent ways in which the nurses’ stories would be re-presented and interpreted within a given research approach.

**Theoretical beginnings and flipping the research**

Jean Chow (1999) asserts that methodological choices are often filters which predetermine what data are deemed acceptable for a particular research project. There are times, however, when research participants disrupt the methodology by disregarding the plan and presenting data that are disruptive, so the research “flips” (Chow, 1999, p.39) and becomes driven by life rather than theory. Kathryn Church noted this process in her work with psychiatric survivors in Canada, writing that her “research acquired theory” (Church, 1995, p.2) as the importance of her data challenged her to review an initial methodology that was based in her early assumptions. In her final report, she held that her theoretical position emerged as a result of the direction of her research rather than the research being contained and constrained by a theoretical position.

During the proposal phase of the research I considered several approaches that would be effective in achieving an answer to my research question. Traditional approaches to nursing research such as grounded theory (Glaser & Strauss, 1967) and phenomenology (Crotty, 1998; Polit, Beck, & Hungler, 2001) were initially appealing because of their emphasis on finding meaning from the lived experience of the participants. Both these approaches were considered for this study and discarded because their positioning of the researcher as expert and the reduction of whole stories into codes and themes were ill-fitting for this project. Additionally, neither grounded theory nor phenomenology provided the mechanism for moving the research from a recording and analysis of the ‘victim’ experiences of mental illness into strategies for reducing the impact of mental illness upon nurses.
Discourse analysis (Cheek, 2000; Foucault, 1973; Gordon, 1980; L. Phillips & Jorgensen, 2002; Powers, 2001; Wetherell, Taylor, & Yates, 2001) became my methodology of choice going into the research because of its emphasis on power relations, multiple realities and the importance of recognising contextual issues, including the positioning of the researcher. Once the nurses began to respond to my request for participants, however, and the research had moved from a theoretical proposal to a practical reality, my approach to the stories shifted from a position of viewing them from a distance as raw data to recognising and empathising with the embodied emotion presented through the stories. I wanted my analysis to move to a more inclusive interpretation of these features. It became clear that although discourse analysis still had advantages, it would involve a level of researcher distance that acted to remove the unique constituents from the nurses’ stories through the foci of analysing language and the application of power (Powers, 2001; Wetherell et al., 2001).

With hindsight, I could see that the data collection process, negotiated narratives (discussed in Chapter Three), would inevitably result in tension between the research plan/proposal of discourse analysis and the substance of the nurses’ stories. The disruption occurred in this research when the nurses articulated or intimated their distress\footnote{This issue is discussed in the ethics section on page 88.} in ways that centred it over and above the concrete events they described. Additionally, they did not question that their stories would be presented, through me, to the benefit of other nurses. This belief instilled in me a sense of responsibility to share this research as widely as possible, and to do so in such a way that the nurses would recognise that their revisiting of painful experiences as they wrote their stories was worthwhile. At that point, the research seemed to be “drifting away” (Noy, 2003, p.4) from the original proposal, opening a gap between the theoretical beginnings of the project and its practical application. In staying with the proposed discourse analysis approach I risked losing the wholeness and intimacy of the research, although it offered the safety and certainty of a well
known methodology in an academic climate. Jean Chow (1999) refers to the gap between theory and application as a border. By resisting the border, I was challenged to discover the limits to which I could take this research. In recognising the potential of flipping the plan and choosing substance driven research, I chose to conduct research that is “dominant, alive, rich, image filled . . . that . . . [I am] . . . deeply and personally engaged in” (Chow, p. 43); requirements that are met with an autoethnographical approach.

The nurses demanded that the result of the research should be to create change for nurses who, in the future, would be vulnerable to mental illness. They also required that the research, whether through this thesis or through the associated articles and presentations, should reach and influence an audience of other nurses including colleagues, managers and nurse leaders. The nurses’ desire for change defined the purpose of the research and flipped the research from a theoretical discourse analysis to a substantive and evocative autoethnographical approach.

**Autoethnography**

Autoethnography was first used as a research term in 1979 within the context of a study of culture by researchers who had insider status with the group being studied and therefore wrote from a position of personal knowledge (Hayano, 1979). While accepting that meaning is derived from social constructions, traditional research in the human sciences nevertheless draws on the scientific method of looking outward, at others, in order to understand them (Adler & Adler, 1987; Bochner & Ellis, 1992; Few, Stephens, & Rouse-Arnett, 2003; Gaitan, 2000; Neumann, 1996; Sampson, 1978). This position of ‘othering’ has been challenged, particularly by writers and researchers from within postmodernism and feminism (Chinn, 1994; B. Davies, 1992; Fine, 1994; Fine, Weis, Weseen, & Wong, 2000; Haraway, 1981, 1988, 1989; hooks, 1984; Lather, 1991; Lincoln, 1997; Lincoln & Guba, 2000; Tierney, 1999). More recently, challenges to ‘othering’ have emerged from marginalised populations such as the indigenous (J. Anderson, 2002b; Behar, 1996, 2003; R. Bishop, 1996, 2005; Brown, 1991; Donnelly, 2002; Glover, 2002;
L. T. Smith, 1998, 2005b) and the stigmatised or silenced (Dent, 2002; Ellis, 1995; Ellis, Kiesinger, & Tillmann-Healy, 1997; Frank, 1994b, 1998, 2002a; Tillmann-Healy, 2002; Vickers, 2000, 2003). The results of these challenges can be seen in the growing literature from researchers who are employing methodologies such as autoethnography that aim to reduce the gap between the researcher and the researched (Camden Pratt, 2002; Church, 1995; Ellis, 1995; Ellis & Bochner, 1992; K. Foster, 2006; Kiesinger, 2002; Ronai, 1992, 1995; C. Smith, 2005a; St. Pierre, 1997; Tierney, 2000; C. Watson, 2006). Ruth Behar (1996) conceptualises the researcher-researched gap as “an intermediate space we can’t quite define yet, a borderland between passion and intellect, analysis and subjectivity, ethnography and autobiography, art and life” (p. 174).

Autoethnography is grounded in social constructionism and draws on the well established literary traditions of feminism, postmodernism, postcolonialism and indigenous knowledge. It differs from these approaches, though, in its goal of transforming action through evocation. “Autoethnography wants the reader to care, to feel, to empathize and to do something, to act. It needs the researcher to be vulnerable and intimate” (Ellis & Bochner, 2006, p.433).

Examples of autoethnographical research are found in the literature that addresses areas such as mental health and mental illness (Camden Pratt, 2002; Church, 1995; Ellis et al., 1997; K. Foster, 2006; K. Foster et al., 2005, 2006; Ronai, 1995; Tillmann-Healy, 1996), physical illness (Ellingson, 1998; Frank, 1998; C. Smith, 2005a; Sparkes, 2000; Vickers, 2000, 2003; S. White, 2003) and other transformational experiences that arise through life changing circumstances such as transgender surgery, abortion, sexual abuse, death of a loved one and ‘coming out’ (Berger, 2001; Dent, 2002; Ellis, 1997; Ellis & Bochner, 1992, 2000; Ellis et al., 1997; Gilbert, 2002; Kiesinger, 2002; Picart, 2002; Tillmann-Healy, 2002).

During the 28 years since its advent, the basic tenet of autoethnography has evolved into myriad terms and applications such as critical autobiography (Church, 1995), evocative autoethnography
(Ellis, 1997), personal narrative (Ellis & Bochner, 2000), reflexive ethnography (Ellis & Bochner, 1996), vulnerable anthropology (Behar, 1996), reflective topical autobiography (Johnstone, 1999), autobiology (Payne, 1996), complete-member research (Adler & Adler, 1987) and narratives of the self (Richardson, 1994).

The differences in the above approaches occur in the nuances of researcher focus, which could be more on the self (auto), the group being studied (ethno) or the research process itself (graphy). Although the terminology suggests that each type of research is clearly differentiated from the others, there is debate over the boundaries that separate each type – including whether there are such boundaries (Ellis & Bochner, 2000). Regardless of perceived differences, autoethnographical research universally shares certain features. These are:

- The visibility of a connection between the personal and the cultural, particularly through the portrayal of embodied emotion, through which the research moves from a position of personal knowledge to include the broader cultural context
- The display of multiple, partial layers of consciousness within the research text or performance
- Research reports which are written in the first person voice, reflexively include the researchers’ own experiences, and utilise story, poetry, fiction, performance, layered writing and journals to convey meaning and shared humanity
- Recognition that action, emotion and language reveal situated meaning, and the opening of a dialogue to debate and negotiate that meaning
- Research that recognises the audience as possible agents of personal and/or cultural change and aims to motivate the audience to examine their own lives in response to the research in order to bring about that change
- The blurring of boundaries that have traditionally separated researcher from researched and the research itself, research from literature, and the personal from the academic (Bochner & Ellis, 1992; Ellis, 1997, 2004; Ellis & Bochner, 2000, 1996; Holman Jones, 2005; Richardson, 1992, 1994; Ronai, 1992, 1995).
In conducting this research, I have adhered to the commonalities of autoethnography through my use of my own partially situated story about my experiences of mental illness as a starting point for the research, my involvement with the nurses as we negotiated their narratives, and through the layered presentation of the research to explicate an increasing depth of interpretation. Initially, I located myself as a person who has shared some of the experiences contributed by the nurses. Throughout the research I have drawn on critical, autobiographical and reflexive techniques, and vulnerable discussion to interpret the research findings in a layered account that includes poetry, prose, theoretical thinking, excerpts from the nurses’ stories and personal commentary. These techniques will be discussed further as the thesis progresses. For convenience I have maintained the overarching term *autoethnography* in discussions of methodology and method throughout the thesis.

**Stories of the soul**

Storytelling is at the heart of this research in several ways. Stories filter through all aspects of autoethnographic research as a starting point, as data, as a tool for interpretation and a method of dissemination (Ellis, 2004). Storying is a vital part of my Māori heritage, and nursing, too, is a culture of stories – handover stories, war stories, stories of affirmation, of teaching and of warning (A. Carson & Fairbairn, 2002; K. Foster et al., 2006; Koch, 1998; Nelson & Gordon, 2004; Walker, 1995). The validity of stories in research is also well established, partially through its use, partially its theorisation and partially by the legitimising act of contesting its value (Barker & Buchanan-Barker, 2004; B. Davies, 1992; Frank, 1994a, 1994b, 2000, 2002b; Gilbert, 2002; Tierney, 2000; Wiltshire, 1995; Zurbriggen, 2002). These authors refer to stories and narratives as similar entities, although some authors appear to privilege ‘narrative’ as more authoritative than ‘story’ (Lapsley et al., 2002; Mishler, 1986; Wiltshire, 1995). Throughout this thesis I have used the terms interchangeably, as representing the content and context of the lives and literature under discussion.
The stories the nurses told for this research are compelling. They are told from the heart and contain a great deal more than facts about being a nurse who has a mental illness. There are, indeed, facts and events in the stories. There are also emotions and information about beliefs, events and people who have shaped the nurses’ lives and given rise to these personal stories. These levels of story are discernible, yet there is more to be learned from them. As Clarissa Pinkola Estes recounts;

Ancient dissectionists spoke of the auditory nerve being divided into three or more pathways deep in the brain. They surmised that the ear was meant, therefore, to hear at three different levels. One pathway was said to hear the mundane conversations of the world. A second pathway apprehended learning and art. And the third pathway existed so the soul itself might hear guidance and gain knowledge while here on earth.

Listen then with soul-hearing now, for that is the mission of story (Estes, 1992, p22.).

Estes writes that she sheltered and protected the wisdom she encountered during her studies because “sometimes old father Academe, like Kronos, still has an inclination to eat the children before they can become either curative or astonishing” (Estes, 1992, p.21). In this situation, my own adherence to academic convention could swallow the stories and prevent their soul value from being heard. The easiest and most conventional option for positioning the stories would have been to either leave them out, re-presenting only my own interpretation/story of their stories herein. Or I could have tidied the stories away into an appendix. These options, it seemed to me, would have literally marginalised the nurses, and would have deprived you of the chance to listen with your soul-hearing.

Instead, the stories are placed throughout the thesis, in their entirety, in an unconventional, disruptive, but carefully considered action. They appear in physically intrusive positions in the document and also occupy the metaphorical centre space as the foundation around which the research is created. Their sheer volume challenges convention as they interrupt the structured flow of academic writing and defy the assumption that any other could know more about that of
which the nurses speak. Unlike the nurses in the physical world, the nurses in the written world of this thesis do not have to negotiate from a position at the margins, they occupy the centre of this world.

Stories in this research are not limited to data collected at the commencement of the research process. The nurses’ stories are more than data, and demand something more than intellectualised analysis in return. In soul-hearing these stories, my response is to tell stories in turn. My first story has already been told as the tale of how this research came to be. As the thesis progresses, however, more stories will be told. Each motif\(^\text{11}\) contains a vignette constructed from the merging of my soul-hearing, my insider knowledge and my researched knowledge. Later in the thesis, I tell anecdotes about the reactions nurses have had to my stories of this research when I have told them at conferences and in classrooms. A recent conference presentation consisted entirely of fictional stories, poems and excerpts from the nurses’ stories. Reactions to this from academic colleagues are related in Chapter Three. My embodied story of the research is related as the thesis draws to a close, and the final words come from a story I dreamed many years ago and which has only now found its home.

While the nurses’ stories form the data for this research, stories from other sources are implicated within those stories and also provide contextual information. It has been an important part of this research process to locate those other stories, whether they appear as metanarratives or local and partial truths. The variation in the kinds of stories demands that they be theorised in such a way that one is not legitimised over another, a position which is made possible by Jean-François Lyotard’s concept of regimes of phrases.

\(^{11}\) Motifs are an interpretive strategy and are explained fully in Chapter Three.
Lyotard’s ‘regimes of phrases’

Postmodernism has been highlighted several times in this chapter and Chapter One as being the distrust of a single metanarrative and notions of causality. In their place, postmodernism expects that truths are plural, partial, contradictory and indefinite (Best & Kellner, 1991; Haraway, 1989; Lather, 1991; Rosenau, 1992). This definition of postmodernism is widely accepted by nurses who undertake postmodern research, and is useful for illuminating alternative truths and raising questions about apparently hegemonic areas of knowledge (Barker et al., 1998; Cheek, 2000; Crowe, 1997, 2000; Crowe & Alavi, 1999; Freshwater, 2003; C. Stevenson, 1996, 2000, 2005a).

The research above analyses and questions powerful metanarratives and those who reside within them, such as psychiatry, psychiatrists and mental health nurses, medicine and medical reporters, and professional education and educators. This research differs from those above because the nurses’ stories are located in the minutiae of individual everyday life yet also intersect with metanarratives and the inarticulate realities of practical experience. As I worked with the stories I struggled with how to interpret, for example, the impact of the well documented psychiatric metanarrative on one nurse and the way another nurse describes disclosing her mental illness to her manager. These are significant differences in scale and articulation, particularly since the nurse writing about her experience of disclosure draws on the language of emotion and sensation to explain what she went through. Jean-François Lyotard’s work on postmodern theory has provided a useful way to manage this disparity.

* * *

Lyotard’s work is extensive and comprehensive. It is outside the scope and purpose of this thesis to engage fully with his ideas, so I have focused on two texts that are particularly relevant to this research: *The Postmodern Condition: A Report on Knowledge* (originally published 1979, translated 1984), and *The Differend: Phrases in Dispute* (originally published 1983, translated 1988). In these texts Lyotard develops an argument for the existence of narrative knowledge or
“regimes of phrases” (1988, p.39) as alternatives to the singular truth offered by the metanarrative.

Lyotard discusses metanarratives as being unquestioned, totalising, homogenous discourses that carry with them the power to prescribe legitimacy and consequently to delegitimise and marginalise other forms of knowledge (Lyotard, 1984, 1988; Malpas, 2002). He originates his argument for the existence of narrative knowledge on the belief that metanarratives such as science, economics and academic intellectualism do not represent the only truth, but exist along with other truths that are correspondingly legitimate. He contends that challenges to the legitimation of metanarratives occur when people who are confined and restrained by a metanarrative destabilise it from within by changing the way they speak. In arguing this, Lyotard turns to micropolitics and examines the way language is used at a local level.

In *The Postmodern Condition* (1984), Lyotard draws on Wittgenstein’s (1958) concept of language games to explain the way new knowledge is produced outside of the homogeneity of metanarratives. He notes that speech occurs according to rules which define what can be said, who can say it, and under what circumstances it can be spoken. These rules are the result of a contract between the players in a language game, so when one player speaks in a way that is not congruent with the rules of the game, then that speech does not belong to that specific game. Every instance of speech is a part of a language game. Thus, Lyotard’s first conception of language is that it is a contest or game between adversaries. His second conception is that language games constitute a social bond that locates the players within their social structure and therefore defines the kind of messages that will be sent and received by them. Players are located at the intersection of many language games of varying sizes and with different rules. They are not held immobile within their social bonds. Lyotard contends that players can be displaced from their social location when moves are made by adversaries, particularly when the move is made outside of an existing language game and thereby creates new knowledge.
When he wrote *The Differend: Phrases in Dispute* (1988) Lyotard shifted his concept of language games to a more micro level, employing instead the term “regimes of phrases” (p. 39). He contends that all communication consists of phrases, including silence, and adapts his language to assert that phrases are constituted according to their own regimen. In this way, he has deconstructed language games into smaller parts and has also identified that a further important function of language games is illuminated when one examines the way that phrases are linked together. Phrases are linked according to their purpose, such as finding agreement between the players, showing, describing, teaching or justifying. The purpose of linked phrases is found in the “genre of discourse” (1988, p.128). Lyotard contends that phrases occur according to the genre of discourse they are used within. Genres act according to what is at stake, and therefore exclude phrases that do not contribute to its final purpose.

The relationship between metanarratives and genres of discourse is not explicit in Lyotard’s texts. My interpretation is that Lyotard conceived genres in the assumption that life and language are heterogenous, and therefore homogenous metanarratives do not exist at the micro level. Genres nevertheless support the hegemonic location of local, heterogenous narratives by positioning some phrases in such a way that they are excluded or marginalised.

When phrases are linked within the same genre there are few issues of dissent. However the concept of linking phrases is particularly interesting when the phrases that are being linked have originated from different genres and therefore have different purposes at stake.

Where phrases belonging to different genres have collided in some way and need to be linked, there is frequently a sense of injustice. Lyotard uses the example of the gas chambers of the Second World War to illustrate an extreme case of this injustice. He asserts that although it is thought that such chambers existed for the purpose of killing certain people, there is no proof of it. The only way to prove the purpose of the gas chamber is to have someone who has been killed by it, provide evidence as to its purpose. This is a condition that cannot be fulfilled. He notes that
such conflict of purpose, with the search for justice at its core, results in a differend: “the
unstable state of language wherein something which must be able to be put into phrases cannot
yet be” (1988, p.13). Simon Malpas, in his analysis of Lyotard’s differend elaborates

The differend is a moment of silence, a stutter in the flow of language, where the
right words will not come. It marks a point of suffering where an injustice cannot
find a space to make itself heard, where an injury is silenced and becomes a
wrong. . . . A differend occurs when one language game imposes its rules and
values on another and prevents it from retaining its own, autonomous way of
speaking. All that remains is a feeling of injustice and wrong (Malpas, 2002,
p.61).

Lyotard’s articulation of the moment of silence that occurs at the collision of two or more genres
also circles back to his previous argument that even silence is a phrase, and he locates this
silence as “what one ordinarily calls a feeling” (1988, p.13). This conceptualisation of silence as
a feeling calls for the use of idiom to attempt to convey the existence and meaning of the silence
while new rules are formed that allow the differend to be put into phrases.

While asserting the local and plentiful nature of genres, Lyotard chose as his example of a
differend a socially extreme example. His example also implies the use of metanarratives as
powerful oppressors, creating the differend entirely through the imposition of power. This
difference in scale between his theorising and his example leaves the significance of the
differend open to interpretation. I have chosen to align the differend with Lyotard’s postmodern,
macro level and his assertion that such dissent is a frequent phenomenon. I have also located the
differend independently of metanarratives, so the issue of power is addressed at the micro level
and is bound by the genres at each differend.

* * *

In this research, Lyotard’s ideas about regimes of phrases and genres have enabled me to view
each story from its own context and therefore to move my interpretation beyond the
metanarratives within which nursing and mental illness are commonly defined. As discussed
above, there is a disparity of scale and also of legitimacy when the nurses’ stories conflict with
genres such as psychiatry. An example of this is evident in Jayne’s story, where she relates her struggle to assert her ability to undertake her nursing education in the presence of a diagnosis of schizophrenia. Her assertion that she was capable and safe was in conflict with the evidence surrounding the vulnerability and incapacity of people who have schizophrenia. When both positions are viewed in terms of the phrases they use and the genres that position them, it becomes possible to engage with each text at a local, micro level. This local level of engagement allows, in turn, the emergence of multiple, plural, partial and indeterminate forms of legitimate knowledge. The psychiatric view of schizophrenia may well be congruent with the experience of some people, but Jayne has her own truth which resides in the genre of phrases that has its purpose in ‘resisting’ the psychiatry genre. That Jayne identifies times when her illness does render her unsafe to work, exemplifies the partiality of her truth but does not negate it.

In addition to engaging with the genre of psychiatry, I also encounter that of intellectual mastery. Lyotard’s work is similarly useful in this context, as will be seen in the next chapter when I interpret the current context of nursing practice in New Zealand.

Although Lyotard makes mention of the importance of the social context of speakers and language, he does not develop this aspect of his argument into a social theory (Best & Kellner, 1991). Indeed, in his later work he recognises his move away from analysing and theorising “man” (Lyotard, 1988, p.viii) and asserts that “the time has come to philosophize” (ibid.). This presents a limitation in the usefulness of Lyotard’s texts for this research. My emphasis on the individual nurse within her social context requires a social theory to enhance my interpretation of what is occurring for the nurses in this study.

Furthermore, although the differend is a compelling way to explain the injustice and pain of having your reality oppressed, it relies on the polarity of the phrases and the inarticulate nature of the sufferer. It does not incorporate the negotiations and compromises that individuals undertake between the regimes of phrases, nor the ability of the contested person to manipulate the phrases
that define their experience. So while the differend represents the extremes of oppression, this research required a more social and even more local way to theorise the way the nurses managed their lives. This is found in Michelle Fine’s concept of the hyphen.

**Working the hyphen**

In 1994 Michelle Fine introduced the hyphen between self-other as a way for researchers to work the connection and separation between the research(er) and those it/she examines. I have noted above that the concept of ‘othering’ has been identified and contested by, for example, postmodernist, feminist and indigenous researchers as they assert the legitimacy of non-metanarrative truths. Fine asserts that the work of othering and interrupting othering occurs at the metaphorical space which is reflected by the use of a hyphen between the two words and all that they represent: researcher-researched/self-other. The hyphen is where boundaries are blurred, and is entered into by “working the hyphen” (Fine, 1994, p.70).

This research adopts Fine’s (1994) notion of the hyphen, and in the next section I examine the hyphen that both joins and separates me from the nurses in this study. The hyphen also offers an opportunity to explore the “hyphenated selves” within the life of one person as they negotiate dual or multiple identities emerging from race, gender, culture and socio-political identity (Sarin & Fine, 2007). These identities are often the result of overt social positioning related to, for example, skin colour, ethnicity, age, dress and immigration. In this research, the nurses are positioned and/or position themselves according to their career choice and their illness, so the hyphen is again a useful tool for examining the way they negotiate their socially influenced identities.

Drawing on Lyotard’s regimes of phrases (1988), it is possible to work the hyphen to a more local level than the social. In my interpretation of the nurses’ stories, I have worked the hyphen as a multiple and partial metaphor that links to the inner and outer worlds of the nurses and those who share their stories. The concept of regimes of phrases (hereafter referred to as ‘phrases’)

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encourages the examination of how phrases link to each other, which genre(s) own and direct the
phrases, how many there are, how they are negotiated and/or altered, and what happens for the
nurse when the links are so incompatible that they just don’t work and a differend results.

**The Self-Other hyphen**

This research ostensibly started with burning, persistent questions about my nursing practice as I
worked with distressed colleagues as clients and team members. Internally, I also acknowledged
a vulnerability and history of distress that made this research personally relevant, although I did
not initially admit this to myself. Thus, the self-other hyphen is a complex space, negotiated at
many levels. One of these levels is the extent to which I am a part of the research, another is
found in the conversations about ‘othering,’ and a third is in the relationship the nurses have with
the research and with me, exemplified through their stories and their ongoing engagement with
the process.

In contrast to more traditional research methodologies where the outsider, objective position is
privileged, self, or the ‘I’, is the starting place for autoethnographical research (Camden Pratt,
2002; Church, 1995; Ellis, 1997, 2004; K. Foster et al., 2005; C. Smith, 2005a; Sparkes, 2000; S.
White, 2003). This means that the research questions, the process of researching and how the
conclusions are reached are all closely linked with personal experience and knowledge. The use
of the ‘I’ is consistent with nursing practice in mental health and cultural safety, where it is
accepted wisdom that in order to connect with and understand the stories of clients it is necessary
to first understand the meaning and origin of one’s own stories (Barker, 1996, 2003; Church,
1997; Eckroth-Bucher, 2001; K. Foster et al., 2006; New Zealand Branch ANZCMHN, 2002;

The ideal of an unified and stable self is, however, contestable and undesirable from a
postmodern social constructionist view, within which the situatedness of knowledge and the
inevitability of change are celebrated (Barker, 1996, 2001b; Barker & Buchanan-Barker, 2005;
Denzin, 1992; Fine, 1994; Lincoln, 1997; Richardson, 1994). The insider-outsider location of a researcher is not a binary, whereby either one position or the other is adopted, but is a matter of degree of insider-ness or outsider-ness that is context dependent. The postmodern, feminist antecedents of autoethnography accept and expect that research will reveal “multiple sites from which the world is spoken” (Lather, 1991, p.160). Thus, there are levels of ‘insider-ness’.

As a nurse, I was an insider with this research by virtue of my registration and clinical practice experience. The group identity is a powerful one for nurses (Baptista, 2002; Gregg & Magilvy, 2001; Papps, 1997), so my acceptance by the academic nursing community and the nurse participants as a nurse who has the right to conduct this research was not questioned.

My practice area, mental health, added another level to my insider experience as I knew about many of the illness experiences the nurses discussed, the medications, the language of psychiatry and the settings in which it is enacted.

Bullying and isolation have been a part of my nursing experience, so they contributed to another level of insider-ness that was shared with the nurses through a tacit acknowledgement of their stories, rather than through openly sharing my own during the meetings to negotiate the narratives. That I did not choose to share my stories with the nurses is an aspect that returns to each level of this examination of the self-other hyphen.

Another level, largely unspoken, is added with my experience of mental illness. I did not discuss my personal knowledge during the proposal and recruitment phases of the research. It did not seem relevant to me at the time, and I only rarely thought about those experiences in a deliberate manner because they were a part of a painful past.

As I read and reread the nurses’ stories in preparation for interpreting them, I was increasingly confronted with memories of my own illnesses. For a time I was unable to move further through the research as I endeavoured to ignore them. Progress in the research was possible only after I deliberately remembered my own story. Catherine Camden Pratt (2002) conceptualises this
process as re-membering, pulling aspects of the self together that may have been forgotten or marginalised over time. I was only partially successful.

* * *

I sit at a small round table with my academic supervisors in June 2007. I am nervous, having just completed my first complete draft and sent it in for reading. This meeting is to discuss feedback arising from that draft. Peter Adams has written in my draft his concerns that I “reify the accounts [of the nurses] as immediately accessible” and oversimplify the way I have actively framed the texts. I want to explain to Peter, but I can’t find the words. I think he is asking me to engage with the stories at a different, deeper level, and critically examine the multilayered perspectives of the injustices the nurses write of. Mary Finlayson, my primary supervisor, has also urged me to “dig deeper,” but I have resisted her. Now, with the written feedback forming a barrier to my completion of this project, I am cornered.

Throughout the first draft I have been adept at intellectualising the self-other hyphen, at keeping myself reserved by keeping the nurses’ stories at a tightly packaged distance; I othered them by not touching them. In doing so I have done something that appears to Peter as ‘reification,’ to Mary as ‘superficial,’ but that I conceptualise as loss of ‘presence.’

Michelle Fine, whose work is critical to the development of this thesis, refers to the “slippery” spaces between researcher and researched (1994, p.74). She warns that where the researcher is mindful of the risk of colonisation and speaking over the researched there is also the risk of the “romanticizing of narratives and the concomitant retreat from analysis” (ibid. p.80). This is a helpful excerpt in that it motivates me to look further. I struggle with the idea that I am romanticising the stories. My experience of mental illness in myself and second-hand through my practice is that it is painful, messy and unappealing. Not the stuff of romance, nor yet of an experience that is so foreign that I am unable to articulate it. Rather, I suspect that my struggle is to navigate the slippery space between the nurses and me without getting messy myself.
I describe the difference between someone who has had a mental illness and someone who has not as knowingness. As a result of my history, I can never again assume wellness and coherence. I protect my sleep, my thinking time, my music and my writing with a passion that is fed by fear. I know that a dark place is waiting for me, and I know I must not let myself go there. While my head stoutly announces that I could get through it again, my puku\textsuperscript{12} says that I might not. I believe my puku, so I have tried to avoid the unavoidable.

Terry Kettering (1998) writes about loss in a way that conjures up the image of the experiences I am trying to avoid:

There's an elephant in the room.

We all know it is there

We are thinking about the elephant as we talk together.

It is constantly on our minds.

For, you see, it is a very big elephant.

It has hurt us all.

But we do not talk about the elephant in the room.

Yet I have written myself into a place where I need to be brave enough to grapple with the stories from the fullness of the ‘self’ position.

* * *

I have, on many occasions, experienced depression. The first time as a teenager, after the births of each of my children, and at other times as well. Although I do not think about those times every day, researching with this group of nurses, reading about nurses with a mental illness, and talking about it almost daily, brought my experiences into the spotlight. More particularly, I began to question the impact my experiences were having on the research.

\textsuperscript{12} Puku is the Māori term for stomach, which is known metaphorically as the centre of feelings and emotions.
Catherine Camden Pratt (2002) describes her own experiences as an added dimension in her research about daughters growing up with mentally ill mothers. She writes (2002, p.4) that the impact of her own experience on the research provides “an indelible and embodied knowing of the fractal nature of each moment and the multiplicities that live within each participant of that moment.” The latest impact my experiences had on this research (after my topic and methodological choices, which are discussed in other areas) lay in my attempted avoidance of the indelibility of embodied knowledge, which contributed to the othering of the nurses. For a period of time, I romanticised, reified and avoided engaging with the stories, thereby locating the nurses as different, important, untouchable and Other. After reaching a point of acceptance and engagement rather than avoidance, the impact of my insider/self knowledge was to expand my understanding of othering as a choice I could make in my research approach. In doing so, I began to explore the notion of othering and justice, to recognise the complexity of the interactions that contribute to othering, and to address the multilayered concept of othering as a colonising process that is ‘done to’ the powerless by the powerful.

Othering and colonisation

European and American texts tend to refer to colonisation as an abstract term that relates to the assimilation of one group of people by a more powerful group (Barker, 2003; Fine et al., 2000; McClelland & Fine, 2008). From my perspective, colonisation is a violent, personal experience, with far reaching consequences for the health and wellbeing of my people. Colonisation, for me and other Māori, is an historical event that persists in contemporary New Zealand, as the dominant European culture continues to develop new social and economic means of controlling Māori (Duff, 1993; M. Jackson, 1992; King, 1985, 2003; Marsden, 1986, September 5; Mitcalfe, 1972; Ramsden, 2001; Rochford, 2004). One very effective part of the colonisation process was the 1858 enforced prohibition of te reo Māori (the Māori language) in the education system
(King, 2003), resulting in a profound loss of identity and connection, and the silencing of the Māori voice. In an oral and aural culture, this has been a particularly cruel blow. Where the indigenous voice remains audible, it creates widespread (but not universal) discomfort which leads to the indigenous voice being shouted down, scorned, ridiculed and otherwise undervalued into silence, predominantly through the media. Thus, colonisation is a mechanism for assimilating, silencing and rendering invisible. A converse, but similarly effective, mechanism is the attribution by the uncomfortable listener of romantic or sentimental origins to a group of people, enforcing visibility and difference and reframing them as “other.”

**Othering by cellophane: laminated identities**

In a less violent but also effective way, othering can be achieved by ‘romanticising’ a group. I have discussed Fine’s (1994) assertion that romantic or unrealistic notions about a group can result in a retreat from engagement. In later work about sexual desire in young women, she and her colleague Sara McClelland refer to the women being laminated in cellophane which is produced by racist, sexist, and purist discourses. In their wrapped state, the young women’s voices of desire are silenced (McClelland & Fine, 2008).

People who have experienced mental illness are similarly laminated in cellophane by stigmatising and discriminatory practises and a lack of expectation that they can achieve a professional career (Corrigan, 2005; Johnstone, 2001; Krupa, Kirsh, Gewurtz, & Cockburn, 2005). Othering can result in research that further wraps them in the cellophane of fearful and ignorant discourses and speaks about them and for them, assuming that they are unable to speak for themselves.

Colonisation and othering are two sides of the same coin, with the aim of undermining and oppressing a group of people. This is an important concept, which is revisited and expanded upon as the thesis progresses.
I wonder whether it is possible to avoid othering completely. I am laminating the nurses as I wrap their stories with my cellophanes of academia, of non-madness and of the high-achieving nurse, even as I avoid the cellophanes of stigma and lowered expectations. I am that nurse who has apparently negotiated the demands of advanced nursing competence and a shift into academia while maintaining a family. Relinquishing the partial voice of non-madness does not alter my achievements as a nurse, an academic and a woman. Michelle Fine (1994, p.80) argues that researchers like me “cut a deal: listen to the story as long as the teller is not the Other.” Her argument cuts at the heart of my efforts to speak these stories that are usually silenced. I want, and the people who told their stories tell me they want, to have their silences spoken. In doing so, I may be laminating the nurses into the partial identities they wrote into their stories, but I am also laminating myself into an equally partial identity.

That I can make this choice of location is a behaviour known as “passing” (Haynes, 1999, p.661) whereby the other can pass as a member of the dominant group. I can also pass, by virtue of my white skin, as European. I am doubly dominant in appearance and articulation while being doubly other in vulnerability. In passing, I choose the power of the dominant academic, white group to speak, laminate, and other the stories of the nurses.

Othering by choice

As an alternative to passing, I can use the authority of an autoethnographic methodology to integrate my identity as academic, researcher, woman and nurse with the self that speaks of a ruptured life, confusion, medication, fear and marginalisation. Almost all of the nurses told me at some point in our conversations that they wanted to make a difference for future nurses. While I

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13 Working with the nurses’ stories raises issues of veracity and transparency, which are addressed in Chapter Three.
cannot do justice to their stories from a disengaged location, I also cannot disregard the
importance of my academic training and my professional experience if I am to produce quality
research. As with the nurses’ hyphenated selves I will be describing in the interpretation
chapters, my own hyphens are not neat binaries. The slipperiness of the relationships among my
insider-ness must be negotiated according to the aims of the research: to explore the way being a
nurse or doing nursing work can affect mental health and develop strategies for reducing the
impact of mental illness upon nurses.

The altruism the nurses expressed in wanting their pain to improve the lives of other nurses is not
open to question. In relation to partially situated, multiple and plural truths, however, there is
more to consider. One nurse told me bluntly that she had been waiting a long time for someone
to ask about her story. She also said in her story that she has hidden her mental illness for most
of her professional life. This apparent contradiction leads me to wonder why she chose to expose
herself to the possibility of being othered. Is it simply that she wanted other nurses to reap the
benefits of her pain? I think there is more.

* * *

In my teaching role, I have often stood in front of a class explaining why people who self harm in
visible ways such as cutting should be listened to carefully and not dismissed. I display my own
unscarred wrists to the students and tell them “isn’t it a great way to show people how much you
hurt? You don’t have to say it and listen to them tell you it’s not real. You can just show them
your scars. It’s like saying – see? It’s real, it’s painful and I’ve got proof in my scars.”

As I think of the ways people write their pain on their bodies (and reflect on my ongoing struggle
with my weight) I am struck with another way to write pain and have it made real. You can get a
researcher to write it for you. You can have your pain legitimised by the very people who might,
in another forum, deny your experiences. Peter, my co-supervisor, likened the nurses telling their
stories to courtroom testimonials. He commented that the stories bear witness to the struggle, so
they have “a credentialing as well as communicative function . . . Maybe the images, the metaphors, the delivery etc are aimed at conveying that these really happened and I was subject to them” (Peter Adams, personal communication, 7th July 2007).

* * *

In choosing to be a part of this research, the nurses and I are bearing witness to our experiences by telling stories about them and subjecting them to academic interpretation. My intimate knowledge of mental illness is unquestionably brought to my research, although the language to describe it is lamentably limited. My outsider knowledge of nursing and mental illness is augmented and embodied by the intensely evocative knowingness of the insider. Working the self-other hyphen as a slippery, mobile relationship means that I bring my own embodied knowledge to the conversations, and can experientially understand the distress, confusion and dis-ease that the nurses brought through their stories. In moving through the stories and the identities rather than resting in them, the partial and local nature of the stories belies the layers of cellophane and defies lamination. These movements, and the impact of colonisation and othering, are described further as the thesis progresses and the interpretation is first explained and then conducted.

This concludes the theoretical map of the research project. In this chapter the foundational concepts of autoethnographical theory have been examined and links made with this particular project. Lyotard’s phrases and genres have been discussed as a means to interpret the nature of the stories told within and outside the research, and are the particular focus of the next chapter, wherein extant literature about mental illness is discussed. Furthermore, in this chapter I have introduced Fine’s work on the hyphen. I have signposted that the hyphen will provide a local and partial way of interpreting the nurses’ stories and that the differend is an important concept for understanding the nature of mental illness for nurses.
My interpretation of the self-other hyphen and the slipperiness of the many levels of insider-ness in this research concludes the synthesis of theoretical positions presented in this chapter.

Chapter Three: Autoethnography as method takes a more applied approach to the research as it describes the practicalities and ethics of negotiating, collecting and interpreting the stories.
**Alice’s story**

I trained as a general nurse from 1969–1973, and have worked in an acute area since then, until last year when I moved to a longer term nursing area. I am also really proud to say that I recently completed my Bachelor of Nursing degree.

I have a family history of depression. I remember as a child that my mother spent a lot of time in bed, and on one occasion seeing her manhandled and transferred to a psychiatric institution. I guess that has influenced how I feel about mental illness.

My overwhelming feeling about having a mental illness, in my case depression, is one of fear. Participating in this research makes me worried that I am bringing things up that should be kept quiet. I’ve had depression forever, it seems, and have been on medication for it. I’m not on any meds now, but I am very aware that admitting to a mental illness gives people power over you. For instance, the researcher could easily report me to Nursing Council, and I could lose my practicing certificate. That is a big concern to me. I even made sure that I had a psychiatrist who worked away from the hospital. I just can’t trust anyone, especially with my practicing certificate at risk. I used to feel that I had that certificate as of right. I had earned it, and just renewed it every year. But now I am worried about it, although I don’t believe that I am unsafe in spite of my diagnosis, and I feel that I have to constantly prove myself.

As a nurse, you are the pillar of the community, seen as caring, compassionate, always helping. If a nurse breaks the rules, you always hear about it. Look at Lesley Martin – she’s not a practicing nurse any more, but that is how she is perceived and talked about. If you are pulled up for drunk driving, you are in the news as a “nurse.” So not being a nurse would be a big loss to me – I’d be devastated if I lost my registration.
Right through my career I’ve been kind of timid – quiet, tried to stay away from attention, even sensitive. In fact, I may have been too sensitive sometimes, and let the caring side go overboard. In a lot of my early performance reviews I was told that I was too sensitive and needed to improve in that area. I’m much better, now, at setting boundaries. I do think that feeling so timid could have been a result of my depression, and wanting so much to hide my illness from everyone. I have told only a very few friends throughout my whole career about what I went through on a regular basis.

Nursing is hard work! As a senior nurse on an acute ward, I was team leader and responsible for the sickest patients, having the heaviest patient load, supervising and delegating to/directing health care assistants and Enrolled Nurses, liaising with the MDT members like OT’s and physio’s, and precepting new staff and students. With all these roles, it isn’t possible to give your best to everything, so you get no sense of completion and everything is only half done, if that.

I never really thought about nursing making my depression worse, but now I’m wondering about how nursing and depression connected. I think, now, that being depressed and trying to hide it has made me an easy target for bullies. I’ve been bullied all my life, I suspect. And that is what finally moved me out of acute nursing – bullying. I think now that I had stayed in the one area of nursing for too long, but I had a sense of loyalty to the area, to the specialty area of nursing, and to the whole system. I also had a sense, though, of doing a good job there. I was a senior nurse, and had specialised skills and knowledge. The nurse manager of the area, however, did not have those skills, and I think that underpinned the whole bullying issue. She seemed to have a need to control everything and everyone.

In my case, the bullying went on for 2 ½ years before I put a name to what was happening and managed to get away from it. During that time my nurse manager was directly, actively bullying me. My practice was constantly under scrutiny, and even though there was a lot that I
know I did right, the focus was on the things that I didn’t do as well as I could have, or did differently to the way the NM wanting things done. I realise now that there were aspects of my practice that weren’t what they could have been – but how could it be when I was so afraid? I was spending my time trying desperately not to be noticed.

Throughout the whole time, I had quiet support from some of my colleagues, but they also didn’t want to be noticed. Their silence when it counted had much the same effect as the bullying, really – it was isolating. I also had support from a couple nurses in supervisory positions, but their input was completely disregarded by the NM – yet they were around the ward much more often than the NM was, and were in a better position to comment on my practice than she was. I experienced continual knockdowns, in spite of trying to stay quiet and unobtrusive. My health suffered – I had dermatitis so severe that I needed steroids, hypertension, severe menopausal symptoms, weight problems, and I was using too much alcohol to try to relax and forget about what was happening at work. I went to my GP, who was helpful as far as medication went, but couldn’t do much else. I felt that I was working, eating, crashing and going back to work.

One of the hardest things was that there was an anonymous complaint put in against me, and it was upheld. I lost all the privileges that I had accrued over the years. I wasn’t even allowed to be a preceptor any more. I was very distressed about it, and actually I still am. It felt very unfair. As a part of my “rehab” I had to redo my portfolio to re-prove my right to practice at a certain level. That was a huge stress, and felt very punitive. I feel that the goal posts for practicing at a particular level keep changing, and there is a lack of information about which direction to go in.

I did try to talk to the NM about how I was feeling. I went to her office. She became so angry that I was afraid and decided I needed to leave the office. She beat me to the door, though, and closed it, preventing me from leaving. She was very red in the face and shouting, and I reached for the phone. She disconnected it. That was absolutely the worst time I’ve had, and it propelled me out
of that environment. I went to the HR department and asked to be moved. When I left that meeting, I was so distressed that I couldn’t even remember where I had parked the car. It was very frightening. What’s more, that NM is still in her role. Once I felt better, I took some documentation to the CEO of our organisation and talked to him about what had happened. He told me that he thought I was over-reacting.

I know I should probably have left earlier, but when you get knocked down so often, you lose the energy and the ability to get back up again. I even stayed long enough to complete my rostered shifts! I should have just walked out. I was also worried that if I moved out of the area I would be losing my skills that I’d worked so hard to build up. And I grieved for the loss of the direction my career should have gone in, and the loss of the nurse I felt I could have been. I went to EAP, but was advised that since I would be moving areas I should wait and see if my feelings resolved once I moved. I’ve never been back.

So I was moved into a long term nursing area. I’ve found that it is a much more supportive environment and that the NM there actually gives out compliments and says “thank you” to her staff. The first time that happened to me, and she thanked me for something I’d done, I became tense and fearful, because I was so used to having a comment like that followed up with a list of the things I hadn’t done well. I’ve now made a decision, though, and I consciously incorporate those little things into my practice. It really helps with the atmosphere and morale of the staff.

One of the things that helped me is a book by Andrea Needham about workplace bullying. She absolutely laid out the whole thing and it helped me to recognise what was happening to me. It was a relief, actually, to be able to name it and then I could try to deal with it. One of the things I did was to write an assignment about it, which acted like a debrief for me. It felt so good to write about it!
I love nursing and being a nurse. I think that a lot of us see the hospital as being like home – a place where we spend our days, and invest huge energy. For me, after work I come home and study. Being a nurse is that important to me, and loyalty to nursing and to the service is a big part of my life. I guess I want to be liked and loved! I have found, though, that my family don’t really know what to do when I cry and feel bad. That can be frustrating and lonely – I shed most of my tears alone, which is sad.

I’m seeing other nurses going through some of what I went through, and I can’t help them very much except hang on in with them. Some are being bullied, and are having time off for stress and depression. At times I have tried to say something, but it is an issue that is not discussed, so I back off. I think that we are not at all kind to ourselves as nurses, and at times we are downright horrible to each other. I acknowledge that we don’t always “get it right,” and we have this need to be seen to get it right for the patient – but we need to have the right environment to achieve this, one that is supportive and encouraging, and free from the kind of bullying behaviour that we subject each other to.

I am looking forward, not backwards and I am being positive. I also have to look after me before I can help others

These words were written by G Martin in 1999 and are sung by Charlie Pride. They sum up this whole thing for me.

I was born to be exactly what you see
Nothing more or less
I am not the worse or the best
I just try to be exactly what you see
Today and everyday
I am just me.
North Island Bunny’s story

I trained in New Zealand, registering in the 1960s. I then completed a BHSc (Nursing) and a Master of Nursing.

On my first duty as a Charge Nurse in a hospital wing in a retirement home, I was welcomed with “I don’t like nurses who are university trained.” The speaker was a registered nurse aged in her sixties who worked part-time.

Over a period of months this lady went out of her way to make put down comments, undermine my instructions and she kept making her opinion known during handovers. Her aim seemed to be to make a scene in front of other staff members intending at the same time to “show me up as she had threatened.” She also was capable of shouting down the corridor. I was not her only target – caregivers if they questioned her instructions or commented that what she was ordering was different to the handover instructions given by me were also scathingly put down.

On discussion with my staff I found that this behaviour was not new. Management had known about this behaviour for a long time prior to my arrival in the unit and had done little. The situation was in the too hard basket. Initially I was made to feel that it was my problem. I was then advised that my best response was to be understanding, calmly responsive, and to make it clear that this behaviour was not acceptable. “Be nice to her, make positive comments.” When I continued to complain to management about the ongoing behaviour and the fact that staff absenteeism frequently occurred as caregivers did not wish to be rostered on to duties with this RN it was then inferred by the manager that I should consider if this was “a personality problem between myself and this registered nurse.”

Despite my assertive responses the aggressive behaviour continued. As the aim of the onslaughts was to create attention at times the noisy aggressive behaviour was at times best ignored. I was not however the only victim of this bullying and aggression.
Caregivers and in particular those who questioned or stood up to this RN received the same treatment.

A new RN who was also university trained started in the wing and was also told that she was not welcome. She advised the abuser her behaviour was unacceptable but continued to receive “the treatment” – interruptions at handover and the undermining of her instructions also occurred.

Eventually, for me personally, the ongoing onslaught, lack of management activity and in combination the appointment of a new manager who made inappropriate comments regarding my work injury “what are you going to do when you can’t work here any more because of your back” created intense stress levels. In tears I went to my GP and asked for a referral to a psychiatrist. It was a relief to find “I wasn’t responsible for this woman’s behaviour” and yet that is how I felt. I learnt to identify my stuff and her stuff. Eventually she was sacked but the traumatic toll on me personally and for many members of my staff was appalling.
Chapter Three: Autoethnography as Method

Looking back, I think I was depressed for a good year before I finally admitted it. I’d had a long term low mood, and I couldn’t find solutions for the things that bugged me. I also wonder now whether, if I were more open, or they were more supportive, maybe it wouldn’t have happened.

Julie

This chapter presents and examines the practicalities of the research project. In it I discuss the process from finding the nurses who comprised the sample, describing the demographic of the sample, collecting and negotiating the stories, through to how the data were interpreted. Finally, issues of what constitutes ‘good’ research and the many ethical considerations in conducting such research are discussed.

Finding the nurses: the sample

When planning the research, I considered the possibility that nurses would not want to engage in this project with me. I discussed my proposal with numerous colleagues, resulting in a reasonable certainty that nurses who have had a mental illness would be willing, even eager, to talk to me about their experiences.

I proposed that the sample group would be registered nurses who were in clinical practice at the time of developing a mental illness for which treatment was sought. My rationale for restricting
the sample to nurses in clinical practice was related to the significant differences in the workplace context of nurse managers and nurse academics. Incorporating these contexts would have broadened the research, but their inclusion would also have reduced the depth of interpretation possible in a work of this size. Further research projects including nurses who were working in management or teaching roles at the time of developing a mental illness would enable a comparison with the findings of this research, resulting in a wider analysis of the ways certain types of nursing work and the nursing role impact on nurses’ mental health.

The requirement that the nurses in this study should have sought treatment for their illness arose from my concern that minor or transient distress in the nurse participants would change the focus of the research to one of ‘stress’ or ‘burnout.’ As I discussed in Chapter One, with the knowledge I have developed over the course of the research I now recognise this to be a factor that has shaped the research in ways that may have excluded or marginalised some nurses.

Sample size for a qualitative study such as this required a small enough number that I would be able to engage in in-depth interpretation and enough participants to bring new knowledge to light (Sandelowski, 1995). Thus I anticipated that a sample size of between nine and fifteen nurses would provide sufficient data for the scope of this project.

In order to ensure a range and depth of data, a theoretical sample was proposed, whereby the data sought are guided by the data already collected (Coyne, 1997; Glaser & Strauss, 1967). The initial sample would draw from a range of practice settings and both genders, with further participants being sought as the research progressed to help elucidate the emerging findings. Sampling would cease when no new patterns emerge and a full range of data have been tested. This approach, borrowed from the grounded theory methodology, enabled the content of the nurses’ stories to direct the research. I would access further data according to what the early participants related. In addition to adopting a grounded theory approach to the sample, I also adopted it when considering a literature review. Although my personal and professional insider-
ness is an acknowledged part of this research, I avoided searching out other literature that would add to this knowledge and perhaps add to my assumptions about the nurses’ experiences. I hoped to minimise my impact on the data, so preferred to wait until the nurses had told their stories, and then seek out literature to contextualise them.

The next consideration in the planning process was the way in which the nurses would be recruited for the research. I anticipated using a series of advertisements to attract the nurses. Firstly, I would write a letter to the editor of Kai Tiaki, the New Zealand nursing journal published by the New Zealand Nurses Organisation. This letter would reach nurses in current practice, primarily those in general settings as mental health nurses tended to belong to a different professional organisation and read a different journal. Secondly, I would write a similar letter to a mental health journal. Thirdly, I would place a small advertisement in a women’s magazine in the hope of accessing nurses who had left the profession. Participants would self identify by responding to these advertisements, and the process could be repeated if I had insufficient participants or needed to make requests for particular attributes in potential participants according to the needs of the research.

Common sense and educated expectation about achieving my desired sample were, however, insufficient preparation for the reality of conducting this research. My first letter was published in Kai Tiaki in February 2005 (Kidd, 2005) (see Appendix Two). The response to my advertisement was immediate, with nurses calling from the day of publication and continuing for the next 6 weeks. In total I received 45 expressions of interest which resulted in consent forms being received from 25 nurses. This response necessitated a return to the University of Auckland Human Participants Ethics Committee to request an increase in the agreed number of participants (Appendix Three), which was duly approved (Appendix Four).

Of these 25 nurses, two withdrew prior to the research commencing. A third nurse withdrew after our first meeting, when recounting her experiences became too distressing to continue.
Three nurses were lost to follow-up; they all completed the first draft of their stories, but did not respond to my attempts to contact them to finalise the draft story and consent to its inclusion. I made three attempts for each nurse, leaving messages or emailing, then I assumed that they did not wish to continue with the research. One nurse sent her consent form to me six months after I posted it to her, and then did not respond to any messages, so I also assumed that she had changed her mind. This resulted in a final sample of 18 nurses who consented to their completed stories being included in this research.

**A comparative snapshot of the sample**

These stories were all created between February and November 2005. Statistical information gathered in 2004 by the Nursing Council of New Zealand and the New Zealand Health Information Service is presented here to provide some context for the qualifications and working hours of the 18 nurses who participated in the research. The two sources for statistical information do not correlate completely, although both sets of data are accessed through the same annual questionnaire, which was sent to all nurses and midwives by the Nursing Council of New Zealand as part of the application for an annual practising certificate. The Nursing Council of New Zealand data provides the total of all nurses, midwives and enrolled nurses who have practising certificates (51,583), regardless of whether they are currently practising at the time of completing the questionnaire, together with a breakdown of their qualifications (Nursing Council of New Zealand, 2004). Using this information, midwives and enrolled nurses were excluded from the total number of nurses presented in Table 1, as these groups were not part of the research sample.
<table>
<thead>
<tr>
<th>Nursing qualification</th>
<th>Research sample n = 18</th>
<th>New Zealand nurses n = 40,863</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive</td>
<td>7 = 40%</td>
<td>20,955 = 51.2%</td>
</tr>
<tr>
<td>General and RGON</td>
<td>10 = 55%</td>
<td>18,129 = 44.3%</td>
</tr>
<tr>
<td>General/Psychiatric/Psychopaedic nurse</td>
<td>1 = 0.5%</td>
<td>4 = 0.01%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>7041 = 4.3%</td>
</tr>
</tbody>
</table>

Table 1: Comparison of qualifications for nurses holding practising certificates

The New Zealand Health Information Service provides gender, work hours and practice setting information about the 34,660 registered nurses and midwives who were practising at the time of completing the questionnaire (New Zealand Health Information Service, 2004). Of the national group, 2,205 or 6.3% were males and 31,497 or 90.8% were females. In this research one nurse is male, representing 5.5% of the sample. Nationally, 11,469 or 25% of nurses and midwives were not working, while in this study there were 6, or 33.3% not working. Of these 6, it is likely that one or more of the nurses no longer holds a practising certificate, so the percentage is likely to be somewhat lower. The remaining 12 nurse participants are in paid nursing employment, as presented in Table 2.

<table>
<thead>
<tr>
<th>Working hours</th>
<th>Research sample n = 12</th>
<th>New Zealand nurses and midwives n = 34,660</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time (&gt;33 hours per week)</td>
<td>8 = 66%</td>
<td>17,465 = 50.3%</td>
</tr>
<tr>
<td>Part time</td>
<td>3 = 25%</td>
<td>16,667 = 48%</td>
</tr>
<tr>
<td>Not reported</td>
<td>1 = 8.3%</td>
<td>528 = 1.5%</td>
</tr>
</tbody>
</table>

Table 2: Comparison of working hours for nurses and midwives in New Zealand
Overall, these figures demonstrate that the sample of 18 nurses who self selected for this study is similar to that of the national picture, although there is no attempt to generalise this research to all New Zealand nurses. The largest variation is shown in Table 2, where the national percentages of nurses in full and part time work seem quite different to the nurses in the sample. This difference may be explained by the slightly higher percentage of nurses from the study who are not in the nursing workforce. Two of the nurses indicated that, although not currently working, they wanted to return to the nursing workforce in the near future.

Practice settings were usually discussed by the nurse participants during the story telling, although one nurse did not do this. However, the nature of the stories meant that most of the nurses discussed their experiences over a range of settings. A feature of the nurses’ self-management (discussed in Chapter Four) was that they deliberately sought to change their practice settings or workplaces in an effort to find acceptance and a style of nursing practice that suited their needs. Thus there is no clear indication about the practice settings where mental illness first occurred or was most severe. Indeed, some nurses included several settings in their stories, while others focused on only one area but intimated that there were other areas they chose not to include. The areas of practice the nurses discussed in their stories were; education (3); primary care (6); acute inpatient (17); gerontology (17); long term nursing, including palliative care (7); mental health (8); acute specialty such as Emergency (4); and senior/charge roles (9).

Similarly, no clear pattern emerged regarding their nursing education, as 13 of the 18 nurses came straight from school, five came to nursing as a later choice and 10 have undertaken post graduate education. The years of commencing training also varied widely, with an even spread from 1959 to 2000. Only one nurse trained outside New Zealand, in England.

Taken as a whole, this information demonstrates that in this sample, there is no simple demographic that indicated the likely development of a mental illness. Therefore strategies

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designed to prevent or minimise mental illness in the nursing workforce will necessarily encompass a complex range of workforce variables.

The substantial response to my initial advertisement for participants, and the range of practice settings and educational preparation of the nurses resulted in a decision not to expand the sample further. One area that could have benefited from further data was the experiences of men who experienced mental illness. The story Morrie tells is the only one from a man and raises some issues that may be gender-based. This is an area that could be researched further, to elucidate an understanding of these particular experiences.

A further area of note is that there is no information about the ethnicity or culture of the nurses in the sample. I made a decision during the planning phase of the research that I would assume that the nurses would define aspects of their lives that are important to them during their storytelling (this is discussed further in the next section of this chapter). Two of the nurses define their lesbianism as important, one discusses her boyfriend, one her husband, two their families, and one her pregnancies and babies. They all talked about their educational preparation and their practice settings. None of the nurses talked about their ethnicity.

My identity as a Māori woman contributed to the decision not to ask about ethnicity. I, my whanau, and many Māori friends are affronted by the current trend in research to isolate ethnicity as a feature that requires special attention, thereby othering Māori. Given that this research project is not generalisable and seeks partial and multiple truths, there was nothing to be gained by asking the nurses for details that they would not have chosen to include in their stories. This is a contestable decision that could be addressed by a research project that focuses on Māori nurses and is conducted within a Māori cultural frame.

**Negotiated stories**

Autoethnographical data usually consists of stories, sometimes presented as conversations, that have emerged from informal interactive interviews and personal experiences (Berger, 2001;
The technique used in this research is negotiated stories, whereby the nurses have written or spoken their stories in their own voices, maintaining control over what is contained in the stories and what is left out, the way they are presented, and where they may be presented (Ellis, 2004; Ellis & Bochner, 1992). Each story forms the entire data for that nurse. There are no field notes or surreptitious observations that would position me as expert, knowing more about the story and its meaning than the nurse. This approach assumes that the nurses, as educated and articulate health professionals, would have decided what they wanted to include in their stories, what they wanted to leave out, and what meaning should be attached.

The ‘negotiated’ aspect of the data collection relates to my presence as a moulding influence on the shape and content of the stories. The nurses were mindful of the need to produce something that would fit within a computer document, although I did not ask this of them. I was prepared to photograph their work, scan it, or describe it. Ultimately the only requirement for this was to scan some pencil drawings. Our negotiations are discussed further during later sections of this chapter, and are reflected upon as I engage with the interpretation of the stories.

**Re-membered stories and ‘truth’**

Writing or drawing about experiences that have happened to one necessarily involve slippages of time as memory conflicts and merges with current experience. Memory is filtered through a lens of subsequent experience, intellectual and emotional processing, and immediate context including the audience for whom the memory is recalled (Ellis, 1997; Lincoln, 1997). Catherine Camden Pratt (2002) refers to the embodied process of gathering one’s thoughts, feelings and memories as re-membering, a pulling together of scattered aspects of the past self(s) to re-present a coherent story that meets the needs of today’s audience. Thus, the experience each nurse presents in her story will inevitably have changed between the time of the events and when the story was told or written for the benefit of this research audience.
Postmodern thought expects that stories will be partial re-presentations of experience that reflect locally situated truths (Best & Kellner, 1991). As time moves on the nurses’ stories are shown to represent only a piece of the authors’ lives. This has been borne out by additions to Julie’s story as she prepared it for the thesis. When we first negotiated the story, Julie related feeling contented in her work and hopeful that her latest medication changes were having a positive effect. It is clear in her story that later paragraphs were added when she felt discouraged and distressed. This change in circumstances and perspective has also been demonstrated by correspondence with some of the nurses after their stories were finalised for inclusion. Their lives have continued in ways that show their stories to be partial or fragmented re-presentations of their lives at that time.

Moreover, Lyotard (1988) contends that the genres within which stories are told impact on the permissibility or exclusion of phrases within the stories. These stories were told and negotiated in response to my desire to hear specifically about the experiences of nurses who have a mental illness, providing a unique set of genres that encompassed metanarratives such as psychiatry as well as more local nursing genres.

My presence during the negotiated telling of most of the stories creates another context for consideration, as I undoubtedly contributed my own assumptions, dislikes and passions to the texts. My presence may have exaggerated the importance of some aspects of the stories and minimised others as I conveyed my overt or subtle interests and prejudices. Although I have illuminated some of these personal influences in this thesis, many of them occur on a level of subconsciousness that renders them inaccessible to me at this time, thereby impacting on the research in ways that I remain unaware of. Furthermore, research tends to attract stories of the dramatic, unusual or violent rather than those of everyday life (Fine et al., 2000), which further shapes the content and re-presentation of the stories.
The presence of families, particularly the husbands of some of the nurses, indicated the plurality of the nurses’ experiences. A part of the negotiated stories for one of the married nurses involved sharing the stories with her husband and accommodating his different truths. Three of the nurses who were lost to follow up and whose stories are not included in the research identified at the time of revising their stories that their husbands did not agree with the content of their stories. I have not contacted these nurses further, but I speculate that their withdrawal from the research may stem from the incompatible nature of the truths the stories re-presented.

In collecting and interpreting these stories, their partial, multiple, indeterminate and plural nature (Best & Kellner, 1991) is recognised and accommodated through flexible, creative and local research practises.

**Collecting the stories**

The practical process of acquiring the stories changed from that which was described in the initial research proposal and the participant information sheet (see Appendix Four). Prior to meeting the nurses I had anticipated that we would meet three times and, through informal interactive interviewing, negotiate stories about their experiences. I had planned the first interview to be rapport building and the opportunity for catharsis. The second interview would involve jointly analysing the incoherent content of the first interview, after which the third interview would edit and polish the final story and bring closure to the nurse-researcher relationship. This plan was consistent with literature that reflected the complexity of gathering situated knowledge and the importance of researcher skill and attributes in eliciting such data (Corbin & Morse, 2003; Ellis et al., 1997; Fontana & Frey, 2003; Mishler, 1986; Oakley, 1981; Roulston, deMarrais, & Lewis, 2003). The nurses in this research, however, showed my early assumptions to be incorrect.

Instead, the nurses almost all had their stories ready, if not written, and had analysed them for context, meaning and impact. My assumptions that the nurses were passively waiting for me to
liberate their stories and assign meaning to them were shown to be unfounded. As 64 told me “I’ve been waiting 30 years to tell this story.” Rather, the shape of our interactions became driven by the needs of the individual nurses, with the only common goal being the production of an autobiographical story that could be included in the research as a text of some kind. Some of the nurses required my typing skills to change their handwritten stories into Word documents, some wanted me to transcribe their oral telling and others simply sent their stories with the expectation that I would accept them in their original form.

This change represents another way in which the research was ‘flipped’ from theory to practice (Chow, 1999; Noy, 2003; Stewart, 1991) and, as with the flipping to substance driven autoethnographical research, this change has also enriched and enhanced the research as a whole. My own position in the negotiated stories moved from my anticipated coordinating role to one of questioning and engaged audience.

In practical terms, negotiating the stories meant that the nurses and I were able to decide what form suited each nurse and each story, a freedom that proved to be valuable. Some nurses preferred not to meet with me or lived too far away for me to be able to meet with them, such as 64 and Morrie. These nurses wrote their stories independently and posted or emailed them to me. Others, like Mary, Anne and Michelle, preferred to meet and share food and drink while we talked in their homes or mine. A number of nurses shared their stories during planned phone conversations, for example Julie and Josephine, while others wished to maintain a more formal interview setting. Most nurses chose privacy, but a few had family and friends present. Several had discussed the research with their therapists and planned to include their stories in future therapy sessions.

These choices empowered the nurses to manage their own experience of the research process and to incorporate it into their lives to the extent that was most comfortable for them. It is of note that an early decision with one nurse to audiotape a meeting immediately changed the dynamic from
negotiating to interviewing. The simple action of placing a tape recorder on the table was akin to bringing another person into the room, creating the impression of me ‘taking away’ her voice. The act of writing as we talked was more powerful and we chose to stop the recording. This decision was discussed with other nurses, which resulted in no further attempts being made to use a passive recording device. During the face-to-face meetings where nurses had chosen to have me take notes while they spoke, they would frequently read my notes as I wrote and make modifications. On these occasions I typed the notes out later and returned them to the nurses for editing and fine-tuning. In all stories, the nurses have made the final decisions about what story is presented and about its inclusion here.

Hearing, editing and finalising the 18 stories that appear here took from February 2005 until January 2006. It was an intense and inspiring year.

**Interpretation**

The interpretation of this research is an individual endeavour that is as partial, plural and indeterminate as the nurses’ stories are (Best & Kellner, 1991; Denzin & Lincoln, 2005). Rather than tidying the research into a plausible ‘truth’ in its conclusion, autoethnographical interpretation acts as a part of a dialogue with the audience, aiming to provoke, evoke and induce change at a personal and cultural level (Ellis, 2004). In a slight departure from a pure autoethnographical project, in this research I have worked with the stories to reach a point of partial and plural understandings of what it means to be a nurse who has experienced a mental illness, and what can be done to reduce the impact of mental illness on nurses in the future.

Interpreting the stories occurred in three distinct phases. The first phase involved the recognition and articulation of the collective stories that the 18 separate stories contributed to. The second phase used creative interpretive practises to illuminate and incorporate emotion and ‘mess’ along with the collective stories into ‘motifs.’ The third phase draws on Lyotard’s phrases and genres
as a means to interpret the context within which the nurses exist. This is enhanced by Michelle Fine’s social theory of ‘working the hyphens’ that the nurses negotiate in their everyday lives.

**Phase one: Collective stories**

As they stand, the stories present a compelling range of individual experiences that illuminate the lives of nurses who have had a mental illness. They offer insight to the audience and are, in and of themselves, a valuable resource. When read one after the other, they are clearly comparable in some aspects but very different in other ways. For example, Morrie’s story stands out as being the only one written by a man, and Jayne’s as the only one written about having schizophrenia and then choosing to begin her nursing career.

Laurel Richardson (1997) asserts that when stories such as these are heard and seen as a group, they have a shape and texture that is recognisably similar. These similarities create a collective story which can transform lives by “offer[ing] patterns for new lives” (Richardson, 1997, p.33) and becoming a visible part of the cultural heritage that is accessible to others who have had the same experiences. My first interpretive task was to examine the stories for similarities and patterns in content and context, then find a way to portray those patterns in new, collective stories.

This first phase of interpretation was a pragmatic, physical process that involved literally reading what the nurses had said that related to the key points of being a nurse and having a mental illness. In practical terms, the stories were daunting. I had briefly considered using a computer programme such as NVivo for this phase of interpretation, but feared losing the sense of intimacy and engagement I had with the nurses and their stories, particularly as I intended that this phase would be only the beginning of my complete interpretive process.

When the stories were complete and approved by the nurses, I arranged them into one computer file and printed them. There were 192 pages of text. I then read the document, using different
coloured highlighters to colour over passages that told of being a nurse, doing nursing work and mental illness.

While doing this, I noted and highlighted other topics that were obvious throughout most of the stories: bullying and silencing, pre-nursing/outside-nursing identities and coping strategies.

However it was soon apparent that highlighting the same copy of the stories was confusing, as some words and passages related to more than one topic. For example, Elizabeth says “But I was too shattered to even consider that [legal action] route. I swore that I would never go back to nursing again, never.” Topics from this passage required different colours for pre-existing issues, leaving her job, taking legal action as a way of managing her experience, being bullied, and the impact of a mental illness. I could have printed off four more copies of the stories, but the paper involved would have been mountainous. This situation arose more and more often as I identified additional topics of discussion. I found myself making judgements about which topics I should highlight and which I should ignore, and became concerned that I would exclude some important passages because of physical limitations in handling the stories.

Returning to the computer, I created several documents, each with the name of one of the topics, and copied all of the stories into each document. In this way, I created a situation in which all the stories were present within every topic, then I went through each file systematically and deleted the passages that were not relevant. If I was uncertain about a passage, I left it in. Although time consuming, this meant that I judged each passage against the topic for the current document, and did not judge a passage by how many documents it might fit and whether it was already coloured. Using this method, I read each story a minimum of six times initially as I probed the topics of being a nurse, doing nursing work, having a mental illness, bullying, coping and disclosure. As I read, a further five topics became evident so I created separate documents for these: self-management, the effects of mental illness on nursing practice, changing jobs, being watched and the nurses’ views about what needs to change. By the end of this process I had
eleven documents containing direct quotes from the nurses. This meant that I had handled and examined each story at least a dozen times, which resulted in a sound familiarisation with the data.

At this point I had a great deal of organised data (over 152,000 words) and was beginning to understand the shape of several collective stories through the eleven documents. The next phase of managing the stories was to get them into a readable form. To do this, I reread the eleven topic documents to discover where there were overlaps and similarities in the nurses’ words and to integrate topics with significant overlap into documents that had a broader scope. Under the topic ‘Nursing’ there were smaller documents of being a nurse and doing nursing work. ‘Tangata Whaiora’ contained descriptions of having a mental illness, coping, self-management, changing jobs, being watched, the effects of mental illness on nursing practice, disclosure and what needs to change. The language of this document was initially problematic. Within it, the nurses spoke at different times of feeling powerless in the face of psychiatric knowledge, hopeful and powerful as agents of their own recovery, angry at being managed and watched, and worried about how and whether to disclose their illnesses. The common thread in all these topics is the illness, so I called the document “Illness.” Later, I realised that the focus remained that of the person/nurse who experienced the illness, so I changed the title to “Patient,” which was inappropriate in consideration of the nurses’ agency in coping, managing and planning their lives. Tangata Whaiora, my final choice, literally means “person seeking wellness” (Williams, 1992). Tangata Whaiora is a common term in the mental health arena, reflecting the person’s experience of mental illness and their actions towards recovery. The final document, Bullying, contained the nurses’ stories of being bullied and silenced.

Another type of data had been provided by 64, when she included drawings with her story. I believed that several of these drawings were too personal or potentially identifying and, although 64 consented to their use, I felt uncomfortable about their inclusion so put them aside with her
permission. There were three that were more anonymous, however, and that serendipitously matched the three documents formed from the nurses’ stories. I sent these to 64 for her comment, and to ensure that I had interpreted their content correctly. She approved their placement, noting that she felt validated by their close relationship with the document content.

These documents and their associated artwork became the basis of three collective stories.

**Phase two: Motifs**

The collective stories of Nursing, Tangata Whaoria and Bullying were, at this point, little more than collections of direct quotes that had been chosen for their similarities. The next phase of interpretation involved synthesising the quotes and the artwork into readable, evocative stories that would meet the criteria for good autoethnographical research. I anticipated that this would be the final stage of my interpretation, and that the resulting stories would illuminate issues that I could discuss in a wider societal context. On the contrary, the process of formulating the collective stories took me on a journey of exploration that resulted in the articulation of ‘motifs,’ a new model for interpretive practice and led to a further phase of interpretation for this project.

Taking each document, I wove short quotes from the nurses with narrator style comments to link them. When I reread my work, my knowledge of what the stories portrayed made it clear that there were important omissions from the collective story, although the content was comprehensive. I felt that I had a multi-coloured vision from the nurses, but this first phase of interpretation had provided a black and white, single dimensional view.

I identified that the important aspects of the stories that were missing from the collective stories were the emotions that attended the content, and the ‘mess’ that was occurring simultaneously with the events. **Mess** is a term that reflects the existential dimension of life, and is increasingly used in autoethnographical literature to denote the everyday and hidden details of life (Dent, 2002; Ellis & Bochner, 2000; Ellis et al., 1997; Picart, 2002; Tillmann-Healy, 1996). In the
context of this research, it captures the unpredictability and overflowing nature of life and includes the off-stage events that were occurring for the nurses such as family dynamics, previous life history, personality traits, economic needs, beliefs and values, habits, dreams and fears. Mess is, therefore, an essential element to retain in the stories if their interpretation is to be authentic. The loss of these human elements rendered the interpretation sterile and uninteresting and raised doubts about its veracity.

**The use of fiction in research**

The practical issue of integrating topical content, emotional, and real-life/messy data into text is discussed throughout qualitative methodological literature. Many researchers have broadened their repertoire of analytic practises to include fiction and poetry as tools for enhancing their understanding. For example, Carolyn Ellis and Art Bochner (2004; 1992; 2000; 1996) note that literary genres have a great deal to offer autoethnographers as they can provide the vehicle to encompass emotional and messy experiences and to engage the audience at a deeper level than that of traditional research reports. Other researchers such as Laurel Richardson (1992; 1994; 1997), Michael Angrosino (2002) and Patrick Bracken and Philip Thomas (2005) have adopted fictional stories or poetry as a way of capturing nuance in their research texts. They contend that stories bring subtle, intimated knowledge into existence.

Storying is not the only creative practice that has been used to enhance research. Catherine Camden Pratt (2002) produced paintings as a key part of her analysis in coming to understand the lives of daughters of mentally ill mothers. Karen Scott-Hoy (2002) also used artwork in her analysis, as did Kay Picart (2002). Kathryn Church (2002) and Richard Quinney (1996) used photographs, while Deborah Austin (1996), Laurel Richardson (1992) and Lisa Tillmann-Healy (1996) interpreted their data using poetry. Chris Stevenson asserts that the use of the arts as a technique for interpretation can “indirectly convey the meaning” of research without claiming to have captured ‘reality,’ by “offering provisional, ever shifting, situated accounts” (1996, p.220).
When describing their processes for creating their art, these researchers agree that it involves engagement with their participants and data, high levels of reflexivity and the recognition of researcher intuition as a legitimate addition to researcher skill.

I decided to incorporate vignettes into the collective stories, using fiction and poems to capture some of the previously missing emotion and mess.

**Writing the vignettes**

Intuition is not a feature of my interpretive practises. Notwithstanding my preference for and training in qualitative research, I am uneasy about drawing on something as intangible as intuition when I am interpreting someone else’s stories of their lives. Writing a part of my interpretation through vignettes of fiction and poetry required my conscious and deliberate engagement in diverse insider-outsider ways. I drew on my knowledge of, and emotional responses to, the content of the nurses’ stories, my memories and journal entries about the process of talking with the nurses, my experience as a mental health nurse and my personal experiences. It was a lengthy process that required careful attention to my embodied knowing to ensure that my work reflected that of the nurses.

Arthur Frank discusses the use of story as an interpretive practice as “thinking with a story,” as opposed to more traditional analyses which think “about a story” (1995, p.23, my italics). I wrote the vignettes immediately after reading the collective stories and with the original stories on the desk next to me for ready access, so that I could think with a story. I read myself into a mental place of knowing the stories, and an emotional place of feeling my embodied response to them. I recognised anger, fear, frustration, anguish and relieved happiness in myself, and I wrote vignettes that induced those same feelings in me. I incorporated awkward social situations, confused professional practice and the presence of families as mess that contributes to everyday life. I drew on my expert knowledge as someone who has heard many anecdotal stories of distress as well as the 18 research stories, as a practising mental health nurse, and as a well-read
postgraduate nursing student. I also drew on my personal experiences that were either similar to those the nurses described or evoked similar emotional responses and incorporated these into the vignettes. It was emotionally draining work which took several weeks to complete. After each vignette was written, I rested, played with my family, listened to music and read novels until I had the reserves to start the next one.

I reviewed the effectiveness of the vignettes in the weeks after writing them, rereading and checking my responses, and rewriting when I needed to. When I was satisfied with their effect on me, I tested them on family and nursing colleagues. When an experienced mental health nurse reported that he had become tearful upon reading one, I was delighted. Further joy followed the comment by another colleague that a poem was “almost psychotic” in its ability to disturb her. Other colleagues noted that the vignettes had made them evaluate what was happening in their own lives, which I interpreted as evidence of resonance. I was satisfied that the vignettes were adding emotion and mess to the content of the collective stories.

The final test of the vignettes came when I sent them out, along with the collective stories, to the nurse participants for their feedback. All but two of the nurses responded. My questions to the nurses related to the accuracy of the collective stories and their feelings about the vignettes. The feedback came in two forms. The first was an impersonal approval, such as “yes, you’ve covered it.” The second form was to tell stories in response. Four nurses did this, recording their emotions, thoughts and memories that were prompted by the material I had sent them. These additional stories are not incorporated into the research because they were outside the original consent to participate. While I could have returned to the ethics committee and the nurses to get consent, I also recognised that there was a difference in these later stories. They were more deeply personal, and had been told to me as another nurse who happened to be writing about nurses and mental illness. It is challenging to articulate the difference here, but I decided that
such stories were more suited to a smaller postdoctoral study wherein the relationships between the nurses and me could be developed as a part of the research.

**Motifs**

Once the vignettes were written, I had an amalgamation of textual representations of the topics contained in the story, 64’s drawings illustrating the topics, and vignettes that captured the essence of emotion and mess. I could find no terminology in the literature that described such an eclectic blend of information. I posted a request for an appropriate term in a literary forum on the internet, explaining my desire to find a way to describe the essential elements present across the nurses’ stories. Allene Edwards, author and editor, helpfully suggested ‘motif’ as being appropriate to my needs (Allene Edwards, personal communication, 14 May 2006). Definitions of motif describe it as a distinct, recurring element or design in a literary or artistic work (Editors of The American Heritage Dictionaries, 2000; Random House, 2006; Soanes & Stevenson, 2005). These definitions corresponded to the needs of this research. Thus, the first phases of interpretation were synthesised into three motifs: Nursing, Tangata Whaiora and Bullying.

At this point in the research, the extant literature was reviewed for the first time. I went through the motifs and listed topics to be searched, for example mental illness, nursing, practice settings, stressors, education, burnout and bullying. The review comprised of a critical analysis of research and expert opinion, looking for ideas and consensus. This review was exhaustive and detailed, and added an international, national and historical context to the motifs.

Throughout the construction of the motifs the location of the nurses, their language and their context are untroubled. That is, they were not subjected to critical analysis or deconstruction but are re-presented as faithfully as possible. For some audiences, for example autoethnographers, presentation at this stage is ideal because it leaves them to interpret the material themselves and act on it according to its resonance with their own lives (Ellis & Bochner, 2006). I presented a synthesis of the motifs to an audience of autoethnographers in the United States (Kidd, 2007,
May 3-5a), where it was consistent with the style and content of other papers which were presented.

* * *

My presentation in Illinois went wonderfully. After I set the context of the research project, I read excerpts from my own story, the nurses’ stories and the vignettes so they created a mental vision that portrayed the essence of the nurses’ experiences. It was terrifying to contemplate, but my colleagues applauded and came up to congratulate me and to discuss the impact of my ‘story’.

Now I am back to the reality of a partially written thesis which, I acknowledge to myself and my supervisors, lacks depth and coherence. What am I trying to accomplish with my research? How am I going to get there? I have the motifs, of which I am proud. I have an enormous, diverse and unwieldy literature review that is marginally critical in places. I feel stuck.

Mary Finlayson tries to explain where I need to build my argument, and I cry. I feel guilty for crying, guilty for being stuck, and guilty for causing her to question the effectiveness of her processes. As I sniff into a tissue, Mary laughs understandingly and tells me that it is at times like this people often experience flare ups of physical symptoms. I am not prone to developing physical symptoms, but I am only too aware that I am perilously close to the blackness of depression once again.

I take my misery and fear to my clinical supervisor, and over coffee I admit that I am having trouble sleeping and feel numb. These are not good signs. He suggests, bless him, that I take a break from my study since it is causing me such anguish. I try to explain that it is not the study, but the stuck-ness that is the problem. I resolve that no matter what happens now with the thesis, I cannot and will not become depressed again. I have lost too much of my life to it already. I repeat this to myself over and over.
I did not become depressed – I became physically ill. I stayed ill for ten weeks, coughing and sneezing, aching in every muscle. And sleeping. I could not get enough sleep. When I was awake, I played with large pieces of paper and coloured pens. I drew my research as a mind map, a spiral, a flow chart and column after column of notes. The more I played with the thesis and physically touched it, the more I recognised and exploited the disconnectedness of the document and the ideas in it. It had no recognisable shape, other than three peaks of the motifs and a large puddle of literature. Disconnection began to be an important feature of the research, rather than a barrier.

I played and coloured my way into the motifs, resisting mental illness this time, but succumbing to physical illness. Playing and researching are not obviously linked. Nor are depression and upper respiratory tract illness. Nor were my motifs and the literature. It is interesting to find that there are spaces between these ideas that contain links and barriers. It is even more interesting to examine the ideas to see whether they contain features which define the spaces.

I am no longer stuck. In a fictional story my physical illness would have resolved along with my academic struggle, but this is not fiction, and I am still coughing.

* * *

Notwithstanding this specific academic audience and my own embodied resistance, further interpretation adds depth to the research and is consistent with the aim of strategising ways to reduce the impact of mental illness upon nurses.

**Working the hyphen: the third interpretive phase**

During the third phase of interpretation, firstly Lyotard’s work is drawn on to illuminate the contradictory, exclusive and authoritative ways the nurses’ lives are impacted by phrases and genres (1984; 1988). To do this, I have begun with an analysis of the pertinent literature in light of the issues raised in the motifs. The resulting elucidation of genres and phrases has contributed
to an understanding of the constitution of the nursing and tangata whaiora identities that the nurses claim in their stories. Lyotard’s philosophy does not provide the means for exploring the social aspects of the nurses’ lives. Therefore, the identities are secondly interpreted in light of Michelle Fine’s notion of the hyphen that joins and separates them (Fine, 1994; McClelland & Fine, 2008; Sarin & Fine, 2007). Much of the detail of Lyotard’s and Fine’s theories was discussed in Chapter Two. This chapter moves them from theoretical positions to their application as interpretive practises.

The literature review that I had visualised as a puddle among the peaks of the motifs now formed the basis for an examination of genres, and the phrases they allowed or marginalised. An example of this is the literature about nursing education. The initial review yielded information about competence, the importance of baccalaureate education for nurses and the use of education as a tool for oppression. A review of literature informed by Lyotard’s (1988) work on genres suggested that there is a genre in nursing that is concerned with intellectual mastery which acts to exclude phrases about experiential learning and legitimises phrases about demonstrable competence.

Concurrently with the literature review, I was also examining the motifs for areas that indicated contradictions, clashes and discomfort for the nurses and was comparing these with the genres from the literature. In doing so, I identified places where the nurses’ lives seemed to be joined and/or separated by hyphens, such as the hyphen between intellectual mastery and the need to be a ‘good’ nurse by doing practical, caring things for patients.

Analogous to stories, genres and hyphens do not always translate into tidy texts. There are aspects of this interpretation, particularly in relation to the differend and other emotionally laden areas, where I have again utilised vignettes. In addition to the tools offered by the arts, I have layered journal excerpts, quotes and anecdotal stories into the text. The layered account provides
the means to present my interpretation as voices that interrupt and disrupt, opening out spaces for generating new questions and understandings with each layer of text (Ronai, 1992, 1995, 1996).

In the next chapters the thesis moves into the presentation of these three interpretive phases. Two of the motifs, Nursing and Tangata Whaiora, relate closely to issues of identity so these are presented first. They define the contexts within which the research occurs and the nurses live. The Nursing motif contains stories of being a nurse and doing nursing work while experiencing a mental illness, while Tangata Whaiora contains stories of experiencing a mental illness while working as a nurse. These are two partial views of the same story, so there are many overlaps, contradictions, inconsistencies and enhancements. They are presented sequentially in Chapters Four and Five.

The third motif, Bullying, reflects some of what happened to the nurses as a result of their dual identities as nurse and tangata whaiora, so it is presented during the interpretive section of the research in Chapter Six.

**Good research: issues of quality**

One of the challenges in conducting autoethnographical research lies in the plethora of ideas about what constitutes ‘good’ qualitative research (Emden & Sandelowski, 1998, 1999; Koch, 1994, 1998; Richardson, 1994; Rolfe, 2006; Tobin & Begley, 2004). These authors are unanimous in their assertions that the indicators of rigorous scientific research are different to those of narrative research. For this project, I have adopted the criteria that was initially advocated by Laurel Richardson (1994) for narrative research and adapted for autoethnographic research (Ellis, 2004; 2000; Richardson & St. Pierre, 2005). These are substantive contribution, aesthetic merit, reflexivity, impact, and lived experience. Similar criteria have also been put forward by Art Bochner and Tina Koch (Bochner, 2000; Koch, 1994, 1998).

Substantive contribution incorporates credibility and veracity, and the extent to which the research contributes to an understanding of social life. Aesthetic merit calls for the text to be
complex, artistically shaped and not boring. It also requires that the use of creative interpretive practices “open up the text and invite interpretive responses” (Richardson & St. Pierre, 2005, p.964). Reflexivity includes transparency and signposting an audit trail to decisions (Koch, 1994, 1998) to enable the audience to evaluate the relevance of the interpretation and conclusions in relation to their own lives. The researcher needs to have included their own life and experiences as a part of the reflexive requirement. Impact relates to the level of resonance the research has for the audience and the extent to which it affects the emotions of the audience and evokes a move towards new questions, new research or action. Finally, the lived experience or concrete details are necessary because to interpret with transparency requires that details of the nurses’ lives are available for examination.

Many of the above criteria for goodness can only be evaluated by the audience. To date, I have presented the interim stories about, and findings from, the research at two doctoral schools and five professional conferences. One of these was an international qualitative research congress and another three I attended as keynote speaker (Kidd, 2005, May 18, 2006, September 28, 2007, August 9-10, 2007, May 3-5a, 2007, May 3-5b). On all of those occasions I have later had conversations with nurses that indicate resonance with my research. Responses from the nursing, academic and health professionals in the audiences have included the sharing of similar stories and discussion about how they, as individuals, can help to advance the overall understanding of this issue. These responses from a variety of audiences indicate credibility and veracity and demonstrate that the research has had an impact on the people who have approached me with their stories and questions.

Reflexivity and the audit trail are accommodated by my self-conscious risks in exposing parts of my life so that judgements can be made about how my interpretations came about. I have included the nurses’ stories within the text of the thesis, not only because of the esteem in which I hold the nurses, but also so that the audience can, if they choose, go back to the original stories.
and conduct their own interpretations. As discussed above, the motifs have been sent out to all
the nurses for comment. I undertook to incorporate their feedback either into the research itself
or as a critique of my work. Of the 18 nurses, 16 responded that the motifs accurately portray the
essence of their experiences and that they are content with the direction of the research to that
point. The other two nurses have not responded.

I have considered sending the nurses copies of my interpretation for their comments, but have
decided against it. In order to follow the research jargon, the nurses would need to read the
introductory and theory chapters, which would constitute a major investment of time and effort.
Furthermore, as the interpretation is grounded in my own context, the question of what I would
do in the event of the nurses’ disagreement is pertinent. Each nurse will receive a copy of the
finished thesis, and also of any publications that result. If they wish to comment on those, there
is the potential to incorporate that feedback into future publications, interpretations or research.

I sent the nurses copies of the recommendations that emerged from the research, and have heard
back from four of them. Their comments form a part of the recommendations chapter.

**Ethical considerations**

The ethics of undertaking this research project emerged in two distinct categories. The first of
these is the known and expected category of ethics, which includes issues such as potential harm
to participants, informed consent, anonymity and confidentiality, and the blurring of research and
therapy. The second category refers to issues that emerged as the research progressed and were
either quite unforeseen or more complex than expected. This category is described by Kidd and
Finlayson (2006) as “uncharted territory” and includes emotional engagement with the nurses,
the professional ethical commitment experienced by researchers who are also health
professionals, relational ethics and concern for the ownership of narratives.

Research into topics that are intimate, socially marginalised or hidden, and distressing is
inherently sensitive because of the clear risk of harm to the participants (Raymond M Lee &
Renzetti, 1990). For the nurses who participated in this study, the risks of harm arose from the topic of mental illness itself, the stigma and discrimination attached to the person who experiences a mental illness, and the risk that having a mental illness poses to the professional nursing role.

Ethical consent for this research was granted by the University of Auckland’s Human Participants’ Ethics Committee (Appendix One).

**Causing distress**

The process of recalling and talking or writing about mental illness was distressing to almost all of the nurses. Many of them cried during our interactions and disclosed hurtful incidents in their stories. I had anticipated their distress prior to commencing the research, and offered three fully funded sessions with a therapist of their choice. This offer was not taken up, as the nurses invariably had their own support networks. When I acknowledged their tears and hurt, reminding each nurse that their participation was voluntary and consent could be withdrawn, most of the nurses expressed the desire to have their experiences make a difference for other nurses: “I don’t want anyone else to go through what I did,” or “telling my story might make a difference for someone coming along behind me.” None of the nurses chose to leave the study as a result of feeling distressed.

Causing pain to the nurses was of concern to me. I recognised the tensions between the utilitarian approach, which privileges the welfare of the group over that of the individual and the deontological approach whereby one’s duty and the rights of others are dominant (Aita & Richer, 2005; Begley, 2005; Doane, 2002). Of particular note, though, is that the nurses identified the welfare of the group as a priority, while I was more uneasy about the welfare of the individual nurses.
Literature clearly shows that giving voice to a narrative can be a powerful experience (Ellis, 1997; Gilbert, 2002; Lapsley et al., 2002; Leibrich, 1999), providing a reason to revisit and have a meaningful event validated as important. The act of manifesting an experience for an interested audience validates the value of the experience and therefore the value of the actors in the experience (Bourdieu, 1998; Frank, 2002b). This was a feature of the self-other discussion in Chapter Two, as I reflected on the choice some of the nurses may have made to participate in the research so their stories could be validated through publication and presentation in academia. Validation is particularly important for groups that have been marginalised and silenced, such as people who have experienced a mental illness and are, therefore, vulnerable to stereotyping, stigmatization, discrimination and marginalization (Johnstone, 2001; Peterson, 1999) and also to a process described by Barker (2003, p. 97) as “colonization of the self.” Colonization of the self occurs through the imposition of the psychiatric language game on individuals, thereby discounting the mentally ill person’s voice and reframing it to fit with the diagnostic story. Thus, where the researched experience involves such a silenced, stigmatised topic as mental illness, the prospect of having stories respectfully validated is a powerful motivator for research participation, no matter how painful (Lowes & Gill, 2006). This may partially explain the large number of nurses who responded to my first request for participants. My ethical responsibility has been to support the nurses through their distress, assuring them of the ease with which they could withdraw from the study, and following quality research process to provide the validation that I intimated would be theirs by requesting their stories for my research.

**Research as therapy?**

Perhaps as a result of the careful attention of the researcher, participation in qualitative research is frequently reported by participants to be therapeutic (Aita & Richer, 2005; Alty & Rodham, 1998; Corbin & Morse, 2003; Halse & Honey, 2005; Hart & Crawford-Wright, 1999; Lowes & Gill, 2006; Smythe & Murray, 2000; Wilkinson, 2001; Zurbriggen, 2002). Nonetheless, there is
an important tension in the notion of therapeutic involvement in research. Ellis, Kiesinger and
Tillmann-Healy (1997) argue that research that aims to make a difference in people’s lives will
always have a therapeutic dimension, but there is a blurring that occurs when a researcher uses
therapeutic skills to support and assist the participants. For example, there is a clear difference
between research that might inadvertently be therapeutic and research that occurs as a part of the
pre-existing therapeutic relationship (Aita & Richer, 2005; Corbin & Morse, 2003; Gilbert, 2002;

In this research, I had initially theorised that there was a concrete therapy-research boundary, and
that I might inadvertently breach it. In practice, that theory was shown to be based on
assumptions that the nurses would need ‘therapy’ and might look to me, as a mental health nurse,
to provide it. As the nurses and I negotiated the construction of their stories and the impact of
distress on the project, it became very clear that the nurses had their own therapeutic
relationships (formal and informal) and that my presence served a particular purpose – hearing
the stories, validating them, and creating positive change with them.

A further assumption that I brought into the research was that emotion within the research would
equate to vulnerability on the part of the nurses. This assumption, too, was shown to be false.
The nurses were insightful and clear about their stories, and did not waver in their desire to
participate. The most intensely distressed nurse, Josephine, illustrates this clarity and also my
therapeutic involvement in her story. Throughout the storytelling, Josephine sobbed. At times,
she cried so hard that I could barely understand her and I stopped the research focus of the
conversation several times to adopt a therapeutic stance and ensure that she actually wanted to
continue. Even after the story was written, I went back to her to ask again whether she would
like to withdraw. Josephine adamantly instructed me to keep her story in the research, and
explained that although she feels emotionally overwhelmed when she recounts her experiences,
participating in the research gives her the chance to have meaning in the lives of other nurses.
She told me that the emotion is “just something that you go through” and that she feels better about being distressed through the knowledge that her distress may help someone else.

Josephine and several of the other nurses pointed out to me that their distress was worrying me more than them, and that they had consented to the research knowing exactly what would be asked of them.

Another aspect of the research as therapy discussion is found in the question of whether I found the research therapeutic and validating for me. In fact, this is a question that was raised in academic supervision. At the time of writing, just months away from my submission date in 2007, I am quite unable to answer this. I have found aspects of the research very distressing and have actively resisted some of the reflection and storytelling that has ultimately been included in the thesis. Equally, I have found some of the research to be exhilarating and I have revelled in becoming a legitimised researcher. The answer to the issue of whether the research has also been therapeutic for me will emerge once the writing is over and I have the time and energy to think about it. I am, as I write, considering the possibility that if I allowed myself to examine its impact on me today, I might not be able to complete these last months of work.

**Informed consent**

Informed consent is a basic tenet of ethical research, yet because of the sensitive nature of this research, there were deeper issues to consider. Literature discussing the ethics of research involving people who have experienced mental illness tends to focus on participants who are thought disordered and therefore potentially unable to make competent decisions (Koivisto, Janhonen, Latvala, & Väisänen, 2001; Peterson, 1999). This study, however, asked that each nurse affirm that they were mentally well at the time of the research. This assumes that mental illness and thought disorder are not necessarily permanent states, and that these nurses could competently assess their own mental wellbeing and choose to participate by formulating and presenting their stories.
Their consent to participate was based upon information presented in the Participant Information Sheet (Appendix Five) and included the right to withdraw from the research at any time until two weeks after they had approved the inclusion of their final narrative in the thesis. The process of creating and editing the story gave time for the nurses to reflect on their involvement, and the delay of two weeks after final approval allowed them time to change their minds about the final story.

**Anonymity and confidentiality**

Another basic tenet of research ethics is the protection of the participants through maintaining anonymity and confidentiality (Aita & Richer, 2005). Anonymity is of particular importance in this research, as nurses are required to be “fit to practice” (New Zealand Government, 2003) in order to be employed. Additionally, stigma and discrimination about mental illness remains pervasive in New Zealand (Gendall, 2006; Johnstone, 2001; Manchester, 2004; Nairn, Coverdale, & Claasen, 2001). Therefore being a nurse and experiencing mental illness is potentially problematic, whether or not there is evidence of impaired practice, with the possibility of losing one’s practising certificate and maybe even one’s nursing identity.

Maintaining anonymity in the relatively small population of registered nurses in New Zealand has meant that in addition to the employment of noms de plume, some narrative detail has been changed so that particular sets of circumstances are disguised. Portrayals of work settings, timelines and details of specific incidents have been carefully managed by the nurses and me to avoid the possibility of identifying the nurse. Rough notes written at the time of the first meeting, as well as all other computer and paper files, only utilized the nom de plume decided upon by each participant. All drafts were destroyed once the stories were finalised, so the only remaining data are the stories that have been approved by each nurse. Consent forms and contact details are kept secure and separate from the stories.
Confidentiality issues that may have arisen, such as the research uncovering unsafe or illegal nursing practice, did not occur throughout the research.

**Relational ethics**

A further category for consideration when undertaking autoethnographical research is ‘relational ethics’ (Ellis, 2004, 2007; D. Goodwin, Pope, Mort, & Smith, 2003; Reason, 2000; Tillmann-Healy, 2002). Relational ethics refers to how researchers treat their participants, the involvement of “intimate others” (Ellis, 2004, p.5) who may be present in the research stories, and the act of writing research that interprets aspects of someone else’s life.

My choice of negotiated stories as data, is derived from an awareness of the ethical issues inherent in how research participants are treated. I was concerned that the nurses should feel that they had control over what was presented as ‘their story’ in the research, hence, their power to decide when the story was ready for inclusion and the lack of field notes and other authoritative researcher observations. Their treatment as valued and knowledgeable participants is also apparent through the inclusion of the stories in the thesis. This inclusion makes it clear that the interpretation is my locally situated view, and that other interpretations are possible.

**Ownership of the stories**

Literature, particularly feminist, postcolonial and indigenous writing, questions the right of the researcher to interpret the lives of the researched (R. Bishop, 1996; Donnelly, 2002; Haynes, 1999; Reay, 1996; Smythe & Murray, 2000). The difference in authority, intent, knowledge and language between the researcher and the researched can result in inaccurate representations, colonisation and the ‘othering’ (Fine, 1994; Fine et al., 2000; Haraway, 1988; hooks, 1984; Lather, 1991) of the participant group.

The essence of this argument can be found in the question of who owns the story that the participant has told to the researcher. Smythe and Murray (2000) suggest that traditional ethical
stances treat participants as sources of data, while narrative researchers may treat participants as co-researchers or whole persons on whom the research process and report will impact. They assert that a dichotomous view is unhelpful and advocate the adoption of multiple, reflexive ethics that can adapt to the needs of the research and the participants.

The nurses in this research retain ownership of their stories, but have consented to their inclusion and interpretation in the thesis. They have also consented to the dissemination of the research through articles, library and thesis distribution. The artwork supplied by 64 remains her own. I have consent from her to include it in the thesis, and to use it when the research is disseminated as long as I have notified her that it will be in the public arena at that time. I believe that managing the research this way protects the nurses from being colonised and re-framed for my own benefit or that of the research, yet allows me to take ownership of the work I have done on developing my understanding of the experiences the nurses have discussed.

**The vulnerable researcher**

During more than a decade as a mental health nurse, I had heard and empathised with many sad, painful, exciting and triumphant stories. I approached this research project with the expectation that these narratives would correspond with that experience. In spite of this belief, without the protection of the workplace and my overt nursing identity, I was more vulnerable to the nurses’ emotions than I had expected. I laughed with them often, cried with them at times and at other times I hid at home where no-one could see my sadness, anger and frustration.

Lalor, Begley and Devane (2006) documented similar emotional responses in a group of nurses researching a sensitive area and advocate that part of the planning phase of such research should include attention to potential harm to the researcher. Researchers from other disciplines offer further insight into the tensions and vulnerabilities inherent in navigating uncharted water. Behar (1996), an anthropologist, argues that researcher vulnerability serves to open to scrutiny the
connection between the researcher and the researched, although she cautions that vulnerability
has to be “essential to the argument, not a decorative flourish” (p. 14).

From a clinical perspective, Perlesz (1999) writes about the complexities of the therapist’s
response when “bearing witness” (p. 11) to trauma. Of particular note is her description of
adopting some of her clients’ feelings of pain, helplessness and frustration, with the attendant
risk that the therapist will either disengage from the client or become so emotional that the focus
shifts from client to therapist. Narrative researcher Carolyn Ellis (Ellis et al., 1997) reports
feeling compelled to re-examine her attitudes to food, eating and her body in response to
research she was co-conducting with women who experienced an eating disorder.

Behar, Perlesz and Ellis each write from single positions as researcher or therapist, but they
articulate deeply felt responses to engaging with people in human inquiry and the risks inherent
to the researcher, the researched and the research itself in the process.

As a mental health nurse-researcher, my vulnerable response is intensified by a sense of
responsibility for the nurses’ wellbeing, which adds another dimension to the research. Davison
(2004, p. 382) describes a similar reaction in social worker-researchers as they experience
“emotional resonance” as a result of engagement with their participants. She notes that more
stress is experienced by the researcher who has a professional ethical commitment towards the
participants. This is further exacerbated where there is tension between the researcher role and
that of the supportive professional. The therapeutic professional role can add yet another
complex layer to the connection between the researcher and the participant.

This particular layer of knowledge, more than any other, created tensions for me as I negotiated
my nurse-researcher identity where the boundaries between the researcher and the nurse were
blurred. A simple example of the blurring occurred when, as a nurse, I had knowledge about the
side effects of medication that some of the nurses were taking. Where they discussed side effects
as though they were a part of their illness, I offered my information and a suggestion that they talk to their prescriber about it.

A more complex example arose when one of the nurses was very distressed during a phone call, and talked about a previous suicide attempt, with a subtle intimation that she was considering suicide again and an overt statement that she would not act on any suicidal thoughts. As a mental health nurse, I have a clear responsibility to ensure the safety of a person with whom I have contact. I had the ‘authority’ in the mental health sector to call on colleagues, disclose the nurse’s name and location, and ask them to intervene. As a researcher, my responsibilities are less clear, as the nurse consented to the research and was offered the opportunity to withdraw from the project. Moreover, I had a responsibility to protect her confidential status. As a person who is both nurse and researcher, I felt an almost unbearable anxiety about my possible courses of action. In attending to the needs of both roles, I asked the nurse to reiterate that she was not contemplating suicide and when she did so and terminated the call, I did not impose my anxiety on her by breaking our confidentiality agreement. In later calls, the nurse expressed her gratitude that I listened to her distress and said that she felt relieved and happier after the cathartic call. I, however, carried the physical consequence of my anxiety for several days, with a lack of concentration, poor sleep, irritability and general malaise. I reflected:

I felt so inadequate. I couldn’t help, but at the same time I couldn’t not help. Blurred roles seem so easy, even poetic, to write about, yet experiencing this one has been painful. I feel at once as though I want to stop researching and hide away from experiences like this, and also I am driven to enter into it more and more so that my pain can also contribute to making change. Then I feel silly for complaining about a few days of discomfort when the nurses have been through so much. Nothing is as clear as it seemed when I began (Research journal, August, 2005).

Managing my vulnerability in ways that would protect me from a recurrence of depression and also enhance the research became an important part of the data collection year. I utilised both clinical and academic supervision, along with writing a research journal as a core means of exploring the emotions and reactions of that year. These were augmented by examining the
literature, and peer support from fellow doctoral students and mental health nurses. I believe that the combination of people, roles, skills and activities has enabled me to explore my own roles and experiences from a broad and inclusive position. Through this supported process I have been assisted to reach new levels of understanding about the profound spaces the research has entered.

**The next phase of the research**

This chapter has focused on the autoethnographical method and the practical application and quality of substance driven research. The sample of nurses was introduced and examined from a demographic perspective. Ethical issues such as informed consent and confidentiality have been addressed, as have more methodology-specific concerns such as relational ethics and the blurred boundary between therapy and research.

Chapters One, Two and Three have set the scene for the research, providing background information about the project including how it began, why it is important and how it was conducted. The next chapter begins the presentation and interpretation of the Nursing motif, followed by the Tangata Whaiora motif in Chapter Five.
**Chloe’s story**

I graduated with my degree in 2000. Right through my training I’d had a mental health focus, but when it came time to get a job I didn’t want to be pigeonholed. I had also had enough of study, and so I really didn’t want to go into a new grad programme. Those decisions kind of pushed me into theatre nursing. So I started work in a major city hospital, doing mostly respiratory theatre cases, and then moved on to cardiac surgery.

I am a bit of a perfectionist, and when I was training I totally bought into the whole humanist idea of having the patient at the centre of care. I mean, I really lived that idea. Then when I started in theatre I found that it isn’t that way at all. It is a very dehumanising environment – I think it has become that way so the staff can cope with having to face tragedies and move on again really fast. One time, we had operated all morning on this woman, from early morning until mid-day. I was relieved to get my lunch break, but just as I sat down the pager went off. It was the ICU – we had to open her up again, and she died. Then I was told I had 20 minutes to finish my lunch before we started the next case, which was a child. I remember looking down at this child and thinking that I should be able to feel more – this was a life threatening surgery, and I couldn’t raise any energy for him at all. But instead of getting used to it, I got really stressed out and worried that no-one seemed to be paying attention to the patients. There is no respect for the patient at all, and some of the comments that the surgical team make about people are really disrespectful and demeaning. There is very much an “us and them” mentality. Mind you, I can understand it, I suppose. The more you let the patient become a real person, the more you hurt when things don’t go right. The nurses were supposed to do pre-op visits to the patients the night before surgery, but we hated doing it, because then we knew the patient as a grandmother or a husband or something, and got emotionally involved.
I think the whole situation was made worse by the fact that we worked call every 3 or 4 weeks, and would often work literally all weekend, then face the week’s work as well. And since the workload was completely unpredictable, we ended up working really fast all the time. Sometimes I was left alone to clean the theatre and instruments and get ready for the next case. There was the thought, sometimes, that we could cancel some of the elective surgeries, but then there was also the huge sense of guilt and responsibility that someone’s life would be affected. Not that I had the power to call off any surgery, anyway! I was completely exhausted, but also stressed, so I began to have a drink after work to unwind. First it was only on Fridays, then Thursdays, too, then almost every day. I didn’t drink much each time, but the fact that it was so often was worrying. And then I’d go home and sleep. So my whole life became work, drink to unwind from work, go home and sleep so I could wake up and work again. It’s not surprising that I started to feel like I wasn’t coping.

The communication in theatre is awful. There is no sense of looking out for each other, and the senior staff doesn’t support nurses who are given a hard time by the surgeons. One time I didn’t have the equipment that this particular surgeon wanted. It wasn’t sterile after the last surgery, and we didn’t have enough to use a fresh one every time. So the surgeon had to make do with another instrument. He told me that I was killing the patient. This really upset me, and I talked to the charge nurse about it. I am still amazed that her response to this was to baby talk to him, and use sexual innuendoes to jolly him into a good mood. I mean, that is just ridiculous. I think that when a nurse is treated badly, then senior nurses should be very clear and direct that the abusive treatment is to stop. It is crazy that the surgeons are not challenged on their behaviour or made to behave appropriately. I really feel that nurses need to step up here, and demand to be treated well, and senior nurses need to support their staff.
One of the other things that added to my feelings of stress was that other staff dealt with the constant rushing by cutting corners on the protocols. For instance, the 2 minute hand wash before catheterising someone was rarely done, and that really bothers me. Other protocols like that one, and documentation during surgery, were cut all the time. But I felt this sense of responsibility for the patient, and would be torn between what was needed so the team could get on with the surgery and doing the right thing for the patient. I’d be standing there washing my hands, knowing that the surgeon and the anaesthetist were both ready to go and wanting to know where I was, and I would be seemingly wasting my time doing a long hand wash. I feel that those are moral issues, as well as safety issues, and I filled in lots of incident reports, and tried to improve things, but never got anywhere.

I talked to some of my friends about what was happening, and I was reassured when they told me that it was good that I cared so much. I also talked to some senior staff about it, but the response I got wasn’t helpful. Basically, if I wasn’t coping then there must be something wrong with me. I was told to toughen up, and that I was being unprofessional, and eventually my charge nurse began to performance manage me, with weekly meetings and reports.

I went to my GP at that point, feeling that there must be something wrong. It wasn’t my usual doctor, but was a locum. I flatly rejected his idea that I was depressed, and got some bloods taken which showed that I was low on iron. I really hated going to work by that time and used up some of my annual leave to drop my work to 4 days a week. I was still struggling to cope, but I had a holiday over Christmas and hoped that it would make a difference. When it came time to go back to work I was just miserable. I cut back to 3 days, and went back to my GP. It was my own GP this time, but I still refused to allow a diagnosis of depression. I’d been depressed before, as a teenager, and this wasn’t it as far as I was concerned. I insisted on filling out a depression rating scale and it showed that I wasn’t depressed. But I had come from managing multiple personal,
professional and social roles to having panic attacks and only just surviving working three days a week. It was awful.

I felt very strongly that the patient on the table was being neglected, and that something in my practice was going to “give”. I was scared about what it would be that would go wrong, and knew that whatever it was, I wouldn’t be supported by senior staff. The fact that everyone was cutting corners or ignoring protocols wouldn’t mean anything when it came down to it. The whole thing was to do with group think – utilitarianism, where the needs of the group are more important than the needs of the individual. And I knew that if I cracked, the group would take precedence.

So, I went back to my GP, and accepted that I was depressed. I stopped work, went on a benefit, tried several meds and had therapy. I went from believing that the system was failing to thinking it was me. I’m clawing my way back now, and am working some casual shifts in a much more caring environment.

I’m the kind of person who needs to know why these things happen, and I think about it a lot. At polytechnic we are really indoctrinated into the humanistic thing – putting the patient at the centre of our care, taking care of them. In reality, nurses (and doctors) keep patients at arms length so as not to be destroyed by grief. But when the grief happens, the patient dies or is no better, there is nowhere to go to talk about it. No way to process it. After a while of talking to a therapist about how I was feeling, she told me that I was “going down with the patient”. I thought this life of a surgical nurse, in that acute setting, would be glamorous and exciting. I never knew about the intense sense of responsibility, and that the more senior you get, the more responsibility you take. My psychologist has now said that I’m not suited to work in theatre – but I wonder who is suited, really. People talk about the turnover of staff, and not being able to
get enough staff, but they never ask why the nurses don’t stay, and why nurses don’t want to work there.

I think that students and registered nurses should be taught how to deal with stress and grief, and I think senior nurses should support their staff – stopping them from being abused or treated badly, and helping them to deal with stress and grief when it happens.

**Jenny’s story**

There are three aspects I’d like to talk about:

- The effect of non-supportive nursing training.
- The effect of territorial ‘pack nursing’.
- The effect of burnt out nurses within psych.

I didn’t really know I was mentally unwell during my training, because I’d got used to being me, and I was too busy being in the early stage of survival mode to have the insight and understanding that really only comes from learning the hard way over time. In hindsight I can see that I was unwell for most of my nursing training. I can also see in that nursing training definitely worsened my mental health.

I was 18 when I started my training. I’d moved away from home to a new city, made new friends and lived a student life full of heavy binge drinking and occasional to moderate marijuana use.

I don’t think I was genetically predisposed to live the student lifestyle! (I have a family history over-represented with psychiatric illnesses). Maybe if I’d got drunk once or twice a year I would have been reasonably OK. But because I didn’t really realise there was anything much amiss
with me compared to everyone else, I expected that I could join in with everyone else and not suffer for it. Wrong.

I didn’t ever feel comfortable with my identity as a nurse. I had a strong preconceived notion that nurses were stereotypically kind creatures, softly spoken, feminine girly-girl maternal types. By comparison I felt too ‘gumbooty’ and disinterested in making small talk and adopting a bright social nursey persona, to consider myself a ‘real nurse’. As a sort of shy and introverted 18 year old (although others don’t see me as such) the thought of introducing myself to strangers or groups and playing hostess of the ward was truly nerve-racking and daunting. For that reason, I can’t think of a more poorly suited role for me than nursing.

I knew early on that nursing and I were not compatible, but I didn’t want to be seen as a failure by quitting the training. Besides, what else would I do? At the time, I attributed the ill-fit of nursing to my own personal deficiencies. Each nursing practicum was met with more and more dread. I felt claustrophobic, tense, anxious and inwardly desperate to be anything but a nurse!! I’m sure the stress of this ill-fit contributed to further depression and more drinking/drug use.

The only placements where I felt slightly less discomfort than usual were psych placements. I felt there was more freedom to actually have a personality. I felt at home with the openness of the staff, their sense of humour, and being able to listen and be part of deeper matters, rather than forcing myself to take part in the trivial irrelevancies of small talk and playing ward hostess. I also felt a bond with the patients. I still didn’t realise/acknowledge that I had an illness myself.

I sought help via G.Ps and the Health Centre for depression, and although they encouraged me to seek psychiatric help for depression, I always dismissed my health as ‘rough but manageable’. There was no bloody way I was going to end up in a psych ward where my peers were working, or where I’d end up on clinical placement. How humiliating. I felt brittle and breaking, but
'couldn’t’ risk being seen within the Mental Health service, even if it meant I got help. As a soon to be nurse, I didn’t feel I had that luxury available to me.

The real pressure came on when I locked heads with a particular nursing tutor. I found her to be quite haughty and unapproachable. Rather than being keen to teach me what I didn’t know, she seemed to make it her mission to highlight what I didn’t know. I once had to stand in front of an elderly patient and describe his condition. I commented on his facial colour, his hydration as evidenced by the half empty container at his bedside, his urine output based on his catheter bag, etc….I was pretty thorough, and even today would probably say much the same again if asked. She failed me on account that I didn’t state the man was actually alive.

It was around this time that I started to avoid going on clinical placement. It was the middle of winter and I remember that when I left the flat it was dark, and when I returned home after being on placement, it was dark again. That summed up my life at the time. I’d ask my flatmates to ring in sick for me – and feel like a loser each time I did so. At this point I became very depressed. I used to hide in the toilet on placement just to avoid staff and patients, so I could be alone without the need to put all that energy into looking normal – forcing my face to look undepressed. I ended up missing 3 weeks of clinical. The worst day I had was when I arrived to an afternoon shift in the middle of handover, only to be looked at dismissively by the staff - apparently I was supposed to be on duty that morning. I felt totally useless.

Eventually a different nursing tutor met with me on placement and asked me directly if I was depressed. I said yes, but talked my way out of her persuasions for me to accept treatment. I figured it was bad enough to feel this way, but surely I didn’t have to give up my last shreds of dignity by admitting that I needed help and that I was a ‘nutter’. That would just be ten times worse. She also asked me point blank if I was using drugs or alcohol. I lied and said no to both. She then went on to tell me that yet another nursing tutor was so worried about the state of me,
that she was losing sleep at night. Now I felt guilty and depressed. I think at that stage it was hard enough working out how I fitted in with the whole ‘me as a nurse’ concept, and to add ‘me as a patient’ into the mix was just too much.

One of my placements had been to a hospice. I tried following the nurses around, but I didn’t like to intrude on sensitive conversations with dying people and their families – it seemed a bit too clinical of me to be just sitting there learning ‘this is how you deal with a dying patient’. Instead I looked for tasks to do. The Charge Nurse called me in one day to say she didn’t like my attitude – that the staff are not there to hold my hand, and that I should make more of an effort to ‘get in there’. I tried to explain how difficult it is to know where to put yourself when you’re just starting out (I think it was the start of second year). She didn’t seem to have any comprehension of what I meant – her responses were abrupt, impolite, condescending and generally unhelpful. I began to see nurses as a mean spirited, territorial bunch who were caring, concerned and helpful to the patients, but cold, indifferent and territorial with each other. I got the feeling that if you weren’t a fully robust and self-assured nurse, they’d be like pack animals and either bully or ostracise you. I’ve since seen countless examples of this bullying. To my surprise it’s even happened to friends who I consider quite strong assertive individuals. It seems it only takes one person to make your working life a misery.

The placement I most dreaded was the ante and postnatal ward – where I imagined that the girly-girl nurses would be at their most concentrated (and I was right). Each day I was on placement, I got snide remarks from the other students for my complete lack of goosing. I felt like not only was I not going to make a good nurse, I wasn’t going to make a good woman either! Again, I felt like an impostor in a critical and foreign environment.

All of these placements were ‘not me’. I found nursing training to be academically focussed and ‘sink or swim’. There was no ‘schooling’ in the most old-fashioned sense of the word. I wish
someone had pulled me aside and quietly and kindly told me how to broach tough health-related questions, or how to introduce myself to a patient when all their mates the same age as me are sitting around the bed, or how to ask a man for a urine sample while his wife is there, or how to reconcile being friendly with patients without actually being their friend…..

The only positive to come out of this period, was that later as a RN I took considerable care with new grads (and nurses who had moved from medical to psych nursing), to offer them opportunities to discuss such things.

All in all, nursing training was hell for my mental health. The only parts I enjoyed were the student lifestyle, the academic side and the exams. I think deep down I figured that if the tutor I’d had problems with was indicative of the average nurse out there, then I didn’t want a bar of it. My impression was that the nurses on placement often found students to be an additional burden to their already heavy workload. All in all, the fact that I found the nurses on placement (especially during handover) to be such a cold, unfriendly, critical bunch to nursing students – and the vibes I picked up told me they were like that to one another – made nursing a psychologically unsafe environment for me. And for someone who is sensitive to such things on a bad mental health day, it was really quite negative. Seeing what nurses were like behind closed doors left me even more reluctant to become a psych patient myself – no matter what.

By the end of the 3rd year, I’d missed a substantial amount of placements because of my mental health. Fortunately the head of school was an ex psych nurse. I met with her, and while we didn’t discuss my health directly, she said she’d kept an eye on me. In her view I was diligent, conscientious, honest, hard-working, had a good rapport with patients, other students and the staff, so there was no reason why I shouldn’t go through on the hours that I had. I am still thankful to her for that.

Out in the workforce as a real nurse.
During and after graduation, I was so unwell that all I wanted to do was pull a duvet up over my head and sleep for the rest of my life. I found the prospect of being a nurse – hideous. I tried door to door sales, but ended up spending all day having cups of teas with lonely old people. I felt comfortable but I made no money.

In order to not look like a loser to my friends and family, who I felt must surely be wondering to themselves:

“Why isn’t she using her nursing ticket? To which I’d have to honestly reply: “Because I’m shit scared of being expected to be competent with people – because frankly I’m not really a people-person.”

After being offered a RN job in a resthome, I was left to wander around and ‘meet’ the staff following the interview. I walked into the staffroom and tried clumsily to introduce myself and strike up a bit of banter. Hardly any of the staff smiled, or spoke – in fact they pretended I wasn’t there. It smelt of urine, and it was dark and depressing. The thought of being trapped with more hostile, territorial, unhelpful, unfriendly women was too much. I declined the job.

Instead I started fulltime in acute psych. I enjoyed it – loved the camaraderie and the humour. I felt useful and important. Sometimes I felt out of my depth, especially in aggressive situations, but because it was back in the ‘good old days’, just one whack of the alarm on the wall, and I knew within seconds a horde of competent and experienced staff would be on hand. And, dare I say it, most of the staff who would arrive in that situation were big strong robust men ranging in their mid 20s to mid 40s. I almost always felt physically safe. (Not at all like it is these days). I soon made lots of new work friends and began to go out a lot – my recent clean living went out the window and I soon began drinking and using marijuana again – along with all of my new workmates. (Drugs and booze seem to be very prevalent in this professional group!)
Within about 3 months, I noticed I was feeling more sad, less interested in being with others, and I felt more akin to the patients than the staff. I lost confidence in myself, personally and professionally. I became so depressed that I can remember morning handovers being excruciatingly slow. I felt like a zombie – to the point where I suspect I might have become very monotonous when reading out my notes. It must have been very obvious to my new workmates that I was depressed. No one said anything to me about it though. On reflection, I wish some of them had said something and got involved with what I was going through. I got the feeling that they were keeping an eye on me, and did their best to ‘cheer’ me up, but that’s not the same thing as being asked about what I’m thinking and feeling. In my experience, friends and colleagues have been too wary of talking openly about my health. I think it comes down to how it’s done – if someone had said that they had noticed x.y.z with me and that they were concerned I might be depressed etc…..it would have been a welcome relief. Maybe that’s being too rose-coloured – perhaps I would have taken offence (at my own perceived failure to appear as if I was normal) and snapped at them for asking. But I really wish that people would be honest and upfront, rather than keep their distance and quietly keep an eye on things. I think tone is the most important aspect. And depth. A quick ‘how’s it going’ is not what I’m talking about. I wish I had been treated more like the patient I really was (even though I made it my life’s mission to appear anything but a patient). It’s a shame that my battle to retain the illusion of self dignity made/makes it so difficult to reach out and get the necessary help.

At this point I started my first antipsychotic. It worked like a charm but I had quite bad restlessness from it, and found this very distressing. One day at work the charge nurse approached me quietly and privately and asked if I was on an antipsychotic. I felt pretty apprehensive but said yes. She kindly but firmly insisted that I again see my GP – and that if I didn’t ring, she would. I am SO pleased that someone like her stepped in and dealt with it like
that. The worst thing is to be left to deal with it on your own. It seemed there were only two options available to me – either people ignored what was going on, or, people would get insistent to the point it came across as hostile which, in that fragile state, is alarming and even more isolating. I think the way she approached my health was professional and caring, and it’s the best example of support I’ve had. Within a month, the senior management called me in for a meeting. The told me that I was more clinically depressed than any patient on the ward, and that they’d like me to seek treatment, and that I wasn’t really fit for work. I found it very embarrassing (but a little bit relieving), and with my tail between my legs, I opted to resign on the spot. I’m glad at least that they were honest, upfront and kind about it.

After taking about 3 years out of the fulltime workforce to recover, I eventually got a part-time job as a RN in a resthome. I asked the boss if he would consider either giving me 2 weeks on the roster with another RN, so I could gain my confidence and refamiliarise myself, or, pay me and employ me as a nurse aid for 2 weeks just ‘til I got up to speed. He refused. I was put on permanent nights which wasn’t great for keeping depression away. It was only fairly mild depression, so I stuck at it. The woman I worked nights with used to tell me the most horrendous stories about her relationships, her rape, abuse – it was endless. One night during handover, we were all discussing a paranoid patient, and they made some uneducated remarks. Naively, I mentioned that once, years ago, I’d been in a bank, convinced that everyone was talking about me. I thought nothing of saying this at the time, considering what my workmate had told me over the past few months… as far as I was concerned we were all relaxed having a yarn.

When I got to work the next day, the boss called me in and demanded to know what medication I was on. I told the truth and said I wasn’t on anything. He then told me that staff had complained – no names of course – about my stability and that they were uncomfortable working with me, particularly on night shift – I mean, what if I flipped out? I felt kicked in the guts and utterly
sick. Not to mention small, and knocked back to starting from scratch as far as my personal and professional confidence was concerned. I worked a few more shifts, but found it all so upsetting that I resigned. When I asked the boss for a letter to state how long I’d worked there – not a reference – he refused and said: “If I remember rightly, you didn’t even have the confidence to be a real nurse when you started.”

After a considerable absence from the workforce, I worked as a private nurse for a lovely old lady on a farm. I enjoyed the isolation and lack of responsibility. It wasn’t long before I was approached by the local hospital to be an RN. It was a small rural hospital in its last gasps of closing down. I was sole charge of an elderly ward, and a medical ward. I didn’t know a lot, but I felt confident that what I didn’t know, I could soon find out. I only worked there for 4 months, but it was long enough to see the viciousness and bitchiness of the staff to each other – mainly women but men as well. We’d had it drummed into us by management NOT to accept any social admissions. When I refused the local doctor this, he gave me a shouting tirade of: “Did you get your fucking nursing ticket out of a Weetbix box?” That was among the nicer things he yelled at me. I wrote a formal complaint, but even though it was internally investigated, the reality was in a time of a shortage of doctors, no-one was going to do much about his behaviour. While this didn’t make me unwell as such, no doubt it added to my general distrust and scepticism of health professionals being able to be supportive to each other.

On return from my OE, (which was the single greatest boost to my confidence yet), I applied and got a fulltime job as a psych nurse on a brand new acute ward – it wasn’t even really staffed yet. I was more than a little hesitant to get involved in nursing, let alone psych again. My new boss was the former CPN of a man I had formed a relationship with (which had since terminated). This was a little uncomfortable for me, as right from the start I felt an imbalance of power between the two of us. She called me in for an informal interview. When I got there she didn’t
ask me a thing about the job – instead she asked me point blank if I’d ‘got it on’ with my former
partner while he was an inpatient. I was deflated and definitely on the back foot – I was all
psyched for a job interview not this line of questioning. I answered as best I could, and honestly.
When she later rang to discuss setting up a formal interview, I told her that I had some
reservations – that I felt uneasy about peers and managers knowing about my mental health –
that I felt I was being watched for signs of ‘being up to the job’. I had formed the relationship
with my former partner when I was unwell, and he was a great support for me for a long time. I
felt that I was critically and negatively judged for having chosen a psych patient as a partner –
as if a psych nurse should know better, and should pick a far more suitable partner. That in turn,
made me feel even more self-conscious about my own mental health history. I definitely felt as if I
had to prove myself, and once again I felt I wasn’t entitled to the luxury of ever being a psych
patient myself. I felt as if it was an unwritten rule for psych nurses – that there was some sort of
dividing line between them and us – that if you’re a nurse you can’t really also be a patient, but
what if you’re both???

During this time, my ex partner was temporarily staying with my parents. He became unwell,
and needed hospitalisation. His notes contain not only my name but references to my health. I
found this lack of privacy very distressing. Just about as distressing as the day I came across my
own file at work while looking for someone else’s - 6 months after I’d been working there. It was
amazing (in a bad way) the misinformation and wrong conclusions that I read.

There were parts to that job I loved – I was often sole RN per shift for an acute ward, usually
with one support worker. There were times where I loved the work and the drama, the demands. I
felt useful, and I reckon I was a pretty good nurse. But I began to get increasingly worn down by
being spread too thinly, too often. I had serious concerns for my physical safety from aggressive
patients. Patients with personality disorders seemed to reign supreme, and I began to get
depressed again. I worked there for five years. I tried going part-time, I took a year off to study, but still the work seemed to be getting the better of me.

I spent considerable time and energy planning how to get out of nursing for good. I felt a sense of deserting the ‘good fight’ for the mental health system by getting out of it, but I could no longer be in it. I also felt a sense of failure for not being able to cut it as a nurse. My last ditch attempt was to switch to a different DHB and try intensive care. One night there was a lack of communication between my workmate and I in ICU – he had told my patient that it was ok for him to go on to the open side – without telling me. So when I stopped the patient to ask him where he was off to, the patient bailed me up in a corner, spat at me, had his clenched fist near my face, and snarled: “What the fuck is it to you, you white bitch.”

I made myself a cuppa – and put my feet up, knowing that I was never going to return to this ward again.

I moved into computer based work after that, and for the first time - my health really improved. I discovered what it felt like not to fear work. Not to fear being left with bugger all tools to do a life or death job. Not to feel like I’m bashing my head on brick. Not to face endless aggression from patients (although I miss their company and chats and humour). Not to face the distinctly obstructive and disgusting attitudes of burned out RNs. To not fear that my past will come back to question my current ability in the workplace.

I worked briefly as a locum CPN about 2 years ago, just as a fill in job, before my current non-health job. It was interesting – I thought my actual nursing had never been better, but my dislike for the cynicism and ugliness of the some of the burned out staff was also worse than ever. Why is it that the burnout most unsuitable nurses within psych either end up working on the Crisis team (and work crazy overtime for the money), become Clinical Nurse Educators skilled at delegating and deflecting, or worse still – managers. I have sickening memories of how burnt-out
staff almost become competitive at how degrading they can talk about patients. It’s like it’s professionally ‘cool’ to come across as markedly detached, unaffected and unflappable. And that the best way to achieve this look, is to scoff, scorn, belittle and degrade patients (in their absence) as much as possible. No-one ever stands up to these sorts of comments – most staff join in, and those who disapprove remain quiet. The stigma and discrimination from within is rampant and destructive. Once again, it doesn’t make me want to become a patient and be on the receiving end of that derision – no matter what. Intellectually I know that the staff who speak like this are just trying to cope the only way they know how, but to me – the comments still get in and do their damage, because I think ‘that could be me they’re talking about’. It sure is destructive to professional and personal self-image. It’s such a croc listening to these sort of staff talk to patients face-to-face, and then listen to the comments they make afterwards. And it’s not just individuals. I’ve been in countless team meetings, handovers where the whole room jokes and mocks patients. This is the biggest reason I dislike working in mental health – the so called caring profession.

In all my connection to nursing I only have a handful of positive memories:

- Meeting my husband (fellow psych nurse) who is very knowledgeable and supportive to me
- The charge nurse who discussed my health with me directly - and firmly but kindly insisted I get help
- The moments where I felt like I really added something positive to a patient’s experience of their mental health
But by far, my experiences have been horrible – the way I’ve heard nurses talk about patients – how they devalue them, the disdain – why would I ever want to confess to having similar problems myself? Maybe if I hadn’t heard all I’ve heard from within the staffroom/office walls??

I don’t think I’d ever return to nursing – it’s too dog-eat-dog in one hell of a pressurised and aggressive backyard. I’ve thought about getting involved in consumer work, but it would be like coming out of the closet to my former colleagues and workmates, and I don’t want to think about the negative comments I know they’d make. Besides – I still don’t really identify with being a consumer. Luckily my health is now reasonably stable now that I’m out of nursing, and I like to align myself as a non-consumer.

I would like to think that I can still contribute somehow to mental health – hopefully this is one way of doing so.

Mary’s story

I did some Psych training in late 70’s in Auckland – I worked for a year in long term and rehabilitation wards, then I was working in elderly care – dementia units. I could not agree with or accept the custodial care or conditions that prevailed for inpatients especially the elderly in psychiatric wards at that time so I left and went overseas.

On returning from the ‘big OE’, I decided that nursing was for me, so I applied in a Auckland hospital to train as a Registered General Nurse, during the interview the Matron of that hospital said that because I did not finish my Psychiatric training I would not be allowed to undertake general nurse training and had to ‘prove myself’ as an Enrolled Nurse first. I worked for some time as an Enrolled Nurse but senior nurses at that time were very dictatorial and hierarchical
and there was lots of horizontal violence and as an EN I was at the bottom of the heap I again retired from nursing.

I decided to do my RN training later in life in my late 30’s. I didn’t get into it for the money, but I wanted to do something good, and something worthwhile. I was an A student during my degree education, and I loved it. I wanted to go on and do my Masters’ degree, and had all sorts of big plans as a highly competent nurse in clinical practice. I totally bought into the “being a highly skilled and highly competent nurse” discourse. But I think that by the end of my three years, I was beginning to feel the resulting stress of striving to always be the best and having high expectations of myself and when I graduated I remember not really having any sense of joy about it.

I went to work for a surgical hospital, but I was mindful of my tutors saying that it is really important these days to have a specialty and I wanted to prove myself and make it in a high acuity situation. I wanted to get away from the horizontal violence often encountered in ward nursing, of not having any control over shifts, patient loads, or of feeling undervalued as a nurse like I had in the past nursing experiences with regard to the nurse managers of the ward. Surgical nursing wasn’t it for me, so I went to work in an emergency department of a major city hospital. I wanted to be the best nurse I could possibly be. I got along well, I was challenged, and I put a big effort into learning as much as possible about emergency nursing. My colleagues the department staff and I got along really well and I seemed to be coping. We were really busy and staffing levels were tight. As time went on, I became anxious and fearful before each shift in case I couldn’t cope at work. As time went on it was 24 hours before I went on duty that the fear would start. It would take over my life for the whole day before I was to go back to work. There were no big traumatic incidents, so I battled the fear and tried hard to suppress it, I didn’t feel like there was any reason to feel so bad.
At this time, I went to the nurse leader tried to explain how I felt about my clinical abilities especially for advanced situations and asked for help. I thought it was my lack of experience in certain procedures that was the reason I felt so anxious. The Nurse Leader was great, she organised a very experienced senior nurse to agree to be there for me in a ‘buddy’ role if there were situations that I encountered that I needed to talk about or seek advice. The senior nurse was wonderful and would never make me feel that my need for support was bad or that I was an ineffective nurse because I sort this kind of support.

Looking back now, I think that I didn’t trust the institution or my nurse leader enough to tell her what I was really feeling – my fear. I got help for the tasks of my job, but not for what I was feeling.

One day, during the usual winter time stuff of colleagues being off sick and lots of bugs going around, I got to work for a morning shift but I just couldn’t go into the department. There had been other nurses who had been off on stress leave before I lost the plot and it happened to me, but I just broke down crying and went in to see the nurse leader. She said to just go home, she gave me three weeks stress leave, and arranged for me to see a counsellor.

I felt incredibly guilty for leaving my colleagues, during a really busy winter. I could not go back to the department after the three weeks, I was depressed and shameful. My doctor prescribed anti depressants, the counselling was a joke. It still makes me tearful to think about it. The counsellor was awful. She tried really hard to tie my moods to an incident of abuse when I was a teenager, but I didn’t think it was relevant, and didn’t want to go there. I think she was trying to get me the visits free, through ACC.

I managed to get work as a nurse in other areas of the hospital, areas that were less stressful, but I still felt anxious.
I found my anxiety became so powerful that I worried about the patients to a point of wanting to go back and check on them – even when I was off duty. In another place I worked I felt that the nurses were working on a very thin legal line, the situation called for the dispensing medication under fairly wide “standing orders”, the doctors would sign for it later. I became really frightened about where I sat as a nurse, and couldn’t go on, even though I was asked to stay. This was just before Nurse Practitioners became registered and acknowledged, and I felt unsure and compromised about where I stood if there had been an incident. I started an internet course on pharmacology but I needed a classroom situation to learn effectively. There were no such courses available at that time in the town I was working in.

I felt that I must have had some sort of personality disorder because of the times that I have had this fear and anxiety nursing. It has taken over 12 months out of nursing to realise that I am not suffering a personality disorder, but perhaps the messages I gave myself about my abilities and the doctrine I believed, that to be a valued nurse I had to achieve in such complex areas so quickly out of training contributed to my feelings of anxiety.

I think that nursing is incredibly complex; it is difficult to do a good job of caring for the whole person in areas where staff shortages are common place. I feel good about caring for people, but I think my fears come from the pressure of being autonomous and not really having the feeling of being completely clinically competent.

I think that nurses are under tremendous pressure right from the time they start training to adopt the image of the specialist or nurse practitioner role, someone who is totally capable and indestructible. Perhaps it has never changed from the old days and that is why senior nurses were such bullies. I just never saw it then. I agree that nursing is a highly skilled profession; an art and a science. I upheld the ethic of “first do no harm” every day I practiced and I know we have to be the best in the interests of public safety. Sometimes I think it is just too hard, and
then I get sad about losing that part of myself. It is very painful for me to think about not being a nurse because I can’t handle the pressure. I still feel ashamed of not coping as a nurse.

It would have helped, I think, to have someone in the hospital to talk to about this, like clinical supervision, while I was in practice. Someone from mental health, not a counsellor but a nurse who could have listened to me and help me to see what was happening. Maybe I would still be practising today and may have achieved that “super nurse status”. 
Chapter Four: Nursing

As a nurse, you are the pillar of the community, seen as caring, compassionate, always helping. If a nurse breaks the rules, you always hear about it.

Alice
Figure 2: About alienation (64, 1989)
Isolation from the group was, for 64, a long term experience. In her story, she chronicles years of struggle to find acceptance and healing, finding instead rigid attitudes, lack of support, bullying and abuse.

About alienation speaks to me of whispering, anger and sadness. The clear figure with her hands on her hips seems to be the leader of the group, aggressively defending membership of the group and refusing admission. The other group members are turned away, heads bent as they murmur to each other, sharing in-jokes and making judgements. I feel an embodied cold heaviness in my middle as I contemplate this picture. I am challenged to see myself as 64 might see me. I can locate myself on the outside, being laughed at and, sadly, not knowing the joke. Working alone, and returning home, alone. But I also feel the sickness of guilt as I remember conforming to the group at the expense of an outsider. I feel the warmth of belonging, of shared laughter and needs met. As I am drawn into the art, I simultaneously pull away from it, fearing its insight.

Vignette: My job, my life

I smile into Arthur’s eyes as I adjust the oxygen cannula under his nose. I let my hand stroke his sunken cheek, trying to will him into a sense of peace with the force of my caring. I cast a consciously competent eye over the other drains and tubes that surround his body as I murmur quietly to him. This is what nursing is all about for me.

The senior staff nurse bangs into the room, shattering the moment. I turn away from my patient, reluctantly re-entering the real world. I become aware of noises; a rattling trolley, an irritating phone ringing, voices in the next room. There is a new admission coming in, the consultant is due on the ward for a family meeting and
a new graduate nurse has just arrived and needs to be shown around. I am to orientate the new graduate and find him something to do before the admission arrives.

The new graduate is standing against the wall in the nurses’ station. He looks uncomfortable; shoulders hunched but eyes watchful.

"Hello. I'm Angela," I announce, striding briskly past him towards the staff room.

"Um, Josh," he mumbles.

I show him the combination to the staff room; "Make sure you keep the door locked," I instruct. "There are thieves in the building. One nurse lost her bag last week - her cell phone, her purse, the lot."

I show Josh where the staff toilets are, how to fill in his time sheet for the pay office and where the roster is. He is very quiet. I check the watch that hangs from my chest. We have a few minutes before the admission arrives, so we go back to the staff room and make coffee. As we sit down I begin to explain the realities of life as a registered nurse to him.

"We are a 24 bed unit," I begin, "but there is usually an overlap of at least six patients." He looks up from his cup.

"We discharge about six patients a day, and admit that many to the ward. Most days the discharges don't go until the afternoon, but the admissions arrive before lunch. You have to be on your toes to make sure the beds are done early so the admissions have a place to go. We get the discharges to go to the patient lounge and stay there until their scripts are ready and they can leave."

Josh just looks at me, and I feel a flash of irritation. He isn't making this easy, and doesn't seem to appreciate that I had to interrupt my day to see to him.
“I don’t know what they taught you at that University, but you can let all that patient centred stuff go out of your head right now,” I say sharply. I see Josh begin to shake his head and his mouth open to speak.

“There’s no time. You’re in the real world now. You have a responsibility to all the patients and the other nurses on the shift. If you think you can spend ages with just one patient, then this isn’t the right place for you.” I feel my face flush; hot cheeks and a suddenly itchy collar. I feel stupid and mean, and I don’t know why I said that. It’s true, but I’m usually better with the new staff than that. I still remember how hard I found it here for the first few months.

Being a nurse is everything to me. I belong here in the hospital, in this ward. It’s like a second home to me. Being a nurse is a huge responsibility. The biggest. You have to be accountable for every single action you take, and for the work the enrolled nurses and hospital aides do as well. There’s no time to slack off.

I smile at Josh, silently making amends. “Come on; let’s make sure the room is ready for the admission.”

At home I put the jug on and stand at the sink while I take my medication. I’ve been on antidepressants for the last two years, thankfully. Life was almost unbearable before I started them. As a nurse, depression is not an option!

I can hear Rob moving around in the bathroom, and add a second cup to mine. We enjoy this routine time together when I work a morning shift. Just the two of us, before the kids get home.

I glance through the mail as I wait for the jug to boil. Oh, no. There is a letter from Nursing Council. Please, no. My breathing catches, then comes fast and I can feel sweat prickling under my hair. Please please please please please. I push the letter into the middle of the table with one finger, nudging it carefully until it is square with the edge. Turning my back to the table, I keep my head turned away from the menacing white envelope, concentrating on the teapot.
“How are you, love?” Rob leans in and kisses my cheek.

The words won't come out past my frantic breathing. Rob guides me towards the chair, “Sit down, take some deep breaths like the counsellor showed you. I’ll make the tea. Something at work, was it?”

He notices the envelope. “Oh, love. Is it bad?”

I grab the envelope and tear at it. The paper bunches up and I can’t get the letter out. I struggle; finally it comes free and I stare at it. My hands are shaking. The letter has the blue nursing council letterhead, and it takes me a few moments to make sense of what I am seeing. I take a deep breath and feel suddenly light-headed and nauseated. It is an invoice for my practicing certificate. I read it again. It doesn’t say that I will be audited; it doesn’t say that there has been a complaint against me, and it doesn’t say that I shouldn’t be a nurse if I have to take medication. I’m safe. Still anonymous; unjudged.

Rob sits down, hands me my tea. I cradle the mug in both hands and breathe in the fragrant steam. I know he is studying me, watching to see that I am not going to break down and cry. He reads the letter from where I let it fall onto the table.

“Well,” he beams. “That’s OK, then. What would you like for tea? The kids'll be home soon and you know that’s the first thing they’ll ask.”

I keep my eyes on the mug. Rob doesn’t have the slightest idea about how I feel about being a nurse. I’ve tried to explain it to him, but it comes out sounding feeble. Or worse, it sounds mad. Even when I feel sad about something obvious and ordinary at work, like a patient dying. It’s like he misses the point. He tries, he really does. But the intensity, the responsibility - I guess you have to be a nurse to feel it. I feel like I’ve had a lucky escape today, but I still feel the grief that lodged itself in my chest at the thought of being found out, of being deregistered. If I’m not a nurse, then I don’t know who I am.
I smile at Rob, pretending to relax. When he goes back to the workshop I’ll start tea, then I’ll just give the ward a quick call. I’m sure I remembered to tell them that Arthur needs to have his ointment put on his heels tonight, but it never hurts to check, does it?

* * *

The collective story of nursing

Being a nurse

The weight of the nursing identity features in many of the stories as something to be proud of, something to rail against, something to be fearful of and something to grieve when it is lost. The nurses talked about society’s expectations of nurses being higher than for everyone else. Nurses should be indefatigable, altruistic, and good. This identity was discussed by several nurses as being instilled through the years of undergraduate education, whether this occurred in a hospital or polytechnic. Several of the nurses identified that their previous life experiences and personality traits have impacted on their understanding of what it means to be a nurse. Chloe describes herself as “a bit of a perfectionist,” as does Julie; “I’ve always been a perfectionist. Anything I did that didn’t live up to my standard for me was a disaster. Any small errors at work meant that I was a terrible nurse.” Julie also describes the rift with her spiritual identity when she came out as a lesbian being a contributing feature to her mental illness. Similarly, Elizabeth notes “I came from an abusive background and I was afraid of everything,” and Alice says “Right through my career I’ve been kind of timid – quiet, tried to stay away from attention, even sensitive.” For these nurses, feeling fearful and anxious was a feature of their lives prior to becoming nurses. While many of the nurses did not comment on the reasons behind their decision to nurse, Alice says of her decision, “I guess I wanted to be liked and loved!” and Josephine disclosed: “Looking back now, I can see that I became a nurse because of the abuse I suffered as a child. I guess I thought that if I cared for everybody, then they’d care for me.”
Jayne, too, identifies that “ultimately I want to be a psych nurse, because of my own history.” In contrast, Mary wrote about her motivation for becoming a nurse; “I didn’t get into it for the money, but I wanted to do something good, and something worthwhile. . .” but notes:

I think that nurses are under tremendous pressure right from the time they start training to adopt the image of the specialist or nurse practitioner role, someone who is totally capable and indestructible . . . I totally bought into the “being a highly skilled and highly competent nurse” discourse. But I think that by the end of my three years, I was beginning to feel the resulting stress of striving to always be the best and having high expectations of myself and when I graduated I remember not really having any sense of joy about it.

Like Mary, other nurses discussed their education. For example, Jenny says:

I found nursing training to be academically focussed and ‘sink or swim’. There was no ‘schooling’ in the most old-fashioned sense of the word. I wish someone had pulled me aside and quietly and kindly told me how to broach tough health-related questions, or how to introduce myself to a patient when all their mates the same age as me are sitting around the bed, or how to ask a man for a urine sample while his wife is there, or how to reconcile being friendly with patients without actually being their friend.

Elizabeth remembers “the warm nest of prelim,” but Chloe’s recollection is tinged with anger about her subsequent experience:

When I was training I totally bought into the whole humanist idea of having the patient at the centre of care. I mean, I really lived that idea. Then when I started in theatre I found that it isn’t that way at all. It is a very dehumanising environment.

Similarly, Julie notes that “I was trained to pick up responsibility for the whole ward, rather than just your own area. . . You take this huge responsibility for others’ feelings, and you try to make everything better.”

Helen and Michelle also discussed their education as a contributing factor to their mental illness, particularly in the context of bullying by senior nurses or tutors.

The expectation of near perfection that many of the nurses developed through their education is carried into nursing work, but is particularly distressing for those nurses who identified feeling uncomfortable in their nursing persona. Elizabeth notes, “I love nursing, but I’ve never felt
comfortable in my ability to be a nurse.” Likewise Helen says “I felt conflicted within the role of nurse,” and Jenny says “I didn’t ever feel comfortable with my identity as a nurse.” Jenny adds:

I attributed the ill-fit of nursing to my own personal deficiencies . . . I felt like an impostor in a critical and foreign environment. . . I also felt a sense of failure for not being able to cut it as a nurse.

The sense of failure Jenny identifies is echoed by other nurses, as they address the issue of what it means to them to be nurses. Alice says “I love nursing and being a nurse . . . not being a nurse would be a big loss to me – I’d be devastated if I lost my registration . . . loyalty to nursing and to the service is a big part of my life.” Josephine, who did in fact have to leave nursing against her will, says:

I feel that after all this time I am no good to anyone, like my life has been wasted, am worthless and incredibly hurt. I have been passionate about caring, about nursing, and about patients. Now I feel that I don’t care about anyone any more. I’m lost.

Mary has also had to leave nursing as a result of her experiences. She relates; “it is very painful for me to think about not being a nurse because I can’t handle the pressure. I still feel ashamed of not coping as a nurse.”

The sense of shame is repeated in Jenny’s story, where she explains, “I felt a sense of deserting the ‘good fight’ for the mental health system by getting out of it . . . I also felt a sense of failure for not being able to cut it as a nurse.”

Gemini, too, touches on the theme of shame. She notes . . . it is hard to accept that you’re just a human being. For some reason, mental health nurses are supposed to be immune. By accepting that we need treatment, we ‘let the side down.’ It’s not supposed to happen to you.

That the nurses feel that they have failed their colleagues or the health system in some way by becoming mentally unwell has resonance in the issue of stereotyping.

Alice discusses the stereotypical image of nurses as “caring, compassionate, always helping,” and comments that “if a nurse breaks the rules, you always hear about it.” When Chloe felt
overwhelmed by her feelings of frustration and despair at work, she “talked to some of my friends about what was happening, and I was reassured when they told me that it was good that I cared so much.” However, she also feels the weight of a “huge sense of guilt and responsibility” about being a nurse. Helen, on the other hand, reports that she did not feel “that commitment that said I would work all night after my shift, work without pay, do anything for anyone, be humble . . . That kind of commitment is expected of nurses, and I couldn’t give it.” Nor did Jenny fit with her own “strong preconceived notion that nurses were stereotypically kind creatures, softly spoken, feminine girly-girl maternal types.”

It is clear that the nursing identity holds strong emotion for these nurses, whether they adopted or rejected it. A close attendant to the nursing identity, however, is nursing work. Some of the nurses found that the work they did had little effect on their experiences of mental illness, while it is central to the problems the other nurses described.

Doing nursing work

For most of the nurses, the work they perform is integral to their identity, so the two are barely distinguishable. There are, however, aspects of contemporary nursing work that the nurses clearly do not perceive should be a part of nursing work, such as short staffing, having little control over the hours worked, or working in unsupported environments. Two of the nurses in this study have chosen to leave nursing. As they discuss their early experiences of doing nursing work, it is evident that they are trying to cope with aspects of their lives that were not necessarily compatible. For example, both Helen and Jenny refer to social aspects of nursing work; “waiting on the patients” (Helen) and “being the ward hostess” (Jenny). Helen notes that she “had little sense of how to relate to patients in the role of being a nurse,” and Jenny says that “I can’t think of a more poorly suited role for me than nursing.” Jenny describes feeling anxious about the reactions of others if she left nursing. She imagines the question:
Why isn’t she using her nursing ticket? To which I’d have to honestly reply: ‘Because I’m shit scared of being expected to be competent with people – because frankly I’m not really a people-person.’

Jenny’s comment about being uncomfortable with the expectation of being competent with people is contrasted later in her own story when she identifies mental health nursing as the area where she felt the most comfortable and useful:

I felt at home with the openness of the staff, their sense of humour, and being able to listen and be part of deeper matters, rather than forcing myself to take part in the trivial irrelevancies of small talk . . . I felt useful, and I reckon I was a pretty good nurse.

The importance of feeling competent is further demonstrated in Josephine’s story. One of Josephine’s areas of expertise and comfort was in caring for people with head injuries. There is a palpable sense of pride as she describes being “extremely creative in managing certain behaviours they exhibited.” On the other hand, Vicky’s story illustrates the profound effect losing that sense of competence had for her:

I was used to being on top of things and a competent skilled mental health nurse who could manage most situations in a calm rational and safe manner – my colleagues had come to rely on this. Maintaining this level of practice became more and more difficult . . . on one particularly stressful night I had the awful realisation that there was nowhere to go for help – that I was it . . . I changed jobs . . .

Alice describes being unable to experience feeling competent at times; “with all these roles, it isn’t possible to give your best to everything, so you get no sense of completion and everything is only half done, if that.” Similarly, Elizabeth talks of the difficulty being competent in particular clinical areas, “I don’t do well when things happen fast. In the surgical area I was a nervous wreck. I did much better in medical areas, where it was slower and I could form relationships.” Mary, too, describes “the pressure of being autonomous and not really having the feeling of being completely clinically competent.” She goes on to say “I think that nursing is incredibly complex; it is difficult to do a good job of caring for the whole person in areas where staff shortages are common place.”
In line with Mary’s comment about staff shortages, many of the nurses discuss the impact of working in areas where staffing and support is inadequate. Michelle reports:

We were understaffed . . . I was working 60 hour weeks in spite of having a contract for .8 and received no recognition for the work. The working conditions were awful. . . None of the three staff on the unit had full time contracts, so there were unfilled shifts every week. The kind of work we do is very precise, and there is no room to change the routine around. So we would work through our lunch breaks . . .

Similarly, 64 wrote about the ward she worked in being chronically understaffed and I would frequently find myself running the ward with 2 ‘agency’ nurse aides neither of whom knew the ward layout; or the patients; or how to care for a patient. I found this very stressful, as I was only just able to cope with doing my own work, let alone theirs as well.

The increased stress levels as a result of working in understaffed environments are clearly a significant contributor of distress to these nurses. Further to this, though, is the sense that nursing work is not well understood by non-nurses, thereby reducing the support that is able to be offered by other disciplines and family. For example, Ellie recalls

We went through a tough time at work, when 12 children died in a 3 week period. That was very hard. My staff turned to me for support, which was fine, but I had nowhere to turn, no-one to talk to about what I was experiencing. I did talk to my family, of course, and they were great, but they couldn’t really understand what I was going through from a nursing perspective. They did try, though. The doctors weren’t any help, either – their attitude was to just “get on with it.” They didn’t like to talk about it at all.

Alice, too, notes that “my family don’t really know what to do when I cry and feel bad. That can be frustrating and lonely – I shed most of my tears alone, which is sad.” For Anne, however, there is a lack of support from her manager, a non-nurse. Although Anne’s position carried full responsibility for the patients and direct care staff, she says that her manager “didn’t understand well the job I was doing . . . [and was] uncomfortable that I was earning almost as much money as she was.” Anne asks, “Where do Nurse Managers go for support?”

This theme is echoed in Julie’s story about the events following the death of a patient which resulted in the threat of a Health and Disability Commissioner’s inquiry. Julie says
I was kept busy supporting my staff, and also supporting management who were terrified of being on the front page of the newspaper. So I looked after everyone else except myself. I received a lot of negative feedback around that time, which I took on board. I pretty much kicked myself in the head over it! Yet, looking back, I didn’t do anything wrong.

In this story, Julie also raises the issue of responsibility. Although she did not act incorrectly, and the inquiry did not eventuate, she talks of feeling responsible. Mary’s sense of responsibility for her clients had her feeling so anxious “that I worried about the patients to a point of wanting to go back and check on them – even when I was off duty.” Chloe, who worked in theatre, talked about tensions in her role between what she believed her responsibility was towards the patient’s needs and the time constraints involved in making efficient use of theatre time; “I felt this sense of responsibility for the patient, and would be torn between what was needed so the team could get on with the surgery.” Vicky, too, discusses responsibility with regard to being on call. Although she was prescribed sleeping tablets to help to cope with her anxiety, she did not take these while on call, for fear of not being able to respond to her pager. Vicky recalls, “I felt a huge responsibility to continue as part of the roster and never reneged on my commitment to it, but I became so anxious that I could hear the pager going off even when I was not carrying it.”

The impact of nursing work is something that took Chloe by surprise. She says:

I thought this life of a surgical nurse, in that acute setting, would be glamorous and exciting. I never knew about the intense sense of responsibility, and that the more senior you get, the more responsibility you take

Helen, too, felt “deceived and let down” by nursing work. She says, “My belief in medicine was shaken by the things I saw, and the way I was treated which left me feeling very hurt and isolated.” This feeling of being overwhelmed by the realities of nursing began for Morrie as a mature student:

I felt I could manage with the volume of study that was expected from the undergraduate nursing course, as well as cope with the day-to-day reality of supporting a family. Not so! . . . As I have progressed into my registration as a nurse I have had the odd period where the type of nursing I do tends to have an impact on my mental health and well-being.
Along with the recognition that nursing is hard work, the nurses also raised issues related to feeling powerless to control their own environments. Mary reports

not having any control over shifts, patient loads, or of feeling undervalued as a nurse. . . . In another place I worked I felt that the nurses were working on a very thin legal line, the situation called for the dispensing medication under fairly wide “standing orders”, the doctors would sign for it later. I became really frightened about where I sat as a nurse, and couldn’t go on.

Rachel, too, reports that,

without any kind of consultation, I was put onto full time in a very heavy geriatric ward, then I was put onto 6 weeks of night shift. I wasn’t sleeping, and was trying to function on about 2 hours of sleep a day, if I was lucky. I just about fell apart then.

This experience is also consistent with 64’s story. She recalls being exhausted and knowing that she needed to have consistency in her working hours. 64 requested that she be rostered regular afternoon shifts because:

1. jumping from am to pm to am etc was exhausting. 2. she rostered me double duties, e.g. 3 – 11pm then 7am – 3pm the next day. Because I was on a large dose of nortriptyline and epilim, if I took it at 10pm I was too hungover to work a morning shift. 3. I was inclined to be groggy in the morning because of the drugs I was taking and therefore functioned better in the afternoons. My superiors were deliberately obstructive over this . . . in spite of the fact that all the other RN’s did NOT want to do this shift.

Jayne and Michelle both commented that their regular working hours have assisted with their mental health. Jayne notes that, “getting good sleep is very important to my ongoing mental health, and it is so good to wake up at the same time every day,” while Michelle received support to change her hours;

I’d been working night shifts, and finding it impossible with the pills and everything. So I applied for a job that meant I would be working days only. I met with the CNE and the new grad co-ordinator about the position. They could see that my hands were shaking, and knew that I’d been having trouble with the shifts, so they decided it would be best if I had regular working hours.

The nurses recount their experiences of doing nursing work and the impact the work had on their health. Nursing work has been shown here to be inherently stressful, with the nurses articulating their distress when dealing with low staffing levels, working beyond one’s competence and
capacity, and the sense of responsibility engendered by society in the identity and work of nursing. This is accompanied by a lack of control by nurses over their work environment.

The two sections of the collective story, being a nurse and doing nursing work, both identify tensions and stressors for nurses as well as positive and affirming aspects of a nursing career. Some of the nurses cited undergraduate education as creating unrealistic expectations of clinical practice and nursing responsibility, and discussed feeling let down by their induction into the nursing group. The importance of the nursing identity is highlighted, and education and nursing work are both identified as contributing to the development of nursing stress and distress. Workforce issues such as understaffing, poor skill mix and shift work are all discussed by the nurses, but it is noteworthy that the nurses did not relate these stressors as distressing in settings where they described their environment as supportive or caring.

Although the nurses speak about their individual lives, this motif has drawn together aspects of the nurses’ experiences into a collective story that suggests the wider nursing population might have some similar experiences. This possible connection will be explored in the next section, which examines the body of literature pertaining to the nurses’ collective story.

**The Literature**

There is a very large body of literature that addresses being a nurse and doing nursing work. I have selected literature for this review based on its value as being relevant, contemporary, foundational, and/or authoritative research findings.

This literature review is initially guided by the topics that emerged in the collective story of nursing. Further than this, the literature expands to include areas that have emerged from the original literature. For example, the collective story contains information about experiences with education and educators. This linked with literature about how nursing is taught and performed, which correlated with literature about emotional work. In this way, the literature review connects
the ideas and contexts generated by the collective story, rather than being applied rigidly to the topics covered.

I began the literature review into nursing by examining the current context of nursing in New Zealand. This is followed by an examination of the literature about who chooses to be a nurse, how nursing identities are formed, and behaviours that attend and sometimes define the nursing identity. In this section I also review the literature about education and nursing identity. Practice issues constitute the next body of literature examined here, and include the causes and impact of nursing stress, emotional work, responsibility and competence.

The literature that addresses these areas is critically reviewed against the backdrop of the Nursing Motif, the current New Zealand context, and Lyotard’s theory of phrases and genres (Lyotard, 1988).

As discussed previously, Lyotard (1988) defines genres of discourse by their ability to supply “a set of possible phrases” (p. xii) that work in concert to attain a particular goal. In this way, genres are explicated by both the phrases they employ and those phrases that are marginalised or excluded. Additionally, Michelle Fine’s notion of ‘working the hyphen’ (1994) is employed during the literature review where an interpretation of the social context of genres is required, as this is not a feature of Lyotard’s theoretical position. This is particularly relevant where the discussion turns to the nurses’ experiences of two or more genres.

**Nursing in New Zealand**

Nursing practice in New Zealand takes place within a neo-liberal political society whereby individual freedom of choice is the prime focus of the market economy (Crowe, 1997). The primacy of the individual and the rise of a market economy has had a profound impact on the healthcare sector and therefore on nurses. Desirable outcomes from nursing practice include patients being moved through the healthcare system and discharged within an allocated period of
time, minimal consumer/patient complaints, few side effects from treatment, and a cost effective use of resources. Whitlock (2002) notes that contemporary nursing has responded to this by focusing on demonstrable expertise.

National and international literature highlights the increasing complexity of the nursing role. This is evidenced by a high degree of responsibility for quantifiable practice and positive outcomes, high levels of work related stress, staff shortages, and high staff turnover (J. Goodwin, 2002; Ministerial Taskforce on Nursing, 1998; Olofsson, Bengtsson, & Brink, 2003; Philips, 1996; Ruggiero, 2003; Shirey, 2006; Stevens, 2002; Street, 1992; Taylor, White, & Muncer, 1999; Whitlock, 2002). Nurses are also under pressure from the imposition of frequent healthcare reform, an aging population, an aging nursing workforce and the rationing of resources (Carroll, 2002). Furthermore, the drive for evidence based health care requires that nurses be continually updating their practice in line with the latest research, and also incorporate advances of information technology and improvements in medical technology into their practice (Bucher, 2006; Holmes, Perron, & O'Byrne, 2006; Mandzuk, 2006; McArthur, 2002; Rycroft-Malone, 2006; Spear, 2006; Traynor, 2006).

Notwithstanding these pressures, nurses are held more accountable than ever before for their practice under national statute and the monitoring function of the Nursing Council. These include the Health and Disability Commissioner Act (New Zealand Government, 1994), the Health Practitioners Competence Assurance Act (New Zealand Government, 2003), the Competencies for the Registered Nurse Scope of Practice, according to which ongoing fitness to practice is assessed (Nursing Council of New Zealand, 2005) and the Code of Conduct (Nursing Council of New Zealand, 2001).

Using Lyotard’s (1988) philosophy, the phrases in the above literature about nursing practice include ‘competence,’ ‘responsibility,’ ‘evidence,’ and ‘accountability.’ Nursing is articulated there within a frame of expertise which is aligned with evidence and is demonstrated by
competence. The demonstrability of expertise and evidence enables nurses to be accountable for their practice. The use of these phrases suggests that nursing is aligned with a positivist genre which allows language to focus on measurable and finite knowledge. The literature about nursing education enables further examination of this impression.

Education

The education of registered nurses in New Zealand can be traced from its formalisation in 1901 as an apprentice-style process of learning-through-doing, through its move to a more academically focused studentship in polytechnics in the 1970s and 1980s, to the adoption of the current three year undergraduate degree as the basic preparation for registration from the 1990s to the present (Carpenter, 1971; Department of Education, 1972; Department of Health, 1974; Horsburgh, 1991; Papps & Kilpatrick, 2002; Prebble, 2001). The location of the early apprenticeship style of training was in the hospitals, with nursing students an active, paid part of the health workforce. The move to educational institutions signalled a change to the nursing workforce as a whole, as the emphasis moved to academic preparation and student nurses became less visible in the clinical nursing infrastructure. Additionally, the pedagogy in nursing education moved from teaching to ‘do’, to teaching to ‘know’ (Papps & Kilpatrick, 2002). Concurrent with this change in education practice, nursing became increasingly focused on its status as a profession.

A key requirement of a profession involves the possession of a body of knowledge that is specific to the profession, thus rendering education vitally important not only for individual nurses, but for the future prospects of nursing as a whole (Crowe, 1997; Law Harrison, 1990; Salvage, 2006; Street, 1992). With undergraduate education established to baccalaureate level, postgraduate education for registered nurses has assumed an important position for New Zealand nurses.
New graduate nurses entering mental health settings and, increasingly, general settings within the public health sector do so through one-year new graduate programmes designed to support their beginning practice to a competent level and develop a postgraduate academic knowledge of their chosen specialty (Expert Advisory Group on Post Entry Clinical Nurse Training Programmes, 2004; Kemp, 2005; Ministry of Health, 2004). For experienced registered nurses, Annual Competency Based Practising Certificates require that nurses undertake a minimum of 60 hours of professional development within a three year period and demonstrate links between their ongoing education and competent clinical practice (Nursing Council of New Zealand, 2005). Moreover, the emphasis on evidence based practice, discussed above, reinforces the need for ongoing education for nurses.

The literature about nursing education adds phrases about ‘baccalaureate education,’ ‘postgraduate education’ and ‘professionalism’ to that of practice. However, an examination of the phrases of nursing thus far reveals that there is more to consider than a positivist way of knowing. Nursing, although laying claim to a measurable body of knowledge, is also interested in the application of knowledge in practice. Requirements of demonstrated competence, specific practice areas of expertise, and measurable outcomes, combined with evidence based practice and ownership of a professional body of knowledge, suggest a local nursing genre of ‘mastery.’

Postmodern expectations of pluralism and multiplicity (Best & Kellner, 1991) indicate that the literature I have drawn on above is a partial and contestable view of nursing. Within the genre of mastery, there have been expressions of disquiet from nurse academics about the changes to nursing education and the development of a professionalism focus (Freshwater, 1998, 2000; Papps, 1997). Other dissenting nurses have published their opinions in letters to the editor, editorials and opinion pieces in nursing journals (N. Anderson, 2007; Cottingham, 2007; J. Reid, 2007), while non-nurses have also been published on the subject of mastery (Chua & Clegg, 1989, 1990; Street, 1992). These authors assert that mastery is an elitist discourse that
marginalises non-academic nurses, disregards the practical nature of nursing work and creates conflict within the nursing profession. Even so, in the bulk of the nursing literature, the genre of mastery remains evident.

**Caring practises**

In addition to phrases located by the mastery genre, the nursing literature also reveals a focus on caring practises. Caring is not described as a quantifiable aspect of nursing practice, but its importance is affirmed in literature which describes it as a moral or ethical practice and a socially determined imperative (Finfgeld-Connett, 2006; Hamilton, 1986; Takase, Maude, & Manias, 2006; J. Watson, 1999, 2005). Caring is also variously held to be associated with maturity, humanism, competence, nursing’s claim to a professional body of knowledge, and a tradition that is subjugated by evidence-based practice (Barker, 2000; Benner & Wrubel, 1989; Bjorkstrom, Johansson, & Athlin, 2006; Cortis & Kendrick, 2003; Fahrenwald et al., 2005; Helin & Lindström, 2003; Law Harrison, 1990; Maeve, 1998; Morse, Solberg, Neander, Bottorff, & Johnson, 1990; Salvage, 2006). In this literature, caring is viewed as a practical nursing skill, in spite of its apparent intangibility and immeasurability. The tasks of bedside nursing such as ensuring physical comfort, anticipating patient needs, empathy and efficiency with nursing tasks are all aligned with the concept of caring.

Through the plurality of phrases such as ‘competence’ and ‘professional body of knowledge,’ caring is aligned with mastery and nurses are held accountable for their caring practises. Demonstrating caring is a complex process that involves receiving testimonials from clients about how they experienced nursing care, or from nursing colleagues who bear witness to caring practice, and re-presenting them to a nursing audience (Nursing Council of New Zealand, 1996, 2005). Synonymously, the testimonials are located within the social context which has constructed caring as a key part of nursing practice. This creates an affirming feedback loop for the nurse who is overtly caring in her practice, for example, the nurse provokes in the patient a
feeling of being efficiently looked after and is rewarded for this. Moreover, the value of the
caring aspect of nursing practice is explicated and reinforced by public acclaim such as the
annual ‘most trusted’ survey. Every year the National Business Review conducts a poll of the
people and professions New Zealanders’ trust the most. Nurses are consistently in the top four
most trusted professions (Anonymous, 2006, June; Bryant, 2005; Hill, 2000; N. Smith, 2004;
The Press, 2002). Thus, caring is constructed as an inextricable part of nursing practice and is
embedded there through the auspices of the mastery genre. The more nurses are required by
society, patients and other nurses to demonstrate caring, the more embedded it becomes in the
way nursing is described and practised.

Once more, the expectation of plurality suggests that there will be an alternative view. In
addition to its links with mastery, the intangible and subjective nature of caring practice
simultaneously locates it outside the more positivist genre of mastery. In the above nursing
literature and in conversation with nurses, caring is frequently described as a core nursing value
and an essential feature of nursing practice. There is a homogeneity among the phrases of caring
that locates it as a ‘truth’ of nursing. There is no available literature that argues against caring as
a key aspect of nursing practice. In line with Lyotard’s contention that a genre “imprints a unique
finality onto a multiplicity of heterogeneous phrases” (1988, p.129), caring is revealed as a genre
in its own right.

I have already noted that some phrases about nursing practice occur within both mastery and
caring genres, for example ‘competence.’ This indicates that there are areas of alignment
between the genres. This is contrasted by literature that records dissent between nurse-authors
who theorise nursing as a profession and those who write about caring practises. This dissent is
frequently conceptualised as a ‘theory-practice gap,’ whereby mastery of theoretical knowledge
and the application of practical skills are polarised (Astin, McKenna, Newton, & Moore-
Coulson, 2005; Higginson, 2004; Hoare, Forster, & Holland, 2004; Landers, 2000; Maben,
Latter, & Clark, 2006; McNamara, 2000). Viewing the ostensible theory-practice gap from the perspective of Lyotard’s scheme of genres, phrases pertaining to mastery and caring are clearly in conflict. Michelle Fine’s notion of the hyphen (1994) provides further elucidation of what happens for nurses in the space that joins and separates theory as an important facet of mastery, and caring practises as vital aspects of nursing practice.

**The mastery-caring hyphen or the theory-practice gap**

The Nursing motif contains a collective story about nurses’ struggles to integrate the caring and mastery genres into their practice. The literature uses the phrase ‘caring professional’ (Benner & Wrubel, 1989; Cortis & Kendrick, 2003; Noddings, 1996) to describe the practitioner who combines mastery and caring. Mary, one of the nurses in this research, conceptualises the person who achieves the combination of both genres as the “supernurse.” The collective story in the nursing motif illuminates the difficulty many of the nurses in this research have had in negotiating a connected and cohesive mastery-caring hyphen. In particular, Mary, Jenny and Chloe describe a disconnectedness between their mastery based undergraduate education and their desire to focus on the caring aspects of their clinical practice after they graduated. For these nurses, the hyphen signifies separateness and barriers between inescapably vital aspects of their nursing practice.

In general, nursing literature locates student nurses in educational institutions as the site of a struggle between academic theory and clinical practice, claiming that the result of the struggle is confusion and incompetence in new graduate nurses (Astin et al., 2005; Higginson, 2004; Hoare et al., 2004; Landers, 2000; Maben et al., 2006; McNamara, 2000; C. Stevenson, 2005b; P. Walsh & Jones, 2005). This is evidenced by new graduates in their first nursing positions being unable to complete nursing tasks that are conceptualised as ‘basic’ by their experienced peers, while being capable of challenging the evidence surrounding the performance of such tasks. The discomfort experienced by new graduate nurses as they negotiate learning caring practises is
mirrored by the discomfort of their colleagues who are being challenged to demonstrate and
defend their mastery of nursing practice.

*   *   *

The literature about the new graduate experience is unequivocal in its description and
explanation of new graduate nursing experiences. I wanted to check it further, in the
immediately local environment of the new graduate mental health nursing class I am teaching
this year. I took the literature to class yesterday and summarised it for the 18 nurses in the class,
asking them to comment on it. My request was met with a lengthy response that confirmed the
findings from the literature, involving personal stories of being belittled for their lack of
practical ability, being told by more experienced nurses to shut up and do what they’re told
instead of questioning, and having their knowledge consistently disregarded in their workplace.
The most dramatic stories involved being denied opportunities to expand their practical
knowledge, verbal abuse, and being ‘treated like a child’ and told to stay in the office while their
colleagues did the nursing. These were balanced by stories of being sought out by colleagues
and recognised as having the most current knowledge of theory, science and best practice. Also
on the positive side of their experience, some of the new graduates related stories of preceptors
and other colleagues who included them in all aspects of the workplace in a deliberate plan to
build their self-esteem as competent and capable nurses.

The plurality and multiplicity of these stories reflects the variety of practice settings, and
preceptor and new graduate abilities, expectations and attitudes. They are very local stories, and
my previous experience with new graduate nurses suggests that the stories are also partial re-
presentations of their new graduate year which may change as time goes on. Some new
graduates who rail against restrictions on their practice will later evaluate their supervisors as
wise, recognising limits in knowledge and ability that the new graduate is, in her neophyte
location, unaware of. Others may have the converse experience of recognising apparent
confidence by their preceptors as a laissez-faire attitude that placed clients and new nurses at risk.

Regardless of the content of the stories, the atmosphere in the classroom and the personal conversations that accompanied the stories illuminated the struggles for these new nurses as they negotiated the differences between what they expected of clinical practice and their colleagues, and the reality of their daily experiences (Research journal, July 2007).

*   *   *

The defensiveness of nurses who champion the primacy of either mastery or caring is a feature of research which investigates education from the theoretical stance of power and emancipation. Such research asserts that nursing students are the site of a power struggle to define the legitimacy of nursing knowledge (Freshwater, 1998; Meissner, 1986; Papps, 1997; S. J. Roberts, 1983; Street, 1992; Waldow, 1992). The results of such struggles are new graduate nurses who are uncertain about their ability to practice, unwilling to risk asking questions for fear of being verbally abused, or who are aggressive in their assertion of mastery. These responses align with the theory of nurses as an oppressed group, which is discussed in Chapter Six.

Integrating both the mastery and caring genres into clinical practice was an unachievable aspiration for Mary, Chloe and Jenny. Literature suggests that their experience is shared by many nurses, and is fostered by the rigid and often conflicting requirements of theoretical knowledge and caring practises throughout education and practice settings (Bjorkstrom et al., 2006; DeVries, Dunlop, Goopy, Moyle, & Sutherland-Lockhart, 1995; Fahrenwald et al., 2005; Freshwater, 1998; Greenwood, 1999; L. Hall, 2001; Hamilton, 1986; Papps, 1997; D. W. Roberts & Vasquez, 2004; S. J. Roberts, 1983, 2000; Takase et al., 2006; Wamsley, 1995). Adding to the complexity of the mastery-caring hyphen, Cinnamon Whitlock (2002) and Jane Goodwin (2002) assert that societal trust in the caring role adds an emotional load to new nurses’
requirements of professional knowledge, accountability and developing competence in their early practice experiences.

The consequence of hyphenated, dissenting genres for these nurses has been discomfort and distress. For Mary and Chloe, education was a joyful experience, but the chasm between the theoretical ideal of nursing and the practicalities of caring in the workplace was too great to negotiate. Both of these nurses attribute their mental illnesses to dissent in the hyphen between the genres of mastery and caring.

Lyotard (1988) defines a differend as a feeling, a moment of silence when words cannot express the injustice of being caught between genres. At the local, individual and partial level, the differend has been a feature of Mary’s and Chloe’s experiences. For Mary it occurred at the mastery-caring hyphen where she relates that she was unable to achieve the level of mastery she expected of herself and believed was expected of her by other nurses. In her inability to achieve mastery, she was unable to demonstrate caring and went to extremes in her personal responsibility for her clients. For Mary, the differend contained feelings of fear and shame, and it became impossible for her to continue to work as a nurse.

For Chloe, the differend also occurred at the mastery-caring hyphen but was complicated by limitations in workplace resources and the pragmatic values of her team members in theatre. Her outrage at being located by her team as unable to feel a connection with her small patient, while being prevented from demonstrating mastery that met the requirements of her educational expectations, is reflected in her story. For Chloe, too, her experiences at the differend ultimately resulted in leaving her nursing work, as she developed a mental illness that she attributed to her confusion, distress and anger when she was unable to effectively negotiate the mastery-caring hyphen.

Lyotard (1988) identifies and theorises the differend, but he does not discuss what happens for people when they experience a differend. As I discussed in Chapter Two, Michelle Fine’s (1994)
notion of the hyphen provides a conceptual framework to underpin an exploration of how people negotiate the space between genres, but she does not specifically identify a moment of powerlessness where negotiation is not possible and feelings of injustice and pain take the place of speech. Mary and Chloe both negotiated the hyphen between mastery and caring by seeking help from colleagues and mental health professionals, compromising their personal values and seeking recognition for their concerns\textsuperscript{14}. When their negotiations were not effective, they each reached their local differend and they were silenced.

A differend at the micro level is partial. Mary and Chloe had social identities that were independent of their nursing identities so they had resources beyond the differend. They each took action to end the differend by removing themselves from it, leaving nursing work, but their silence remained as a phrase in the discourse of nurses who leave (Stevens, 2002). This action is explored further during Chapters Six and Seven, when further hyphens within and between mental illness, nursing and tangata whaiora are interpreted.

\textbf{Negotiating (gendered) knowledge in the hyphen: The ‘good nurse’}

For Jenny, there was an additional predicament in her education as she attempted to negotiate a mismatch of expectations that were grounded in gendered knowledge. Jenny identifies herself as “gumbooty” and lacking in the ‘feminine’ social skills and attributes that appeared to be requirements of the nursing persona. Although she “attributed the ill-fit of nursing to [her] own personal deficiencies,” Jenny does not express any doubt about her innate ability to do the work of nursing, only doubting the effectiveness of her education and her ability to meet the perceived expectations of the nursing image.

Jenny’s experience of her education points to gendered knowledge being used during the education process, yet gender is not overtly present in the literature about the practice of

\textsuperscript{14} The mechanisms by which nurses negotiate the hyphens are discussed in Chapter Seven
educating new nurses. The extant literature in this area reveals that much of the concern about gender in nursing education centres on its negative impact on men entering the profession (Anthony, 2004; Braun, 2003; Jinks & Bradley, 2004; McPeck, 2003) or its use as an instrument of oppression (S. R. Bishop, 2004; Freire, 1971; Freshwater, 1998; Group & Roberts, 2001; MacIntosh, 2002; Papps, 1997; Randle, 2003; S. J. Roberts, 1983; Waldow, 1992). The application of feminist theory to inculcate nursing values is widely accepted (Begley, 2005; Benner, 1984; Carper, 1978; Cortis & Kendrick, 2003; de Raeve, 2002; Doane, 2002; Freshwater & Stickley, 2004; M. Roberts, 2004; Webb & Warwick, 1999; Woods, 2005), but undergraduate nursing education as inherently female-gendered is a premise that has been advanced by few authors (Dahlberg, 1994; MacIntosh, 2002).

In nursing practice, gender is linked to the caring genre through phrases that evoke the socially constructed image of the nurse as a feminine, intuitive, selfless angel (Hallam, 2000; Meier, 1999; Strasen, 1992; Ulmer, 2000). Key among those phrases is ‘the good nurse’ (Alavi & Cattoni, 1995; Fairman, 2004), wherein nurses are judged by their peers as good or bad nurses according to their adoption of feminine attributes such as the aforementioned selflessness and invisibility. The gendered self-judgement of women nurses is also discussed in the above literature as contributing to a drive to be a visibly ‘good’ nurse. As Jenny says of her perceived lack of “gooing” over babies in her obstetrics placement, “I felt like not only was I not going to make a good nurse, I wasn’t going to make a good woman either!”

In his doctoral work about being a man and a nurse, Thomas Harding (2005) asserts that while men’s style of articulating their nursing care may be constructed from a male-gendered social position, their desire and ability to care for their patients is comparable to the nurse who is a woman. His research findings indicate that when men are challenged to demonstrate or articulate their caring practises, they too feel that they are being challenged to prove that they are good men as well as good nurses. Harding’s work demonstrates an alignment among nurses that
transcends gender difference, moving the discussion of the good nurse beyond the exclusive experience of women and into the realm of the socially constructed image of the nurse. Invisibility, intuition, caring and selflessness are features of the ‘good nurse’ regardless of gender.

The literature pertaining to gendered knowledge and practice in nursing is thus shown to be partial and contradictory. As my research progresses, I resist the assumption that nursing practice is able to be neatly divided into feminine and ‘other’ attributes. It is outside the scope of this thesis to explore such a significant topic in depth, but Jenny’s story and the extant literature conveys that further research into gender based assumptions and practises in nursing is indicated to fully understand its impact on nurses.

The ‘good nurse’ fits with Michelle Fine’s (1994) notion of a laminated other, whereby social, historical and cultural influences wrap a person firmly into a preconceived form, objectifying and distancing them. The collective story and the literature record nurses as ‘good,’ reliable, competent people who care selflessly. This image does not take into account an individual nurse’s motivations and needs.

Nursing: A ‘good’ career choice?

There is a paucity of research into why people choose to enter the nursing profession. What little there is focuses on the decision from a pathologising perspective and refers to Bowlby’s theory of attachment (1984). From this perspective, people compensate for early inadequate care by providing caring to others as reparation, thereby rendering pathological their attraction to caring professions such as nursing. Certainly some contemporary research appears to demonstrate that many people entering the helping professions such as nursing, counselling, medicine and psychotherapy do so out of a need to be needed, a condition variously known as ‘helping professional syndrome,’ ‘compulsive caring syndrome,’ or ‘the patient within’ (Farber,

New Zealand nurse and psychotherapist Sue Thompson (2000, p.3) writes about compulsive caring syndrome as an “overdeveloped commitment to caring for others,” arguing that this is a strength in nurses rather than a condition to overcome. Thompson aligns the need to care with altruism and feeling ‘called’ to nurse from a service paradigm. This is a position which is presented in some literature not only as a legitimate reason to enter the nursing profession but also as an indication of a ‘good’ or virtuous nurse (Hamilton, 1986; C. Jackson, 2004; J. Watson, 1999, 2005).

In contrast to this pathologised perspective, Thomas Harding (2005) found that some of the nurses in his research became “sensitised” (p. 126) to the need for caring professionals through personal experience. Others in his study referred to a family history of nursing, and still others to an altruistic desire to make a difference in the world. These reasons all align with the caring genre. Alice and Helen described their past experiences of family members with mental illnesses in the introductions to their stories, which suggest that they may have come to a nursing career as a result of a caring commitment. This is explicit in Josephine’s and Jayne’s stories as they directly relate their nursing career to their illness experiences and relate a desire to help others who might have had similar issues.

An alternative to this is the choice to become a nurse on the basis of its mastery, evidenced by a bachelor’s degree and a practising certificate. Literature suggests that the move of nursing into higher education has contributed to an international increase in the numbers of men choosing nursing as a career (Cohen, Palumbo, Rambur, & Mongeon, 2004; Fanning, 1997; T. Harding, 2005; Whittock & Leonard, 2003). New Zealand statistical information records an increase in men who are working as registered nurses from 1,567 in 1997 to 1,974 in 2000, and 2,205 in 2004 (New Zealand Health Information Service, 1999, 2002, 2004), but there is no definitive
research into the reasons for this increase. Morrie, the only man who participated in this research, did not discuss his reasons for choosing to become a nurse. In light of Harding’s (2005) assertion that men have similar caring motivations and aspirations to women, it seems likely that some women have also been attracted to nursing because of the appeal of the mastery genre and its tangible rewards. Nonetheless, the nursing motif contains phrases which align these nurses’ motivations with the caring genre such as ‘patient-centred,’ ‘compassionate,’ and ‘helping.’

The pathologising of a nurse’s ‘need to care’ creates a tension with the notion that a ‘good nurse’ is there for the purpose of caring. A hyphen is apparent, whereby nurses negotiate a balance between working within the caring genre, for example as they undertake daily care of their patients, and having their own need-to-care needs recognised. If a ‘good nurse’ is also selfless, then the tension involved in being rewarded for care is heightened. This tension is evidenced in the literature that examines the need for nurses to engage in self-care and the difficulties encountered in getting nurses to do so (Helin & Lindström, 2003; Hodgkins, Rose, & Rose, 2005; Hope, Kelleher, & O'Connor, 1998; Masters, 1995; Wamsley, 1995).

One way for nurses to have their recognition needs met is through belonging to the nursing group.

**Belonging**

While the caring aspect of nursing work might meet a need to care for others, the need to be needed can also be a powerful motivator for becoming a nurse (Finke, 2006). This need can be met through membership of an exclusive cultural group, such as nursing, whereby a bond is shared through common experience (Kehily, 1995; Sarup, 1996). Thus, the Registered Nurse title itself is rewarding for nurses as it confers group membership.

Nursing education and initial practice encounters support the formation of the nursing identity and build on aspirations to be a ‘good nurse’ by locating the neophyte nurse as a member of the
nursing group (Baptista, 2002; Cook, Gilmer, & Bess, 2003; Depoliti, 2003; Fagerberg & Kihlgren, 2001; Gregg & Magilvy, 2001; Waldow, 1992). Negative feedback and punishment delivered by senior nurses throughout education and early clinical experiences results in a new graduate nurse who feels the need to “conform to established patterns” of behaviour in order to avoid hurtful experiences (Alavi & Cattoni, 1995, p.8). In a process of ‘fitting in’ with the local environment, students and new graduate nurses compromise and negotiate their practice and at times their values as they attempt to match the often covert demands of the clinical setting with the expectations created by their education (Bradshaw, 1995; Maben et al., 2006; Papps, 1997; Randle, 2003; Street, 1992).

Fitting in is therefore a complex process involving meeting multiple expectations based on negotiating the hyphenated space between caring and mastery. It is particularly difficult for new nurses who have learned the skill of critical thinking but have not learned how to implement the ideas they generate through its application, or how to cope with the conflict they will experience as a result (S. R. Bishop, 2004; Freshwater, 2000; J. M. Hall, 2004). The tension generated by a desire to be a good person, a good nurse by applying their new skills, and being good by conforming to a group identity that may not value such skills, is such that new nurses often become disillusioned and exhausted, and leave nursing (G. McCarthy, Tyrrell, & Lehane, 2007; Stevens, 2002).

The Nursing motif contains several examples of the desirability of the nursing identity and the extent to which nurses will go to remain a part of the group. Alice, in particular, says that she would be “devastated” by the loss of her registration. She, Mary and Elizabeth all comment on their fear of making an error in their practice that would result in being ostracised from the nursing group. Josephine and Mary had, at the time of telling their stories, lost their nursing identity and therefore their group membership as a result of their illness. Both nurses identified significant grief reactions to this loss, in addition to the distress they were experiencing as a
result of their illnesses. 64 (Figure Two) uses her art to illustrate the power of the nursing group and the pain of being excluded.

The value of belonging to the nursing group is visible in the strength of the distress experienced by most of the nurses when they described being deliberately silenced, ostracised or otherwise excluded from the group. Elizabeth, Ellie, Josephine, Alice and 64 discuss being victimised by colleagues and managers. Vicky, Rachel, North Island Bunny, Julie, Chloe, Jenny and Morrie recall being isolated in their workplace to the extent that they needed to leave and find alternative nursing employment. North Island Bunny, Elizabeth and Alice all comment that the lack of support from their colleagues when they were being victimised by others outside the group was as bad as the victimisation itself. The violence implicit in the process of negative feedback and enforced fitting in is also a feature of the behavioural patterns of oppressed groups (S. J. Roberts, 1983).

Horizontal violence, bullying and silencing are all behaviours that are evident in the nursing culture and have been attributed to oppression (McCall, 1996; McKenna, Smith, Poole, & Coverdale, 2003; Meissner, 1986; Thomas, 2003; Waldow, 1992). Although the literature pertaining to nursing as an oppressed group could have formed a part of this motif, it is a more prominent aspect of the interpretation that follows in Chapter Six and is accordingly placed there. However, deliberate acts are not the only factors that can impact on a nurse’s membership of the nursing group. It is timely to note that inadvertent isolation from the nursing group can happen as a result of the experiences that brought the nurse into the group in the first place.

Throughout her story, Elizabeth records a wish to care for others and to maintain her nursing identity. She also relates a fear of making a mistake which, in addition to harming a patient, may also result in her being ostracised from the nursing group. Her vulnerability to mental illness has complicated her membership of the nursing group, and she has responded by hiding not only her illness, but the ways in which she managed it.
Eating disorder is very hard to manage when you’re nursing because of the irregular food intake. You have to be careful to eat regularly and that can be hard in some nursing environments . . . I’m sure that people think that there is something odd about me, but they’re not sure what it is (Elizabeth).

Secrecy for Elizabeth enables a vicious circle of not discussing the need for regular and predictable food intake, not telling colleagues why it is important to have breaks on time, and increasing anxiety about breaks, food and being ‘found out.’ The next step in Elizabeth’s anxiety cycle is a binge to control her anxiety, sabotaging the wellness plan of regular meals and further contributing to her isolation from the nursing group as her secret becomes more distressing. This pattern of hiding an illness, being unable to access the necessary support because of the secrecy, and the resulting exacerbation of the illness, is one that is also described by Gemini, 64 and Vicky during parts of their stories. These links between the collective story of the importance of the group identity and the impact of mental illness upon it are explored in more depth in the Tangata Whaiora motif. Of importance in the Nursing motif is the extent to which some of the nurses will go to avoid the possibility of being denied membership of the nursing group.

The value of the nursing identity is further evidenced in that even the nurses who have chosen to leave nursing work still responded to my advertisement in a nursing journal that specifically asked for nurse participants. Jenny, 64, Ellie and Helen’s responses suggest that being engaged in doing the work of nursing is not necessary in order to maintain the nursing identity, although their stories indicate that they have left the nursing group. All of these four nurses report being excluded from the nursing group in traumatic circumstances which include being bullied, silenced, unsupported, laughed at and derided. Yet they all still respond to their Nurse title. This apparent inconsistency will be further explored as the interpretation progresses in Chapter Six.

The emotion attending the formation and maintenance of the nursing group has led me to the consideration of how emotion features in nursing education and nursing work. The literature on emotional work is contained in the next section of this chapter, which examines work related stress and the concept of burnout.
Stressors, distress, emotional work and burnout

Stress is a complex, multilayered phenomenon that is experienced both cognitively and physiologically. In his 2002 literature review into workplace stress in nursing, Andrew McVicar (2003) notes the difficulty in assessing stress and distress due to its individual nature and the importance of considering contextual issues such as experiences, personality traits, environmental factors and varied understandings of the stress phenomenon.

In this examination of nursing stress, I have adopted Andrew McVicar’s (2003) framework that recognises stress as a continuum comprising the positive, exciting effects of some stressors, through to distress as a moderately negative response, and severe distress comprising significant physical and psychological symptoms.

There is a large body of literature that clearly establishes nursing as a stressful occupation that is present at all points of the stress continuum. A single search of the database EBSCOhost using the words “nurs* and stress” resulted in over 4,000 peer reviewed articles. Further similar results, although with new authors, were obtained from psycINFO and CINAHL. The articles explored stressors and moderate to severe distress from a geographical perspective, from Egypt (Arafa, Nazel, Ibrahim, & Attia, 2003), Taiwan (Chen, Wu, Yang, & Yen, 2005; Yang et al., 2004), Sweden (Olofsson et al., 2003), the UK (Prosser et al., 1999), and Australia (Lam et al., 1999); from a practice setting perspective (D. Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2001; Jenkins & Elliott, 2004; Prosser et al., 1999); and from a seniority/management perspective (Judkins, Massey, & Huff, 2006; Shirey, 2006). The sense of responsibility recounted by the senior nurses in these latter papers is consistent with distress arising from emotional work, rather than that of overwork or poor resourcing.

Further points of consensus among researchers include shift work as the main factor that results in the development of chronically exhausted nurses (Jamal & Baba, 1992; McVicar, 2003; Winwood, Lushington, & Winefield, 2006), closely followed by workload (Chang, Hancock,
Johnson, Daly, & Jackson, 2005; McVicar, 2003; Tummers, Janssen, Landeweerd, & Houkes, 2001), and the experience of types and severity of distress that differ between practice environments (Hemingway & Smith, 1999). Further literature identifies aggression from patients and their families as a frequent, distressing stressor for nurses (Farrell, Bobrowski, & Bobrowski, 2006; Lam, 2002; I. Needham, Abderhalden, Halfens, Fischer, & Dassen, 2005; Rodney, 2000; B. R. Walsh & Clarke, 2003).

Recent research into nurses’ stress expounds three findings. First, that acute fatigue resulting from workplace stress, in the absence of an adequate recovery period, can transition into maladaptive chronic fatigue. Second, that psychological stress is more damaging to nurses in the long term than physical stress. Third, that nurses who have domestic responsibilities tend to recover more completely from a stressful shift than their independent counterparts (Winwood & Lushington, 2006; Winwood, Lushington et al., 2006; Winwood, Winefield, & Lushington, 2006). This latter finding is not universal, as other researchers assert that balancing a demanding home life with workplace stress increases overall stress loads on nurses (Majomi, Brown, & Crawford, 2003). These findings highlight the individual nature of stress and distress, and indicate that the emotional component of stress and distress is an important factor when considering the impact of nursing work.

Practice settings and the type of nursing work may both be considered stressors, particularly the level of distress and trauma experienced by patients. Nurses working with severely damaged people, particularly when violence has caused the damage, may be exposed to ‘vicarious traumatisation’ (Buyssen, 1996) or moral distress. A model of moral distress suggests that the nurse experiences emotion-based distress from bearing witness to violent and/or unexpected trauma and values-based distress from being unable to practice in the most optimal way because of practical limitations in their environments (Abendroth & Flannery, 2006; Altun, 2002; Fry, Harvey, Hurley, & Foley, 2002; Severinsson, 2003). However, the nurses who work in settings
that are designed for rapid crises and seriously ill patients are not necessarily the most distressed (Gillespie & Melby, 2003; Happell, Martin, & Pinikahana, 2003; Taylor et al., 1999). The defining factors in this type of stress are whether the nurses are participating in the kind of work they expect to be doing, are experientially and personally suited for, have made an active decision to engage in, and that occurs in an environment that supports that work. Where these factors are present, nurses may experience significant stressors but remain excited and energised by their work rather than distressed.

The concept of being energised by stressors in a supportive environment is one that is reinforced by the Nursing motif. It is notable that when the nurses reported distressing levels of stress it was in the context of feeling isolated, victimised or ignored. Where they discuss working in a supportive environment, no mention is made of distress arising from nursing stressors, and work is portrayed as stimulating. For example, Rachel, Elizabeth and Alice discuss their work in supportive environments with an air of excitement and satisfaction. To the practice-based range of stressors, McVicar also adds management practises, professional conflict and emotional labour, asserting that these have been “the main collective sources of distress for nurses for many years” (McVicar, 2003 p. 637). These stressors are representative of those the nurses describe in their collective story of stress, so it appears that for these nurses the combination of the more relationship-based stressors with workload, patient distress and shift work is more distressing than the latter stressors alone.

A further factor in nursing distress lies in the public image of ‘good’ nurses as angelic, always available and selfless, which was discussed above (Baptista, 2002; Cook et al., 2003; Deppoliti, 2003; DeVries et al., 1995; Hamilton, 1986; McIntosh, 2003; Strasen, 1992). Alice, in particular, describes how community opinion functions as a stressor for her.

As a nurse, you are the pillar of the community, seen as caring, compassionate, always helping. If a nurse breaks the rules, you always hear about it . . . If you are pulled up for drunk driving, you are in the news as a “nurse” (Alice).
Alice’s perception is also echoed by Elizabeth and Mary. The social construction of the nursing image incorporates an emotional connection between nurses and those they serve. This connection is explicated in the literature about emotional work.

**Emotional work**

Research has highlighted a link between nursing work, emotional labour and stress (Bolton, 2001; J. Carson, Fagin, & Ritters, 1995; Mann & Cowburn, 2005; Philips, 1996; Zerbe, 2000). In her foundational work on the use of emotion as a commodity, Arlie Hochschild (2003) argues that there are two types of emotion at work – surface acting, whereby the employee pretends to be feeling the way the work dictates, and deep acting, whereby the person tries through emotional work to actually feel the way she believes she is supposed to. Further to this, Hochschild notes that there are three stances employees take towards emotional labour: the deep actor, who identifies too fully with the job and therefore “risks burnout” (2003, p.187) because she loses the sense of acting and is unable to separate the job from the personal self; the person who is aware of surface acting, but who may blame herself for not being sincere; and the cynical surface actor who may become “estranged from the acting itself” (2003, p.188). Hochschild maintains that actively choosing surface acting is the healthiest stance to adopt. However, she notes that emotional workers may not have the freedom to choose how they act because they are instructed by their organisations to act in a particular way as a condition of their employment, thereby forcing the workers into positions of either deep acting or cynicism.

The nurses in this research problematise these findings by indicating that the decision to enter the nursing profession is, for some nurses, underpinned by emotion. This suggests that emotional acting is superseded by their commitment to caring. In addition, the nurses’ emotional attachment to belonging to the nursing group and maintaining their nursing identity generates doubt about emotional work being primarily a result of the healthcare organisation’s behavioural requirements of nurses. This is brought into further doubt by the literature that links emotional
work with meeting the requirements of being a ‘good’ nurse according to a socially constructed image. These distinctions about the origins of the emotion in nursing work and their means of reinforcement have important implications for nursing education and workplace stress management because of their emphasis on the personal context. Emotion, for nurses, may be less of a commodity and more of an individual striving to meet requirements that emerge from personal history, emotional needs and the perceived status of the ‘good nurse.’

Further research shows that the happiest workers are those whose feelings and emotional display are congruent (Kruml & Geddes, 2000; Zerbe, 2000). These findings have resulted in training to teach employees “how to exert emotive effort” (Kruml & Geddes, 2000, p.185) in order to achieve authenticity in the emotions expressed. Nurse researchers Mann and Cowburn (2005) align themselves with the literature supporting emotional congruency, recommending that nursing education should teach nurses how to emotionally connect with the needs of the job in order to achieve authenticity in their emotions and work. The Nursing motif shows this to be problematic, as there is already dissent and emotion in the hyphen between the mastery and caring genres, which some nurses have reported difficulty in negotiating. A more appropriate focus would be on discovering the extent to which emotion is already expected in nursing settings, including undergraduate education, and whether it contributes to the dissent and distress between the mastery and caring. The collective story of nursing suggests that education in how to work with and manage emotion would be a useful addition to nursing education.

**Burnout**

The concept of burnout is contestable from the context of this research. The nurses’ stories do not differentiate between categories of distress and, as will be observed in the Tangata Whaiora motif, categorising distress may not be useful for distressed nurses or their colleagues. Furthermore, applying the label ‘burnout’ to a nurse’s distress can focus the responsibility for the distress on the nurse and pathologise her, rather than looking at the whole context for her
distress. Nonetheless, the literature about burnout is frequently drawn on by nurses as a way of understanding work-related distress, so I have included it here. The issues raised here will be revisited during the interpretive phase of the research when the hyphenated selves of nurses are examined.

Much of the literature that explores nurses’ distress and emotional work also discusses burnout. Varying degrees of distress and dysfunction are associated with burnout. In their foundational work on the measurement of job related burnout, Maslach and Jackson (1981) proposed a model, the Maslach Burnout Inventory, whereby the extent of burnout is measured through a series of questions comprising three main elements: emotional exhaustion, depersonalisation and personal accomplishment. Further to this, Paine (1982) argued that there are two presentations of burnout, the first being “Burnout Stress Syndrome”, referring to a mild form of distress that does not impact significantly on work performance, and the second, “Burnout Mental Disability” denoting serious distress found in the end stage of burnout. This work has been largely undisputed, however there has been discussion in the literature about the relationship between burnout and depression.

Glass, McKnight, and Valdismadottir (1993) suggest that symptoms indicative of depression may arise as a result of burnout, as severe burnout impacts on overall wellbeing. Schaufeli et al. (2001) also recognised two distinct types of burnout, labelling them “mild” and “clinical” burnout. Although they note that there is considerable overlap between clinical burnout and depression, they suggest that each is a distinct disorder. Iacovides, Fountoulakis, Moysidou and Ierodiakonou (1999) concurred that there are two types of burnout; one that is limited to the professional environment and one that is more pervasive and severe, and has similarities to depression. They suggest that both types of burnout may coexist, with or without attendant depression. Furthermore, Iacovides et al. propose that the nurses who developed the more severe type of burnout had a predisposition that stems from personality traits of hostility and isolation,
leading to loneliness and difficulty functioning in work environments. Similarly, Schwab (1996) links personality traits to the ability to cope with stress. This view is clearly disputed by Maslach and Leiter (1997), who assert that burnout is not related to the personality of the person who experiences it, but to their occupational setting, and also by Toscano and Ponterdolph (1998) who found that there is no positive correlation between ‘personal hardiness’ and burnout.

Although the question of the origins of burnout seems likely to be disputed for some time yet, the most reasonable explanation is proposed by Hall (2001) who argues that it is a complex, multidimensional issue that is individually variable. This explanation is the closest to the experiences contained in the Nursing and Tangata Whaiora motifs. Burnout will be examined further in the next chapters, as it impacts on the nurses’ stories of experiencing mental illness while being a nurse.

The literature about nursing stress, emotional work and burnout has highlighted some of the complexities in nursing work. The caring and mastery genres both incorporate the importance of the caring connection between the nurse and patient. Although links between nursing stress, distress and mental illness are demonstrated in the above literature, establishing and maintaining the nurse-patient connection in the face of the current healthcare environment is poorly addressed through research.

**The segue**

This chapter has explored experiences of nurses who have a mental illness from the perspective of nursing. Issues of nursing practice contexts and education have been juxtaposed with the nurses’ stories and have illuminated two genres, mastery and caring. The genres exist in harmony for some nurses, but for others there is dissent which is conceptualised by a hyphen that either joins or separates the genres. Nurses negotiate this hyphen with varying degrees of success or distress.
Nurses bring their own needs to their work, which may include caring for others, and belonging to the nursing group. These increase the complexity of the nurses’ negotiation of the mastery-caring hyphen. Further complicating the hyphen are issues of gender, goodness and the societal image of nurses and nursing.

Emotional work and its connection to distress, being a good nurse, and the hyphenated spaces of nursing will be interpreted further in Chapter Six in light of information from the Tangata Whaiora motif.

The next chapter, Tangata Whaiora, follows the same format as this one. It begins with a vignette and 64’s artwork, and then moves on to a review of the relevant literature.
Elizabeth’s story

I am an RGON. I went into nursing straight from school, and have done some post graduate study as well.

I was terrified right from the beginning of my training – even before that actually. I came from an abusive background and I was afraid of everything, although I didn’t know as a child that my family were abusive. I thought it must be like that for everyone.

My training was very strict, as it was everywhere in the 1960s, and the Charge Nurses used to fill us with terror. I loved learning, though, and the academic lifestyle during prelim. After that we had 5 days in the wards and one in the classroom – a six day week. I was fearful of leaving the warm nest of prelim. In the wards, we were the cleaners. Our work was checked by Matron, which instilled great fear in us. By the time I was one year into my training I was on night shift by myself in a ward of 20 patients.

It was 18 months into my training before a patient died on my shift. This was a neighbour, who died while I was at lunch. The Matron pushed me through the door of the room to look at the body. I had tears streaming down my face, and I would only look as far as my neighbour’s feet. I don’t know what she thought she’d achieve by doing that. Afterwards, I was crying while I mopped out the sluice room and the Matron saw me. She just said “Oh, you’re pathetic. Go off duty.” I fled.

On one ward, my work wasn’t up to standard so I had to stay there for another 3 months as a punishment.

I have an anxious personality, and I don’t do well when things happen fast. In the surgical area I was a nervous wreck. I did much better in medical areas, where it was slower and I could form
relationships. When I became an RN I found it terrifying because I was suddenly supposed to know what to do.

My eating disorder kicked in during my training. In the nurses home we were provided with bread, butter and honey. After I got home after my shift I would eat half a loaf in a sitting. It was the beginning of binging to reduce my anxiety – I was always very tense after the duty.

I love nursing, but I’ve never felt comfortable in my ability to be a nurse.

At the end of my first year as an RN, I left nursing. I had a passion for children and I wanted to work with them. I went to Bible College for 2 years and worked with children. I loved the academic work, and also did 3 months of specific training in working with children. I stayed there for 3 years.

After those 5 years, I went back to nursing but I was always in dread of making a mistake and killing somebody. I would read the disciplinary notices in the nursing journal and be filled with terror in case I made a mistake and it was me in there next time.

A year later I was married and pregnant. I worked in the outpatient area throughout my pregnancy, and loved it there. There was no bitching and bullying when the doctors were around, I knew what I would be doing every day, and there were heaps of opportunities to build up my knowledge. An environment like that builds confidence. I am very sensitive to bullying. I left nursing late in my pregnancy.

After my baby was born, I had severe post natal depression. I was advised that having another baby would cure the depression, so I got pregnant again. I had 2 babies in a year. After my second baby was born I had very severe PND again – I was running away, hiding in the wardrobe, hitting myself until I bled, and eating non-stop. Some-one I’m not sure who) had the bright idea that I would get better if I went back to work – that it would “take me out of myself.”
I worked 6 – 11pm shifts on a medical ward. I was reported by a nurse who had picked up that I lacked confidence. She was an EN, and I think that my practice of talking decisions over with her made her feel insecure. So I had to meet with the Powers That Be – the nursing supervisors. It was terrifying. I don’t know why they think that meetings like that would help! They decided that I should go onto days to build up my confidence. But I had 2 babies so it was very hard. I had to be supervised, so everyone was aware that I was “not coping” – but the more I was watched, the less I was able to cope. It did help my PND a little bit; it made me aware that there were people with bigger problems than mine. I left nursing again when I developed morning sickness with my third child.

I had more severe PND, but this time I knew what was happening. With the first one I wasn’t sure what was wrong with me, but this time the Dr got me onto some treatment straight away. When I was 3 days post-birth, I packed my bag and tried to leave the hospital at 2am. The GP put me on doxepin, which didn’t really help but at least I knew that someone was aware and looking out for me. He didn’t refer me to anyone – I’m not even sure he knew what was available.

I referred myself to mental health services and did get some help for my anxiety. I had a pounding chest, turning stomach, sweating, urinary frequency, and over-eating. I didn’t take any meds for the anxiety, and I stopped taking the antidepressants 2 years after the baby was born. I decided that I didn’t have PND any more, since I couldn’t be called post natal any more. But I discovered that it was depression – ongoing. I was a real mess. A year later I went back to work in a geriatric hospital doing 6 – 11pms again. Fear was still a major problem – I was fearful of the staff. However, there was a really supportive nursing aid there and that helped.

A position for a clinical educator position was advertised, and I thought how much I’d love a job like that but I didn’t do anything about it. Then the same job was readvertised a month later and I applied. I was terrified! I got the job and absolutely loved it. I was terrified most of the time. It
involved some public speaking, which made me even more nervous but I did it and felt really 
good when it was over. It felt that it was a very worthwhile job, and I loved watching patients 
get better. After 2 years in the job I was made redundant. The job just ceased to exist. I was 
devastated, and grieved enormously. I kept thinking “what have I done wrong, why didn’t this 
work?” At the same time I was angry, because it wasn’t as though all the patients had gotten 
better so I wasn’t needed any more. I had kept careful documentation throughout those 2 years of 
how patients had improved and admission rates had dropped. Just before I left I was called to a 
meeting. I took all my research and documentation, sure that they were about to reassess the 
redundancy and prepared to argue for the position. But they only wanted to make sure that I’d 
leave all my notes behind for their future use.

It was only with great difficulty that I got myself back to work after I’d “failed.” The safest place 
to go was geriatric nursing, so I went back there. I didn’t choose the right place, though. The 
head nurse was a real dragon, a Hitler. She had spies all over the place who would report back to 
her. It was the job of the afternoon RN to close all the 2nd floor windows, which I didn’t do so I 
was reported and then told off. I mean, those were tiny windows and high up off the ground. It 
seemed very unfair and extreme. I felt invaded and unsafe, and went to pieces. I left, with the 
knowledge that I had failed again.

My depression went on. I finally got a job in a Church based geriatric home. It was an 
empathetic, supportive environment. The Charge Nurse didn’t know my story, but she put her 
arm around me and loved me. I believe that God sent me there to heal. They were generous and 
kind, and helped me quite a bit.

I moved on to a job as a practice nurse. Why? I don’t know! I do know we needed money and the 
rest home just didn’t have the hours to give me. The practice was in a poor area, frantically busy 
and I was scared out of my wits. The waiting room was constantly full, patients would wait for
2-3 hours to be seen, the phone rang non-stop, and there was potentially serious stuff just coming in through the door. I don’t cope well with these situations – it was my worst nightmare. One day a father came through the door with his little boy, saying he had trouble with his heart. I had to do a cardiogram, and hadn’t done one on a child before so I got a colleague to help. I did comment to the father that heart problems weren’t that common in children. Anyway, I checked the notes and went to talk to the Dr. The father was upset over what he saw as a delay. In fact I didn’t delay at all, but I was hauled over the coals at a meeting in front of everyone. I did, though, get some collegial support for the first time when my colleagues spoke up.

A few weeks later a man came to the counter for his blood results. I read the form and the Drs notes, but I misinterpreted the instructions and told the patient to increase his meds. That was the wrong advice, and I was given a letter of warning. I was deeply mortified, depressed. I resigned and walked the streets, cried, and swam (so that no-one could see the tears). I did contact the union, who said that I had a case. But I was too shattered to even consider that route. I swore that I would never go back to nursing again, never.

However – I found a lovely little job, 2 mornings a week in a rest home. The Principal Nurse was wonderful and supportive. God used her to re-establish me. But eventually she resigned. The nurse who replaced her wasn’t so nice – in fact she was pretty bitchy and bullying. I saw a colleague blamed for a patient being admitted to hospital with diabetic shock, but I knew for sure that she hadn’t given the wrong dose of insulin. I tried to stand up for her, partly because I knew it would happen to me sooner or later. It was an atmosphere of blame.

Anxiety attracts bullies. I know that is why the Charge Nurse took a list of 15 complaints about me to the manager. I was called to the Manager’s office and told that the complaints had included claims that I was cold, cruel, unkind and a bully. There were 15 examples. I said to the manager that he knew I wasn’t like that – I’m like butter. But I still took it on board, and felt that it must
be my fault. The manager knew the complaints weren’t true, but he still put me through it. He even offered to take me out for coffee!! I cried all night, but decided that I had to fight this time. I was having counselling at the time, and the counsellor offered to act as my advocate. I asked for a meeting to put my case to the manager and the three staff involved. I staff member resigned before the meeting. I addressed all the issues and got an apology from the Charge Nurse. All the accusations were withdrawn except one. In the meantime, though, I lost my job. The roster went up and my name wasn’t there. I called the union and was told that I had a good court case, and I won a settlement. I stayed working there for another year. I believe that the Charge Nurse was a very sad and angry lady, and so were the three people who joined with her. They just seethed rage when they were together. I happily did my job – including things that they had refused to do.

After that I worked for an agency doing domiciliary palliative care. It was a wonderful job – I got to know families, neighbours, dogs, friends – everyone! They loved me and I loved them, and they were appreciative. It was a healing time, not frantically busy and very meaningful. But the agency closed down. I was known by the hospice by then, and went to work there. They wouldn’t have taken me on if they’d known about my psychiatric history – an anxious, overeating, depressed nurse on prozac doing palliative care? I don’t think so!

But palliative care nurses can be bullies, too. There were 2 big incidences of horizontal violence there. I am now a lot better and older, and I took them on by myself. The first issue was denied by management – it “doesn’t happen here.” But as soon as I opened my mouth, everyone else started to talk about it. We did a survey and discovered it was a huge issue. There is a policy in place now that deals with horizontal violence and about how to deal with it. I took on the bullies this time. One of them actually threw equipment at me, and directed me to do the cleaning while she nursed. We have a good relationship now.
The staff who made a stand feel like we deserve a medal for it! Bullies always do their thing while there is no-one else around, and can do it in such a way that they undermine you so that you don’t believe in yourself, lose confidence, and believe the things they say about you.

I still work in palliative care and am also doing some primary health work. We have a great team in primary health; all mates, laughing and having fun. We have a huge range of experience but are all on a level plane. The Team Leader is great.

I’ve been through enormous growth. I still get some anxiety from time to time, and I never tell anybody about the meds, depression, anxiety or overeating.

Recently I heard a nurse “have her say” about prozac – she said it makes you frigid and affects your libido. I was sitting close to her at morning tea, so I heard the whole thing. I went up to her and said “I take prozac, and it saved my life.” As I went away, I heard someone say “that ended the conversation.” That was the first time I ever told anyone. I’m sure that people think that there is something odd about me, but they’re not sure what it is.

Eating disorder is very hard to manage when you’re nursing because of the irregular food intake. You have to be careful to eat regularly and that can be hard in some nursing environments. It’s an additional stress on you if you are trying to overcome compulsive eating. I got lots of support from Overeaters Anonymous.

When I apply for jobs I always say “no” to questions about whether I have any health issues that could affect my work.

It grieves me to hear jokes and comments about mental illness. I feel so sad. This is no different than any other illness. Sometimes I wish I could bang them on the head. I didn’t choose to be born into a family that abused, but I was and this is a result of it.
Jayne’s story

I started my degree training about 6 years ago, and have been registered now for 3 years. My first year out I completed a new graduate programme, and then did a year in acute medicine. This year I am working in the area of public health. Ultimately I want to be a psych nurse, because of my own history.

As a teenager, I got involved in drugs and alcohol, and although I still managed to start University, I tried to take my life and ended up in an acute mental health unit. I went through lots of diagnoses in the following year, and ended up being diagnosed with schizophrenia. I experienced lots of serious symptoms, like hearing voices, depression, self harm etc. (I’ve seen a lot of people, since then, who have the same kind of symptoms, but because of their circumstances they never get diagnosed or committed.) It’s amazing, but during the time I was in the acute unit being medicated and diagnosed I still managed to complete 2 extra mural papers in science. I spent the best part of a year in the acute unit, and then was discharged to a residential programme where I spent 5 years. The first 2 years were spent basically keeping me alive. The second 2 years prepared me to get “out there” into real life, and in the last year I started working on my Diploma of Applied Science. During that time, I was involved with a few nurses who were absolutely inspirational, and who helped me to do more than just overcome my symptoms. They helped me to actually get a real life.

When I completed my Diploma, I applied for a Bachelor of Nursing course. Initially I was told that I wouldn’t be accepted because my academic preparation was insufficient. With a bit of support, I went back and challenged the Dean, saying that she was discriminating against me. She agreed that my application could be considered if I would agree to have psychiatric reviews by 2 doctors, to assure her that I was safe to be a nurse. The implication was that they would be
giving me access to sharps, drugs and syringes, and would I attack them? I agreed to the reviews, and I got into the programme.

I feel that I was watched pretty carefully for the first year or so. It was a bit like being under a microscope, but once people realised that I wouldn’t cut their throats if they said something wrong, they seemed to relax a bit! In our institution we had mentorship groups, where everyone had access to mentors. Mine were pretty good, and they helped to smooth the way to a certain extent.

I decided that I had to fully disclose my mental health issues when I applied for a job, because I didn’t want to give them the opportunity to get rid of me later on because I’d lied on the application form. I don’t worry too much about the Nursing Council declaration, though, because I believe that all I can do is answer the question (about being fit to practice) to the best of my ability on the day. I can no more predict my mental state in the year to come than anyone else can, and the same goes for being physically fit to practice. No-one knows what’s ahead of them, health wise.

I don’t, though, tell people about my schizophrenia until we have gotten to know each other. I much prefer to be known a “quirky,” rather than “that schizophrenic girl.” Actually it amazes people once they know about my diagnosis.

The job I have right now suits me because of the regular hours. Getting good sleep is very important to my ongoing mental health, and it is so good to wake up at the same time every day. Just recently, though, I did have a crisis situation. I have good insight into my mental health, and I dealt with it by accessing crisis services. We worked together to get me stabilised, and I let my boss know that I would be able to get back to work. When it first hit me, I asked one of my supportive colleagues to let my boss know that I was seeking treatment for a crisis, and she had let me know that I should take care of myself and take as much time as I needed. She even worked
with my colleague to make sure that I would still have money coming in, which I appreciated.

But when it came time for me to go back to work, she called me and told me that I’d have to have a medical assessment to confirm that I was fit to return. I found this pretty insulting, really. If I’d had a physical illness, would I need to get medical confirmation before I went back to work? I mean, this is not a new illness for me, and I maintain my own wellness. In fact, I had accessed the crisis service for myself – it’s not like I had to be committed or anything! I had recognised that I needed help, and I got it for myself, so needing to be checked like that is just crazy.

Along the same lines, I am sometimes told that I have brought my illness on myself. Would you say to someone with bronchiectasis that they had caused their latest hospitalisation because they walked out to the letterbox? It doesn’t make sense, and I get tired of the discrimination.

I do still hear voices, but my conscious mind is very strong and I can control the amount of attention I give to the voices. I am really lucky that way. But when I get tired that control is harder to maintain and I can get unwell.

The people who have shown the most prejudice towards me are the people who you’d expect to understand – nurses, doctors, and social workers. Maybe it’s because all they see are the acute aspects of mental illness. But what I want nurses to know is that they shouldn’t be embarrassed by the diagnosis. Just like any chronic illness, there is a pattern of remission and exacerbation, but people with mental illness are still normal people who work, pay their bills, talk to their families and friends. I would really love to see a group of nurses with mental illness out there, visible, showing their colleagues that they are normal and should be treated like people. But there is a chicken and egg situation, where the nurses who have mental illnesses are scared to step out and tell people because they will be treated badly, and a lack of knowledge and acceptance among nurses in general because there is no-one brave enough to step out and tell others!
Josephine’s story

I trained in a hospital in England 1974. I also undertook my degree in 1997 and have done some post grad work since then.

My story really begins in terms of being diagnosed when I was a 2nd year student nurse. I worked on a gynae ward and the ward sister was a real old dragon. I worked very hard and one day I recall vividly. She asked me to do a dressing and I was admonished by her in front of everyone for using the wrong dressing. Something went off in my head and I went and smashed her precious glass trolley. I was bailed up and taken to the Psych unit and locked in a room where it was easy for others to peer in at me. It took me right back to my childhood where I was in a children’s home and I was locked up in a broom cupboard for hours. My psychiatrist diagnosed me with cyclothymic disorder and I was then on and off every antidepressant and psychotropic drug imaginable. The school of nursing, on reflection, wasn’t too bad. They worked with the psychiatrist who said I wasn’t mad.

Looking back now, I can see that I became a nurse because of the abuse I suffered as a child. I guess I thought that if I cared for everybody, then they’d care for me. I’ve been nursing now for over 30 years, and for most of that time I’ve hidden my diagnosis from my colleagues. It takes a huge toll, hiding, but I have been a senior nurse, and a nursing tutor during that time, so I guess that says it all. During manic and depressive phases it has been a nightmare trying to be seen as normal. The only advantage has been that I relate very well to people who come into A&E with a mental crisis. I have been called a “full on, blunt, out there kind of person,” but until recently, no-one called me MAD.

One part of my nursing career that has meant a great deal to me is when I cared for people with head injuries. Perhaps I was good at this area because I could understand their sense of chaos and
disruption, and I also really felt for the families. I was passionate about this nursing and somehow I had to be extremely creative in managing certain behaviours they exhibited. What I’m saying really is that I understood their chaos and tried to help minimize it for them, by working with the families and loved ones. I sort of knew what they were going through. I felt comfortable and useful nursing severe head injuries, it was where I felt valued and it was also my favourite topic in teaching.

My life has really been a roller coaster of events. I don’t have a major bipolar disorder, but am kind of on the fringes of it. For all these years, when I have had to talk about my illness I have said it is a “depressive disorder” – that seems more acceptable, somehow. But now I think that hiding it that way is as though I have something to be ashamed of. I did decide, a while ago, to discuss my experiences in a public arena. I had cleared it with my manager, and he warned me that there could be a backlash against me. Well, there has been, but it is from my management and colleagues rather than the general public. I feel that since that time I have been marginalized, abused and maligned. Their judgmental attitude appals me. I’ve never had so many incident reports made out against me, and I really believe that if I hadn’t been a nurse then this wouldn’t have happened to me. Some friends were supportive to begin with, but have backed away now. My condition has been used against me more recently where the manager has requested a letter from my psychiatrist re my prognosis etc. I wonder if he would ask that of an orthopaedic surgeon if I broke my leg.

I am very alone, and have been asked not to contact anyone at work. I hung in there for so many years, but have now had to leave the job I love. I feel that after all this time I am no good to anyone, like my life has been wasted, am worthless and incredibly hurt. I have been passionate about caring, about nursing, and about patients. Now I feel that I don’t care about anyone any more. I’m lost.
Nursing compounded my problems and just writing this has triggered huge feelings for me, having had to leave nursing for who knows how long. I do not feel supported; I don’t think the general public with mental disorders would be treated the way I have by my peers and managers. The so called caring profession is a myth.

I really have got to tell this story and be a part of this research – I need to have my story heard in a way that isn’t just “lip service.” I am not just having a bad day, I am not uncontrollable and irrational, I am not off the wall, and I am not mad. I am saying that I can’t hang in there any more, and I can’t pretend any more, and I need to be heard.
“I’ve been nursing now for over 30 years, and for most of that time I’ve hidden my diagnosis from my colleagues. It takes a huge toll, hiding . . .”

Josephine
Figure 3: About a lack of balance (64, 1989)
The striving for balance between wellness and illness, the personal and the professional, and the internal and external worlds are all brought to the fore in 64’s drawing “about a lack of balance” (Figure Three).

64’s visual commentary speaks on many levels. I imagine different discourses/language games/stories/people on an imbalanced see-saw, each speaking out but with only one positioned to achieve dominance. Yet each end is joined to the other, is balanced on a fulcrum which is, in turn, grounded in the earth which contains the seeds of possibility and the realisation of growth. Thus each position is constructed by the others, which are constructed by the others, which are constructed by the others. Furthermore, each position contains the elements of light and dark and is delicately balanced, suggesting the possibility of movement. I wonder what will happen if the spheres move? I notice that growth occurs more on the side of the lower level, while the dominant level contains seeds. I recognise my own beliefs in my reading of 64’s work.

Vignette: Support group?

“I have to be really vigilant about my health. I can’t work shifts at all. I get too tired and mixed up.” I look tensely around the group, checking their responses to my statement. There are four other women here, sitting in a circle on hard school chairs. This is the third time I’ve come to the nurses’ support group meeting. It took weeks of agonising thought to decide to come to the group. This is my third meeting, and the first time I’ve started the conversation.

Rosie nods, “Me, too. I’m so afraid to get run down. I just know where it will end.” We smile at each other. I feel myself relax back in my chair a little. Being open
with other nurses about my mental health was not an easy decision, and tonight is the first time I’ve felt that I made a good choice in coming along.

“I have to go to a meeting with my manager and HR.” Billie’s voice cuts harshly across the group. We all turn to look at her. Mouth visibly trembling, she stares at her fingers, which are pinching and picking at each other. From my position across the circle I can see the skin around her nails is reddened and scratched.

“It’s supposed to be a supportive meeting, my manager told me,” she pauses a moment. “I don’t know why they think meetings like that are supportive. They’re mostly terrifying - to me anyway.” Billie looks directly at me.

“What am I supposed to do?” she pleads. I am dumb, can think of nothing except thank god it wasn’t me.

“I haven’t told anyone about my bi-polar,” Billie continues doggedly, hanging her head again and talking to the floor. “But they know there’s something weird about me.”

Maggie snorts a laugh, drawing our attention. “Better weird than mad,” she grins. Sara reaches over and takes Billie’s hand, gently separating her twisting fingers and gripping them in hers. She smiles at Billie, “Maggie’s right, you know.” Sara frowns across at the still grinning Maggie, “She’s being silly about it, but there’s nothing wrong with being different. Have you been OK at work?”

Billie nods, although she looks uncertain. “I’ve been doing OK with the patients, but I have stayed back after my shifts this week. Just to get some extra things done. You know?” Oh, no, she’s looking at me again. I cross my legs tightly, feeling angry. I thought coming here would give me some answers, but Billie keeps looking to me for them. Coming here was not a good idea.

I study my own nails and wish I had stayed home.

* * *
The collective story of illness and wellness

This motif addresses the nurses’ collective story about what it is like to have experienced a mental illness as a nurse. It begins by discussing the illness experience, then moves into coping with and managing illness, being well and finally, the impact mental illness has had on their nursing practice.

Being unwell: the ‘patient’ identity

The accounts of symptoms, diagnosis and treatment of mental illness throughout the nurses’ stories reflect only one aspect of their experiences, that of a patient. Additional to this were their prior life and illness experiences, stigma, stereotyping and discrimination by other nurses, management and society in general. Clarifying the contribution these factors make to the overall distress of the person experiencing the symptoms of mental illness is an important part of beginning to understand the nurses’ experiences, as people who are seeking wellness; tangata whaiora.

The experience of mental illness is shown through the stories as being disorienting and messy. Gemini comments; “The hardest thing to deal with was that the psychiatrist I saw was a colleague. That degree of distress and disorder freaks everyone out.” Symptoms described by the nurses ranged from feelings of worthlessness and hopelessness, to acute anxiety and panic attacks, through to hallucinations. Most of the nurses utilised medication as a part of their treatment, and also turned to exercise, talking therapies and spiritual therapies. The parts of the stories that focused exclusively on the experience of mental illness tended to be small, with the main emphasis on the nurses’ distress and the impact the illness had on their working lives. Furthermore, not all the nurses talked directly about illness or symptoms. I experienced some of what the nurses did not say as silences which contained meaning, and have endeavoured here to find a way to express the meaning the nurses conveyed.
Lyotard (1988) asserts that silence is a phrase, and also that silence is a feature of the differend. However, interpreting the intent and location of the silence requires attention to nuance and context. Lisa Mazzei (2003) uses poetry as “a filter through which to understand metaphors present and absent in the conversations” (p.359), aiming to come to an understanding of silence as ‘inhabited.’ The inhabited silences are pervasive when talking about stories that are told by people who live with mental illness. I struggle to locate the nurses’ words among their silences and resist the convenient ease of applying existing language to them. To illuminate some of the nurses’ silencing without speaking over them, I have snipped a phrase or sentence from each story and composed a poetic re-presentation of the nurses’ experiences. Inevitably my choices and arrangement of the words illuminate my own stories, but the resulting rendition is still more authentic than a belaboured explanation in my own words would be. Although this poetic rendering speaks some of the silences, further silences exist in the white space and the three dots . . .

* * *

**Intense stress levels . . . I felt claustrophobic, tense, anxious and inwardly desperate . . . I became very depressed and anxious, suicidal and psychotic . . . I was running away, hiding in the wardrobe, hitting myself until I bled, and eating non-stop . . . I began to have a drink after work to unwind . . . I was working, eating, crashing, and going back to work . . . I just broke down crying . . . deeply distressing to me . . . this hurts too much . . .**

**I have been marginalized, abused and maligned . . . desperate, traumatized and very alone . . . very hurt and isolated . . . feel like crap . . . anxious, tearful, despondent . . . like I’ve done something wrong and I’m being punished . . . I do still hear voices . . . I remember sitting in the kitchen one day with a craft knife in my hand, contemplating suicide . . .**

**I have found my experience of prolonged mental illness to be exhausting, humiliating, terrifying, confusing, isolating and financially crippling. It has wrecked my life . . .**

**I kept it to myself . . .**
I wonder
what we are missing
because we must have
all the hows, whys, and wherefores

(Austin, 1996, p.214)

““So you can see,” Laura says, looking up, “I have decided to revel in the mess rather than clean it up”” (Ellis, 2004, p.230).

Coping

The nurses discussed many strategies for coping with their distress and illness. Some of these strategies were actively designed with wellness in mind, and others are a result of trying to ameliorate distress through numbness. Many of the nurses chose to change work settings in order to escape from an environment that they perceived had triggered or exacerbated their mental illness. In some cases it worked – especially if they traded a pressured work environment for one that had more chance to interact with the patients. It is interesting that none of them chose to move to a setting where there was less interaction. This has interesting implications for the management of mental illness, and is discussed further in Chapter Seven. For some nurses, though, this didn’t work and they faced the same issues over again.

The use of substances such as drugs, alcohol and food is a feature in several stories, as the nurses, for example Alice and Chloe, attempted to numb their feelings of distress. Of course, medically prescribed treatments for specific symptoms were mentioned, but these were not discussed at length and have not been addressed here because of their highly individual nature.
Of the nurses who chose to change their practice settings, Mary says, “I managed to get work as a nurse in other areas of the hospital, areas that were less stressful, but I still felt anxious.” For Julie, changing jobs was a difficult choice. She says, “I tend to be a very committed person, and settled . . . this is the only time I have ever left a job without carefully considering it for quite a long time.” Prior to resigning, she had taken time off, and had also trialled working part time. Alice moved, at her request, “into a long term nursing area.” She reports that this setting was a more supportive environment that enabled her to be “better at setting boundaries” and she has developed the philosophy that “I have to look after me before I can help others.”

Chloe used her annual leave to reduce her working hours to 4 days a week, but still struggled to cope. She cut back her working hours even further, but eventually “I stopped work, went on a benefit, tried several meds and had therapy.”

Helen, who ultimately left nursing, says that until she found a way to leave permanently, she maintained a pattern of short term employment to manage her conflicted feelings about being a nurse, and also her symptoms of undiagnosed depression; “in 10 years of doing nursing work, I didn’t stay longer than 6 months in a nursing position.”

For Jenny, nursing had never been a comfortable role, although she attempted to find a way to stay in the profession:

I sought help via GPs and the Health Centre for depression . . . I tried going part-time, I took a year off to study, but still the work seemed to be getting the better of me. . . My last ditch attempt was to switch to a different DHB and try [psychiatric] intensive care.

She changed careers eventually, and says that she will not return to nursing; “it’s too dog-eat-dog in one hell of a pressurised and aggressive backyard.”

64, in particular, describes multiple attempts at finding successful therapy through talking and medication. It took many years and many different approaches to find one that worked for her. She is also an artist and sculptor, and, as mentioned above, has included some of her art along
with her story for this research. Rachel found counselling to be helpful, and adds “I also had
support from my friends and church. Having the spiritual support has meant that I am looking at
my life from the whole aspect, which has been powerful in my recovery.” Mary accessed EAP
(Employee Assistance Programmes, whereby counselling by an independent party is provided by
the employer for distressed employees) in an early attempt to overcome her anxiety. She says,

The counselling was a joke. It still makes me tearful to think about it. The
counsellor was awful. She tried really hard to tie my moods to an incident of
abuse when I was a teenager, but I didn’t think it was relevant, and didn’t want to
go there. I think she was trying to get me the visits free, through ACC.

Alice, too, went to EAP but “was advised that since I would be moving areas I should wait and
see if my feelings resolved once I moved. I’ve never been back.” The provision of EAP for
distressed staff is discussed further in the next section of this chapter.

Michelle and Anne both comment on the financial burden of accessing effective care. Michelle
decided that she needed private medical care “so I could have some kind of consistency in my
treatment,” but has had to take on “another part time job, partly to pay for my medical care. The
cost of a psychiatrist and a psychologist is enormous.” Anne says:

The money is important to me – but even when I was paid a very low salary I still
kept paying for the psychologist! To think through matters carefully with him
helps me to be safe in emotionally risky jobs.

Mary attempted to access support from her workplace, and found that while she received what
she asked for, it was not what she needed.

I thought it was my lack of experience in certain procedures that was the reason I
felt so anxious. The Nurse Leader was great, she organised a very experienced
senior nurse to agree to be there for me in a ‘buddy’ role if there were situations
that I encountered that I needed to talk about or seek advice. The senior nurse
was wonderful and would never make me feel that my need for support was bad
or that I was an ineffective nurse because I sought this kind of support . . .
Looking back now, I think that I didn’t trust the institution or my nurse leader
enough to tell her what I was really feeling – my fear. I got help for the tasks of
my job, but not for what I was feeling.

Rachel has had contrasting experiences with managers while she was depressed, and says:
This last time I became depressed has been a real contrast – very special . . . My manager has been incredibly supportive. She reassured me straight away that I would be “rehabbed” back into work, and that I could work part time.

In addition to the support at work, Rachel identifies that “there is, I think, a feeling that ‘nurses shouldn’t’ get unwell and need help,” and has chosen instead to accept that “depression is just as much an illness . . . if I have to be on meds for the rest of my life, then so be it.” As part of this philosophy, Rachel uses an early warning plan “that gives details of my early warning signs and triggers, with a time frame and what I can do at each stage.” She has included her friends in her recovery by giving them copies of the plan, although she comments that it is “disconcerting . . . knowing that people [are] keeping an eye on me!” Morrie, too, has found that “certain of my colleagues, whom I have a lot of faith in, tend to pull me aside and inform me as to where they feel my mental state is heading. I thank them very much for this input.” Vicky also actively manages her mental health, and notes, “I have a good awareness these days about my early warning signs and am able to head off full-scale depression before it hits.”

Ellie and Alice comment that while their families are supportive, they “couldn’t really understand” (Ellie) their distress over work-related issues. Alice says “I shed most of my tears alone, which is sad.” Rachel adds that she receives help from sources “. . . not so much from my family – they either have their own problems or they don’t want to face it.”

Two of the nurses describe other ways of coping. Julie was advised by her GP to try exercising to improve her symptoms of depression, and Alice has processed some of her experiences through study. She says:

One of the things that helped me is a book by Andrea Needham about workplace bullying. She absolutely laid out the whole thing and it helped me to recognise what was happening to me. It was a relief, actually, to be able to name it and then I could try to deal with it. One of the things I did was to write an assignment about it, which acted like a debrief for me. It felt so good to write about it!

The demands of shift work and on call work were raised by several of the nurses. 64 notes that she found night shift to be helpful during her depression as “night duty is more straightforward
and the demands less conflicting,” although she says that “being on antidepressants doesn’t always mix well with night duty.”

In fact, 64 is the only nurse in this study who chose to work night shift. Rachel found being rostered onto six weeks of night shift worsened her depression, and her GP provided a letter stating that “I was clinically depressed and wasn’t to be on night shift.” Michelle notes, “I’d been working night shifts, and finding it impossible with the pills and everything.” Jayne identified that she needs to be careful with her health, and prefers to work day shifts. She says, “getting good sleep is very important to my ongoing mental health, and it is so good to wake up at the same time every day.” Jayne assertively manages her own wellness, and is comfortable accessing mental health services to prevent or minimise the effect of crises.

Julie and Vicky both discuss the difficulty of managing being on call while needing to take sedatives. Vicky says; “On the nights where I was on-call I could not take these and the lack of sleep was catching up with me.” Julie negotiated with her new employers to not do on call work, a plan that had to change when management changed and Julie’s call work “fell to another care manager which she resents having to do that, and I don’t blame her.” Julie tried reducing her medication to accommodate the call work, “but if I dropped it below 50mg I just ended up falling over again.”

Several of the nurses discussed using substances to cope with stress and distress. Alice, Chloe and Michelle refer to using alcohol “to relax and forget about what was happening at work,” (Alice). Chloe became concerned when her Friday after work drink changed to almost every day, “my whole life became work, drink to unwind from work, go home and sleep so I could wake up and work again.” Michelle recalls how, as a new graduate nurse, she was, “still depressed, couldn’t sleep, contemplated suicide and drank lots of wine,” and that she began “taking sedatives and anxiolytics to help me through, and often mixed them with alcohol. They didn’t have the effect that I wanted, but I became addicted to them.”
Jenny, too, discusses using both alcohol and drugs, and says that, as a student, her life was “full of heavy binge drinking and occasional to moderate marijuana use.” After she graduated, Jenny knew that she did not want to be a nurse and felt very uncomfortable in the nursing role. She notes, “I’m sure the stress of this ill-fit contributed to further depression and more drinking/drug use.” During her time as a mental health nurse, Jenny developed an active social life, and “soon began drinking and using marijuana again – along with all of my new workmates (drugs and booze seem to be very prevalent in this professional group!).”

Gemini commented:

> It is no surprise that addictions are so common in health professionals, we self medicate. Nurses, alcohol, war stories and letting off steam are all a part of the culture of nursing.

Elizabeth is the only nurse who described using food to overcome her feelings of anxiety. She dates this coping technique back to her days as a student nurse:

> In the nurses home we were provided with bread, butter and honey. After I got home after my shift I would eat half a loaf in a sitting. It was the beginning of bingeing to reduce my anxiety – I was always very tense after the duty.

These nurses all expressed feelings of dissatisfaction about their substance use and a desire to reduce or eliminate them as a part of their plans for wellness.

**Being well**

In the last section of this chapter, the nurses briefly mentioned personal strategies for wellness, such as maintaining a supportive environment and adding exercise to their daily activity. They also discussed more general ideas for improving the mental health of nurses, and the issues involved with disclosing their illness to colleagues.

Most of the nurses discussed the need for support in their workplaces. This was described along a continuum; ranging from support while coping with distressing workplace practices; through to assistance in managing the experience of mental illness; and support that reduced or eliminated
workplace bullying or isolation. At the amelioration end of the continuum, Anne says: “I received advice and support from colleagues both in the private and public sector. I was grateful for that, because I felt very isolated,” while Chloe asserts,

I think that when a nurse is treated badly, then senior nurses should be very clear and direct that the abusive treatment is to stop. . . I really feel that nurses need to step up here, and demand to be treated well, and senior nurses need to support their staff.

Further to this, Alice discusses the need for support, not only in the light of mental illness, but for the everyday work of being a nurse. She says:

I acknowledge that we don’t always “get it right,” and we have this need to be seen to get it right for the patient – but we need to have the right environment to achieve this, one that is supportive and encouraging, and free from the kind of bullying behaviour that we subject each other to.

Alice notes that the Nurse Manager in her current workplace provides this ideal environment and “actually gives out compliments and says “thank you” to her staff.”

The education process was mentioned by Chloe, Mary and Jenny in the Nursing Motif as a contributing factor to their distress. In particular, they talk about unachievable expectations for clinical practice creating a dichotomy of idealism and realism after graduation. However, Chloe also identifies that there is a lack of education for nurses in dealing with the realities of nursing work and suggests that, as a part of the education process, “students and registered nurses should be taught how to deal with stress and grief.” Ellie and Gemini both address the issue of the emotional after-effects of nursing work, although they do not single out the education of nurses as a place to do so. Ellie says:

Although debriefing after traumatic events is a bit more common, it still seems to happen in a haphazard way. So nurses are still not taking care of themselves and each other, and threats to mental health aren’t talked about and acted on in any coherent way.

Gemini comments:

The issue of mental illness is out in the open to a certain extent, but there are often not good processes around how to care for mental distress. In fact, there are
often not any overt processes at all, except for EAP, which is a bit of a mixed
bag. I have heard of EAP being really useful for some nurses.

The use of Employee Assistance Programmes (EAP) has been, for this group of nurses, the
“mixed bag” that Gemini suggests. Alice reports getting little assistance through EAP and
concludes, “I never went back.” Ellie notes:

I think that although more people seem to know about things like EAP, the
perception of them isn’t all that positive, and it still takes quite a bit of courage to
access them.

Ellie goes on to say that “it’s really clear that the best people to help nurses are other nurses!”

This theme of nurses having the in-depth knowledge required to help other nurses is echoed
through more of the stories. Mary reports that her EAP counsellor was “awful,” but goes on to
say wistfully:

It would have helped, I think, to have someone in the hospital to talk to about
this, like clinical supervision, while I was in practice. Someone from mental
health, not a counsellor but a nurse who could have listened to me and helped me
to see what was happening.

Gemini specifically advocates for the use of professional/clinical supervision. She asserts:

Mental health is fairly reflective and conscious, partly through the use of
professional supervision. The general side of nursing tends to just cope with
stress and trauma, and try to manage it. If work affects you, it is a personal
weakness. To date, the general side and midwifery don’t yet know about the
value of supervision.

Vicky and Jenny, who both worked in mental health settings, do not discuss professional
supervision in their stories.

Anne, Michelle, 64, North Island Bunny and Rachel have all successfully accessed
psychologists and/or psychiatrists in their search for wellness. North Island Bunny used her
psychiatrist to process significant workplace bullying, and says “I learnt to identify my stuff and
her stuff.” Michelle, Rachel and 64 all chronicled their active search for effective care. They
changed health professionals until they found a team or person that they could work with. Rachel
says that changing her GP to a “fantastic one” was “one of the best things I could have done.”
Julie comments on the importance of getting to know “your own self talk, your patterns, your feelings, and how to make changes.”

Aspects of the dilemma faced by nurses about whether to disclose their mental illness to their managers and colleagues have been raised in every motif. In the Nursing motif, the stereotypical image of the super-nurse who can cope with anything and not need to be taken care of herself is raised. In the Bullying motif, later in the thesis, the effect of bullying and symbolic violence in silencing nurses is discussed. Disclosure of mental illness is a feature of Jayne’s story:

I would really love to see a group of nurses with mental illness out there, visible, showing their colleagues that they are normal and should be treated like people. But there is a chicken and egg situation, where the nurses who have mental illnesses are scared to step out and tell people because they will be treated badly, and a lack of knowledge and acceptance among nurses in general because there is no-one brave enough to step out and tell others!

Ellie also dreams about nurses “stepping out.” She says, “I wanted to be a part of this research, to tell nurses to think about and talk about what is happening for them and to not hide it.” That nurses are choosing to hide their mental illness out of fear of discrimination appears to be a feature of their distress. Some of these nurses, however, invite their colleagues to become involved and to help the nurses to move out of the position of fear. Jenny says that her friends and colleagues have been “wary of talking openly about my health,” but that “on reflection, I wish some of them had said something and got involved with what I was going through.” She adds that although their noticing her distress would have been “a welcome relief,” she also may have been irritable and defensive. However, she says:

I really wish that people would be honest and upfront, rather than keep their distance and quietly keep an eye on things. I think tone is the most important aspect. And depth. A quick ‘how’s it going’ is not what I’m talking about. . . The worst thing is to be left to deal with it on your own. It seemed there were only two options available to me – either people ignored what was going on, or, people would get insistent to the point it came across as hostile which, in that fragile state is alarming and even more isolating.

Morrie notes that “certain of my colleagues, whom I have a lot of faith in, tended to pull me aside and inform me as to where they feel my mental state is heading. I thank them very much
for this input.” Julie and Michelle, though, both caution that they don’t want to be judged or pitied for their illnesses. Julie warns other nurses not to “tell someone to get their act together, understand that even with drugs they are still going to be subject to stress which can lead to mood swings.”

These nurses agree that, as a workforce issue, mental illness in nurses is worthy of attention. As Julie notes, “the big question for me was ‘is work life-giving, or is it life-sapping?’ I decided that it wasn’t life giving, so I chose to leave a job that wasn’t good for me.”

Chloe challenges those who “talk about the turnover of staff, and not being able to get enough staff, but they never ask why the nurses don’t stay, and why nurses don’t want to work there,” and Gemini states that, “nurses are a valuable resource. When they get damaged, you need to look after them.” However, Rachel has the final, hopeful, word for this section about being well:

On the whole, I believe that things are slowly improving for nurses with mental illness . . . There are people out there who understand, even though it can be hard to find them. I want nurses to know that there is a way out. We’re no less worthy just because we struggle with this sort of illness.

Effects of mental illness on nursing practice

Not all the nurses commented on the effect their illness had on their nursing practice. However, several of them stated that going through a mental illness makes you a better nurse; more thoughtful and empathetic and a more forceful advocate. For example, Ellie notes “I feel that my experiences have made me a more compassionate person, much more open to accepting people as they are;” as does Alice; “I’m much more compassionate . . . I consciously incorporate it [empathy and appropriate self disclosure] into my practice. It really helps with the atmosphere and morale of the staff.” Jenny comments on her return to nursing after an absence, “I thought my actual nursing had never been better, but my dislike for the cynicism and ugliness of the some of the burned out staff was also worse than ever.”

Similarly, Vicky says:
On my return to work I felt this amazing vulnerability – like an onion that had been peeled. I was very emotional and unable to screen out any emotional stimulus. It actually felt great; I was more tuned into things than I could ever remember being before. . . . I was more able to sense vulnerability in others and with sensitivity was able to build and maintain rapport with clients that I had not previously experienced. Some of the outcomes for my clients during this initial time were exciting and innovative. My work with clients since this time has maintained a different quality – it is difficult to explain, but this new dimension has to do with the enhanced quality of empathy experienced in relationships with clients since my own experiences of mental illness.

Josephine, too, draws a direct link between her mental illness and enhanced practice ability:

One part of my nursing career that has meant a great deal to me is when I cared for people with head injuries. Perhaps I was good at this area because I could understand their sense of chaos and disruption, and I also really felt for the families. I was passionate about this nursing and somehow I had to be extremely creative in managing certain behaviours they exhibited.

Some of the nurses actively worked to improve the situation for others. Gemini says; “. . . I was involved with a colleague who became psychotic. Along with other friends and family, we tried to manage her at home,” and Julie relates; “. . . my partner and I cared for a young relative of hers who was manic. We managed him at home as I did not want to screw him up with the mental health service.”

Rather than simply noting a one-way impact, however, Morrie notes that in addition to being “involved, or close to people,” some patients also have an effect on his emotional wellbeing. He adds, “I have found though that sometimes I feel okay about sharing a part of my experiences when I was in the psychiatric ward as a patient.”

Elizabeth, Mary and Alice all talked about a fear of making a mistake, although Elizabeth’s comment appears to be more from the context of her self-identified anxiety disorder than from a concern that her symptoms would make her practice unsafe:

I was always in dread of making a mistake and killing somebody. I would read the disciplinary notices in the nursing journal and be filled with terror in case I made a mistake and it was me in there next time.

Julie said that she had recognised the risks of being on call while taking medications, and “trying to make the right decisions over the phone in a drugged state, let alone come into work,” and
negotiated with her manager at that point not to do call. Similarly, 64 identified that it was not “safe for me to try to work with all that medication on board. I didn’t trust the Principle Nurse enough to tell her the truth, so I said I had the flu.” For several of the nurses, the effect their mental illness has had on their nursing practice is integral to their decision about whether or not to disclose their illness to others.

Throughout this motif, the collective story has reflected the nurses’ association with mental illness, including their distress and their ongoing efforts to achieve and maintain wellness. The effect of a supportive working environment has been discussed, particularly the need to have someone to talk to who fully understands the nature of mental illness as well as the realities of nursing practice. EAP, debriefing and clinical/professional supervision were noted to be potential tools for distressed nurses.

The role of nursing education has recurred throughout the motifs, with a specific focus for each exploration. The educative focus for the Tangata Whaiora motif has been the potential for nursing education to prepare new nurses for the stressors inherent in entering the nursing workforce such as strategies for self care in the face of increasing responsibility, stress and grief. The nurses concur that nurses who have experienced mental illness have significant contributions to make to the nursing workforce. Increased sensitivity, a willingness to be vulnerable with clients and the power of shared distress are all identified as adding value to nursing practice and suggest the need to ensure a systematic approach to assist nurses who have a mental illness to remain in nursing employment.

The Nursing and Tangata Whaiora motifs have illuminated a dichotomy for the nurses in this research as they attempt to negotiate the dual and often contradictory requirements of being a nurse and attending to their experiences of mental illness. This chapter now turns to the literature about mental illness, stigma and discrimination, and the search for wellness.
The literature

When viewing the literature about mental illness from Lyotard’s (1988) philosophy, ‘mental illness’ is shown to be only one of the phrases used to signify mental distress. The dominant discourse for people who have experienced mental illness is that of medicine, which is associated with the phrases ‘patient,’ ‘symptom,’ ‘diagnosis,’ ‘mental disorder’ and ‘treatment’ (American Psychiatric Association, 1994; Barker et al., 1998; Bracken & Thomas, 2005; Church, 1997; Crowe, 2000; Deegan, 1994; Hellzen, Asplund, Gilje, Sandman, & Norberg, 1998; Kutchins & Kirk, 1997; Ridgway, 2001; C. Stevenson, 2000; Szasz, 2001).

As discussed previously, Lyotard (1988) defines genres of discourse by their ability to supply “a set of possible phrases” (p. xii) that work in concert to attain a particular goal. However, medicine with its many interests, specialities, and purposes defies the finality of purpose required of a genre. For example, palliative care is interested in mitigating pain, surgery in the technical removal or remedy of problems, and obstetrics is focused on pregnancy and childbirth. Lyotard conceptualises such multiplicity as a “supreme genre” (p. 138) or a “genre that contains all the genres” (p. 139), but instead asserts his interest in locally situated genres and the ways in which they link or do not link together with others.

In this way, ‘medicine’ is seen as a supreme genre. The above phrases are taken from the psychiatric literature, and demonstrate the universality of a search for symptoms in a patient, which aims to uncover a diagnosis from which a treatment plan can be formed (American Psychiatric Association, 1994). These phrases arise from the goal of treatment, and possibly the higher goal of alleviating ‘suffering’ which is another phrase associated with psychiatry (Hellzen et al., 1998). Thus, ‘psychiatry’ meets Lyotard’s (1988) requirements for a genre.

There is a further multiplicity within the psychiatry genre that is demonstrated by phrases used by a variety of interested groups. A full examination of these is outside the scope of this thesis, but they include psychiatrists, psychologists, occupational therapists, social workers, nurses,
mental health support workers, service user advocates, managers and academics. While their
phrases take different forms, the goals of the phrases concur, for example ‘symptomology,’
‘presentation,’ ‘mental state,’ ‘compliance,’ and ‘outcome’. The homogeneity of purpose, being
the treatment of mental disorder, indicates their location within the psychiatry genre. Therefore,
the literature in this review has been categorised according to its phrases and purpose rather than
by author, professional identity or journal. The literature about and within the psychiatry genre is
presented in the section called ‘The Psychiatric Story.’

A second grouping of literature about mental illness challenges the psychiatric story. This
literature comes from a variety of sources, some of which maintain an alliance with the purpose
of alleviating the ‘suffering’ caused by ‘mental disorder,’ and some which dispute suffering
and/or the existence of ‘mental disorder’ (Bracken & Thomas, 2005; Deegan, 1996; Grant, 2006;
Lapsley et al., 2002; Leibrich, 1999; Like Minds Like Mine Project, 2007b; McNeil, 2006;
Ridgway, 2001; Szasz, 1960, 2000, 2001, 2005). The multiplicity of phrases in this literature is
heterogeneous, although their purpose lies in resisting, destabilising or questioning the
psychiatry genre. This illuminates the ‘resistance to the psychiatry’ genre, hereafter referred to as
the ‘resistance’ genre for brevity’s sake.

My decision to subsume these phrases into the single genre is contestable on the grounds that
each cultural group therein operates within their own genres. Examples of these include the
psychiatrists who are attempting to reframe the work of psychiatry from within the discipline
(Bracken & Thomas, 2005; Szasz, 1960), and the self-named psychiatric survivors who dispute
the right of psychiatrists and the mental health system to define human experience and forcibly
mould it into the dominant image (Deegan, 1994, 1996). Again, the scope of this thesis is such
that a full examination and re-presentation of these ideas is not viable. The literature pertaining
to the resistance genre is grouped under ‘Inner distress: an alternative story’.
The final section of the literature review consists of an examination of discrimination and stigma. These were identified by the nurses in their collective story of seeking wellness, and also throughout the two sections of psychiatry and resistance literature as being of prime importance in the lives of those who have experienced mental illness.

The Tangata Whaiora motif also contains the collective story of nurses seeking wellness, which includes EAP, clinical supervision, changes to nursing education and the need to speak out. These subjects are not addressed in this chapter because, although the nurses spoke of them synonymously with their illnesses, their value in this research is in their specific resonance with the nursing identity rather than in the more general context of mental illness found in this chapter. They also form a part of the nurses’ negotiation of their hyphenated lives and therefore offer potential solutions for all nurses. As such, they are examined in Chapter Seven to avoid repetition or the loss of emphasis which is the likely result of fragmenting the discussion between two differently focused chapters.

**The psychiatric story**

In an ongoing attempt to define ‘mental disorder’, the American Psychiatric Association (1994) has produced the Diagnostic and Statistical Manual of Mental Disorders (DSM), a catalogue of mental disorders categorised into lists of behaviours, symptoms and potential treatments. It is currently in its fourth edition, although the fifth edition is in the planning phase. In order to meet the criteria for a mental disorder, according to the DSM, it is necessary to display the requisite number of recognisable symptoms. Causal explanations for mental illness arising from the psychiatry genre are primarily biological, biochemical or genetic, although these may be triggered by stressors including those of an environmental or emotional nature (American Psychiatric Association, 1994). Some recommendations for optimal treatment approaches are made in the DSM, including medications, psychotherapy, behavioural therapies and physical therapies.
The psychiatry genre is embedded in legislation through the Mental Health (Compulsory Assessment and Treatment) Act (New Zealand Government, 1992), thereby providing the means for the enforced or coerced imposition of psychiatric diagnoses and treatment on “those people considered threatening and undesirable in mainstream society” (Symonds, 1998, p. 953). This is a powerful legitimisation of the psychiatry genre and the psychiatrists who maintain it (Foucault, 1973; Szasz, 1960, 2005), and is also the focus of some of the resistance literature that follows.

A second causal explanation for mental disorder asserts the importance of social and behavioural features. William Cockerham (2002), a sociologist from America, has authored six editions of a text entitled The Sociology of Mental Disorder. In his text he calls on the “substantial body of evidence [that] has accumulated over the past decades supporting the conclusion that the nature of the social environment has important consequences for mental health” (p. 2).

While not disputing that some mental illness has its roots in the physical, Cockerham asserts that the limitations of the biological explanation of mental disorder lie in its focus on symptoms, rather than the causes of distress. In exploring this weakness, Cockerham (p. 66) cites French physician René DuBois (1959), who noted, “while drenching fire with water may help with putting out a blaze, few are the cases in which fire has its origin in a lack of water.”

His position is that while managing symptoms through medication can be useful, cure for mental disorder lies in uncovering the cause of the original problem through the examination and management of the social environment. He asserts that the emphasis in the sociological model is on “mental disorder in terms of group or larger societal processes that have an impact upon people . . . [which result in] significant deviations from what is usually considered ‘normal’ ” (Cockerham, 2002p.95). Cockerham describes ‘normal’ as conforming to social rules and notes that “deviant behaviour is a violation of social rules and has no reality apart from those rules” (p.122).
It is important to recognise that there is a large literature from within the psychiatry genre about causes and treatments of mental disorder, in addition to those texts I have mentioned here. Reprising it fully is outside the scope of this thesis and is a task of such magnitude that it may constitute another complete research project. My intention with this short précis is to indicate the power of the genre and its position as only one way of understanding mental illness.

The literature that follows is grounded in the psychiatry genre, and records its story of the prevalence and impact of mental disorder. Its inclusion in this thesis asserts the location of this research as psychiatric although, as I discussed in earlier chapters, only in partial and multiple ways according to the needs of the nurse participants, myself, and our varied audiences.

**Prevalence of mental disorder**

The WHO Global Burden of Disease Study (C. J. Murray & Lopez, 1996), based largely on a small number of limited studies and literature reviews, suggests that mental and substance use disorders are among the most burdensome in the world, and this burden is projected to increase.

In 1986 a small New Zealand study examined the mental health of 1,498 adults living in the Christchurch region (Oakley-Browne, Joyce, Wells, Bushnell, & Hornblow, 1989). Based upon this research, which applied diagnostic criteria to a probability sample, it was estimated that the prevalence of certain diagnosable mental disorders (including depression, anxiety, phobias, substance use, schizophrenia and eating disorders) was 20% of New Zealanders at any one time, and 65% over their lifetime. These estimates, along with an Australian study (Andrews, 1991) formed the basis for the development of mental health services in New Zealand from 1994 until 2006 (Minister of Health, 2005; Ministry of Health, 1994). The New Zealand branch of a cross national study of 28 countries has validated these estimates in the findings from the New Zealand Mental Health Survey (Oakley-Browne et al., 2006). In this study, a geographically diverse sample of 12,992 people has revealed that approximately 20% of New Zealanders will
experience a diagnosable mental disorder in any given year and approximately 46.6% of New Zealanders will experience a diagnosable mental disorder in their lifetime.

A significant limitation of this study, however, is that disorders such as schizophrenia and schizoaffective disorder were not included in the diagnostic criteria. Nor were people who live in institutions such as hospitals, prisons or supported accommodation, or who were homeless, included in the sample frame. These omissions suggest that actual totals of people with a diagnosable mental disorder may be higher than those proposed by the study.

**Workforce implications**

Universal workforce issues arising from mental disorder range from economic to the quality of work performed. These issues have been the focus of international research projects since the early 1990s. In the United Kingdom, psychiatric illness was found to be a significant cause of long or very long spells of absence from work (Stansfield et al., 1995), and in the United States of America depressive disorders are identified as the highest medical and disability cost (Conti & Burton, 1994). A United States study (Berndt et al., 1998) describes a link between perceived poor work performance and depressive disorder, and suggests that improved mental health also improves performance at work. More recently Whiteford, Caleo and Coulter (2002) have begun to conduct the Australian component of a Harvard Health and Work Performance Initiative, a large scale multi-national study to screen for and treat depression in the workplace, and measure the economic effect of this. The hypothesis for their research is that the cost of screening and treatment is less than the economic gain from having a healthy workforce.

Also, the World Health Organization has identified mental health as a part of their Global Strategy on Occupational Health for All, with a particular focus on recognising and treating the adverse effects of workplace stress on individual mental wellbeing (Cassito, Fattorini, Gilioli, Rengo, & Gonik, 2003; Harnois & Gabriel, 2000; Richards, 2003).
This literature indicates that mental disorder is a significant issue, within the psychiatry genre, for many people in their individual and workplace contexts. In their collective story, the nurses’ experiences support the literature. They describe difficulties functioning at work, short and long terms of sick leave, leaving their jobs, and leaving nursing completely. Anne, 64 and Michelle explicitly discuss the costs involved in managing their illness, relating these to the search for the right healthcare professional for their needs as well as to earning time lost as a result of illness. These issues will be revisited as the interpretation of the nurses’ stories continues in the subsequent chapters.

The next body of literature adds a further perspective to the nurses’ collective story as it examines the contribution of the resistance genre.

*Inner distress: an alternative story*

As Catherine Camden Pratt (2002) notes, there are some discourses that inhabit a central position against which all other stories are placed. The difficulty inherent in research such as hers and mine lies in wrestling the focus from the psychiatric genre and centring the voices that have been silenced (Camden Pratt, 2002; Lincoln & Denzin, 1994). In the collective story above, I utilised a poetic rendering of the nurses’ distressed voices to convey their silences while also revealing some of their meaning. Finding a way to centre the silenced voices has been essential for the interpretation process and for identifying literature that could illuminate aspects of the nurses’ stories and experiences that fall outside the dominant genre of psychiatry.

Lyotard (1988) hypothesises silences such as these occur at the differend; the place where dissenting genres collide. Further, he asserts that silence is a phrase which carries meaning in the same way as the spoken word. In adopting his position, I searched for genres which would collide with that of psychiatry with enough force to produce the silences that were demonstrated by the white space and three dots, above. In the genre of resistance, the literature suggests such dissent.
In the resistance genre, ‘mental disorder’ is viewed as a metaphor used to evoke a word picture of internal distress that is epistemologically privileged to its speaker (Barker, 2001a, 2002). Usually framed by the phrases ‘mental illness’ or ‘mental distress,’ this metaphor is fractal, time and context bound, “embodied, encultured and temporal” (Bracken & Thomas, 2005p.107). The metaphor uses the language of sensation, which portrays experiences that cannot be fully understood by anyone except the person who is experiencing them, for example feeling ‘miserable’ or ‘frightened’. The fundamental nature of the resistance genre is its dissent with the way the psychiatric genre has “colonised health and established a hegemony through drawing on a knowledge base that is seen as legitimate through its claim to be scientific” (Stevenson, 2000, p. 24).

The resistance literature is particularly interested in disputing the centrality of the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association, 1994), which lists symptoms and categorises them into diagnoses of mental disorder. This manual is the object of many deconstructive texts. The most persistent of these comes from psychiatrist Thomas Szasz, who maintained the use of the phrase ‘mental illness’ when he wrote that mental illness is a myth (1960) which imparts “legitimacy to the exercise of psychiatric power” (2000p.44). He asserted that the constantly expanding notions of what constitutes a mental disorder is, in fact, the pathologising of “problems in living” (Szasz, 1960p.181). This position is also taken by Kutchins and Kirk (1997), who have chronicled the development of the DSM and who continue to challenge its claims of diagnoses based in scientific truth. In fact, they contend that the diagnostic categories therein have more to do with political manoeuvring and ensuring insurance reimbursements in America than with research based knowledge. They note that ‘mental disorder’ is a social construct that is able to be manipulated by interest groups. They assert that this provides the means for pathologising everyday behaviour and “sweeping increasing numbers of human problems into the realm of psychiatric disorder and medical jurisdiction” (Kutchins & Kirk, 1997p.16). These authors all contend that the motive for using the DSM to reorient social
perceptions about behaviour is found in the economic and power base of an ever increasing psychiatric jurisdiction.

More recently, Marie Crowe (2000) challenges the assumption within the DSM-IV that mental disorder is a feature of a context free individual. She suggests that this perception increases the likelihood of pathologising responses to life events and serves to separate the individual from society and family. Similarly, Bracken and Thomas (2005) suggest that the concept of mental disorder is a problem because it lies within a medical/psychiatric discourse that emerged from Cartesian dualism, therefore imposing an epistemological separation between what is in the mind and the outer world. This separation, they suggest, situates the problem of mental disorder firmly within the mind of the individual, and thereby negates the need for society to take responsibility. Jane Ussher (1991, p.149) concurs with this position, noting “whatever the exact location of the ‘problem’ . . . it is most certainly not within the individual who is labelled mad. It is within the wider system.”

Jan Dirk Blom (2004) asserts in his doctoral dissertation that contemporary understandings of schizophrenia are flawed and that rather than the overarching description found in medical texts, individualised, contextualised understanding is required for each person. Marie Crowe and Christine Alavi (1999) illustrate this by twice analysing the narrative of a woman called Madeleine, firstly from the medical perspective whereby she met the diagnostic criteria for schizophrenia, and then through a poststructural feminist reading whereby her experiences were read as metaphorical and contextual. In the latter reading Madeleine’s distress appeared as a logical and understandable consequence of her life experiences. This exemplifies the power of the discursive lens through which language is filtered – particularly when internal distress is filtered through the phrases of the psychiatry genre.

The resistance literature illustrates the partial, multiple, plural and indeterminate (Best & Kellner, 1991) nature of the experience of mental illness. The nurses’ re-presentations of
moments of illness, distress and sensation do not portray the fullness of the individual experience. Many of the nurses move between instances of living within the psychiatry genre and the resistance genre. For example Chloe says

So, I went back to my GP, and accepted that I was depressed. I stopped work, went on a benefit, tried several meds and had therapy. I went from believing that the system was failing to thinking it was me.

Yet she also views her illness as a logical result of nursing stressors and unremitting distress. Her movement between genres, and that of many of the other nurses, indicates the presence of a hyphen between the unrelenting and distressing symptoms of mental illness and the desire to create wellness through individual efforts. The collective story shows the nurses negotiating this hyphen most of the time as they balance their individuality and desire for wellness with their diagnoses and treatments that are associated with being ill. Where this negotiation is not possible or is unsustainable, for example when Chloe could not work as a nurse at the same time as accepting her diagnosis, the nurse is immobilised in a differend. The experience of the differend is of injustice and suffering, which is consistent with Chloe’s story.

The partial and multiple nature of experience is also indicated by Lyotard (1988), who notes that people are located at the nexus of many genres of discourse. Their ability to negotiate the genres is limited by their personal history and context, including their socialisation into groups such as the family and the profession. This notion of limitation is an important one for nurses who, as was discussed in the last chapter, are involved with a significant socialisation process. The juxtaposition of the nursing identity and the psychiatry genre appears to create an imperative for nurses to embrace the resistance genre in order to remain in the nursing group. This complex nexus is revisited in greater depth in the following chapters. Of importance in this Tangata Whaiora motif, however, is the location of narratives of survival and recovery as a feature of the resistance genre.
Recovery

In the New Zealand context, recovery is a specific phrase that describes “a journey as much as a destination” leading to people being able to “live well in the presence or absence of their mental illness” (Mental Health Commission, 1998, p.1). This quote forms the basis for a shift in the focus of mental health services from institutional to individual. There is some dissent about the philosophical underpinning of the recovery approach, as it appears to have been endorsed from a neo-liberalist economic foundation and be focused on reducing the amount of government funded institutional bed days (Barker, 2003; Kidd, 2002). Nonetheless, the recovery focus has been embraced by the mental health consumer movement in New Zealand, and has led to an acknowledgement that mental illness is not necessarily a life sentence of suffering. This perspective is attended by an increase in the availability of personal narratives that explore the meaning of mental illness and recovery (Fenton & Te Koutua, 2000; Lapsley et al., 2002; Leibrich, 1999; Like Minds Like Mine Project, 2007b; Malo, 2000; Mental Health Commission, 2000a, 2000b).

The location of recovery is multiple and partial, as it is discussed and enacted to varying degrees within both psychiatry and resistance genres. Recovery as it is defined by the Mental Health Commission (1998) refers to specialist mental health service delivery. Recent studies have taken a narrative approach to the exploration of recovery as a phenomenon that sits outside the illness focused medical discourse (Lapsley et al., 2002; Ridgway, 2001). A common theme in such research is that the participants made choices that positioned them as being central to their own stories instead of marginalised by assigning the central position to psychiatry. Their stories changed from being primarily about what the doctor said and what medications were taken (or thrown away) to being about what felt good, what helped and what didn’t.

Recovery is aligned with, but not completely synonymous with ongoing work on notions of rehabilitation, reclamation, discovery and re-integration (Barker, 2003; Barker & Buchanan-
Barker, 2005; Deegan, 1994, 1996; Krupa, 2004; Ralph, 2002; Ridgway, 2001). These are all important aspects of the forthcoming interpretation of nurses, nursing and mental illness, particularly regarding the issues of maintaining or regaining nursing employment. Recovery and all its allied approaches are, however, problematised by societal and internal responses to mental illness.

**Stigma and discrimination**

Before leaving this exploration of the genres of mental illness, it is necessary to consider the existence and impact of stigma and discrimination. Research and opinion related to stigma and discrimination is plentiful in the literature (Corrigan, 2005; Gendall, 2006; Johnstone, 2001; Lawrence, 2004; Nairn et al., 2001; Pyne et al., 2004; Vickers, 2000), with several studies asserting that the presentation of mental illness in the media contributes significantly to the stigmatisation of people who have experienced a mental illness (Coverdale, Nairn, & Claasen, 2002; Hazelton, 1997; Nairn, 1999; Nairn et al., 2001; Wilson, Nairn, Coverdale, & Panapa, 1999a, 1999b).

Patrick Corrigan and colleagues (2005) assert that stigma is the result of stereotyping, which leads to prejudice (agreeing with the stereotype and having a negative emotional response to it), and is frequently followed by acts of discrimination. Stigma may be experienced as external, or public, and internal, or self. The effects of stigma on people with a mental illness include the loss of life opportunities such as employment and housing, an association with violence issues leading to a distorted experience of the criminal justice system, and a lack of appropriate medical care.

Causes of stigma and discrimination include moral judgements, whereby the ill are judged to have brought their condition on themselves by such actions as using drugs, being promiscuous, or by not eating properly or exercising; lack of knowledge or inaccurate knowledge such as contagion or malingering; and fear such as an association with violence and unpredictability
(Vickers, 2000). These beliefs cause “a vicious cycle of fear and ignorance” (Leibrich, 1999, p.6) and underpin acts of discrimination that arise from the need to avoid what is feared, and to fear what is unknown. Leibrich further asserts that the visible aspects of discrimination such as denial of human rights are able to be “pinned down and dealt with in the end,” but “much harder is the invisible, intangible prejudice, such as seeing mental illness as a person’s primary characteristic, or even as their entire identity” (ibid.).

Evidence of overcoming the stigma of mental illness may be found in the increasing numbers of people who have experienced mental illness being employed in mental health support worker positions (Krupa et al., 2005; Lawrence, 2004). Additionally, the Like Minds, Like Mine antidiscrimination campaign of television advertisements in New Zealand includes people who work in the arts, design and sporting fields (Like Minds Like Mine Project, 2007a). This does not appear to extend to an acknowledgment that such people may also work as nurses, doctors, therapists and more. This lack is, in itself, discriminating.

Internal and external stigma and discrimination are the constant companions of people who have experienced mental illness, impacting their everyday lives and decisions (Johnstone, 2001). The collective story in the Tangata Whaiora motif relates many instances of external and internal stigma and discrimination affecting the nurses. Morrie, Jayne and Ellie report the stigma and discrimination they faced as destabilising and destructive, and it took considerable personal resources to combat. Ellie, Vicky and Josephine lost friends over their diagnoses. Jayne, Michelle and Jenny have confronted discriminatory employers, and Morrie, 64 and Elizabeth have been excluded from workplaces because of the perceptions of their illnesses. The frequency of the emergence of stigma and discrimination in this research is unsurprising and reflects New Zealand and international trends (Gendall, 2006; Lapsley et al., 2002; Like Minds Like Mine Project, 2007b; Mental Health Commission, 1998; Peterson, 1999).
I have undertaken further interpretation of stigma and discrimination in this research under the banner of ‘bullying’ in Chapter Six. This decision reflects the similarity in purpose of discriminatory behaviour and bullying behaviour; the systematic and deliberate process of harming another person or group of people (Ironside & Seifert, 2003; Lewis, 2006a; A. Needham, 2003; Zapf, Einarsen, Hoel, & Vartia, 2003). The results of discrimination and bullying are similarly aligned and include an erosion of personal wellness, lack of confidence and a myriad of physical and emotional responses. These results factor significantly in the experience of nurses who have had a mental illness.

Being subjected to the nexus of hyphens between genres that emerge from mental illness and nursing has been shown in the motifs of Nursing and Tangata Whaiora to be complex and sometimes distressing. Combining these with stigma and discrimination, the uncertainty of knowing oneself when in the grip of a mental illness, dreams of a reclaimed life and the frustration of negotiating the minefields of antipsychotics, antidepressants, mood stabilisers and tranquillisers is an unsettling and tension-filled way to live (Camden Pratt, 2002; Church, 1997; Deegan, 1994, 1996; Grant, 2006; Lapsley et al., 2002; Leibrich, 1999; Ridgway, 2001; Rippere & Williams, 1985; Ussher, 1991).

**The segue**

This completes the presentation and discussion of the Tangata Whaiora motif and the attendant literature. In the motif the emotional content of distress, frustration and misery is expressed as spoken and silent phrases. The collective story speaks of illness and the quest for wellness, and 64’s art eloquently depicts the nurses’ struggle to find balance. The literature revealed genres of psychiatry and resistance which conflict for some of the nurses and create a differend wherein the nurse is silenced in pain and injustice. The difficulty in finding balance is further complicated for the nurses by internal and external stigma, and discrimination.
These ideas do not conclude my interpretation of mental illness for nurses. The literature herein has been limited to that pertaining to illness and its context, and has not addressed the social contexts of wellness or negotiating a balance between illness, wellness and nursing. These aspects of the collective story will be examined as a part of the interpretation that follows. It engages with the nurses’ experiences and the genres and hyphens identified thus far.

The next chapter, Hyphenated Lives, integrates the two motifs of Nursing and Tangata Whaiora in an interpretation of the hyphens that join and separate the identities present in the nurses’ lives.
Julie’s story

I trained as an RGON in the late 1970s, and commenced working in the med surg area, but really found my place working with the elderly, in rehab. That’s where I’ve been except when I worked as a social worker for a Christian child and family service. I was diagnosed almost 3 years ago with a major depressive disorder, which has been really difficult to get on top of and be in a place where I can function adequately.

I think it was triggered by 2 things. The first is that I came out as a lesbian 10 years ago, and didn’t really know how to process some of the things that happened around that time especially with my church, which was very disapproving, as was the Christian agency I worked for, who left me with no choice but to leave unless I changed my colours. Rather than face rejection from people who I had had close relationships with, I changed jobs and moved towns, but couldn’t find a Pentecostal church that I could plant my roots down at. I looked at traditional churches, plus a gay and lesbian church group, but found that very tightly knitted together, and couldn’t be bothered making the effort to break into their circle, so flagged God away, or rather shelved it, as anytime I tried to sort things or process my spirituality I would just end up feeling hopeless.

In the new town I was in I worked in the rehab service, and after 7 service reviews, 4 managers later, I became disillusioned with the ageism that existed in trying to get elderly people who deserved rehab in, with the problem being that they didn’t fit the entry requirement. I found the nursing staff and the allied health team unsupportive, so moved back into managing a dementia unit.

About a year after moving my partner and I cared for a young relative of hers who was manic. We managed him at home as I did not want to screw him up with the mental health service, at the same time I developed a supportive friendship with the local minister and had begun to look at spiritual issues but had to flag that away to look after the nephew as I couldn’t do both. I
think that’s when I first began to feel down. When I was ready to look at spirituality the minister was moving on.

The second thing that happened was that a patient died. I was in charge of the unit, and was seen as responsible. There was the threat of a Health and Disability Commission inquiry, although it never actually came to that. But it was incredibly stressful, and I was kept busy supporting my staff, and also supporting management who were terrified of being on the front page of the newspaper. So I looked after everyone else except myself. I received a lot of negative feedback around that time, which I took on board. I pretty much kicked myself in the head over it! Yet, looking back, I didn’t do anything wrong. I would maybe change a couple of small things I did, but nothing major and nothing that would have affected the outcome. The death was unavoidable. In the end, the family were Ok with the care, and the case didn’t go any further. Management were incredibly unsupportive of me at that time, and made comments like “we really need to get some decent RNs into that unit”. The DON was scared stiff that she’d end up in the paper and the implication was that if they’d had anyone else in there that it wouldn’t have happened.

Anyway – I’m not much of a talker. I just pushed things aside and carried on, ignoring them. You do don’t you? I mean, you’re a nurse, you just carry on. Stuff happens. But the bubble had to burst somewhere along the line.

I fought a real battle to own that I was depressed, I was working full time, no one at work new how I felt, and I was managing so I didn’t really believe that I could be that depressed. People had told me for ages that I was depressed, but I kept on denying it. Finally I decided to end my own life, and I thought that that was a clue – maybe I was depressed after all! But when I went to my GP, I tried to convince her that suicide was a rational idea. I was still working at that time, and it was a part of my rationale that I couldn’t be depressed because I was still working.
No-one at work had any idea of what I was going through. It worked the other way, too – because I was working, I couldn’t let myself be depressed. So when I acknowledged that I was depressed, I immediately believed that I was a bad nurse and I couldn’t cope. I needed that image of myself in order to keep going.

I’ve always been a perfectionist. Anything I did that didn’t live up to my standard for me was a disaster. Any small errors at work meant that I was a terrible nurse. Eventually I left work because I lost my cool with one of my staff. I have always been very controlled – maybe overly controlled – and when this happened I felt absolutely terrible afterwards. (The ironic thing was that the staff member didn’t even know I had lost my cool) it was more of that feeling of having lost control.

My GP gave me 6 weeks off, and I went and told my boss that I was depressed and that I would need to leave work for a while. She immediately launched into this story about a relative of hers who was depressed and would have that illness forever and that I would have to learn to live with it because it is a lifelong thing. She also said that because I’d be at home and not doing anything, that there were some conferences that I could attend. I’d never before allowed myself to be put in a position of being vulnerable, so this lack of understanding was just horrible.

I went back to work part time after this, but it was terribly stressful. The managers were very unsupportive, and I never got to leave work on time. I had previously had social contact with one of the managers, drinks once a week but that stopped when I said I was depressed. I got the message that I was really wicked for needing the time off. When I went back my staff was worried about me because I’d lost so much weight, so I also had to contend with rumours that I had terminal cancer! I had chosen to work part time because my GP had been very clear about the things I could do to help myself, including regular exercise. I took that advice very seriously, and
went to the gym and walked to get healthy again. However, I started to work full time again after about a month.

I am very stubborn, and I pushed myself to do all the things that could help my health, while I worked fulltime, but I was struggling to cope. I was constantly and had rung in a few times and said that I was starting late which didn’t go down well. In the end on the recommendation of my psych and GP I told management that I needed to go down to part time again. My boss at that time said that if I needed to exercise, that she would walk with me every lunchtime. That lasted 3 days before she said it had to stop because the staff were unhappy that I wasn’t on the floor. I went off work again, and in the meantime had been seeing my GP and trying all sorts of combinations of drugs. I did go back again, but I sort of floated through, doing half a job because I was so tired. I was still trying to keep up my exercises. My boss then advised me to go off my meds because they were making me so tired and they weren’t “good for you”.

At that point I resigned from my job and accepted a job that I had been offered 4 months prior. Management had stopped talking to me, and it was clear that I didn’t fit in there any more. I tend to be a very committed person, and settled. I don’t take to change very well, and this was the only time I have ever left a job without carefully considering it for quite a long time. In fact, I gave in my notice, and talked with management about working through my leaving with my staff as I knew they would be distressed. I had another position to go to, and I was aware of the risk that several of the staff would leave with me and I didn’t want that for the residents. So I wanted to take time to work through any grieving the staff would do. Management said no. they gave me a months pay and I had to leave that day. I may be oversensitive, but they had done several things like that – chopped my legs off from under me and left me with nothing to stand on.
When I agreed to take this new job (they'd offered it to me ages before, but I had been happy where I was working), I laid all my cards out on the table. My depression and my sexuality. They were very supportive, and said that my sexuality was nothing to do with them. They also said that they would work with me on the depression, and that they valued my professional skills. They have no problem with me having time off to see my medical team – it's just not an issue for them. In my last job, they kept asking me why I couldn’t make them for after work.

Looking back, I think I was depressed for a good year before I finally admitted it. I’d had a long term low mood, and I couldn’t find solutions for the things that bugged me. I also wonder now whether, if I were more open, or they were more supportive, maybe it wouldn’t have happened. I found it very hard to talk about things that were important to me. I always needed to make out that it wasn’t anything serious, and brush it off.

I think nurses need to be prepared, that if you “own” being depressed then you’ll be kicked in the teeth by most of your colleagues. That sounds pretty pessimistic, but that’s how I’ve found it. Healthcare staff feel that it isn’t acceptable for staff to have a mental illness.

As a nurse, you can just run on empty sometimes, and you have absolutely nothing to give. Then you’ve got a distressed relative coming to you, and you give out to them. I think that as an old school nurse, I was trained to pick up responsibility for the whole ward, rather than just your own area. I think that’s a difference between the old school nurse and the comp trained nurse. You take this huge responsibility for others’ feelings, and you try to make everything better.

I have found, though, that there is huge value in being in a supportive environment. It is important to recognise what is going on for you and refuse to be a pig headed health professional! I believe it is really important to be aware of your own self talk, your patterns, your feelings, and how to make changes.
The big question for me was “is work life giving, or is it life sapping?” I decided that it wasn’t life giving, so I chose to leave a job that wasn’t good for me. Seeing that it was draining was a big realisation for me. It was better for me to leave the job for that reason than to stay around feeling slacked off, or leaving just because I got a better offer. It was a good reason to leave – it is not selfish to look after myself. I needed to look at my own needs and how I can get them met. You can’t go around giving out from nothing for too long.

So here I am almost three years after I first started meds, still feeling a bit like a guinea pig having trialled 6 – 7 different combinations of drugs and only just feeling that I am coming right.

I’m very aware of the huge risk of being on call, and trying to make the right decisions over the phone in a drugged state, let alone come into work. When I started in the new job I had arranged that the acting general manager would come in if needed, but that changed when she left, so it fell to another care manager which she resents having to do, and I don’t blame her. So several times I tried reducing the seroquel but if I dropped it below 50mg I just ended up falling over again.

I had a really really stressful week at work that resulted in me going down again, and contemplating taking my life, being the rational girl I am I calculated out how much venlafaxine and seroquel I had, and decided I didn’t have enough to do the job, so ended up talking to my psychiatrist over the weekend, which resulted in me totally changing my drugs around keeping one and introducing two others.

Now that I feel well, work just seems so overwhelming that my anxiety has increased 100%. I would never have said I had an anxiety problem before, but I woke up with a major panic attack (that’s the best way I could describe it). The two managers above me are unable to give support to me in any meaningful way, so I’m back to not sleeping well (took a week and a half after
coming back from a holiday). I tend to use my psychotherapist to help me with some work-related issues, as those needs aren’t met at work.

I’ve been told that if I go down again and fall over that they would need to look at what is best for the company and me, and they would want me to go on leave until well. So I can’t afford not to be well, I can’t afford to let work see any vulnerabilities, or weaknesses. Right now as I sit and write this I feel like crap I feel anxious, tearful, despondent, don’t know if I really give a stuff any more. It just feels like I reached out and touched wellness for 2 – 3 weeks and then lost contact. One begins to wonder is there ever going to be an end, or is this all that life has in store for me, and if it is as well as I will get, then you really have to think about the point of it all.

Anyway enough about the doom and gloom, other things I would recommend for nurses would be to set boundaries around their time, and block a time when you are unavailable to others and stick to it, do something nice everyday at work, set into place a weekly work schedule, if nurses aren’t supportive find someone else outside of work, keep work and personal life separate.

For those nurses who work with a colleague with depression, try a bit of love and compassion, don’t tell someone to get their act together, understand that even with drugs they are still going to be subject to stress which can lead to mood swings. I don’t want someone’s pity I want someone who will understand me and not judge and condemn me.

Michelle’s story

I completed my degree a couple of years ago, as a mature student. I am now practising in a highly specialised area, working day shifts.

The story I want to tell starts during the last year of my degree, when my partner had a mental breakdown. Although I had assignments piling up and placements looming, I dropped
everything to help him. He refused to talk to his family, so I walked a kind of tightrope, supporting them all. I developed sleep and anxiety problems, made worse because I was away from my home base when all this happened. I started taking sedatives and anxiolytics to help me through, and often mixed them with alcohol. They didn’t have the effect that I wanted, but I became addicted to them. I tried to carry on with my education, and arranged to go to my next placement. Things came unstuck with my partner again, though, and I had to let the clinical area know that I’d be delayed in getting there as I was still out of town. They seemed fine with that, but I nearly failed the programme because of non-attendance. My tutor actually asked me “what’s more important, your partner or your degree?” Well, my partner was more important, of course! We’d been together for years. Anyway, I carried on with the course, and went to see my GP. He diagnosed psychotic depression, and gave me what I now know was a very large dosage of melleril. I was very unhappy with this and asked for a referral to a psychiatrist.

While all that went on with the meds, I passed my course and became a registered nurse. The new grad programme I applied for was away from home, so I moved to a brand new area where I didn’t know anybody. My partner was planning to move to this area to work, but he initially stayed behind. I was still on the melleril, and feeling really depressed. I went to my new GP for a purely physical reason, and he did a full assessment. He told me he suspected that I had a bipolar disorder and referred me to mental health services for an assessment. He also started me on an antidepressant. When I went to the psychiatrist, he diagnosed me with melancholic depression and started me on a mood stabiliser. I was supposed to go back for a review in 2 weeks, but didn’t get sent an appointment. I called and ended up having an argument with the receptionist, who said I couldn’t see him for 2 months – but I only had enough meds for 2 weeks! In the end, I called back and talked to another receptionist who sorted out my appointment. I think that kind
of power in an uninformed person is pretty frightening. If I hadn’t been so sure about what the psychiatrist had told me, I would have been off my meds for 6 weeks before I got to see him again.

After the initial review, I had another appointment – this time for in 2 months time. When I went for that appointment, there was a new psychiatrist who diagnosed me with bipolar disorder and changed my meds again. At that time, I decided to go private, so I could have some kind of consistency in my treatment. I hated seeing someone different and having everything changed around.

While all this was happening, I was in the first placement of my new grad programme. I was still depressed, couldn’t sleep, contemplated suicide, and drank lots of wine. Unfortunately the new grad programme wasn’t organised well, and I was left not knowing what my second placement would be. I kept trying to find out, and in the end they told me that they didn’t have room for me. I was really annoyed, because there were other new grads who started after me, and they had all been placed. I was trying to keep up with the paperwork part of the programme, but I felt like utter crap.

I had my first appointment with my new psychiatrist, and had my meds changed again. I’d been on 25mg of quetiapine, and that was put up to 600 mg – quite a jump. I was also put on lithium and became toxic. I was really sick and throwing up for about 2 months. The only time I took off work, though, was a week when my meds were first changed. My partner moved at that time, and was unsupportive and horrible, he made it all worse.

So, while all this was happening, I realised that I needed to apply for an RN job, since the new grad programme was not working out. I’d been working night shifts, and finding it impossible with the pills and everything. So I applied for a job in a very specialised area that meant I would be working days only. I met with the CNE and the new grad co-ordinator about the position. They could see that my hands were shaking, and knew that I’d been having trouble with the
shifts, so they decided it would be best if I had regular working hours. They were actually great. But as a new grad, I wasn’t considered to be qualified for the position I’d applied for. In the end, though, I got the job because of the experience I’d had prior to doing my nursing education.

I’d been advised to tell my bosses about my bipolar disorder, and that I may need to have a day off occasionally. The boss in this new job immediately started to play with me. She seemed pretty unstable herself, and a bully. She’d do things like write on her desk pad that I needed a health review, then later she’d have crossed it off and would deny ever writing it. She would back me up in the office and quiz me about my meds, and she also held me responsible for mistakes that other nurses had made. She was actually removed from that position, but it involved a long process of lawyers, interviews, panels – having to make statements and be taped, and then sign stuff. It was drawn out and horrible. When she had to leave, the long serving RN in the area left, too. That left three of us. I was the most experienced, and became responsible for teaching the other staff. I found that doing the management side of the work was really different, and unfortunately it spun me into a manic period. That was actually OK at first, but it got out of control. In addition to the work issues, my partner dumped me, and my Mum had been diagnosed with a serious illness. There was a lot going on!

I started seeing a psychologist every 2 weeks, and she noticed that I was getting more manic as time went on. I avoided the psychiatrist for fear of being admitted to the mental health unit.

I was running around doing loads. I had been like this in the past, but this was the worst I’d ever been. I couldn’t stay on topic – but I didn’t do anything dangerous to any patients. I did, however, decide to stop taking my meds on 2 occasions, and stopped sleeping. I arranged a couple of meetings with management and told them what I thought about various issues. We were understaffed, partly because they hadn’t advertised for a new manager of the unit. I guess that’s because of the process they were going through, but it left us in a mess. I was working 60 hour
weeks in spite of having a contract for .8 (my colleagues had families and couldn’t do extra work), and received no recognition for the work. The working conditions were awful. My parents wanted me to go back to my home base, but I stayed on. None of the three staff on the unit had full time contracts, so there were unfilled shifts every week. The kind of work we do is very precise, and there is no room to change the routine around. So we would work through our lunch breaks. I really lost faith in management through that year. First the new grad programme fiasco, then the first unit I had a job on was just a horrible mess and I was pushed into taking on responsibility far too soon. We did have agency nurses sometimes, but in an area like this, they weren’t equipped to do the work. They’d end up just standing there, or sitting in a corner reading a book while we did their work. They just weren’t qualified. I told management at one of our meetings that the agency nurses were inadequate. That didn’t go down well at all!

I stayed manic for about 6 weeks, before I saw my psychiatrist and he increased my meds. After I stabilised, I tried reducing them again but was manic again within 2 days. It makes me feel very discouraged to know how closely my moods are tied to the meds.

We had a new service manager at that time, and he saw me one day in the cafe and told me I had to have a health review. I got really stressed about that, and went to my manager to sort it out. In the process of that, I told my boss that I had BPAD and saw her whole attitude to me change. She started to take delight in docking my pay. For example, she’d see that I claimed overtime and say that there wasn’t a problem. Then when I was paid I’d find that she had not approved it. She refused to pay me for the days that I missed lunch – and even though it was only about $13, it still mattered that she wouldn’t pay it. She also got very resistant to talking to me at all, and I know my colleagues noticed it. She was rude. I also knew that another of my colleagues had been advised to take an additional 2 weeks of unpaid leave each year, because of depression. When she learned about that, her response was that you “shouldn’t be a nurse if you have depression.”
I approached the service manager to ask for a full time contract, and he initially said that he didn’t see a problem with that. But within a very short time he came back to me and said that the area I worked in was “too stressful” to work in full time. I think that during that time he had been told about my illness.

There were service issues with the unit as well, with some of the outreach we had been providing being cancelled. That meant that very ill people had to travel to us, and we found that some people were being very rude to them. That really upset us. Also, the whole issue of what we were to wear to work kept getting changed. Not a huge issue, but it was something else that kept us unsettled. In the end, the consultants who we work closely with asked to have a meeting with us. They told us that they believed that it wasn’t possible for us to keep working this way.

Management decided that they would come to the meeting, too, and in spite of the consultants deliberately arriving early to have a private talk, management arrived early too and refused to leave.

Things have improved since then, largely because an acting CNL has been appointed. But I know that one of my 2 colleagues is going to resign, and I suspect that the other one will go because of that. I don’t want to be the only one left, so I don’t know what I’ll do.

I have taken on another part time job, partly to pay for my medical care. The cost of a psychiatrist and a psychologist is enormous. I feel really different from other people at the hospital because of my mood going up and down so rapidly. I’m not stable at all at the moment.

After I was told that I couldn’t have the full time contract because the work was “too stressful” I seriously contemplated suicide – I had all the pills lined up. I feel like I’ve done something wrong and I’m being punished – yet we picked that unit up and made it a safer place.

My message to other nurses in a similar position? Whatever you plan to do, get it written into a contract. That would have probably improved the mess of the new grad programme. And – don’t
tell anyone about your illness. I actually told about 5 people, not counting my close co-workers – and although some of them were great, the ones who were awful have had the most impact on me. I don’t want to be judged, especially by another health professional. The thing that freaks me out the most is the thought of being put into a ward. I’m not incapable of doing my job, and I have a lot of insight into my condition. I haven’t decided whether to tell nursing council on the application form – but I do know that shift work doesn’t suit people on meds!

**Morrie’s story**

Following is a summary of my journey of a mental illness that impacted on my nursing practice and the stigmatisation and discrimination I endured.

I had a few traumatic experiences from the early part of 1991 and again in 1994 with unforeseen tragedy in my family. I retrained and began the nursing programme in 1994. As a mature student I felt I could manage with the volume of study that was expected from the undergraduate nursing course, as well as cope with the day-to-day reality of supporting a family. Not so! In 1995 after struggling through my first year of study I made it to the second year mainstream. Midway through the year I didn’t realise it but my marks were getting low, and I began failing exams, then to top this off I failed a placement. I am sure this was the “final straw!”

Was this what “tipped me over the edge” so to speak? I believe, in hindsight, that there were a combination of factors, anyway that was then, and this is now.

I spent approximately eighteen months in and out of the sub-acute psychiatric service. A lot of this time I have no recollection of although other users of the mental health system reminded me of ‘things’ I was purported to have done; e.g. restrained physically and placed in seclusion on numerous occasions.
I spent time away from my nursing training to try and regain some stability with my life. When I eventually returned to my training I was met with many ‘barriers’ due I believe to the nurses perception that because I had been unwell that I was either still unwell or unable to nurse. The stigma and discrimination to patients/clients from professional colleagues since then, and currently, still never ceases to astound me.

In my final year of training in 1998 I had been well, and out of hospital, for a good 18 months. I was employed by a nursing agency to work in rest homes and to do some hospital work; namely one to one specialising. I had been doing this work before becoming unwell initially.

On this particular occasion I had been asked to work in the sub-acute ward at the main hospital and to sit with a person who needed close monitoring. Upon arriving I was greeted warmly by all but one staff member. I sat throughout the handover and proceeded to take over my duties with specialising. I was in the ward for approximately one hour from the beginning of the shift before I received a phone call from my employer. They had been rung by one of the nurses and were informed that I was not ‘suitable!’ What this meant was the rest of the staff except one nurse who no one could find were really annoyed by my having to leave. This added extra pressure on their already stretched workload. Needless to say I was not impressed, as no valid reason had been given to my employer or myself.

To cut a long story short neither my employer nor I was given any rationale as to why I had been asked to leave. It took eighteen months and much correspondence with the health board before it was recognised that I was wrongfully asked to leave.

As I have progressed into my registration as a nurse I have had the odd period where the type of nursing I do tends to have an impact on my mental health and well-being. I have really struggled at times to continue working and find that certain of my colleagues, whom I have a lot of faith in, tend to pull me aside and inform me as to where they feel my mental state is heading.
I thank them very much for this input. I also wonder if being a male makes me less aware of wishing to share my feelings. It is this bottling up that I did in the past that initially tipped me over the edge. Old habits die hard I suppose.

I have had numerous comments in the past from ‘gossip mongers’ who hear snippets of a persons’ past yet never know the full story. When I heard a comment about my mental health history I felt really upset. It dragged me down realising that other nurses were judging me from my history. It took some weeks after hearing the initial comments, and some counselling, before I become strong enough to approach the situation in a structured and logical manner.

- How did I deal with this issue?

I confronted the instigator and told them the truth. I withheld some things I wasn’t going to share. Another situation/issue I had just recently was transferring a patient to the sub-acute ward from our surgical ward. When the nurse asked me to enter the office to handover the patients’ details I became really stressed and was unable to enter the office. This was due to the nurse at the start of this narrative being there, as well as some psychiatric nurses who, in the past, had looked after me when I was unwell. I spent the rest of that shift really stressed out, and this impacted on the rest of my shift that day, as I was unable to function properly.

I feel that the experience of certain patients can have an effect on my emotional stability. I suppose I allow myself to become ‘involved’ or ‘close’ to people. This is just who I am and how I practice. I have found though that sometimes I feel okay about sharing a part of my experiences when I was in the psychiatric ward as a patient.

I could continue on about many instances of horizontal discrimination yet feel this hurts too much. One that does stand out markedly is the male nurse whom I remember, when I was really unwell, dislocated my shoulder during a restraint. I was working on the general ward when my charge nurse asked if I would preceptor him. This I really struggled with yet I do not hold
grudges so moved on. I did find this episode really uncomfortable. Needless to say it was awkward for both of us.

An example of the kind of effect this all had on me was that I was getting unexplained chest pain which came about through stressors at work, and after examination at accident and emergency, on varying occasions, was informed the symptoms were a ‘figment of my imagination’. Also commented was it is “probably related to his psychiatric history.” I do have the progress notes/documentation from one visit with this written very clearly by a registrar. I just felt this again highlights the rationalisation given by medical staff to unexplainable phenomenon, and to people with mental illnesses.
“I felt as if it was an unwritten rule for psych nurses - that there was some sort of dividing line between them and us - that if you're a nurse you can't really also be a patient, but what if you're both???”

Jenny
Vignette: a window to her life

The Johari Window.

Four squares
quadrants.

A child’s rendition of a window
(to her life?)

Known to others, known to self.

“I am a good nurse.”

“She is a competent, reliable nurse,”

Known to others, not known to self.

“She gives too much, cares too much, is unprofessional and emotional.

Work is much easier when she’s not here.”

Not known to others, known to self.

Tears, panic, fear, hiding medication packages and wine bottles,
dread, anxiety, bruises, comforting food, agonising purging, isolation,

isolation,

ISOLATION.

Not known to others, not known to self.

White noise
white space
silence

She has been drawn and quartered.

Eviscerated and exposed.

It will take a miracle to stitch her back together.

“I have been waiting for you.”

Jacquie Kidd, 2006
This poem explores the compartmentalised identities from the previous two motifs. The topic of a separation in identities recurred across the stories, along with intense emotion and confusion for the nurses, which was often apparently engendered or exacerbated by the actions of those around them. The words that best describe the nurses’ experiences contain implicit separations, such as dis-connect-ion and dis-ease.\textsuperscript{15}

In identifying the dis-connected nature of the experiences of the nurses, I endeavoured for quite some time to produce a connected and cohesive vignette that would illustrate the dis-comfort and dis-stress present in the stories. After several aborted attempts, I realised that the task of connecting the dis-connected and comforting the un-comfort-able did not belong to this research or to me. Thus, this is a dis-connected and un-comfort-able piece of writing. The Johari Window provided a vehicle for illustrating the dis-connection demonstrated through the stories.

The Johari Window is a model that demonstrates four cognitive processes that influence communication (Luft & Ingham, 1984). These are presented as a metaphorical window; a matrix with four quadrants which are categorised as things that are known to both the person and to others; known to the person but no-one else; known to other people but not the person; and not known to either the person or anyone else.

The final stanza in the vignette refers to the reaction of many of the nurses to me as the researcher. Although they identify their need for secrecy and isolation, many of the nurses expressed thankfulness that I wanted to hear and record their stories and the hope that somehow I would be instrumental in their quest to pull the disintegrated aspects of their lives together into a cohesive whole.

\* \* \*

\textsuperscript{15} Catherine Camden Pratt (2002) did this in her thesis
This chapter offers an interpretation of what happens for nurses who are living the hyphenated lives of nurse and tangata whaiora. The first section of the chapter interprets the identities of nursing and tangata whaiora, and explores the ways in which they impact upon each other at the hyphen. The second section examines bullying as the third and final motif that emerged from the nurses’ stories, locating it as a phenomenon that happens in hyphenated spaces.

As my interpretation moves into the wider area of how the nurse and tangata whaiora identities interact, the use of genres to explicate meaning is problematised. Lyotard (1988) asserts that genres are local and plentiful, and act to confine and define phrases that exist for a single purpose. ‘Nurse’ and ‘tangata whaiora’ are each heterogeneous entities that have been demonstrated in the motif chapters to contain multiple and partial genres with different purposes. Thus these two identities do not meet Lyotard’s definition of genres. A more inclusive ‘supreme genre’ provides interpretive possibilities, in that a supreme genre would allow or forbid multiple phrases and purposes within the overarching meaning of ‘nurse’ and ‘tangata whaiora.’ However this construction lacks an acknowledgment of the social context of the two identities and risks homogenising and oversimplifying their meanings for these nurses. In order to achieve a broad, contextual view in this interpretation, I am putting Lyotard’s more theoretical philosophy of genres to one side and will instead draw on the notion of laminated identities and the hyphens that join and separate them (Fine, 1994; McClelland & Fine, 2008; Sarin & Fine, 2007).

In her foundational work on hyphenated lives, Michelle Fine (1994) asserts the need for researchers to “rupture the textual laminations within which others have been sealed” (p. 71) by finding and working the hyphens that exist within and between such laminations. As I discussed in Chapter Two, Fine describes lamination as a socially constructed process of othering, achieved by tightly wrapping the subject in layers of powerful discourse. Her collaborative work on lamination describes societal attempts to other, while individuals disregard, resist and challenge those attempts.
Othering has been textually aligned with colonisation in the social justice literature (J. Anderson, 2002b; Fine, 1994; hooks, 1984; L. T. Smith, 1998). Such literature is concerned with issues of inequality, oppression and the silencing of peoples and perspectives. This alignment is problematised from a New Zealand Māori perspective. In my earlier discussion of colonisation\textsuperscript{16} I defined it as a means of assimilating one group of people into the identity of a more powerful group (M. Jackson, 1992). Conversely, othering aims to keep a group of people at a distance from the dominant culture by using dominant discourses to demonstrate and enforce difference. In this research I locate othering and colonisation according to their different impact on people’s social position, although these processes are not mutually exclusive. For example, people who have experienced mental illness are simultaneously othered by the discourses of psychiatry and fear, whilst also being the focus of colonising processes which aim to eliminate their difference and silence their stories (Corrigan, 2005; Szasz, 1960). Self proclaimed ‘nutters’ like Susie Crooks (Leibrich, 1999; Like Minds Like Mine Project, 2007b) demonstrate a ruptured lamination. She defies the dominant discourse which contends that phenomena such as hallucinations are ‘symptoms’ to be eliminated by the beneficent acts of the powerful psychiatrist. She also refuses to be silenced and is involved in making films, writing books and influencing policy at local, national and international levels (Personal communication, Susie Crooks, May 2007). Crooks asserts her right to be manifestly different as she resists and challenges attempts to other or colonise her identity or her story.

Lamination is one of the mechanisms by which othering is achieved (Fine, 1994). Further mechanisms of othering and/or colonisation that are discussed in the forthcoming chapter include bullying, silencing and oppression. An exploration of these provides a perspective on how the nurses in this research experienced the formation of the nursing identity and the tangata whaiora

\textsuperscript{16} See page 50.
identity, and the factors that influenced their ability to rupture, resist and challenge their identities and their colonisers.

The identities of nurse and tangata whaiora have been explored in the previous motif chapters. The ‘nurse’ identity has been shown in the Nursing motif to be othered by discourses of femininity, selflessness, indefatigability, caring and expertise (Hallam, 2000; Meier, 1999; Takase et al., 2006; Ulmer, 2000). The laminated image of the nurse was identified as a source of tension and conflict for some of the nurses in this research as they negotiated the caring-mastery hyphen and struggled to make meaning of their nursing identity in relation to their personal values and needs.

‘Tangata Whaiora’ is a term which, as was discussed in Chapter One, is located within the psychiatric discourse. It reflects a person who has a mental illness but who is focused on seeking wellness. While Suzie Crooks might view this location as colonised, the nurses in this research do not often resist the psychiatric location, but focus their attention on reducing their distress and regaining or retaining their ability to work. Despite the focus on wellness, the Tangata Whaiora identity is simultaneously othered and colonised through the power of psychiatry, stigma and discrimination (Appelbaum, 2005; Barker, 2001a; Blom, 2004; Corrigan, 2005; Gendall, 2006; Nairn et al., 2001). This identity is partial, plural and indeterminate (Best & Kellner, 1991), as is evidenced by the changes in language and focus within the stories as the nurses move between the locations of psychiatry, mental illness and emancipatory personal agency. These movements, conceptualised in the motif as a psychiatry-resistance hyphen, are examined further as the chapter progresses.

**Hyphenated identities**

The nurses in this research frequently acknowledged a belief, reinforced by personal experiences, that the nursing identity does not allow for nurses to experience a mental illness, appear distressed, or receive assistance in the form of medication, sick leave or therapy. They
describe efforts to contain their symptoms and needs, compartmentalising the nurse and tangata whaiora aspects of their lives to the extent that each takes on a discrete identity. Nonetheless, each identity occurs within the one nurse and necessitates individual negotiations according to the time and context of the nurse. These negotiations often involve the rupture of one or both laminations, and occur in the hyphenated space between ‘nurse’ and ‘tangata whaiora’ which can act as either a joining or separating feature for the nurse.

Throughout the motifs and the individual stories, the hyphen works in several ways. An overall description of the hyphen between the nurse and tangata whaiora implies that the nurses negotiate their lives in a space that is outside of both (Figure Four).

![Figure 4: The nurse – tangata whaiora hyphen](image)

In this visual re-presentation, tangata whaiora and nursing are conceptualised as mutually exclusive identities as a result of their laminations. This is consistent with the collective story of nurses who have a mental illness being isolated from the nursing group and literature recording stigma and discrimination in the workplace (Johnstone, 2001; Manchester, 2004; Vickers, 2000). Separation from the personal needs associated with mental illness is a feature of the lamination of nurses into others who are always caring and are not permitted to need, or to be cared for. It is also consistent with the discriminatory notion that people who have experienced a mental illness are not ‘suitable’ to maintain a professional career (Krupa, 2004; Krupa et al., 2005). 64’s story
records a long career which involved a consistent effort to maintain separate identities. She captures this with her stark comment, “I told no-one.”

The motifs suggest that there are three further ways in which the nursing and tangata whaiora identities are linked. These links emerge from the timing of coming to a nursing career and developing a mental illness.

The first of these links is demonstrated by nurses who have experienced a mental illness prior to undertaking their nursing career, for example Jayne and Josephine (Figure Five).

![Diagram](Figure 5: Mental illness as a precedent for becoming a nurse)

Such nurses may choose a nursing career because of their illness experiences and wish, as Jayne does, to help others to negotiate similar experiences. As discussed in Chapter Four, the motivation for such nurses may include viewing nursing as a means to meet their need to care for others, and to be cared for in turn (Kevern et al., 1999; P. Phillips, 1997; Thompson, 2000). The hyphen for these nurses suggests an ongoing vulnerability to mental illness as a result of nursing stressors such as complex and/or traumatic work environments, shift work, and environmental issues, for example under-resourcing and under-staffing. This hyphen also enables the transmission of experiential knowledge in nursing practice, as Josephine notes of her effective and satisfying work with the “chaos” of the head injured.
The second link is illuminated by nurses who have experienced a mental illness as a result of being a nurse and doing nursing work, for example North Island Bunny, Chloe and Mary (Figure Six).

![Diagram](image)

**Figure 6: Nursing as a precedent for a mental illness**

Literature supports the notion that nurses who develop a mental illness as a result of stressors and tensions in their clinical practice are acting in a predictable and understandable way to the forces that are acting upon them (Barak et al., 1996; Lam et al., 1999; I. Needham et al., 2005; Ussher, 1991). Mental illnesses in this hyphen may be conceptualised from a psychiatry perspective as burnout, maladaptive chronic fatigue, vicarious traumatisation and post traumatic stress disorder (Altun, 2002; Buyssen, 1996; L. Hall, 2001; Iacovides et al., 1999; Winwood, Lushington et al., 2006). The nurses, in their collective story, described feeling overwhelmed, victimised, exhausted and alone. This hyphen is conceptualised by a one-way arrow into a laminated Tangata Whaiora identity because these nurses do not discuss rupturing that part of their experience. Rather, they have actively compartmentalised it into a part of their nursing identity, and describe a desire to get their lives back to the way they were before they became ill. Mary and Chloe described this as an untenable position and removed themselves from their nursing work, while North Island Bunny seems to have been able to accommodate both identities.
The third link between nursing and mental illness is shown by nurses such as Michelle, Ellie and Morrie, who have developed a mental illness concurrent with their nursing career. Although these nurses do not attribute their illness to nursing work or the nursing identity, they describe a rupture of laminated identities as the nurse has a need to be cared for and the tangata whaiora asserts a professional identity and competence. Within this link, the hyphen indicates the direction of the impact so two illustrations are used. In the first example, mental illness may impact on nursing practice (Figure Seven).

![Diagram](image.png)

**Figure 7: Concurrent nursing and mental illness, with impact on the nursing experience**

A feature of the nurses’ stories is the way in which mental illness has changed and often enhanced, clinical practice. Vicky, Jenny and Morrie comment that their experiences of mental illness have improved their ability to empathise with their clients and to more fully understand their needs and those of their families. They all describe deliberate disclosure of their illnesses to comfort, encourage and experientially inform their patients, however Morrie also notes that some patients can have a detrimental effect on his mental health although he does not offer details about when this might occur. An early draft of a national policy document that maps the future of mental health nursing asserts the value of such experiences for mental health nurses (Hughes & Hamer, 2004), but this was removed in the final version of the document (Expert Reference Group to the Deputy Director-General; Mental Health, 2006). The perspective of mental illness as a positive feature for practice is not present in the research literature, and requires further
research to develop an understanding of the ways a mental illness can impact on nursing practice.

In the Tangata Whaiora motif, 64, Vicky and Julie all noted the impact their medications had on their ability to fulfil their nursing duties and the steps they took to ensure that they remained safe to practise. Alice and Elizabeth reported their fear of making a mistake, but did not link potential errors to their illness symptoms. As I discussed in Chapter One, the issue of practice impairment in nurses due to mental illness is poorly addressed in the literature and is usually linked to impairment because of substance use and abuse (Darbro, 2005; Grover & Floyd, 1998; Swenson & Foster, 1993). The notification of impairment figures cited by the Nursing Council, 20 nurses in the 12 month period of 2006\(^\text{17}\), suggests that nurses who have a mental illness may not experience impaired practice to the extent that investigation is necessary.

Conversely, the nurses report an impact from the nursing identity towards the tangata whaiora identity in the form of an exacerbation of their distress and assert that their recovery has been hindered by their work and role (Figure Eight).

![Figure 8: Concurrent nursing and mental illness, with impact on the illness experience](image)

The notion that nurses are not ‘permitted’ to have a mental illness was frequently expressed by the nurses, resulting in their decision to hide their illness from their colleagues and management. This perception is reinforced when nurses, for example Julie, Ellie, 64 and Rachel, were not

\(^{17}\) See page 12.
permitted by their managers to negotiate hours and shifts that were appropriate to their needs. Julie and Vicky both took sick leave when they were particularly unwell, and report being led to understand that they were “wicked” for needing time off.

In the collective story of nursing, secrecy is attributed to a quest for professional perfection and fear of other nurses’ intolerance of vulnerability. Based on a small research study, Jane Muscroft and Carolyn Hicks (1998) suggest that nurses are intolerant of and pathologise nurse colleagues who show the effects of stress and anxiety because of a failure to conform to the requirements of deep emotional acting. These requirements align with the laminated image of the nurse as selfless, untiring and caring. Furthermore, Muscroft and Hicks hypothesise that mental health nurses, in particular, ostracise and bully their distressed colleagues because nurses with a mental illness are demonstrating the same characteristics as the patients, and exactly the opposite of how they ‘should’ appear as nurses. Jenny, Vicky and Gemini all tell their stories from the mental health setting and report experiences that support Muscroft and Hicks’ paper. However, the small numbers in the study renders the evidence insufficient to support this claim completely.

Multiplicity and fragmentation suggest that these explanatory links are unlikely to be the only truth for these nurses. For example, the nurses who have developed a mental illness associated with prolonged stressors or tensions between undergraduate education and early practice experiences may have had a pre-existing vulnerability to mental illness, and the nurses who developed a concurrent illness may not have done so if they worked in a less emotionally demanding job. Indeed, several of the nurses recorded more than one of these negotiative directions during their stories, which indicate the partiality of the explanations. Gemini locates the compartmentalisation of Figure Four as a way of coping with early recognition of mental illness and suggests that the selective disclosure of Figure Seven emerges as the nurse becomes more familiar with her illness. These are areas which would be further explicated by research into emotional work and the reasons why people choose nursing as a career. Such research is
discussed further in the next chapter as potential postdoctoral or affiliated projects to emerge from this study.

The next aspect of the hyphen concerns how the nurses negotiate it. In the Tangata Whaiora motif the collective story identifies a supportive environment, Employee Assistance Programmes and private medical and psychological care as important factors for the nurses. More commonly, though, stories of stigma, discrimination, isolation and bullying have emerged. These stories were present in every nurse’s story. Bullying consequently emerged from the nurses’ stories as a distinct motif and is examined in depth in the next section as a feature of the hyphen between the ‘nurse’ and ‘tangata whaora’ identities.
The bullying motif

Figure 9: About being silenced (64, 1989).

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There is hope in this drawing, of light and growth. But the dark stillness where the mouth should be, the slumped shoulders and the listless arms evoke oppression and hopelessness. My reading of 64’s story is of a nurse who had no voice to explain her distress and no expectation of being heard if she found a way to speak out.

Vignette: Same stuff, different day

“What are you doing?”

The tone is sarcastic, the demand is clear. I stumble in my response, inwardly cursing at my need to please. I feel the tears begin to sting and swallow furiously. I am inwardly so angry, and outwardly docile. The list of my failures follows, devastating in its coverage of my personality, my timekeeping, my ability. This is not new, so I lower my head and wait for it to pass.

I am in danger, I know it. My manager is my bully. My colleagues are her allies (who can blame them? Not I!). I have become pitiable, avoiding contact when I can, and thus even more of a target. I seek and find comfort with my patients, who call me ‘love’ and thank me for my work.

As I approach the door for yet another day, my stomach clenches into a painful ball and my head aches with the weight of my tears.

This is the final motif to emerge from the nurses’ stories. In line with the way the previous motifs were presented, literature and interpretation occurs in the section immediately after the nurses’ voices are heard in a collective story. In the collective story that follows, the influence of isolation and bullying is the focus of the subsection ‘being bullied,’ and the complex decision of whether to disclose mental illness to colleagues, managers and Nursing Council is discussed in
‘silence.’ I have not differentiated between the causes of the bullying or silencing at this early point because the nurses do not. Interpretation of the reasons for such experiences occurs later in the chapter.

**Being bullied**

Throughout the stories there are frequent accounts of bullying. Indeed, not one story is without an account of violence of one sort or another towards the nurse. The nurses reported a range of behaviours from colleagues, managers, other healthcare professionals and employers. These ranged from being physically assaulted, being verbally abused and threatened, being ignored and silenced, to being physically isolated from the workplace. It is important to note that although some instances of bullying clearly originated in an awareness of the nurses’ mental illness, such as Morrie’s experience, other incidents do not appear to have an overt cause. Thus, stereotyping and fear of mental illness do not provide a convenient (if unacceptable) scapegoat for all of the behaviour. While re-presenting aspects of the nurses’ stories about bullying, there is a risk that the readers’ perceptions will be of an account devoid of emotion and therefore rather clinical and lacking meaning, or of a series of complaints that desensitise the reader, even perhaps causing derision towards an apparent group of pathetic people, or even that the nurses are confusing their workplace experiences with the symptoms and presentation of ‘mental disorder’. Indeed, as Gemini notes:

> There is a tendency to avoid [addressing mental illness in nurses] by getting into ‘blaming the victim’ – labelling the nurse with an Axis II diagnosis and writing off the whole issue as a deficit in the nurse.

These nurses exhibited a pervasive sense of sadness that appeared to be quite independent of any symptoms related to mental illness. Additionally, they displayed a sense of righteous anger at their treatment and an urgent desire to improve the experiences of other nurses out of these stories. In contrast to the bullying theme, where the workplace environment is supportive, the nurses report relief from their symptoms and an enhanced ability to get on with their work. The
bullying begins very early in their careers. During her nursing education, Michelle’s partner was in a crisis. She reports feeling very alone after a tutor demanded “what’s more important, your partner or your degree?” Feeling isolated is a theme that recurs throughout the stories.

Elizabeth reports being emotionally abused during her training:

> It was 18 months into my training before a patient died on my shift. This was a neighbour, who died while I was at lunch. The Matron pushed me through the door of the room to look at the body . . . I was crying . . . [the Matron] said “Oh, you’re pathetic. Go off duty.” I fled.

And later in her career she describes being physically assaulted when “one of [my colleagues] actually threw equipment at me, and directed me to do the cleaning while she nursed.” Alice, too, experienced physical abuse when she attempted to address her feelings with her manager:

> I went to her office. She became so angry that I was afraid and decided I needed to leave the office. She beat me to the door, though, and closed it, preventing me from leaving. She was very red in the face and shouting, and I reached for the phone. She disconnected it. That was absolutely the worst time I’ve had . . . When I left that meeting, I was so distressed that I couldn’t even remember where I had parked the car. It was very frightening.

Alice noted, with an air of disbelief, “that Nurse Manager is still in her role. . . I took some documentation to the CEO of our organisation and talked to him about what had happened. He told me that he thought I was over-reacting.” Michelle was similarly bullied by her manager:

> I’d been advised to tell my bosses about my bipolar disorder . . . The boss in this new job immediately started to play with me. She seemed pretty unstable herself, and a bully. She’d do things like write on her desk pad that I needed a health review, then later she’d have crossed it off and would deny ever writing it. She would back me up in the office and quiz me about my meds, and she also held me responsible for mistakes that other nurses had made.

Michelle’s experiences of bullying continued under another manager:

> I told my boss that I had BPAD and saw her whole attitude to me change. She started to take delight in docking my pay. For example, she’d see that I claimed overtime and say that there wasn’t a problem. Then when I was paid I’d find that she had not approved it. She refused to pay me for the days that I missed lunch – and even though it was only about $13, it still mattered that she wouldn’t pay it. She also got very resistant to talking to me at all, and I know my colleagues noticed it. She was rude. I also knew that another of my colleagues had been advised to take an additional 2 weeks of unpaid leave each year, because of
depression. When she learned about that, her response was that you ‘shouldn’t be a nurse if you have depression.’

The discrimination inherent in Michelle’s story is echoed in Ellie’s experience of having a physical illness which presented clinically as a mental illness. Her story clearly highlights the messiness and complexity of what it means to have a mental illness; “I lost a lot of so-called friends when I became unwell, especially when I was diagnosed as schizoaffective, and some of them wrote to me after my lupus was diagnosed, apologising for having ‘misjudged me’.” She reflects on being isolated through a lack of acknowledgement both while she was attempting to return to work and after she resigned:

I tried going back to work, but there was no recognition of the issues I faced, and I didn’t have the option of starting to work part time and building up from there. I didn’t receive any support at all. It became obvious that I couldn’t work any more, so I resigned from my position. Management just treated me like dirt. Their whole attitude to my resignation was “thank god we’ve got her off the books – she’s a nutter.” I received no letter, no recognition of the work I’d done in service development, nothing.

Gemini, too, comments on the effect of isolation and its use as a technique for bullying:

There is often a secrecy around the treatment of nurses with mental illness, maintained to protect them. They can end up being really isolated. When you unpick that, it is based in stigma and discrimination . . . Real horizontal violence.

Other nurses have had similar experiences with their managers and colleagues. For example, Jenny relates an incident that occurred after she mentioned a previous experience of paranoid thinking in casual conversation with a colleague:

. . . the boss called me in and demanded to know what medication I was on. I told the truth and said I wasn’t on anything. He then told me that staff had complained – no names of course – about my stability and that they were uncomfortable working with me, particularly on night shift – I mean, what if I flipped out?

This discrimination is also evident in Jayne’s comment that “The people who have shown the most prejudice towards me are the people who you’d expect to understand – nurses, doctors, and social workers.” Josephine, also, is clear about the level of distress caused by her nursing colleagues:
I did decide, a while ago, to discuss my experiences in a public arena [the local newspaper]. I had cleared it with my manager, and he warned me that there could be a backlash against me. Well, there has been, but it is from my management and colleagues rather than the general public. I feel that since that time I have been marginalized, abused and maligned. Their judgmental attitude appals me.

After disclosing her mental illness to her manager in the process of explaining her need to take some sick leave, Julie says her manager advised her that “because I’d be at home and not doing anything, there were some conferences I could attend.” She notes, “I got the message that I was really wicked for needing the time off.” Following her sick leave, Julie was prevented from easing back into the workforce; “I never got to leave work on time,” nor was she permitted to leave the building to exercise during her lunch break because the manager asserted that “the staff were unhappy that I wasn’t on the floor.” The final straw for Julie was when “my boss then advised me to go off my meds because they were making me so tired and they weren’t ‘good for you’. ” Julie resigned from her position, which caused her further distress.

Jayne encountered active discrimination when she applied to enter a nursing baccalaureate programme. The Dean, having initially declined her application, was challenged by Jayne, resulting in agreement that

my application could be considered if I would agree to have psychiatric reviews by 2 doctors, to assure her that I was safe to be a nurse. The implication was that they would be giving me access to sharps, drugs and syringes, and would I attack them?

Jayne comments, with humour, that “once people realised that I wouldn’t cut their throats if they said something wrong, they seemed to relax a bit!” Although Jayne has actively confronted discrimination, some of the nurses related that they intuitively understood that it was not acceptable for a nurse to have a mental illness and consequently did not disclose their distress. Jenny relates an event that occurred while she was a student nurse; “I felt brittle and breaking, but ‘couldn’t’ risk being seen within the Mental Health service, even if it meant I got help. As a soon to be nurse, I didn’t feel I had that luxury available to me.” There is a cost to being unable to be honest about what is happening. Josephine notes that; “It takes a huge toll, hiding. . . .

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During manic and depressive phases it has been a nightmare trying to be seen as normal.” In a similar vein, Morrie explains:

> When I eventually returned to my training I was met with many ‘barriers’ due I believe to the nurses’ perception that because I had been unwell that I was either still unwell or unable to nurse. The stigma and discrimination to patients/clients from professional colleagues since then, and currently, still never ceases to amaze me.

Morrie concludes his story by saying, “I could continue on about many instances of horizontal discrimination yet feel this hurts too much.”

Chloe related an upsetting incident whereby “the surgeon had to make do with another instrument. He told me that I was killing the patient.” This verbal abuse resonates with Jenny, who recalls that she disagreed with a decision made by a medical colleague and was subjected to “a shouting tirade of ‘did you get your fucking nursing ticket out of a weetbix box?’ ” She notes that although she complained about the abuse, a general shortage of doctors at the time meant that it was unsurprising that nothing was done about his behaviour. Chloe, too, reports that the surgeon who abused her was not called to account for his behaviour, but instead the Charge Nurse’s response was to “baby talk to him, and use sexual innuendoes to jolly him into a good mood.” Chloe says that she is disgusted by this reaction on the part of her senior nurse, and sees it as a continuation of the bullying as it effectively negates her hurt and silences her story. North Island Bunny also found that her experience of being bullied was worsened by her manager’s refusal to offer support:

> Management had known about this [bullying] behaviour for a long time prior to my arrival in the unit and had done little. . . When I continued to complain . . . it was then inferred by the manager that I should consider if this was ‘a personality problem between myself and this registered nurse.’

Eventually for me personally the ongoing onslaught, lack of management activity and in combination the appointment of a new manager who made inappropriate comments regarding my work injury “what are you going to do when you can’t work here any more because of your back” created intense stress levels. In tears I went to my GP and asked for a referral to a psychiatrist. . . Eventually she was sacked but the traumatic toll on me personally and for many members of my staff was appalling.
Alice recorded a deeply distressing time in her career where she was unable to understand what was happening to her. She says:

In my case, the bullying went on for 2 ½ years before I put a name to what was happening and managed to get away from it. During that time my nurse manager was directly, actively bullying me. My practice was constantly under scrutiny, and even though there was a lot that I know I did right, the focus was on the things that I didn’t do as well as I could have, or did differently to the way the NM wanted things done. I realise now that there were aspects of my practice that weren’t what they could have been – but how could it be when I was so afraid? I was spending my time trying desperately not to be noticed.

Alice reflects that although some of her colleagues quietly supported her, “their silence when it counted had much the same effect as the bullying, really – it was isolating.” Helen, who has left nursing, recalled an incident that reinforces her decision to leave:

My first real realisation of how damaging the nursing hierarchy was to us was, as a third year student, when a nurse from my class bawled out a first year nurse for a minor transgression. When I asked my classmate about it she was self-righteous in saying that she had been treated that way, so it was her right to do the same to those ‘below her’. . . I certainly associate my time as a nurse with feeling hurt, disrespected, disregarded and isolated. I believe that being treated like that is a part of the nursing culture – the hierarchy creates a climate of mistreatment and abuse of power. The doctors treated us like maids, but the way the senior staff treated other nurses was just as hurtful.

In telling her story, Elizabeth reflects on her past experiences and comments that bullies “always do their thing while there is no-one else around, and can do it in such a way that they undermine you so that you don’t believe in yourself, lose confidence, and believe the things they say about you.” She draws on this knowledge as she goes on to relate a victory in her workplace after she has been bullied:

There were 2 big incidences of horizontal violence there. . . The first issue was denied by management – it “doesn’t happen here.” But as soon as I opened my mouth, everyone else started to talk about it. . . There is a policy in place now that deals with horizontal violence and about how to deal with it. I took on the bullies this time.

On a different occasion, Elizabeth recalls that after a long period of being bullied in various positions, she “cried all night, but decided that I had to fight this time.” She credits some of this courage with having effective counselling at the time, but says proudly, “I took them to court and
I won a settlement.” Anne, too, has used the courts as a mechanism for defending herself against bullies. She comments:

    The thing that sets me apart from some of my colleagues, I believe, is that I recognised that the mistreatment I was experiencing was not appropriate and I sought legal advice. My education and experience meant that I knew I wasn’t at fault.

She credits her current sense of emotional safety with taking prompt action when she is bullied, and maintaining an independent support system.

The intolerance by colleagues and managers, whether overt or intuitively understood by the nurses, has resulted in consistent attempts by them to appear mentally well. The effort involved in this appears to have resulted in a sense of dis-connectedness for many of the nurses, as they strive to contain the messiness of mental illness into that part of their lives that is not visible to their peers. It is important to note, however, that where the nurses experienced support and tolerance rather than bullying, their wellbeing was improved. Rachel notes; “My nurse manager worked out a plan with me to rehab back to work . . . the support I have received from my workplace has given me a vital hand up throughout my recovery” Elizabeth, too, reports working in “healing environments” in two rest homes and a primary care team where she felt that she was “restored” and “loved.”

The nurses’ exposure to bullying, violence or silencing has inevitably impacted upon the decisions they have each made about whether they should tell any of their colleagues or employers about their illnesses.

**Silence**

Silencing is a complex phenomenon that is described by the nurses as arising from internal and external stimuli such as stigma, the enforcement of unspoken rules and fear of the consequences of speaking out. These underlying motivations for silencing and the nurses’ own choices relating to disclosure may be located in different discourses, but are not discussed that way in the nurses’
stories. Interpretation of the context of silence and silencing occurs in the next section where literature is brought into the motif. The decision relating to whether to keep silent or talk about the presence of mental illness was raised in every story.

Although some nurses, for example Jayne and North Island Bunny, talked about their experiences with colleagues and managers throughout, it was still an issue they considered. Jayne, who has a history of mental illness that pre-dates her nursing career, comments “I decided that I had to fully disclose my mental health issues when I applied for a job, because I didn’t want to give them the opportunity to get rid of me later on because I’d lied on the application form.” This is in contrast to the process North Island Bunny describes, as her mental illness was a direct response to a workplace stressor and she openly sought help from management as soon as she became aware of the problem. While neither of these nurses hesitated to make their distress known, they do not report positive experiences from doing so. North Island Bunny says “I was made to feel that it was my problem,” and Jayne notes that “I am sometimes told that I have brought my illness on myself.” These comments are echoed by other nurses who disclosed to colleagues and/or managers later in their experiences, or even after they were over. Of these nurses, Josephine reports I really believe that if I hadn’t been a nurse then this wouldn’t have happened to me.

Other nurses, such as Michelle, Julie, Chloe, Ellie and Morrie discuss varied responses from their colleagues, but comment that it is the hurtful, negative reactions that they remember most vividly. Michelle says:

I actually told about 5 people, not counting my close co-workers – and although some of them were great, the ones who were awful have had the most impact on me. I don’t want to be judged, especially by another health professional.

Julie is even more emphatic on the topic when she asserts: “I think nurses need to be prepared, that if you “own” being depressed then you’ll be kicked in the teeth by most of your colleagues.”
Chloe experienced spiralling stress levels while working in theatre as a new graduate. She accessed senior staff for support, but reports; “the response I got wasn’t helpful. Basically, if I wasn’t coping then there must be something wrong with me.”

Even after Ellie decided that she needed to resign, the hurtful behaviour of her immediate managers continued: “Their [management’s] whole attitude to my resignation was “thank god we’ve got her off the books – she’s a nutter.”

Morrie discusses some instances of working with colleagues who are aware of his mental illness experiences, but does not elaborate; “I could continue on about many instances of horizontal discrimination, yet feel this hurts too much.”

Alice, Elizabeth and 64 did not disclose their experiences of mental illness to work colleagues and managers. They discuss the vulnerability inherent in letting others, including Nursing Council, know about their mental illness. Alice, in particular, was fearful about taking part in this research lest her confidentiality was breached and other nurses discovered her identity; “I am very aware that admitting to a mental illness gives people power over you . . . I just can’t trust anyone, especially with my practising certificate at risk.” Interestingly, though, Alice also discusses her willingness to selectively disclose to other nurses who are “being bullied, and are having time off for stress and depression. At times I have tried to say something, but it is an issue that is not discussed, so I back off.”

Elizabeth discusses her certainty that her job is incompatible with having a known mental illness; “an anxious, overeating, depressed nurse on prozac doing palliative care? I don’t think so!”

64 uses a particular experience to illustrate why she does not disclose her mental illness when she describes the consequences of taking a sedating medication:

I didn’t think it was safe for me to try to work with all that medication on board. I didn’t trust the Principle Nurse enough to tell her the truth, so I said I had the flu. I don’t think she believed me – but it is a good example of how difficult it is to
tell the truth when you have a mental illness. I doubt that she would have understood the truth.

Vicky describes contrasting experiences in two workplaces. In the first, she becomes unwell in an environment where she has significant autonomy and responsibility. She notes; “I could not imagine telling anyone at work what I was going through because I understood there would be no going back from such a disclosure – that the truth would no longer just be in my head but part of other’s realities as well.”

However, for Vicky there is a shift in experience when she moves to another workplace after the crisis phase of her illness has passed;

I am mostly ‘out’ in my workplace now and this feels great – I find there are a lot of other nurses who also have mental health problems.

. . . I am selectively open with both clients and colleagues about the general nature of my experiences when this is appropriate. I have not had any negative experiences from these disclosures.

Julie also found that a change in environment brought more support; “when I agreed to take this new job. . . I laid all my cards out on the table. . . They were very supportive.” Unfortunately, Julie recounts that this supportive attitude did not survive a change in the management structure, resulting in her later fear of being “let go” if her mental state did not improve.

Rachel reports positive experiences from being open about her mental illness at work, crediting her nurse manager with a key part in her recovery: “I’ve had so much support it has just blown me away. . . The support I have received from my workplace has given me a vital hand up throughout my recovery.”

It is clear from the stories that the nurses who have chosen not to hide their illness, which is different to indiscriminately disclosing it, have an advantage over those nurses who are trying to hide their experiences from their workplace. There is a gradation of disclosure ranging from being completely open to all, to disclosing selectively, through to hiding this aspect of their lives. The nurses who disclose their experiences selectively are able to use this self-knowledge as a
foundation to standing up for themselves and taking care of themselves. They have no big secret
to hide, and are therefore able to visibly look after themselves, yet do not expose themselves to
the scrutiny of those they do not either trust or need. This is true of Anne; “I recognised that the
mistreatment I was experiencing was not appropriate and I sought legal advice” and Jayne; “I
went back and challenged the Dean, saying that she was discriminating against me.” In contrast,
nurses who opened themselves up to everyone, whether forced to because of becoming visibly
unwell, as Ellie did, or choosing to as Josephine did, had a significant professional and personal
backlash that still impacts on their lives.

Some nurses chose not to tell anyone about their experiences of mental illness, yet still managed
to integrate their experiences into their nursing work by finding a workplace that values the
qualities they bring by virtue of their experiences. For example Elizabeth, who works in
palliative care, reports that her employers value her nursing, which she sees as enhanced by her
illnesses and which they are unaware of. Although she comments; “I’m sure that people think
that there is something odd about me, but they’re not sure what it is!” Similarly, Jayne asserts
that she doesn’t tell people about her illness because “I much prefer to be known as ‘quirky’,
rather than ‘that schizophrenic girl’.”

The point of decision for many of the nurses is the declaration contained in the Nursing Council
application for a practising certificate. There is a climate of fear for many of these nurses, as they
contemplate the professional result of having their mental illness known. Nursing Council’s
image among this group of nurses is not one of benevolence or compassion, but rather a severe
and paternalistic role, always ready to judge and punish. The nurses who have actually had
contact with them, however, have found them to be supportive and humane. This fear of being
noticed and the potential consequences of being exposed clearly stems from the stigma and
discrimination associated with mental illness (both internalised and external) and the perception
of a punitive Nursing Council.
Jayne had a diagnosed mental illness at the time of choosing to become a nurse. For her, the decision contained in the form is a clear one:

I don’t worry too much about the Nursing Council declaration, though, because I believe that all I can do is answer the question (about being fit to practice) to the best of my ability on the day. I can no more predict my mental state in the year to come than anyone else can, and the same goes for being physically fit to practice. No-one knows what’s ahead of them, health wise.

Rachel, too, notes; “I haven’t specifically told my new employers about the depression, but if it comes up I know I’ll be comfortable talking to them about it. I don’t have any worries about the Nursing Council declaration, either.”

For Michelle it is less clear: “I haven’t decided whether to tell Nursing Council on the application form.”

The decision about whether to tell colleagues and managers about a mental health problem is clearly complex. Gemini notes:

There were a number of years when I kept it to myself. I think that’s a process everyone with a mental illness goes through; taking time to overcome the internal stigma, and the timing and intensity of it depends on where you are, when it happens and who you are, as well as to some extent what is happening to you.

A final note from Jenny, though, reflects the ramifications of hiding one’s experiences; “it’s a shame that my battle to retain the illusion of self dignity made/makes it so difficult to reach out and get the necessary help.”

In this collective story, threads about what it is like to be a nurse who has a mental illness have been drawn out of the stories to create a picture that is dominated by experiences of bullying, being silenced and isolation. As a result of these experiences, the decision about whether to disclose their mental illness to anyone, including Nursing Council, is a complex one, with some of the nurses choosing to remain silent about their illness.
Researchers such as Bishop (2004) who studied nurses and conflict, Freshwater (1998) who focused on nursing education and Randle (2003) who researched the concept of self esteem in nursing students have noted, as I have, that bullying became a significant theme in their non-bullying related research. The nurses in this research have all contributed stories about being bullied. The Bullying motif gives voice to the nurses’ experiences of bullying, stigma and discrimination, being silenced, and the intricacy of the decision the nurses face about whether to disclose their mental illness to anyone, including the Nursing Council.

The location of stigma and discrimination is problematic in this research. Literature does not subsume stigma and discrimination into bullying, but the nurses in this study do so. I have examined the extant literature in Chapter Five and note that although acts of stigma and discrimination arise from prejudice and fear, they result in similar emotional, social and physical consequences for their victims as those arising from the act of bullying (Corrigan, 2005; Johnstone, 2001; Pyne et al., 2004; Schreiber & Hartrick, 2002). For these reasons, I have included stigma and discrimination in this Bullying motif in addition to that of Tangata Whaiora.

In considering why stories of bullying are so prominent in this research, I revisited my initial framing of the project. I did not expect bullying to feature in the nurses’ stories, and certainly not to the extent it has, so it is unlikely that I positioned the nurses to respond to any overt or subtle cues during the negotiations for the stories. This is supported by my lack of involvement in the creation of several of the stories, for example 64’s, North Island Bunny’s and Jenny’s, all of which were autonomously sent to me in their final form and have significant content relating to bullying. I revisited my initial request for participants (Appendix Two) and participant information sheet (Appendix Five), and have been unable to discern any subconscious effort on my part to elicit stories of bullying. Enabling features of the research include my request for stories, which provided the nurses with the freedom to focus on whatever phenomena were the
most distressing to them, and my location as a mental health nurse which may have encouraged
the nurses to disclose painful aspects of their professional lives which might not have been
discussed with a member of another profession or specialty. As a consequence of this re-
evaluation of the research process, it is clear that bullying has been spontaneously identified by
these nurses as a significant factor that is associated with their mental illness experiences.

**Bullying in the workplace**

Workplace bullying is widely experienced and its effect can last for many years after the actual
event (Agervold & Mikkelsen, 2004; C. Anderson, 2002a; Ironside & Seifert, 2003; Kivimaki et
al., 2003; P. McCarthy, 2003; A. Needham, 2003; Quine, 2001; Zapf et al., 2003). Detailed
definitions of bullying vary, although there is consensus in the literature that it involves one or
more perpetrators inflicting deliberate psychological harm on one or more targets over a period
of time. The means of inflicting harm can take the form of physical and verbal aggression, sexual
abuse and harassment, taunts, sarcasm, teasing, isolating and freezing out, denying professional
advancement, surveillance, unfair disciplinary procedures and mediation, discrimination, and
accusations of poor practice. The effect, over time, is an erosion of personal wellness, lack of
confidence, general anxiety and fear of the workplace, poor work performance, depression, and a
host of physical and emotional symptoms.

There are variations in the language employed in the study of bullying, such as ‘workplace
violence’ (C. Anderson, 2002a), ‘internal violence’ (Richards, 2003), ‘corporate abuse’ (A.
Needham, 2003), ‘psychological harassment’ (Cassito et al., 2003), ‘horizontal violence’ (Freire,
1971; McKenna et al., 2003; S. J. Roberts, 1983, 2000), and ‘mobbing’ (Leymann, 1990) which
describes the psychological terror of being the target of group bullying behaviour.

From the late 1990s to date, the literature has become steadily more prolific and specific, with
particular types of workplace or behaviour being singled out for examination, such as bullying
by line managers (Lewis, 2004, 2006a, 2006b), bullying by physicians (C. Anderson, 2002a;
Rosenstein, 2002) and bullying during periods of organisational change (Hutchinson, Vickers, Jackson, & Wilkes, 2005). Bullying behaviours are generally ascribed to individual (C. Anderson, 2002a; Zapf & Einarsen, 2003), social (Agervold & Mikkelsen, 2004; P. McCarthy, 2003; Neuman & Baron, 2003), and organisational (Ironside & Seifert, 2003; Lewis, 2006a; A. Needham, 2003) causes.

There is additional literature available that details the consequences of aggression from patients and their families towards nurses, but that is outside the scope of this research.

**The prevalence of bullying**

Lyn Quine has undertaken several surveys into bullying in healthcare settings (1999; 2001; 2002). She reports that during the previous 12 months, 38% of 1100 staff in a UK community trust experienced bullying, with 44% of nurses and 31% of doctors reporting being bullied (1999; 2001), and 50% of nurses witnessing the bullying of others. 37% of 594 junior doctors reporting being bullied in a similar study (Quine, 2002). These figures are almost half of the 85% proposed by Lewis (2006a), although Quine suggests that there is a significant variance in how researchers define bullying, which alters prevalence statistics. Merecz, Rymaszewska, Moscicka, Kiejna, and Jarosz-Nowak (2006) note that prevalence figures relating to co-worker aggression range from 97% in a US study of verbal aggression (Cox, 1987) to only 5% in an Australian study (Holden, 1985). There are clear variations in the studies relating to how bullying is defined by the researcher (some studies have a narrow definition that requires clear intent by the bully), the time period that is studied (some ask about incidents that took place during the last month, while others cover the respondent’s whole career), and the cultural context of the study. Merecz et al. note that issues such as psychological violence may be underreported in countries where it is not publicly debated. A further variation is found in the type of work that is performed (Agervold & Mikkelsen, 2004), whether between nursing and non-nursing work, or the different environments and specialities within nursing. For example, mental health and emergency room
nurses have been found to have a significantly higher incidence of workplace aggression among nurses (Merecz et al., 2006; Quine, 2001). Despite the variations in definition and context, the figures suggest that a significant number of nurses internationally face bullying in their workplace.

**The effects of bullying**

The links in the literature between being the target of bullying behaviour and developing mental and physical illness are clear (Cassito et al., 2003; Hourani, Yuan, & Bray, 2003; Kivimaki et al., 2003; A. Needham, 2003; Quine, 1998, 2001; Ramos, 2006; Richards, 2003). Physical symptoms are closely allied with those caused by high levels of ongoing stress, such as high blood pressure, high cholesterol, gastric upsets, ulcers, headaches and cardiac disease. Several large surveys revealed that exposure to verbal abuse has a negative impact on nurses’ self esteem, job satisfaction, morale, patient care, work productivity and rates of error (Cox, 1987, 1991a, 1991b). Similarly, a substantive study of the general population of Denmark concluded that “threats and violence in any type of employment may entail serious mental disorders requiring specialist hospital or outpatient treatment” (Wieclaw et al., 2006p.774). Further, these researchers assert that the fear of aggression can be as damaging as actual aggression, and that healthy coping strategies such as a sense of personal coherence may be affected by aggression or the threat of aggression, rendering a person susceptible to mental disorder.

In addition to the personal consequences of bullying in the workplace, Ramos (2006) adds that patient satisfaction is reduced as there is a positive correlation between it and nurses’ job satisfaction. She also lists the expense of managing increased staff turnover, litigation, sick leave costs and more frequent accidents as does Needham (2003) and Quine (2001).
Locating the bully

Bullying is located by some authors as an individual problem, relating it to gender (Leiter, Frizzell, Harvie, & Churchill, 2001), personal coping styles and skills (Rowe & Sherlock, 2005; Thomas, 2003, 2004) or a personal vulnerability based on childhood trauma (C. Anderson, 2002a; Kevern et al., 1999; Thompson, 2000). The bully as an individual is also the focus of some literature which pathologises the individual bully with labels such sociopathic and evil (Vickers, 2002), and narcissistic personality disorder (A. Needham, 2003), and has likened bullying to the exercise of paternal authority over subservient subjects (Alavi & Cattoni, 1995). There is little evidence about the reasons why an individual adopts bullying behaviour, although expert opinion tends towards a belief that the bully has been previously victimised, has few social skills and establishes his or her own comfort through stripping the target of their own personal power (B. Foster, Mackie, & Barnet, 2004; Lewis, 2004; Zapf & Einarsen, 2003). The collective story of bullying contains several instances of individual bullying. For example, Elizabeth reports an instance of having items thrown at her by a nursing colleague, and North Island Bunny discusses a long term campaign of verbal abuse.

Other researchers assert that although bullying is usually perpetuated by an individual or group of individuals, it is in fact enabled and encouraged by the organisation (Ironside & Seifert, 2003; Lewis, 2004, 2006a, 2006b; A. Needham, 2003; Stevens, 2002). In her concern for the business cost of workplace bullying, New Zealand human resource expert Andrea Needham (2003) notes that the organisational culture frequently enables workplace bullies to rise to senior management level as a result of their “tough management” style (p.61). This suggests that individuals who have a propensity to bully may find their niche in management roles. Similarly, Ironside and Seifert (2003) contend that workplace bullying is a result of the organisational use of managers to force compliance on the workforce. This explanatory model seems apposite when considering the student nurse and new graduate nurse accounts of being bullied, which track the attempts of
educators, managers and senior colleagues to enforce visible compliance on professional neophytes (Alavi & Cattoni, 1995; Fell, 2000; B. Foster et al., 2004; McKenna et al., 2003; Randle, 2003). Literature recording the experiences of nurses who are bullied as a result of ‘whistle blowing,’ that is, informing outside authorities and/or the media about nursing practices they are unhappy about, also seems to fit this frame (Iliffe, 2003; McDonald & Ahern, 1999).

The previous research is consistent with that of UK nurse Malcolm Lewis (2004; 2006a; 2006b), who found the issue of bullying in nursing to be organisational and most often perpetrated by nurses who are line managers. He contends that much of nursing practice requires negotiation as a result of role ambiguities, time pressures, rapid change and increased accountability, and that bullying occurs as an intentional act when negotiation is needed in order to achieve organisational goals. Thus Lewis locates the bully as an individual who is supported and encouraged by the organisation to behave in ways which advance the needs of the organisation. This is particularly damaging to the victim because the management role enables bullies to maintain their power “through their ability to impose . . . their definition of the situation within any negotiative processes” (Lewis, 2006a, p.53). This power further complicates the life of the victim because workplace policies tend to direct the target to go through their line manager as a first step in resolving workplace bullying. Where the perpetrator is the line manager, this policy ensures that getting redress is unlikely, and takes an “inordinate amount of time, effort and distress” (Lewis, 2006a, p.55).

Similarly, although writing from within an education context, Herr (2005) discusses domination through the manager imposed process of mediation. She asserts that administrators use mediation to establish control of the flow of organisational information and create change in an individual by giving “an appearance of participation and communication . . . while exercising control over transgressive discourses that threaten business as usual” (p.22). This effectively translates potentially disruptive institutional issues into personal problems, resulting in individuals
becoming the sites for change, instead of the organisation. It also acts to protect the non-
management perpetrators of institutional violence and enables managers to avoid the stress and
responsibility of dealing with the conflict themselves. The misuse of purportedly supportive
organisational practices by bullying managers has significant implications for organisations that
attempt to address issues of staff morale and retention in good faith.

These studies about bullying are consistent with the experiences related by the nurses in the
Bullying motif. Alice, Chloe, Michelle, Ellie, Julie, Elizabeth, Anne, Jenny, 64, Rachel and
Vicky all describe being bullied by their line managers, who used organisational processes of
performance management, assertive management and environmental control (for example, over
shifts and hours of work) as tools of domination.

In their stories of bullying, Michelle and Vicky both mention their manager’s own mental health
issues. This is a significant point that is not specifically addressed in the nursing literature,
although workplace tensions experienced by nurse managers are well documented and provide
some insight into the complexity of the manager-bully issue (Carroll, 2002; Disch, Edwardson,
Lewis (2004) adds a further layer to the picture of senior nurses as bullies when he asserts that
nurse managers “inhabit dual worlds . . . [as they are] . . . constantly looking towards their
futures, but must also look back to the clinical arena from where they came” (p.22), and are often
victims as well as perpetrators.

Lewis (2006a; 2006b) contends that the workplace bully, whether a manager or a colleague, will
deliberately use techniques of denying, lying and deflecting in order to ensure that their
definition of the situation remains dominant. In this way, bullies are able to co-opt organisational
processes with “the intentional outcome of harming participants” (Hutchinson et al., 2005,
p.335). The finding of deliberate intent on the part of the bully is further confirmed by the work
refers to the term ‘bully’ as a euphemism that hides a person who takes delight in hurting others. She differentiates between the bully who acts out of ignorance or stress and is willing and able to change through education and personal growth, and the person for whom bullying is a relentless pursuit of the torture of another. Lewis and Vickers frame their understanding of bullying as a deliberate and systematic imposition of one person or group over another. They view the location of managers who choose to bully as a natural process of people finding the niche that enables, and sometimes even encourages, their behaviour, as does Needham (2003). This view of bullying aligns it to my earlier discussion of colonisation.

**Bullying and colonisation**

A further examination of laminated identities (McClelland & Fine, 2008) provides a useful way to consider the phenomenon of bullying in nursing. As discussed above, lamination can contribute to othering. In the Nursing motif, lamination has occurred as a feature of othering the symbolic figure of the nurse by wrapping her in social discourses of goodness and virtue. Conversely, the literature about bullying reveals it as a part of the colonisation process, as bullying is aimed at achieving compliance with the aims of the organisation or group.

The lamination of the nursing identity has occurred over the period of time since nursing became a recognised occupation for middle-class women in the mid-nineteenth century. In her analysis of the nursing image, Julia Hallam (2000) notes that some historical features of the nursing identity have persisted into the contemporary era, including gendered notions of effacement and subordination, particularly to doctors and the medical system of health care. Thus, the lamination of the nursing identity locates it within the medical discourse, so nurses are simultaneously othered and colonised by medicine. Further features of the historical nursing identity included the adoption of a military-style hierarchy and interpersonal behaviour that was focused on maintaining that structure. Later interpretation of the subordinate character and dictatorial behaviour among nurses has focused on the notions of ‘oppression’ and ‘horizontal violence’.
In 1983 Susan Jo Roberts published her foundational paper on nursing as an oppressed group (S. J. Roberts, 1983). She explored undesirable nursing behaviours such as ‘horizontal violence’ through the lens of Freire’s (1971) work on the way oppressed groups function. Freire asserted that oppressed groups become socialised, primarily through the education system, to hate themselves and the attributes that link them to membership of their subordinate group. In order to survive, members of the oppressed group take on the attributes and attitudes of the oppressors, further contributing to the oppression of their own group.

Roberts (1983) concurred with Freire’s position about education as a means of oppression, and furthermore likened nursing behaviour to that of ethnic and religious cultures whose continued existence was threatened by oppression. She suggested that nurses would attack each other in acts of horizontal violence and self hatred in preference to the more dangerous act of attacking their oppressors; doctors and the medicine-based healthcare system.

‘Horizontal violence’ as a manifestation of internal conflict is exploited by the dominant group as proof that the oppressed group are unable to organise or govern themselves and should continue to be dominated ‘for their own good’ and for the good of society. An example of this is found in nurings’ internal dissent over issues of demonstrable competence and the value of masters’ level education, which can be viewed by the medical profession as proof that nurses are not ready or capable of autonomous practice as prescribers (Bray & Kelly, 2002; M. Jones & Gough, 1997; Maling, 2000; Moller & Begg, 2005; New Zealand Medical Journal, 2000). The relationship between nurses/nursing and doctors/medicine is historically one of the assistant and the master (K. Davies, 2003; Fairman, 2004; Hand, 1991; Willis & Parish, 1997). This balance of power is being contested by nurses as they advance their plan for professionalism and autonomy (Baptista, 2002; Chua & Clegg, 1989, 1990). The above literature portrays nursing’s quest for prescribing rights as self-serving and a danger to the public; elements which are excluded from the laminated identity of the nurse. The implicit threat of rupturing the laminated
‘goodness’ of nurses can be conceptualised as the continuation of oppression, as doctors manoeuvre to maintain the colonisation of nurses. This example is further complicated because nurses are not only resisting oppression but are also challenging the medical power that is represented by the right to prescribe.

Literature consistently locates doctors as oppressors and bullies who function from within the powerful medical and gender discourses, and who actively work to continue the lamination of nurses as subordinate (C. Anderson, 2002a; Daiski, 2004; Group & Roberts, 2001; Rosenstein, 2002). The issue of nurses being bullied by medical staff was recently evidenced in a US survey of 1,200 nurses, physicians and executives (Rosenstein, 2002). This study found that 96% of the nurses surveyed had witnessed or experienced “disruptive physician behaviour.” This somewhat euphemistic term is defined as behaviours ranging from “verbal abuse to physical and sexual harassment” (p. 27). It is noteworthy, I think, that this term was coined by a physician. Alan Rosenstein also limits his discussion of damage to nurses to affecting “nurses’ job satisfaction” and “morale” (p.32) which are terms that minimise the perceived impact of physician bullying and make the nurses appear pitiable. Rosenstein chronicles significant effects of disruptive physician behaviour, such as an increase in medication errors by affected nurses, as well as increased staff turnover. His recommendations for change, however, fall back on the discourse of the dominant group; nurses must address their issues of staffing, scheduling and role ambiguity “before initiating an education programme for nurses, physicians and executives that will enhance nurse-physician relations” (p.34, my italics). This pre-requisite for a physician response to the problem reinforces Roberts’ theory of oppression (1983) in that the physicians require nurses to demonstrate cohesiveness and ‘goodness’ prior to taking steps to end their bullying behaviour. It also aligns bullying by doctors with colonisation, with the implication that if nurses keep to their assigned location then their lives will be free from unpleasant behaviour. It is also noteworthy that Rosenstein positions the ‘nurse’ first in his re-presentation of the education programme. This implies that it is the nurses who require the education to repair the relationship
and is a continuation of the dominant discourse wherein the dominator is in the position of virtue. This latter position is one that is described in literature about how domestic abusers rationalise and maintain their abusive behaviour (Adams, n.d.; Towns & Adams, 2000). There is a possible correlation between the colonisation and othering of nurses and domestic abuse against women that is worthy of further consideration. In addition to the similarities in the discourse of the abusers, there is also the impact of the ‘perfect-love’ image on women’s construction of abuse (Towns & Adams, 2000) wherein there is a marked similarity with the laminated image of the ‘good’ nurse. This is outside the scope of this thesis, but such research could contribute to the understanding of why women choose and stay in a profession that is, as Jenny said, “not a good fit” and causes distress.

This research records two specific instances of doctor-nurse bullying. Chloe and Jenny both record instances of bullying by medical staff and report that although they attempted to get redress through their managers, the doctors were not visibly sanctioned, nor did they apologise for their behaviour. Given the extent to which bullying was discussed in the nurses’ stories, this does not re-present a major consideration for these nurses. In fact, the nurses report experiences that are consistent with Dawn Freshwater’s (1998; 2000) research findings that being bullied by other nurses was more memorable and painful than aggression from any other source including doctor-nurse bullying. However, the concept is applicable in a wider sense than individual doctor-nurse bullying. Indeed, at an individual level doctors are shown to be similarly susceptible to bullying behaviour (Fairman, 2004; Quine, 1999, 2002). Rather than being only an individual endeavour, the doctor-nurse relationship is the location of a longstanding, deliberate campaign aiming at the ongoing colonisation of nurses by doctors (Group & Roberts, 2001). This view aligns such bullying with the notion of bullying as an organisational mechanism whereby individuals act out an organisational agenda of colonisation. In this instance ‘organisation’ is representative of the two cultural groups, nursing and medicine.
A culture of bullying

Doctors and healthcare organisations are not the only bullies. Another phrase, “eating our young,” is frequently used in literature pertaining to bullying within nursing. It was first proposed by Meissner (1986), who wrote that an “insidious cannibalism” (p. 52) is in play in nursing. She asserted that nurse educators begin the process by overloading students with information, jargon and study requirements, and focusing on judging performance rather than supporting the learning and development of an aspiring nurse. After the nurse has graduated, nurse administrators take over the annihilation of the nurses’ self esteem and confidence by refusing to acknowledge the beginning status of the new nurse and setting expectations that the new nurse cannot achieve. However, Meissner asserted that “nurse colleagues . . . [are the worst offenders, because they] . . . seem to be just waiting to smash the novices’ rosy view of nursing and trample their sensitivity to patient concerns” (p.53). This view is consistent with more recent studies into the experiences of new graduate nurses (McKenna et al., 2003; Randle, 2003), although the assumption in such research that new graduates have a collegial relationship with more experienced nurses is problematic. As I discussed in the Nursing motif, neophyte nurses are often lacking in confidence and self esteem arising from inconsistencies in their understanding of their nursing role and identity, and are engaged in negotiations between their ideals, expectations, values, mastery, caring and clinical realities. New graduates are frequently distressed and vulnerable.

* * *

I have personally heard the stories from many practice areas, in classrooms and at conferences for the last 17 years. My own presentations about this research have prompted multiple stories of internal nurse bullying that have mentally and emotionally immobilised me for days at a time because of their horror. The nurse who had a scalpel thrown at her head by a nursing supervisor is one such incident.
In my new graduate class last semester, I raised the issue of horizontal violence. As I expected, but had hoped not to hear, the class enthusiastically responded with many instances of bullying, conflict, aggression and injustice. Even more disturbing than their stories was their acceptance that this is what it means to be a nurse. Some of them earnestly parroted phrases about ‘eating our young’ and being ‘tested’ to see if they’ve ‘got what it takes’ to be a nurse. Others became quiet and related stories of being traumatised by the level of bullying that they have been subjected to. Although the lesson was focused on self-care and collegial relationship building, these 20 nurses related that they are almost all taking antidepressant medication. Sixteen of them take medications now; two are considering visiting their GP to ask for prescriptions; only five were taking medication prior to entering their undergraduate education; five began taking them in the first six months of their new graduate programme. This, while anecdotal, is significant and requires urgent attention.

When I was a student, 20 years ago, we told those same stories but I don’t think there was the same level of trauma. I don’t know why, but I thought this generation might be treated differently, more respectfully. (Research Journal, May 2007).

*   *   *

Freire (1971) and Roberts (1983) assert that the establishment of intra-group hatred occurs at the level of education. This is again consistent with the collective stories of bullying and nursing in this research and the literature (B. Foster et al., 2004; Lewis, 2004, 2006a, 2006b; MacIntosh, 2006; Meissner, 1986; Quine, 2001; Randle, 2003; Stevens, 2002). The mechanism of bullying a student or new nurse into the nursing identity indicates the colonisation of the individual by the more dominant nursing group. Once the nurse indicates a willingness and ability to ‘fit in’ the negative experiences tend to reduce (Alavi & Cattoni, 1995). This is a problem for nurses who may not be able to ‘fit in’ with the nursing identity of untiring selflessness and cheerfulness because of personal vulnerability, the need to be cared for, visible distress and lack of
confidence. These are some of the attributes described by the nurses in this research, and have led to the nurses being silenced.

**Silencing**

Roberts (1983) and Meissner (1986) explored tangible nursing behaviours such as horizontal violence and apparent self-hatred in nurses. However, a more subtle version of bullying is found in Bourdieu’s (1998) notion of ‘symbolic violence.’ Bourdieu observed that cultural norms tend to dictate the worth of phenomena, so when worthiness is withheld, groups can be convinced that what matters to them is worthless. Arthur Frank (2002b) expands on this when he notes that the existence of a known narrative affirms that events are acknowledged and therefore the people embodied in the narrative are worth knowing about. When events such as the ones these nurses have experienced are not accepted by their managers or their peers, the distressing event is intensified because the nurses come to understand that their concerns do not matter, therefore the nurses themselves do not matter. This is evidenced in Josephine’s story, wherein she describes being a capable nurse who has a mood disorder. When news of her disorder became public, Josephine’s perception of herself is lost in the dominant image of mental illness. After that experience, Josephine says she is “no good to anyone, like my life has been wasted, am worthless . . . I’m lost.”

This is an example of othering (Fine, 1994) whereby Josephine has been silenced because of her difference, her mental illness, and has been isolated from the nursing group. The worthiness of her story has been demonstrably withheld, which brings her personal worth into doubt. Michelle, Morrie, Ellie and Julie all record instances of being othered through the silencing of their stories and the subsequent devaluing of themselves as nurses. These instances have all occurred in the context of the nurses disclosing or requesting support for their experiences of mental illness. This
draws in the notions of stigma and discrimination that have been addressed above\textsuperscript{18}. The implication is that, rather than a palpable discrimination, discrimination occurs for these nurses through the removal of their tangata whaiora identity or their nursing identity. Their silencing demonstrates that they are not permitted to be a nurse who has experienced a mental illness. Symbolic violence also has the potential to persuade nurses to recognise their own unworthiness, which is similar to the notion of internal stigma (Corrigan, 2005).

The concept of a nurse who has a mental illness being worthless is resisted in nurse audiences’ responses to this research so far, and highlights the testimonial nature\textsuperscript{19} of participating. To have a previously unheard and/or unacknowledged story sought, interpreted and presented through the dominant discourse of academia is a concrete form of bearing witness to and validating the worth of such stories. This argument circles back to the discussion on page 52 that refers to researchers ‘cutting a deal’ about how stories of the other are permitted to be told (Fine, 1994). In that discussion the other was potentially subsumed by the domination of the researcher identity. In this interpretation, the research is a vehicle for creating an audience to bear witness to the stories.

**Bullying in the hyphen**

The collective story of bullying re-presents the complexity of the events, emotions and consequences of bullying for these nurses. When viewed through the lens of hyphenated lives (Fine, 1994; McClelland & Fine, 2008; Sarin & Fine, 2007), bullying is illuminated as a complex mechanism of othering and/or colonisation.

The timing of bullying behaviour is varied. For some of the nurses it is a feature of the hyphen that separates their identities, while for others it is a mechanism that creates the hyphen. Josephine, Ellie, Morrie, Michelle and Vicky all record bullying that was based in stigma and

\textsuperscript{18} See pages 204 and 252.

\textsuperscript{19} See page 53.
discrimination, was aimed at othering them, and that occurred as a result of their disclosed experiences of mental illness. North Island Bunny, Anne and Helen identify their experiences of being bullied as a mechanism for colonisation and a contributing feature to their development of mental illness. For these nurses, bullying was aimed at silencing their individual experiences and enforcing a ‘fitting in’ process upon them. For nurses who did not disclose their mental illness, for example Elizabeth and 64, bullying was a combination of attempts to other or colonise them, depending on their context. Their illness ruptured their nursing identity, and their non-disclosure and continued nursing work ruptured a potential tangata whaiora identity. For these nurses bullying was a profoundly disturbing experience that excluded them from any comfort the nursing identity might have offered.

The literature about bullying raises issues of nursing’s position in relation to medicine and the notion of oppression. Oppression is theorised as a colonising mechanism which gives rise to internal group violence. Jenny and Chloe relate significant bullying experiences that emerged from the nursing group’s attempts to integrate them into the larger group. While both of these nurses also describe incidents of doctor-nurse bullying, they link their distress to oppression through lack of support, silencing and verbal aggression within the nursing group. This finding is particularly important when considering how nurses might resist and challenge the bullying culture because it suggests that collegial support within the nursing group can alleviate distress and enable resilience. This is discussed further in the next chapter.

*   *   *

At this point I want to say something profound and wise that neatly ties up this discussion of bullying and renders it meaningful. I have searched for a work of art, poem or story either in me or externally and cannot find one. The literature offers multiple explanations for why these nurses were bullied, silenced, oppressed, othered and colonised, but there is no deeper meaning to be found. This chapter begins and ends with dis-connect-edness.

*   *   *

267
Negotiating the hyphens

At the end of the motif chapters, I noted that the nurses in this research are subjected to a nexus of hyphens between genres that emerge from nursing and mental illness. As the interpretation of the nurses’ stories has progressed through working the hyphens, the complexity of the nexus has been further illuminated. Although a hyphen suggests a singular joining or separation, this research has found that these nurses negotiate a postmodern plurality, multiplicity and partiality of hyphens.

The hyphens that have been identified occur between the genres of caring and mastery within the nursing identity, between the genres of psychiatry and resistance within the tangata whaiora identity, and between the inclusive identities of nurse and tangata whaiora. Furthermore, as established earlier in this chapter (Figures 4–8), the hyphen between identities demonstrates multiple ways according to their laminations and ruptures, and othering and colonising influences.

The implications of the hyphens for these nurses are found in a confluence of Fine’s notion of people negotiating the hyphens in their lives (1994) and Lyotard’s differend (1988) whereby the spaces between genres result in the immobility of confused, incoherent silence. For the nurses, the difference between negotiating the hyphens and the differend is one of motion.

As discussed in the motif chapters, while most of the nurses recorded their continued negotiations, for example their meetings with managers to explain their experiences and movement to practice settings that met their need to engage with and care for patients, some of the nurses recorded moments of immobility. Examples of immobility occur in Josephine’s story, where she is frozen in the horror of being excluded from her workplace and says that she is “lost,” and in Chloe’s story, where she reports her awareness that she could be depressed, or she could be a nurse. At the time of coming to this awareness, she is immobilised in a struggle.
between her illness and her nursing identity. The immobilisation they experienced at the differend is analogous with the dis-connect-edness of mental illness for these nurses.

Whether the nurses were engaged in continuing negotiations or had reached a differend, their stories of distress, hurt, bewilderment, isolation and anger are re-presentations of times when their negotiations did not result in the resolution of dissenting genres or identities. Furthermore, the nexus between mastery, caring, psychiatry, resistance, nurse, and tangata whaiora highlight a space wherein bullying, stigma, discrimination, oppression, othering and colonisation occur.

One feature of the nurses’ experiences has not yet been addressed; what happens when the nurses’ negotiations are successful, and their distress is alleviated?

* * *

One of my wisest teachers, Phil Barker, has commented that ‘problems of living’ are important in terms of how they impact on lives ‘now,’ rather than as historical events that are frozen in time (Barker, 2000). In their stories, the nurses have frozen their lives in textual re-presentations that cannot reflect the partiality, indeterminacy and plurality of their experiences. I have revisited those re-presentations, interpreting them using literature and theory, but have reached the limits of theoretical possibility. It is time to leave the stories of the past, and turn to the ‘now.’ It’s odd, but I have a sense of grief about the leaving (Research Journal, August 2007).

* * *

This chapter concludes my interpretation of the hyphens that join and separate aspects of the lives of nurses who have experienced a mental illness. It also concludes my deep engagement with the nurses’ stories, although the nurses’ assertions about how they seek wellness are considered in the forthcoming chapter. In the next chapter the thesis moves into considering ways to establish and maintain the mental health of nurses who are vulnerable to mental illness, and to reduce the distress of those who are experiencing it.
Anne’s story

I did my initial nursing training from 1964 – 1967. Since then I have worked in many areas, and have undertaken post graduate education in nursing/cross cultural management including two Masters Degrees. I have also taken some theological and feminist papers. I describe myself as a feminist Christian, which is pretty unusual, I think!

For this research I want to talk about my experiences as a Nurse Manager in the care of the older person. It is an area that is really important to me, because of my own experiences but also because there are so many other nurses out there who are being treated badly. I have seen them come to meetings with colleagues and sometimes they are just sobbing.

I want to focus on one particular time, about six years ago. What happened then is pretty much representative, I think, of the things that have happened to me throughout my career, and things that seem to be happening to other nurses.

The General Manager in the place I worked wasn’t a nurse. In fact, she didn’t have a degree. I thought she sometimes didn’t understand well the job I was doing, and even though she was my boss, as the Registered Nurse Manager, I was ultimately responsible for the care of the patients and the actions of the staff who delivered the care. This Manager also said to me that she was uncomfortable that I was earning almost as much money as she was – even though I had several degrees and significant responsibilities for staff and patients. It seemed unfair to me, and unrealistic. But from that point, she made it clear that she did not want me in that job any more. She started to scrutinise my work really closely, and I thought she was clearly looking for ways to get rid of me. She began to manufacture reasons to censure me. One particular event that is really painful to remember involved a young nurse who I had employed. She was a very lovely person, but had little experience. Her reference check came back with the recommendation that
she should be supervised in the role due to her lack of experience. I was happy with her and her work. One evening, though, this nurse made a medication error. It did not have any major implications for the patient, and was not a result of negligence on her part. She had actually asked a patient to confirm her identity, which the patient had done incorrectly. The nurse realized her error almost immediately, and called me. I was impressed with her honesty, actually, because if she hadn’t owned up then no-one would have been any wiser. We went through the process of documenting the incident, and the General Manager used that process as a reason to dismiss this nurse. I was devastated for her – and felt awful that my issues with the General Manager had impacted on another nurse in this way. The General Manager then claimed that I had employed her in error, and used that as a reason to dismiss me.

Obviously there were other issues going on at the same time, but I think this incident illustrates the vulnerability of Nurse Managers – particularly in the private sector. While all this was happening, I received advice and support from colleagues both in the private and public sector. I was grateful for that, because I felt very isolated. It is a lonely position to hold. The thing that sets me apart from some of my colleagues, I believe, is that I recognised that the mistreatment I was experiencing was not appropriate and I sought legal advice. My education and experience meant that I knew I wasn’t at fault. I had also been seeing a psychologist on a regular basis. Over the years, it has cost me a small fortune! But it has kept me emotionally intact, which is vitally important to me because I have experienced mental illness in the past caused by workplace mistreatment.

The experience of being pushed out of my job was traumatic, to say the least. And it raises some big questions. Like – where do Nurse Managers go for support? And, when this happens to you, how can you get another job with a poor reference from the General Manager?
I am a member of a union, and a part of a group of gerontology nurses. In fact, most of us in the
group are or have been Nurse Managers. We started to compare notes about how we are treated,
and decided to write formally to the union to ask about support for Nurse Managers. We never
got a response. When I tried to use them once, I had to wait for three weeks just to get an initial
conversation with them! It’s puzzling that they don’t seem interested in our difficult issues, and
it’s a point of trauma for me.

Emotionally, you feel desperate, traumatized and very alone. You work so hard, and you’re so
mistreated. The salary offers for Nurse Managers are often demeaning, given our qualifications
and experience – but if you don’t accept what is offered, then you don’t get a job. Ultimately
money is the bottom line. It’s particularly hard when you know that the place you work actually
has money but you still have to cut back, work harder and longer, and have low pay. The lack of
respect also shows up in a lack of support. I once had to go through a Ministry of Health review,
supporting my staff through it, too. It took two years and I felt that I had to do it alone in spite of
having a General Manager. It’s devastating when you’re not respected.

I think it is sometimes about gender – the fact that we’re mostly women. I think we tolerate a lot
more in New Zealand than they do overseas, but the mistreatment can be horrendous. As women
and nurses, there is a perception that we do this work because we love people, we love to care for
people and the money isn’t important. The money is important to me – but even when I was paid
a very low salary I still kept paying for the psychologist! To think through matters carefully with
him helps me to be safe in emotionally risky jobs.
64’s story

I am a 64 year old single woman. A Registered General Nurse (1962), with an Advanced Diploma of Nursing (medical/surgical) 1980.

I have been in the nursing workforce for 34 years (1959-1997). During that time there were 5 years when I was not employed as a result of mental health problems. These years were 1984, 1985, 1990, 1991 and 1992. I have been out of the workforce from 1997 as a result of ankle injuries; (the support structures in my feet and ankles have collapsed) and mental health problems.

I have struggled with depression since 1966 when I suffered a “breakdown”. I also developed PTSD about 1987. Not diagnosed until 2000. I also have dissociative identity disorder; and am very anxious.

I will document events from 1966 regarding my mental health status; the work I was doing at the time; and my experience of the events. I will try to be brief.

1966 – after 7 years of nursing suffered a “breakdown” (I had begun painting in 1964 and soon realised I was an artist and during 1966 I sat Fine Arts prelim – failed it). I was working as a charge nurse in a 42 bed medical ward. I liked the work and was good at it. The hierarchy moved me to tutoring. I hated it. I left nursing at the end of 1966 – broken and depressed.


I continued to paint seriously and exhibit. In 1970 I saw a psychiatrist about my depression. He prescribed doxepin and mogadon with no effect; and when he raised the subject of ECT I fled. I understood nothing about how I operated. 1973 – stopped seeing the psychiatrist. 1974 – took myself off the above drugs.

I was in a mess and depressed, but “shelved it” at work. I was “in therapy” with a psychologist (unsuccessful).

I was also in a relationship with a violent, dangerous, unpredictable, unreliable, dishonest and abusive man for this time.

During 1983 I proceeded to disintegrate. I was exhausted and needed to get off night duty. My superiors were deliberately obstructive over this. I left my job at the end of 1983 totally broken, depressed, and ??psychotic. I received no support of any sort from my superiors.


1986-89. Worked 2 nights a week in a public hospital as a staff nurse, briefly in a 40 bed orthopaedic ward, then moved onto “pool”. Pool meant going anywhere and everywhere. I hated it. I was totally unsuited to it. I became very, very anxious, and I think it hindered my recovery. (In 1987 I developed PTSD). I simply became more ill – continued nightmares/flashbacks to childhood incest along with all the other symptoms of PTSD including multimodal hallucinations. I was off sick a lot. Left my job mid 1989. I had received no support from any nursing colleagues. I had been “in therapy” again (unsuccessful). Put on nortriptyline 1987 (levels very erratic). I had continued with painting and claywork.

1990-92. unemployed – ill. Unable to function for most of 1990. Started applying for jobs at the end of 1991 (problems with references as my performance in my last job was so poor). I was very worried about how I was going to support myself. Many antidepressants tried.
1993-97. Worked 3 duties per week as a staff nurse in long term elderly care (hospital level). I functioned better in this job; though I continually had to “hold myself together”. I was put on epilim mid 1993 for PTSD and it helped a bit (I was so angry I was frightened I might assault a patient or staff member prior to this). I was basically badly depressed and very hampered by the PTSD.

The sort of work I was doing was not helpful to me as the patients often kicked/hit/grabbed/touched me in the course of me caring for them (my childhood being replicated again). However it was the only job I could get and was grateful to have a job.

Also the noise in the ward was incredible. I did not understand at the time that my inability to tolerate it was part of PTSD.

Also the ward was chronically understaffed and I would frequently find myself running the ward with 2 “agency” nurse aides neither of who knew the ward layout; or the patients; or how to care for a patient. I found this very stressful, as I was only just able to cope with doing my own work, let alone theirs as well.

In 1996 I suffered a bad ankle injury at work. I continued to try to work for the next year (once again I was off sick a lot). I was in continual severe pain in spite of taking large doses of panadeine and codeine phos. This is not surprising as I had a ruptured posterior tibialis tendon in my right ankle (not diagnosed until the end of 1997). I was very crabby at work and was of course reprimanded for this. The stress of this increased my PTSD symptoms. I was terrified of losing my job as I had no idea how I was ever going to find another (my age, 57, and my medical history). Eventually my GP told me my nursing days were over and I resigned mid 1997.

During all this once again I had no support from my supervisors. I also had problems with the Principle Nurse when I had requested to do pm shifts (3 – 11pm) instead of a mixture of am and pm shifts in 1994. In spite of the fact that all the other RN’s did NOT want to do this shift.
Eventually she agreed. I did not tell her my reasons (I don’t think she was interested in my reasons), which were; 1. Jumping from am to pm to am etc was exhausting. 2. she rostered me double duties, eg 3 – 11pm then 7am – 3pm the next day. Because I was on a large dose of nortriptyline and epilim, if I took it at 10pm I was too hung over to work a morning shift. 3. I was inclined to be groggy in the morning because of the drugs I was taking and therefore functioned better in the afternoons.

I also had a problem when one morning (before a pm shift) I wrongly took my night medication instead of my morning medication. I didn’t think it was safe for me to try to work with all that medication on board. I didn’t trust the Principle Nurse enough to tell her the truth, so I said I had the flu. I don’t think she believed me – but it is a good example of how difficult it is to tell the truth when you have a mental illness. I doubt that she would have understood the truth.

I basically tried to act as if everything was all right when it wasn’t. Sometimes I succeeded and sometimes I didn’t.

During the time I was working I also had another period of physical illness which I ignored and didn’t go off sick with; and shows how terrified I was of losing my job, eg. I had a 5 month period of severe diarrhoea starting early 1996. I assumed it to be psychosomatic. It wasn’t – I had a form of amoebic dysentery which was easily cured by an antibiotic.

1998 – I had surgery on my right ankle. While recovering from my surgery I injured my other ankle and was totally immobile for months, then I spent years trying to get my feet and ankles going again. These events of course exacerbated the PTSD and depression.

2000 – sent to one of the “mental health sector bases” for trial of other antidepressants. None of them worked and I got a lot of bad side effects.
2002 – started painting again. My mental health status has slowly improved, in that my PTSD symptoms have lessened (particularly the explosive rage, the nightmares/flashbacks, and the multimodal hallucinations). I do not handle stress well.

I had been “in therapy” again 1993 – 2004, with some success this time.

2004 – Have slowly been weaned off nortriptyline. They were not working very well anyway, and my levels were very erratic and frequently not at a therapeutic level. It was decided that if I am no worse off them then I am better off not taking them. Also because my feet are in such a mess, the less weight I have to carry around the better. If all goes well I may try coming off the epilim later in the year (I also have developed a rash and skin sensitivity to sun, probably as a result of these two drugs).

I hope that this is possible. I hope that all the years in therapy have paid off. I now understand how I operate, which I certainly didn’t at the beginning of all this.

I now understand what is meant by “those who don’t remember their history repeat it”. I certainly have, particularly earlier in my life.

I also understand how people with mental illness end up in the gutter or sleeping on the streets. I am very grateful not to be in that position.

I have found my experience of prolonged mental illness to be exhausting, humiliating, terrifying, confusing, isolating and financially crippling. It has wrecked my life. During this time I have frequently heard experienced registered nurses say things which show that they have no knowledge or understanding of mental illness (mine or others). I will list a few instances:

My second counsellor was a registered nurse. She seemed to have no understanding that I couldn’t just switch off the PTSD symptoms at will.
My ACC case manager (related to my ankle injury) was also an RN. I did not disclose that I had mental health problems. She spent a lot of time shouting at me for not being in the workforce. I was already very upset over my job loss and could barely walk. I did not fare very well with ACC because I was too squashed to stick up for my rights. I did lay a complaint about her, but it was not upheld.

In August 2003 I suffered a fracture dislocation to my right tib and fib. On discharge my GP was away and I could not get enough painkillers. My PTSD resurfaced – many nightmares and much insomnia. I was in tears when another experienced RN arrived (the Parish nurse). She stood at the doorway and shouted “stop it, stop it, stop it this minute! Stop it at once!” So much for the comprehension. On reading this it sounds like a comedy. It wasn’t. She then dumped me.

From 1999-2002 I was involved with a parish nursing group at the church I was attending. I was unable to do a lot of helping other people as I was very unwell myself. The two RN’s in charge, both experienced nurses and one a sexual abuse counsellor, did not seem to understand that if I am too unwell to be in the paid workforce then I’m not able to be much help in the unpaid workforce. They saw me as “selfish” and not caring about other people (they made this very clear to me). I was actually struggling with depression, PTSD, major multiple losses, was living on a pitifully low income, had a car that was unreliable, had very poor mobility and was struggling to do even my own housework. I was incapable of racing around the city looking after other people.

From 1984 – 1991 I was “in therapy” with a counsellor who was also an RN. I was taking large doses of nortriptyline. I was working 2 night duties per week. On the nights I worked, I would take the meds at 8am, then sleep. On my nights off I would get up about 2pm but be too heavily sedated to function. She kept insisting that the medication didn’t do that, and that I was imagining it. She also betrayed me, in that in 1987 when I got to the point of disclosing about the
incest, I was also in a group therapy situation run by her employers. The arrangement was that whatever I said in therapy to her was confidential to her alone (separate from the group). However she disclosed details relating to a sexual matter to the group leader and he brought it up in group, and laughed about it. The result was that once again I did my best to block it all out. Very damaging to me. I do believe it is the therapist’s job to create an environment where the client feels safe to bring up whatever they need to with no repercussions. She didn’t. I didn’t confront her about it for several years, when I did she could not see that what she had done was very unethical.

Some other recent examples, not related to me: an experienced RN (an ex-colleague) referring to another RN “of course she is one of those terrible maniac depressives and shouldn’t be working”. A recent graduate saying at a meeting “I don’t know anything about mental illness – I don’t want to, no, not mental illness”. Said in disdainful tones, giving the impression she thought such people were inferior. Two experienced RNs discussing another RN who had become an orthopaedic patient in one of their wards. The RN saw what drugs the patient was on, and took steps to see that she lost her job because “she might make a mistake”. An experienced RN, working in an intensive care unit discussing patients who had come in after attempting suicide. She “had sympathy for the older ones who had had enough of life, but couldn’t stand the young ones who came in time after time and played up”. She didn’t realise that these very young ones needed her support, they were probably acting out.

It seems to be commonplace for RNs to view other RNs who are having mental health difficulties as “not coping” or having “psych problems”. These same RNs appear to know nothing about mental illness.

I am well aware that if I hadn’t become mentally ill, I could be as ignorant s the nurses I have been complaining about. I have had to put a lot of effort into education myself about it because I
understood so little about what was wrong with me, for a long time. In 1990 I was terrified that I would spend the rest of my life in an institution if I couldn’t get myself together. Since then I have read widely, listened to relevant interviews, and attended other educational opportunities. It has helped.

I have done a lot of night duty, connected to being unwell. Night duty is more straightforward and the demands less conflicting. Being on antidepressants doesn’t always mix well with night duty. With all this complaining about RNs knowing so little about mental illness, I feel I must say I do have three longstanding RN friends who have never insulted me about it, even though 2 of them don’t know much about it. The third has a bipolar illness.

**Vicky’s story**

I am in my early 50s, single, no kids, lesbian, originally a Psychopaedic nurse now Comprehensive with Post Graduate certificate (soon to be diploma) in mental health. I have been working in mental health for about 15 years.

I had a gradual recognition that I was in the grip of a severe major depressive episode. My world became smaller and smaller and I ended up becoming very isolated in my rural home, 35 kms from my workplace. At home everything was becoming more and more controlled and I realised that I was going home from work, eating, walking my dog and then going to bed to watch television and read – both well loved forms of escape. My anxiety escalated, and answering the phone or talking with neighbours became an effort. I rarely went out socially and if I did it was a huge effort to go and a big anxious experience where I couldn’t wait to get home.

At work I was experiencing a huge inner turmoil where things seemed out of control often. I was working in a short staffed crisis assessment team and I was used to being on top of things and a
competent skilled mental health nurse who could manage most situations in a calm rational and safe manner – my colleagues had come to rely on this. Maintaining this level of practice became more and more difficult and I would get very anxious about losing control and get snappy and irritable with people. Often when I felt I couldn’t face it I would stay home from work and hide in bed. I developed a variety of somatic symptoms to rationalise my behaviour. I started feeling paranoid and victimised at work – this was probably, I realise now, a result of my behaviour to others.

Part of my job was to be part of an on-call after hours roster. Because we were short staffed I was on-call about three nights a week and every second weekend. This involved taking a pager home with me and responding directly to after hours mental health crisis calls – triaging these and directly responding to the most urgent calls including those where a duly authorised officer (me) was required to attend. I was taking sleeping pills because I had severe insomnia due to my anxiety. On the nights where I was on-call I could not take these and the lack of sleep was catching up with me. My pager sometimes randomly did not work properly because of my rural location and I would receive irate phone calls from the hospital receptionist on my landline demanding to know why I had not responded. I felt a huge responsibility to continue as part of the roster and never reneged on my commitment to it, but I became so anxious that I could hear the pager going off even when I was not carrying it.

On one particularly stressful night I had the awful realisation that there was nowhere to go for help – that I was it. I could not imagine telling anyone at work what I was going through because I understood there would be no going back from such a disclosure – that the truth would no longer just be in my head but part of other’s realities as well.

I changed jobs within the mental health service but continued with the after hours crisis work as it was expected. Finally I went on holiday to my best friend’s home in the South Island and
I couldn’t go back. I spent two months off work and then a few months later another three months. I eventually left my job because I felt I could not move on in that environment.

On my return to work I felt this amazing vulnerability – like an onion that had been peeled. I was very emotional and unable to screen out any emotional stimulus. It actually felt great, I was more tuned into things than I could ever remember being before.

It was a bit difficult at first in my work with clients – gaining confidence that these new perceptions were OK as long as I was aware of the usual boundaries, transference issues etc. I was more able to sense vulnerability in others and with sensitivity was able to build and maintain rapport with clients that I had not previously experienced. Some of the outcomes for my clients during this initial time were exciting and innovative. My work with clients since this time has maintained a different quality – it is difficult to explain, but this new dimension has to with the enhanced quality of empathy experienced in relationships with clients since my own experiences of mental illness. I have learned to be confident with this and usually follow where it leads. I am selectively open with both clients and colleagues about the general nature of my experiences when this is appropriate. I have not had any negative experiences from these disclosures.

There was a real downside to returning to work. My boss, who had experienced depression some years before, had a mixed reaction to my illness. On the one hand she would regale me with stories about her own experiences and be all understanding and then on the other hand was telling me that “I had a lot to make up to my colleagues” and treated my absence and illness as a disciplinary matter. I was very confused – I felt like a child victim who needed to appease her disapproving mother. During the time away from work my absence was “assertively managed” by my boss – she would phone me at random times at least once a week to “see how I was doing”
this inevitably ended up with me in tears with maybe a week to get myself back together before
the next onslaught. I was not only unsupported by her but also victimised with nowhere to hide.

The most hurtful experience arising from my illness was in relation to a colleague who was a
social acquaintance and also my clinical supervisor, specifically to supervise my role as a detox
nurse. This woman and I are much the same age, both from working class backgrounds with
much in common in our nursing philosophy and approach. Prior to my absence from work I had
been going with her to the occasional movie or for coffee etc. She did not contact me while I was
away – I didn’t worry too much about this but when I returned to work she was very cold in her
attitude toward me. I made an “appointment” to see her, and the ensuing conversation was
deeply distressing to me. She told me that she didn’t believe that I was depressed, that I had
behaved badly and unprofessionally. She led me to believe that she had been involved in lots of
gossip with colleagues while I was away and that others also didn’t believe me and had been
pleased to see the back of me. She accused me of “playing games.” I was devastated by this – she
appeared to have no understanding of the situation and wouldn’t talk about it. She said that she
would no longer be able to have a personal friendship with me. She didn’t understand that when
things were at their worst, my social contact with her was all I could manage and was the only
social contact I was having at that time. I am now able to place this in some sort of
psychodynamic context – but very deep down still feel utterly betrayed. My confidence in the
workplace was totally at rock bottom – it took some months for me to be able to sit and have
morning tea with any of my colleagues – no one ever asked how I was doing and I never felt able
to bring up the subject either. I never fully recovered my former confidence while at this
workplace.

I continue to have the odd “blips” in my mental health. I have a good awareness these days about
my early warning signs and am able to head off full-scale depression before it hits. I am mostly

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“out” in my workplace now and this feels great – I find there are a lot of other nurses who also have mental health problems. The ones I have talked with all agree that personal experience of mental illness does bring a different perspective to the way we are able to do our work.
Chapter seven: nurses seeking wellness

I tried going back to work, but there was no recognition of the issues I faced, and I didn’t have the option of starting to work part time and building up from there

Ellie

This chapter addresses my second aim for this research, which is to extrapolate strategies that the nursing profession might employ in order to prevent or reduce the distress of nurses experiencing mental illness as a result of phenomena related to their chosen career.

Michelle Fine (1994) conceptualises hyphens as spaces that separate and join. In the previous chapters the issues that have separated or only partially joined the nursing and tangata whaiora identities have been explored. The focus of this chapter is to explore the techniques and circumstances that enable nurses to negotiate their identities, move freely between identities and to bring to each identity the features of the other. In this environment, the hyphen is the space that joins genres and identities.

This chapter firstly revisits the interpretation of the hyphens for nurses and clarifies the factors that problematise a joining hyphen. The second section of the chapter critically examines potential strategies to address the identified problems, and the third section offers concise recommendations for the prevention or reduction of distress for nurses who have experience of, or vulnerability to, mental illness.
Nurses, nursing and mental illness: the nexus of hyphens

The first aim of this research was to explore and understand the relationship between being a nurse, doing nursing work, and experiencing mental illness. To achieve this I have illuminated, explored and interpreted hyphens between genres within the nursing and tangata whaiora identities, and between the identities themselves. In doing so, a complex nexus of hyphens has been illuminated.

The motif chapters illuminated hyphens between the genres of caring and mastery within the nursing identity, between genres of psychiatry and resistance within the tangata whaiora identity, and between the inclusive identities of nurse and tangata whaiora. In the last chapter, figures 4–8 demonstrated the multiplicity of the hyphens between nurse and tangata whaiora. These included hyphens between the separate, laminated identities of nurse and tangata whaiora, the tangata whaiora who becomes a nurse, the nurse who becomes a tangata whaiora, the nurse who is influenced by her mental illness experiences, and the tangata whaiora whose mental health is impacted by her nursing identity. The hyphens separate or partially join identities that are unruptured, or occur between an unruptured and a ruptured identity. In none of those previous examples were the laminated identities of nurse and tangata whaiora both ruptured.

This nexus is further complicated by bullying and oppression from within and outside the nursing group. The features of the nexus are précised below.

Being a nurse

The laminated nursing identity of indefatigability, selflessness and subordination is distressing for some nurses, as it leads to tension with the notions of also needing to be cared for and negotiating time to recover from mental illness. The image of subordination is associated with bullying and silencing from external and internal sources.
Caring-mastery

Aspects of the nursing identity are problematic for some of these nurses as they struggle with tensions between the societal requirements of the laminated image, and the professional responsibilities of competence and accountability. The caring-mastery hyphen is a feature of the contested knowledges of education and the clinical environment, and is enacted by educators and clinically based registered nurses upon new nurses. This raises issues of the education and socialisation of new nurses, and the impact the laminated nursing identity has on an individual’s interpretation of how they should do the work of nursing.

Within each genre of caring and mastery, additional issues are visible. Emotional work is implicated in the caring aspect of nursing work because of the connections between nurses and their patients, and nurses and the community. Research clearly links emotional work with stress for nurses. The mastery genre is associated with the stress of demonstrable competence and the threat of withdrawing membership of the nursing group if such competence is not achieved.

Vulnerabilities

In choosing nursing as a career, nurses bring their own needs to their identity. These may include a need to belong to the nursing group, a need to care, and a need to be cared for that emerge from previous life experiences. The need to be cared for may also emerge as a result of the experience of mental illness.

Stress

Nursing work is linked with high levels of chronic stress, under-resourcing, emotional work and poor self care. This latter feature is also associated with the selflessness required by the laminated nursing identity and with pre-existing vulnerabilities that reinforce the individual nurse’s need to care.
Bullying and silencing

Within the nursing identity are issues of bullying which equate to internal colonisation/socialisation into the nursing group and external colonisation of nurses by medicine. Silencing stories of mental illness is a feature of othering and is based in discriminatory behaviour.

Experiencing and hiding symptoms

The tangata whaiora identity has two components: the experience of mental illness and the process of seeking wellness. Many of the nurses described their perception that being mentally ill was not permitted within the nursing identity, and chose to hide their distress and symptoms. This was reinforced by experiences of stigma and discrimination that surfaced as stories of bullying and silencing.

For the nurses in this research, seeking wellness from their experiences of mental illness is complicated by their nursing identity. Psychiatric techniques used by the wider population, such as medication and hospitalisation, are problematised by shift work, high levels of individual responsibility and accountability, and the professionally reinforced incompatibility of maintaining the nursing identity as well as the tangata whaiora identity. Medical responses to mental illness are not addressed in this thesis, however enabling the nurses to utilise them while remaining in the nursing workforce is an issue relevant to this research.

Ruptured identities

The interpretation in previous chapters has illuminated a further hyphen that joins the identities of nurse and tangata whaiora. In their stories, the nurses refer to this hyphen when they report successfully negotiating between their nursing and tangata whaiora identities. For example, Jayne, Rachel and Vicky all record instances when they felt that they were accepted by their
nursing managers as whole people, inclusive of their illnesses. In turn, they selectively chose to discuss their illness experiences with colleagues and patients. Their stories demonstrate that aspects of each identity are able to be incorporated into the other. Although these experiences are partial, featuring only briefly in their stories, each of the nurses describes a sense of wellbeing and relief at being understood by her nursing group at that time.

The reduction in distress and the pleasure these nurses found in their practice on those occasions indicates a profound difference from the laminations discussed in the previous chapter. I have conceptualised this as a rupture in the nurse and tangata whaiora identities in Figure Ten.

![Diagram of ruptured identities](image)

**Figure 10: Ruptured Identities**

Instead of the laminated nursing identity, I have characterised the nurse as a caring professional who brings selected aspects of her personal and illness experiences to her work and is therefore able to integrate the caring and mastery aspects of nursing into one feature. Simultaneously, the tangata whaiora moves from a laminated identity of an ill person seeking wellness into self-determination as a person who experiences illness. In this illustration the whole person moves freely between aspects of her identities, integrating these with each other and with the wider
context of the nursing environment. The techniques for negotiating this change comprise the strategies for nurses seeking wellness.

**Strategising wellness**

The tangata whaiora identity contains the momentum for strategising wellness as it reflects the search for ways to reduce distress, achieve comfort and prevent future occurrences of mental illness. In their stories the nurses record their individual techniques and approaches to their pursuit of wellness. In addition to personal therapy and psychiatric treatment, which was discussed above, these include changing workplaces, taking sick leave, leaving the workforce, taking legal action to contest bullying, the use of Employee Assistance Programmes and clinical supervision.

There is a paucity of evidence surrounding many of the nurses’ individual strategies, for example the effectiveness of legal action in challenging bullying behaviour. Anne and Elizabeth both report doing this and experiencing feelings of relief and pride in their actions. Although they won settlements, their actions meant that they were unable to remain in their jobs and feel settled there. Similarly, there is no available research to indicate whether nurses who leave the workforce for reasons related to mental illness recover and experience reduced stress in subsequent jobs.

Suggestions and strategies for individual mental wellness are readily available in the academic and popular press. These include resilience, self-awareness, healthy behaviours and personal support networks (McGee, 2006). Healthy behaviours include eating regularly, exercising, and getting adequate sleep (Albee, 1998; Montgomery & Haynes, 2001; J. Murray & Jenkins, 1998; Rochford, 2004; Winwood & Lushington, 2006).

indiscriminately encourage people to adopt flexible working hours and engage in healthy stress reducing activities when not at work. Little attention is given to the context of the original target group, who were white collar professionals who have agency over their work environments and a measure of financial security (Caproni, 1997:2004; Doherty, 2004). When applied to dissimilar work groups such as nurses, who often have little flexibility in their working hours and are not usually highly paid, this approach is unlikely to provide a solution and may act to locate the problem of stress and burnout with the individual employee, thereby absolving the organisation of any responsibility (Hutchinson, Vickers, Jackson, & Wilkes, 2006; Vickers, 2002, 2003).

The collective story of seeking wellness, in the Tangata Whaiora motif, highlights three overall areas which, if addressed, would enable nurses to negotiate the nurse-tangata whaiora hyphen and rupture their laminated identities. These are the introduction to nursing through undergraduate education and early socialisation, the workplace environment, and self care and clinical practice. The hyphens that were revisited above are aligned in partial and plural ways with one or more of these three areas.

The introduction to nursing

Literature about the stressors in undergraduate education and early clinical practice is consistent with the findings in this research. Specifically, such literature confirms the presence of contradictory messages about the importance of clinical skills and theoretical knowledge (Astin et al., 2005; Landers, 2000; Papps, 1997; C. Stevenson, 2005b), and individual or collective values (Bjorkstrom et al., 2006; Fahrenwald et al., 2005). Contemporary undergraduate education programmes for nurses have an overt focus on technical expertise and critical thinking, while also advancing covert content that positions the student as the conforming receptacle of societal values and the nursing image (Bankert & Kozel, 2005; Freshwater & Stickley, 2004). Further, the findings from this research and the literature assert the confusion and distress caused
by the laminated nursing identity (DeVries et al., 1995; Hamilton, 1986) and the use of bullying as a colonising technique (Meissner, 1986; S. J. Roberts, 1983; Waldow, 1992).

Undergraduate education plays a pivotal part in strategising wellness for future nurses and the nursing profession. Dawn Freshwater and Theodore Stickley (2004) theorise that emotional competence is the missing feature from the current pedagogy that privileges abstract knowledge and practical skill. Freshwater (1998; 2000) proposes the adoption of a nursing curriculum that supports and examines the emotional lives of nurses. Termed ‘transformatory education’, the inclusion of emotion in nursing curricula addresses tensions between inner and outer dialogues, and the spoken and unspoken culture of nursing. Based on her doctoral research into a group of 42 nursing students engaged in a transformatory learning programme, Freshwater suggests that transformatory education requires high levels of reflective practice and self awareness which are best achieved through mentoring, the arts (poetry, drama and music), and clinical supervision. She asserts that such education facilitates and maintains change because nurses are taught how to translate their creative and ethical ideals into the practice arena, and the ability to resist, defend and advocate is built into nursing education.

Freshwater and Stickley (2004, p.96) suggest the following components of a transformatory curriculum: “reflective learning experiences, supportive supervision and mentorship, modelling, opportunities for working creatively with the arts and humanities, focus on developing self and dialogic relationships, developing empathy, and a commitment to emotional competency.” Many educators would argue that these are already elements of contemporary nursing education, however Freshwater and Stickley assert that they are poorly applied as addenda to the existing curricula and therefore add confusion and widen the theory-practice gap rather than enabling students to develop empathetic and reflexive practice.

Personal resilience is another feature of transformatory education, and can be developed through skills related to self awareness, assertiveness, creative thinking and conflict management during
undergraduate education and ongoing professional education (Freshwater, 1998, 2000). The self-awareness engendered by such education is also an important issue in the early recognition of chronic stress and mental illness (Eckroth-Bucher, 2001; H. Edwards & Chapman, 2004; Wamsley, 1995). Techniques of active recovery from the physiological effects of high and chronic stress levels include relaxation, exercise and social contact (McEwen, 1998, 2003a, 2003b, 2005). Teaching these as a part of a transformatory curriculum would address nurses’ laminated reluctance to engage in accepting the need to be the focus of care, whether by the self or by others. This is particularly important for nurses who come to their undergraduate education vulnerable to the development or exacerbation of mental illness.

A further application of transformatory education is in postgraduate nursing programmes. Such an approach would not only have positive benefits for the practice of experienced nurses, but would also assist in the creation of clinical mentorship and a supportive clinical environment for student and new graduate nurses to engage with.

Of particular interest for the applicability of transformatory education to this research, is the extent to which the process makes burdensome emotional demands on nursing students and new nurses. Emotional work has been identified in this research and in the literature as a stressful aspect of nursing work, and is associated with the laminated nursing features of indefatigability and selflessness (Hochschild, 2003). Although Freshwater (2000) advocates for the inclusion of transformatory and emancipatory learning, she also notes that educators may not be emotionally equipped for this kind of teaching. Furthermore, she suggests that the introduction of such curricula is likely to increase the levels of tension and violence for nurses in the early phases, as the students challenge their teachers and the content of the teaching. In this context, the first cohorts of nurses to be exposed to transformatory education are likely to be more vulnerable than any other as they may be simultaneously bullied, oppressed, colonised and expected to make deep emotional connections in order to complete their programme. Although the implementation
of transformatory education is partially aimed at rupturing the laminated nursing identity, in the first instance the nurses involved will not have incorporated their need for self-awareness and self-care into their practice as teachers or students. It is clear that any change to New Zealand curricula needs to be carefully planned to cause the least distress to both students and educators. The most effective and least distressing point of entry into established educational processes seems likely to be the introduction of nursing educators to the concept of transformatory education, followed by mentorship through a period of increasing knowledge, personal adaptation and change management. This process draws on notions of conscientisation and clinical supervision, which are discussed below.

There are other difficulties in effecting change in the education sector. Educational institutions and educators have been identified by this research and the literature as agents of oppression and bullies, so resistance to encouraging high levels of self-awareness and reflexivity in students is to be expected (Anthony, 2004; Bjorkstrom et al., 2006; Freire, 1971; Higginson, 2004; MacIntosh, 2002; Meissner, 1986; Norman, Buerhaus, Donelan, McCloskey, & Dittus, 2005; Papps, 1997; S. J. Roberts, 1983; Waldow, 1992). In explanation, Freshwater and Stickley (2004) assert that nurse teachers frequently work in uncaring environments and are “highly stressed, often underpaid and disillusioned” (p.96) and so are likely to be experiencing parallel processes with their clinical counterparts and students. It is unrealistic to expect unconsciously or deliberately oppressive educators to initiate change that will, in the short term at least, make their workplace more challenging. While changes to education delivery are necessary to grow a generation of nurses who are actively resistant to damaging inconsistencies and colonising behaviour, simultaneous change needs to occur in the education and clinical environments. Again, this raises workplace and professional issues that are discussed below.

The change to a transformatory nursing curriculum for undergraduate and postgraduate education has emerged from this research as a strongly indicated recommendation.
Transformatory education enables negotiation between caring and mastery through its emphasis on emotional competence, and ruptures the lamination of the indefatigable, selfless nurse by providing an image of nurses as whole people who are working at nursing rather than who are innately caring nurses. Although Freshwater’s (1998) research asserts that such problems are successfully addressed by the move to a transformatory curriculum, the New Zealand context needs to be considered when planning the change.

A recommendation that is not well linked to evidence, and is therefore only suggested, relates to the accreditation of education programmes and the opportunity this provides to establish the move to transformatory education. The New Zealand Nursing Council has the mandate to ensure that nurses are competent and safe to practise (New Zealand Government, 2003; Nursing Council of New Zealand, 2001, 2005, 2006b). This includes evaluating and approving educational programmes. At the national level, Nursing Council should be taking a broad view of education programmes that includes new nurses’ ability to practise effectively in their chosen area. This would require that the assessment of educational programmes include data about the employment and progress of new graduates in their first year of practice. Reports of bullying in education or clinical placements, lack of confidence in practise, high attrition rates, slow progress towards achieving a competent level of practice and poor local employment rates are all areas that are worthy of Nursing Council attention and may indicate problems with undergraduate education.

A further area of concern for new nurses is the socialisation process. In earlier chapters I have aligned this with notions of colonisation, and have discussed horizontal violence, silencing and other bullying as features of socialisation. Transformatory education again offers a strategy for minimising distressing socialisation practices as it empowers new nurses with an internal sense of personal value and a means of critically evaluating the processes to which they are exposed (Freshwater, 2000). It also offers practical training in conflict management and advocacy.
Moving postgraduate education to a transformatory curriculum, as well as the career progression of new nurses into experienced nurses and managers will enable emotional competence to filter into the clinical settings within a relatively short period of time. Additional strategies for addressing workplace violence are addressed in the forthcoming sub-section on the workplace environment.

**The workplace environment**

Mental distress is associated with economic indicators such as increased sick leave, high staff turnover and recruitment difficulties (Conti & Burton, 1994; C. J. Murray & Lopez, 1996; A. Needham, 2003). Distress in nurses is also associated with a reduction in the quality of patient care (Hemingway & Smith, 1999; Rassin, Kanti, & Silner, 2005; Wamsley, 1995). The development of processes that aim to reduce the distress caused by bullying, thoughtfully manage mentally ill nurses and assist them to reintegrate into the workforce, and provide support for nurses to manage their own stress would therefore be beneficial both financially and for quality assurance purposes.

The literature suggests that strategies to reduce nurses’ stress include: educating nurses in self awareness, relaxation, stress and grief management, organisational attention to team building, increasing autonomy and managerial feedback on performance, flexibility in work hours, and increasing nurses’ input into health policy and service delivery (Chang et al., 2005; D. Edwards & Burnard, 2003; Forsyth & McKenzie, 2006; Landsbergis et al., 1998; Laschinger, Finegan, & Shamian, 2001). Increasing an employee’s sense of personal power reduces perceived risk and feelings of exhaustion (Maslach & Leiter, 1997), and can be achieved by increasing the employee’s sense of control over routines and rosters. This is more likely to succeed where the environment is supportive, so is not indicated as a first step towards a healthy workplace. The negotiation inherent in sharing control among a team creates the ideal environment for increased bullying behaviour (Lewis, 2006a).
This research adds the nurse-patient relationship to the context of the workplace environment. A strategy the nurses in this research have identified for reducing distress is to move to a nursing setting where the relationship between the nurse and the patient is openly valued as an important part of practise. When viewed through the lens of the caring-mastery hyphen, this enables the nurse to focus more on caring, particularly as the environments she has moved to are less technically complex. This also implies that the nurse may receive more feedback from the patient and family about her caring, which would reinforce the laminated nursing identity in a positive and affirming way. For these nurses, a workplace environment that does not challenge their identity reduces the need for negotiating the caring-mastery hyphen and enables them to focus on their wellness.

Aspects of building a supportive workplace environment would also include challenging the presence of bullying and silencing, the reintegration back to the workplace after episodes of illness, and making available organisational support for wellness.

**Creating a supportive workplace: challenging bullying behaviour**

There is a great deal of opinion-based literature in nursing journals that exhorts nurses to confront bullies, talk the issue through with them, engage in self care activities such as counselling, and refuse to be a target (Anonymous, 1999, 2000; G. Davies, 2006; Pereira, 2001; Rowell, 2005; Thomas, 2003, 2004). Research suggests that the most effective response to bullying is achieved when a definition of exactly what constitutes bullying behaviour is developed, policies are clearly written and consistently enforced, and managers are trained to recognise and deal with bullying among their staff (Ironside & Seifert, 2003; Lewis, 2006a; Maslach, 2001; Randle, 2003; Stevens, 2002; Vickers, 2002; Zapf et al., 2003).

Vickers (2003) problematises the above approaches when she challenges the assumption that organisations are neutral and consistent. She asserts that most significant events and processes within organisations are fluid, fractal or ambiguous, and that the organisational approach to this
uncertainty is to “write a policy; work towards a practical solution; enhance communication; and provide avenues for conciliation between parties with conflicting interests” (p.96). These approaches, she argues, will not succeed because of the unrecognised dynamics in the organisation. Vickers’ approach to understanding bullying is similar to Lewis’s (2006a; 2006b) assertion that much of nursing is negotiated territory, and that the negotiation occurs within an organisation that does not discern its ambiguous nature. This is consistent with the finding in this research that bullying often occurs in the nurse-tangata whaiora hyphen. These frames of understanding emphasise the difference in the needs of the bullied individual and the response of the organisation. It also explains how organisational processes can be co-opted by bullies and used to perpetrate ongoing abuse against nurses (Herr, 2005; Hutchinson et al., 2005, 2006). As Ramos (2006) notes, the current mode of healthcare management is by clinical governance, a requirement of which is that any issues will firstly be discussed among the protagonists. This expectation is not unreasonable in instances where conflict occurs as a result of stress, lack of knowledge or personality clashes, but where the issue is one of bullying it is more likely to cause added distress for the target and result in reduced reporting of issues pertaining to bullying behaviour. While the development of clear definitions and processes for addressing bullying are needed from an organisational perspective, it is clear that such processes are unlikely to be effective in isolation.

Roberts (2000) proposes a framework for changing oppressive group behaviours such as bullying and intra-group hatred that begins with awareness of oppression and the development of a positive professional identity. The process of becoming consciously aware of oppressive history, culture and behaviour is termed ‘conscientisation’ (Freire, 1971; Freshwater, 2000; Waldow, 1992), wherein education is proposed as the means to develop a conscious, reflective understanding of oppression and its impact. The challenge in this practice, though, is to move through the process of awareness into what Roberts (2000) frames as a synthesis of a positive new image. In the synthesis stage, energy is focused on strategic change rather than anger about
previous hurts. Roberts proposes that as a result of successfully synthesising a new image, nurses’ attention will turn to issues of social justice and advocacy for patient populations.

Strategies for achieving this move are poorly researched, although transformatory education (discussed above) and clinical supervision (discussed below) are indicated through diverse research projects that have focused on other areas of nurses’ wellbeing and development (Anthony, 2004; Gyllensten & Palmer, 2005; McKenna et al., 2003). A commonality of the research into nurse bullying, oppression, and horizontal violence reflects the need for “radical social structural changes” (Randle, 2003, p.400) in order for a change in nursing behaviour to take place.

A strongly indicated recommendation from this research is that a programme of conscientisation be initiated for New Zealand nurses, to begin the process of radical social change that is required for nurses to reduce the impact of workplace bullying. The infrastructure for such a programme can be found in the one that was put in place to address nurses’ cultural safety during the 1990s. In the cultural safety programme, the first phase is to develop an awareness of one’s own culture, beliefs, behaviours and attitudes towards other cultures (Papps & Ramsden, 1996; Ramsden, 2001; Ramsden & Spoonley, 1993). Features of this phase include providing trained and experienced facilitators, a safe environment to explore personal experiences and a clear framework for advancing nurses’ awareness through the subsequent phases of defensiveness, guilt and anger to engagement in culturally competent practice.

A conscientisation programme would also prepare nurses for the introduction of transformatory education, although the strength of the laminated and colonised nursing identity suggests that the proposed programme would engender considerable resistance among some nurses, medical professionals and healthcare managers.
Mentally ill nurses in clinical practice: recovery and reintegration

There are no national or international guidelines for healthcare managers about how to handle the issue of nurses who are significantly distressed, but who still have the ability or potential ability to remain in the workforce. Some information is available about how to manage impairment (Blair, 2002; Darbro, 2005; Grover & Floyd, 1998; G. B. Smith & Hukill, 1996; Swenson & Foster, 1993), but little of this relates to mental illness or how to recognise mental impairment. This may be partially a result of the inherent conflict of interest for managers because the acknowledgement of distress and bullying in their employees does not reflect well on the image of effective management (Herr, 2005).

This research has found that people who have experienced mental illness are often stigmatised and othered through the notion that mental illness and a career as a healthcare professional are mutually exclusive. Almost all of the literature about people with a mental illness returning to the workforce refers to a supported work environment involving little or no responsibility (Dorio, 2004; Marion et al., 2004; Ridgway, 2001). Terry Krupa and colleagues (2004; Krupa et al., 2005) dispute the effectiveness of low level responsibilities for assisting people to regain their autonomy following a mental illness. They assert that the underpinning rationale for restricting the possibilities for employment to non-stressful environments is that people who have had a mental illness are vulnerable to a resurgence of their symptoms. However Krupa asserts that the lack of a genuinely vocational focus for mental health rehabilitation services is grounded in stigma, and fails to recognise that supported and entry level jobs are stressful for individuals who are capable of working at a more complex and responsible level. She found that integrating recovery from mental illness into everyday life was most effectively achieved through retaining or regaining important social roles such as are provided through work. The result of integrating the work role and the illness role tended to produce an identity of a “regular
worker with an illness” (Krupa 2004, p.13) which assists the person to resist the label of 'patient.'

The recovery approach to mental illness, as discussed in Chapter Five, denotes a belief that people can recover from mental illness (Mental Health Commission, 1998). Patricia Deegan (1994) notes that mental illness is often accompanied by a sense of being separate, and that recovery can reconnect people to each other, as it acknowledges that we are all “struggling and wounded” (p. 160). Recovery differs from rehabilitation in that recovery involves discovering the potential for a person to live a full life on their own terms, while the focus of rehabilitation is to attempt to regain what has been lost through mental illness (Barker, 2003; Barker & Buchanan-Barker, 2004; Deegan, 1994, 1996; Krupa, 2004; Lapsley et al., 2002; Mental Health Commission, 1998; Ridgway, 2001).

Recovery does not preclude rehabilitation, however. For the nurses in this research, wellness includes returning to work, whether in nursing or another workplace. This is an area that is not addressed in the nursing literature, but is clearly an aspect of recovery that would benefit from further research as it would have significance for managers and nurses who have experienced mental illness and wish to remain in the nursing workforce.

A recommendation that is strongly indicated by this research is that a national guideline be established for the benefit of nurse managers and the nurses who become significantly distressed. This guideline needs to make clear the difference between distressed nurses and impaired practice, but needs to provide consistent information about supporting and managing both. Findings from this research also indicate the additional distress caused by nurses accessing expensive and/or geographically distant private treatment because of inadequate local and subsidised care, which is a further area for the national guideline to consider.

Further strongly indicated recommendations relate to improving the extant national process of identifying and managing nurses who are impaired as a result of mental illness. As a part of
ensuring safe practice for the community, the Nursing Council assesses and monitors nurses who have a mental illness. In the first instance, Question 10 of the Application for a Practising Certificate currently reads “Do you have a mental or physical condition that means that you are unable to perform the functions required for the practice of nursing?” (Nursing Council of New Zealand, 2006a, p.2). This question is ambiguous, and should be changed to “Have you, during the last 12 months, had a mental condition that means that you were unable to perform the functions required for the practice of nursing?” This change would enable information about overall function to be captured and assessed for all nurses. The nurses in this research identified a tension between the apparent momentary nature of the question (it appears to relate only to the moment they are completing the application) and their concern for the validity of their practising certificate.

A second concern that emerged from this research is the perception of the role and nature of the Nursing Council as a punitive, authoritarian body that is focused on the removal of impaired nurses from the nursing group. Anecdotal evidence from nurses who have been involved in a Nursing Council assessment and monitoring programme, and also those nurses who act on behalf of the Nursing Council, suggests that the processes are supportive and that supporting the nurse to maintain her registration is a focus. This misconception is, in part, a result of the lack of transparency and predictability in the processes of reporting a colleague or oneself as impaired and is able to be remedied by the provision of additional information to nurses on the Nursing Council website and in newsletters. This research suggests that the lack of information about the purpose and processes around potential or actual impairment has an impact on nurses’ willingness to disclose mental illness in themselves or their colleagues. Furthermore, it creates additional distress for nurses.

The monitoring of nurses who are impaired or who may become impaired requires an impartial and individual approach that is palpably independent from the disciplinary processes that are
associated with incompetent or disreputable practice. This will further reduce the distress and fear that is presently associated with nurses’ involvement with the Nursing Council. My recommendation for achieving this is to establish a national group with representation from clinical practice, education, nurses who have experience of mental illness, nurse managers and human resource consultants. The functions of the proposed group would include individual monitoring in collaboration with the monitored nurses and their supporters, monitoring and support for organisations that employ nurses, and the development of national guidelines, as discussed above. This has also been proposed as a key recommendation in a discussion document to the Ministry of Health, although the focus of that document was specific to mental health nursing (Hughes & Hamer, 2004).

A further role for the proposed group would be to establish national visibility for the issues relating to the development or exacerbation of mental illness in nurses. This would be achieved through education, lobbying and advising at national and regional levels. Through these processes, the proposed group would be able to foster the move to a transformatory curriculum and a conscientisation programme as means to improve nurses’ mental health.

An aspect of managing the impact of mental illness on nurses’ careers that emerged from my research dissemination is the use of advance directives. Anecdotal evidence suggests that frequently nurse managers and human resource consultants advise nurses with a known mental illness to write an advance directive about the processes that should be put in place if they become unable to advocate for themselves. An advance directive is a legal instrument similar in nature to a living will, which directs the healthcare team about preferred and prohibited treatments for the consumer (Amering, Stastny, & Hopper, 2005a; Elbogen et al., 2006; Srebnik et al., 2005; Swanson, Swartz, Ferron, Elbogen, & van Dorn, 2006; Varma & Goldman, 2005; Zinkler, 2005). They are more common in general medicine, particularly in end-of-life areas, than they are in psychiatry, which is largely because of the ethical and legal complexities of
establishing mental competence (Appelbaum, 2005; Atkinson, Garner, & Gilmour, 2004; Atkinson, Garner, Stuart, & Patrick, 2003; Backlar, 2004; Saks, 2004; Wareham, McCallin, & Diesfeld, 2005), but also because legislation such as the Mental Health Act (New Zealand Government, 1992) may over-ride such documents. The extant literature about advance directives in psychiatry tends to focus on their use as a preventative measure against involuntary treatments such as inpatient care and electroconvulsive therapy, and the attendant disquiet of psychiatrists. There is, however, a growing body of literature advocating for viewing the advance directive as a tool for empowerment and maximising a person’s autonomy (Amering, Stastny, & Hopper, 2005b; Schouten, 2006; Srebnik, 2004; Swanson, Swartz, Elbogen, & Van Dorn, 2006). There is no available literature that discusses this specifically for nurses, or other professionals for that matter, to use to maintain their workplace safety and support. This is a strategy that has the potential to assist both the distressed nurses and their managers, so is included in the list of suggested recommendations to emerge from this research.

**Employee Assistance Programmes (EAP)**

EAP is defined as a model of confidential counselling that is provided by the employer and focuses on work-related problems (Arthur, 2000, 2002, 2005; Clarke & Cooper, 2000; Cuthell, 2004; Kirk & Brown, 2003). The literature suggests that EAP was initially developed in response to alcohol and other drug use that impacted on the workplace, but that it has expanded into more general areas of employee distress. It is generally poorly defined and its efficacy in dollar terms for the employer is unproven.

Stress, particularly work-related stress, is rarely simple as there is an intermingling of personal, societal and occupational stressors, and environmental and experiential issues for both the employee and the organisation. In a report of two UK studies into workplace counselling schemes, Arthur (2005) found that in addition to occupational stress, mental health issues may exist independently or concurrently for the employee and need to be recognised as being
different from stress and requiring different treatment. He reports that the majority of staff members who used EAP had “longer lasting, moderate to severe [mental health] problems” which most of the employees believed to be personal, but that affected their performance at work (Arthur, 2005, p.277). The use of EAP is further complicated by delays in access, as employees often resist admitting a problem for fear of repercussions. Consequently EAP is usually initiated only after a problem has grown into a crisis and has been noticed by either the employer or occupational health advisors (Cuthell, 2004).

The experience of EAP for the nurses in this research is consistent with the literature. The nurses who used it did not find it personally useful, although there were second-hand, anecdotal reports of its helpfulness in recognising the sources of distress and strategising their management for some of their nursing colleagues. The nurses who reported a concurrent mental illness did not attempt to access EAP as a means of managing their illness.

Further to doubts about its efficacy and cost effectiveness, the focus and impact of EAP is problematic (Clarke & Cooper, 2000; Highley-Marchington & Cooper, 1998). EAP may be effective as a risk management measure for short term, individual, low level occupational stress and is often motivated by an employer’s desire to demonstrate that they care about the employees in times of high organisational stress. However, Clarke and Cooper note that it is a less expensive option for employers than organisational development solutions, and suggest that the purpose of EAP for the employer may be to shift the site of organisational stress to the individual rather than the organisation. This is an act that is discussed above as symbolic violence (Herr, 2005) and/or organisational bullying (Hutchinson et al., 2005; Lewis, 2004), and is aligned with similar notions of pathologising the victim that are raised in the critique of ‘burnout’ (Altun, 2002; Maslach & Leiter, 1997; Paine, 1982). In assessing overall efficacy and the cost benefit to supplying EAP for employees, Arthur (2000; 2002), and Kirk and Brown (2003) note that although employees and counsellors generally report a reduction in the
employees’ distressing symptoms and overall satisfaction with the EAP service, this is not maintained long term and does not translate into organisational change.

The evidence from this research and the literature regarding the lack of efficacy of EAP, and its potential alliance with organisational bullying and silencing has eliminated it as a recommendation arising from this research. Subsequent changes to its delivery as a result of the above research may render it more appropriate in the future.

Other strategies for reducing and managing distress for nurses include individual stress management and the use of clinical supervision. Although it is an organisational and managerial role to enable these processes to be adopted by nurses, their acceptance and utilisation is also the responsibility of the individual nurse. As such, they are addressed in the self-care sub-section of this chapter.

**Self care and clinical practice**

Stress has been characterised in this research as a complex, multidimensional phenomenon. No research purports to understand and ‘cure’ stress, but in aiming to reduce aspects of stress, extant research takes several perspectives. As discussed above, studies have linked a supportive social environment to reduced stress levels in nurses (Caldwell, Gill, Fitzgerald, Sclafani, & Grandison, 2006; D. Edwards et al., 2001; Kilfedder, Power, & Wells, 2001; Y. Reid et al., 1999), asserting the importance of collegial support in reducing the long term impact of stress. This research is consistent with the literature, finding that the nurses discussed the stress of nursing work in the context of abusive and unsupportive environments, but did not discuss it when they were describing settings where they felt valued and supported. Literature about the contestable notions of burnout and resilience reinforces this association (Caldwell et al., 2006; Glass et al., 1993; Hodgkins et al., 2005; Jenkins & Elliott, 2004; Leiter et al., 2001; Maslach, 1982, 2001; Maslach & Jackson, 1981; Maslach & Leiter, 1997; Paine, 1982).
Other researchers support the development of individual coping strategies that centre around how to emotionally accept increasingly stressful working conditions, rather than managing and problem solving to reduce the circumstances that provoke stress responses (Cohen-Katz et al., 2005; Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2004; Dewe, 1993; D. Edwards & Burnard, 2003; Shirey, 2006). Strategies such as mindfulness, grief management and relaxation are suggested, but lack convincing evidence as to their efficacy in helping nurses to accept their stress and avoid experiencing distress and mental illness.

In research from Singapore, Kam Weng Boey (1999) surveyed over 1,000 nurses to examine their adaptation to stress. Boey found that self esteem and stress levels are positively linked, and that nursing requires a high level of clinical competence which, when achieved, lends itself to positive self esteem. He asserts that training in clinical competence which is directly associated with the nurse’s area of practice mediates stress reactions in nurses more effectively than cognitive therapies. Therefore, enhanced clinical ability leads to more stress resistant nurses. As a result of this finding, Boey suggests that practice based training that leads to an increase in competence is an effective strategy for reducing stress in nurses, with training in cognitive coping skills employed as a protective mechanism rather than a preventative one. This aligns with the finding in this research of the distress found at the caring-mastery hyphen, and suggests that if nurses felt more competent in the practical application of their practice they would experience less tension in the hyphen.

A difficulty with this premise that Boey does not discuss is whether the focus on clinical competence results in less caring practice. If this is the case, then tension would continue to surface as nurses experience the shame and guilt associated with not achieving the caring standards set in the laminated nursing identity. Nonetheless, supporting nurses’ self-esteem by ensuring that they are offered practical, competence-based training in their practice area is a recommendation that is consistent with the findings of this research. Outcomes to be measured
from such training would need to include the effect on all areas of practice and self-esteem, not merely competence at performing tasks.

**Clinical supervision**

In a recent document, mental health nurse leaders in New Zealand changed the terminology relating to clinical supervision in New Zealand to reflect that supervision activity in a nurse’s work includes more than clinical work (personal communication, Helen Hamer, 26 January 2007). Referred to as ‘professional supervision,’ it has recently been defined as “a formal process that provides professional support to enable practitioners to develop their knowledge and competence, be responsible for their own practice, and promote service users’ health outcomes and safety” (Expert Reference Group to the Deputy Director-General; Mental Health, 2006, p.22). In her story, Gemini refers to professional supervision but I have maintained the traditional terminology because the change is not in line with the literature. The definition proffered by the Expert Reference Group notably excludes the notion of clinical supervision as a means of enhancing and protecting nurses’ mental health, an exclusion that is also not aligned with much of the extant literature.

In a large multi-site study from England and Scotland, researchers found a clear association between increased job satisfaction and individual clinical supervision that lasted up to an hour and took place monthly or bimonthly (Butterworth et al., 1997). The preferred model for clinical supervision to emerge from that study was Proctor’s three function interactive model which includes managerial, educative and pastoral components (Proctor, 1986). In other literature the managerial function is viewed as problematic as it tends to deter nurses from engaging with supervision and portrays it as a mechanism of organisational control (Butterworth, 1992; Cutliffe & Proctor, 1998a, 1998b; C. Stevenson, 2005a). In this literature the managerial aspect of clinical supervision is redefined as engaging the nurse with the idea of accountability for
practising within policy and professional standards and for enhancing clinical practice, rather than as hierarchical and punitive.

Most of the nursing literature focuses on the use of individual, supervisee selected clinical supervision that aims to enhance clinical practice, but there is evidence that nurses who receive clinical supervision also have more personal confidence, job satisfaction and wellbeing, and experience decreased stress and burnout (Begat & Severinsson, 2006; Berg & Hallberg, 1999; Cutliffe & Proctor, 1998a, 1998b; D. Edwards et al., 2006). Clinical supervision has also been found to support nurses develop self-awareness, personal resilience, conflict resolution skills and integrated practice-theory knowledge (Meyer, 2007; Severinsson & Kamaker, 1999). The latter point clearly associates aspects of clinical supervision with assisting nurses to negotiate the caring-mastery hyphen. Moreover, the above literature suggests that clinical supervision is effective in assisting nurses to recognise and manage their own distress, and is therefore a potential mechanism for facilitating negotiations at the nurse-tangata whaiora hyphens. Meyer (2007) asserts that a narrative form of supervision with a focus on a restorative function will support nurses to maintain their well-being and to handle stress and distress effectively.

The literature about clinical supervision reveals significant differences in the process of choosing a supervisor, engaging in the relationship, the aims of clinical supervision and organisational expectations. The more effective clinical supervision relationships emerge from the recognition that the processes and outcomes are highly individual and should be adapted to suit the nurse and supervisor, the practice setting and the organisation (Cleary & Freeman, 2006; Cutliffe, 2005; Cutliffe & Proctor, 1998a; A. Jones, 2006; Rolfe & Gardner, 2006; C. Stevenson, 2005a; C. Stevenson & Jackson, 2000). In addition to these factors, the nurse and supervisor need to have an awareness of any specific outcomes that are desired from the supervision relationship. Findings from this research suggest that a vulnerability to mental illness may create a need for deeper exploration of personal motivations to care and the tensions that arise from these. This is
an appropriate use of the supervision process as it enhances effective practice and nurse-patient safety. Clinical supervision for nurses is a strongly indicated recommendation that emerged from this research, but carries with it some important provisos.

The evidence about professional supervision is not unequivocal. There is further literature that casts doubt on its efficacy (Hyrkas, Appelqvist-Schmidlechner, & Haataja, 2006; Hyrkas, Koivula, & Paunomon, 1999; A. Jones, 2006; Sirola-Karvinen & Hyrkas, 2006; Williamson & Dodds, 1999). The quality of the supervision experience is dependent upon the ability and characteristics of the supervisor, the availability of organisational resources to support supervision and the level of emotional exhaustion and job satisfaction of the supervisee (Berggren & Severinsson, 2006; Hyrkas et al., 2006; A. Jones, 2006). Thus, clinical supervision may not be the most effective mechanism for a mentally ill nurse when she is in crisis or particularly distressed. A further consideration to emerge from this research is the extent to which clinical supervision is aligned with organisational needs. If the organisation has a part in defining the desirable outcomes for supervisory relationships according to anything other than safe practice and the supervisee’s concept of wellbeing, then clinical supervision can become another form of organisational bullying.

Individually designed clinical supervision, where the supervisor is chosen by the supervisee and they decide together on the form and focus of the sessions is an emancipatory process as the nurse has the opportunity for supported reflection that can result in profound changes in understanding and practise (Heath & Freshwater, 2000; C. Stevenson, 2005a; C. Stevenson & Jackson, 2000). A cautionary note here is that where clinical supervision is emancipatory managers may actively resist it by, for example, refusing to view it as a part of nursing work and insisting that nurses undertake it in their own time (E. White & Winstanley, 2006). For clinical supervision to be effective in aiding with the reduction of nurses’ distress, the practice needs to
be enabled and enforced from a policy level as an integral part of nursing work (Begat & Severinsson, 2006; Berg & Hallberg, 1999; C. Stevenson, 2005a).

In their financial model of data from several empirical studies in mental health settings across Australia, researchers Edward White and Julie Winstanley suggest that the cost to an organisation of providing in-house clinical supervision to nurses is approximately 1% of an annual nursing salary (E. White & Winstanley, 2006). They assert that, as clinical supervision has a demonstrable effect on staff wellness, the cost of implementing clinical supervision is far outweighed by the benefits of a happier and more effective long term workforce and is recoverable from the costs saved from the recruitment budget. They caution, however, that this apparently sensible expenditure is resisted by managers who wish to preserve the status quo and avoid the challenge of an emancipated workforce.

Although there is sufficient evidence from the literature to support seven strongly indicated recommendations from this research, most of these have not previously been implemented in a meaningful way in the international nursing context. The implications of this lack of application are clearly reflected as stories of nursing distress proliferate in the literature and nurses continue to plan to leave the profession (Cobden-Grainge & Walker, 2002; Finlayson, Aiken, & Nakarada-Kordic, 2007; Gower & Finlayson, 2002, September 19-20; G. McCarthy et al., 2007; O’Brien-Pallas, Duffield, & Hayes, 2006). Further implications are seen in the literature which shows that nurses who are distressed and who choose to remain silent about their distress are also likely to leave nursing (Buresh & Gordon, 2000; Copnell & Bruni, 2006; Martin, 1998; Mitchell & Ferguson-Pare, 2002; Peter, Lunardi, & Macfarlane, 2004). The recommendations that follow share the common theme of radical social change for nurses, with the aim of reducing the distress that is associated with the nursing image and nursing work. Attendant with the social change for nurses is the acceptance of the personhood of nurses, including their own needs and vulnerabilities.
Recommendations

The nurses’ stories and the literature have indicated strategies for wellness at two levels. The first level is strongly associated with this research and other research findings. I have categorised these recommendations as ‘strongly indicated.’ The second level is associated with this research, but requires further research to confirm its efficacy. This category of recommendations is ‘suggested.’

Strongly indicated

1. New Zealand nursing’s professional organisations should collaborate to develop a national independent national group, comprised of nurses from clinical practice, educators, nurses who have experience of mental illness, nurse managers and human resource consultants. This group would support and monitor nurses who have experience of mental illness and their employers. It would also develop national guidelines for the recognition, support and management of such nurses, the reintegration of nurses into the workforce, and to lobby for changes to reduce nurses’ distress at a national level. This group would be well placed to implement and evaluate the conscientisation programme and the move to a transformatory education curriculum.

2. The Nursing Council and nurse educators should adapt the content and delivery of undergraduate and postgraduate education programmes to align with the concept of transformatory education. An implementation plan should be carefully formulated and evaluated by the proposed national group (see above) to avoid increasing the distress of educators and students.

3. The proposed national group should formulate, manage and monitor a conscientisation programme for nurses to enhance recognition of oppressed group behaviours and
resistance to perpetrating and tolerating bullying. This programme needs to encompass ongoing support and education to help nurses move through anger and hurt into synthesising a new image into the nursing culture.

4. The Nursing Council needs to alter Question 10 of the Application for a Practising Certificate to read, “Have you, during the last 12 months, had a mental condition that means that you were unable to perform the functions required for the practice of nursing?”

5. The Nursing Council should provide information for nurses about the processes that are followed in the event of disclosing or reporting potential impairment related to mental illness. Within this information the underpinning support for the retention of practising certificates for these nurses should be reinforced.

6. Employers should offer practice based training for meeting the competencies required for specific healthcare settings. Evaluations of such training should consider the impact on how nurses perceive their practise in addition to evaluating task-related competence.

7. The Nursing Council should establish emancipatory clinical supervision as an integral aspect of nursing work and ensure that nurses attend. Employers of nurses should be required to provide the means for nurses to choose their in-house clinical supervisor and schedule supervision sessions within work hours. Effective clinical supervision has the potential to align with the establishment of transformatory education and conscientisation training.

**Suggested**

- The Nursing Council of New Zealand should broaden their criteria for evaluating undergraduate nursing programmes to include the experiences and progress of new graduate nurses in their first year of practise.
Employers and healthcare professionals should encourage nurses who are vulnerable to mental illness to write an advance directive and make it available to the employer in the event that the nurse becomes unable to advocate for herself.

This concludes an examination of the research and the literature to discover and evaluate potential strategies to reduce the distress experienced by nurses as a result of the nursing image and nursing work.

In the final chapter, the research is summarised and synthesised into a visually explanatory model.
Ellie’s story

I started my general training in 1979. I was very young, but I excelled at the course and did very well. I graduated in 1982, and nursed until 1989. I mostly worked in paediatric areas, and specialised in paediatric oncology, which I loved. It is a hard area to work in, but the kids are just magic. Very special.

In 1982 I developed a serious viral illness. Although I was very sick, I recovered, and didn’t think much more of it.

I worked my way up to being a charge nurse when I was still young, and also moved into a service development role. Looking back now, I think I was probably too young to manage these roles. We went through a tough time at work, when 12 children died in a 3 week period. That was very hard. My staff turned to me for support, which was fine, but I had no-where to turn, no-one to talk to about what I was experiencing. I did talk to my family, of course, and they were great, but they couldn’t really understand what I was going through from a nursing perspective. They did try, though. The doctors weren’t any help, either – their attitude was to just “get on with it”. They didn’t like to talk about it at all. During that time my career was developing rapidly, I was experiencing joint pains but, again, I didn’t think about it much. Then I quite quickly developed what appeared to be a mental illness. I became very depressed and anxious, suicidal and psychotic. I did my best to hide the psychosis because I had an absolute fear of being locked up.

I did end up being locked up. It was horrific. I was given wholly inappropriate medications, and was also subjected to ECT without my consent. The whole business went on for ages, and although I had abnormal blood pictures, the potential organic aspects of my illness were not explored. I know now, very much later, that I have cerebral lupus, and it makes me angry and a little sad to think of what “might have been” if I had received good care from the beginning.
During the time that I was so unwell, I was occasionally given steroids as a result of my asthma, and I experienced almost immediate relief from my psych symptoms. Instead of thinking that through, though, I was told that I felt better because the asthma gave me “something else to think about”.

The whole time was very dramatic and traumatic. I tried going back to work, but there was no recognition of the issues I faced, and I didn’t have the option of starting to work part time and building up from there. I didn’t receive any support at all. It became obvious that I couldn’t work any more, so I resigned from my position. Management just treated me like dirt. Their whole attitude to my resignation was “thank god we’ve got her off the books – she’s a nutter”. I received no letter, no recognition of the work I’d done in service development, nothing. It’s left me feeling really bad, like I left on a bad note. Another aspect of the whole experience that has stayed with me is that I lost a lot of so-called friends when I became unwell, especially when I was diagnosed as schizo-affective, and some of them wrote to me after my lupus was diagnosed, apologising for having “misjudged me”. I think that’s appalling.

I don’t have a practicing certificate any more, which I feel quite sad about, because I really loved my job. But my illness has affected my memory so I’m not safe to practice any more. In my current job, though, I call on my knowledge and experience a lot as I am involved in mental health service development. I find that I can really see both sides of the issues, and I can work well with the nurses because I know what they are talking about. I feel that my experiences have made me a more compassionate person, much more open to accepting people as they are. I wanted to be a part of this research, to tell nurses to think about and talk about what is happening for them and to not hide it. I think that although more people seem to know about things like EAP (employment assistance programmes), the perception of them isn’t all that positive, and it still takes quite a bit of courage to access them. And although debriefing after traumatic events is a bit
more common, it still seems to happen in a haphazard way. So nurses are still not taking care of
themselves and each other, and threats to mental health aren’t talked about and acted on in any
coherent way. And it’s not only the talking, either, but it’s things like not expecting nurses to
return back to full time work with a full work load when they’ve been through something serious.
When you consider the confidentiality issues nurses face when they talk about their work, it’s
really clear that the best people to help nurses are other nurses!

**Gemini’s story**

I trained twice, once as a psych nurse and once as a general nurse. I’ve done post graduate study
since then.

I responded to the letter about this study because I have personal and professional experience
with mental health issues as a nurse. It’s an area that is beginning to be talked about a bit more
at conferences or in articles etc.

My position is that until mental health nurses deal with the discrimination and stigma in our
own ranks towards colleagues with mental health issues, we will never be able to work in
partnership with consumers. We need to get our own house in order. We don’t like it when our
colleagues are vulnerable and human in terms of needing support for mental health issues.

I think there are three things going on – the internalised stigma for the nurse involved, the overt
stigma from society, and then there’s outright discrimination.

There were a number of years when I kept it to myself. I think that’s a process everyone with a
mental illness goes through, taking time to overcome the internal stigma, and the timing and
intensity of it depends on where you are, when it happens and who you are, as well as to some
extent what is happening to you. For me, my partner was the one who recognised what was
happening first, which, in hindsight, was important. So I hit the wall. I couldn’t go any further. The hardest thing to deal with was that the psychiatrist I saw was a colleague. That degree of distress and disorder freaks everyone out.

I’ve also been on the other side of the equation as a manager and a colleague, and I’ve seen how other staff cope. After living through this and hearing the stories, I’m much more compassionate and I hope that my colleagues thought that I was OK for them. My feeling is that if you empathise, and use appropriate self disclosure then it can be dealt with. I mean, it happens. Sometimes I have had to debrief colleagues if they’ve been through a messy situation. This issue needs to be taken seriously.

There are prejudices, fears and biases in nursing just as there are in the general population. The issue of mental illness is out in the open to a certain extent, but there are often not good processes around how to care for mental distress. In fact, there are often not any overt processes at all, except for EAP, which is a bit of a mixed bag. I have heard of EAP being really useful for some nurses.

At one point, I was involved with a colleague who became psychotic. Along with other friends and family, we tried to manage her at home. I was there as a friend and a health professional, and clearly this person needed intervention and treatment. I found, though, that in spite of being experienced mental health nurses, we made the same mistakes as families often do. We tried to manage it ourselves, didn’t get intervention as soon as we should have, tried to avoid admission, gave her the benefit of the doubt and kept hoping that things would improve, even when they were clearly out of control. Whether it is caring for a colleague or needing treatment yourself, it is hard to accept that you’re just a human being. For some reason, mental health nurses are supposed to be immune. By accepting that we need treatment, we “let the side down.” It’s not
supposed to happen to you. It shows vulnerability and that you’re human, which frightens your colleagues. Then you get avoidance – people don’t want to have those conversations!

There is a tendency to avoid by getting into “blaming the victim” – labelling the nurse with an Axis II diagnosis and writing off the whole issue as a deficit in the nurse. Even though there is evidence about vicarious traumatisation, where the job of caring induces trauma, institutions are able to pass off responsibility for mental illness in their staff by pinning responsibility back onto the nurse. One example of this is when nurses care for children who have been damaged by other humans. The World Health Organisation recognise that workers are at risk, but it’s not recognised at this level because it will open a can of worms that no-one wants to address it and it will inevitably mean that employers have to take some responsibility for the mental health of their employees.

Nursing Council have always had quite good processes around this stuff, although addiction does seem to be slightly more acceptable than having a serious mental illness.

One of my passions is self care – we have to take care of ourselves. Nursing is, after all, about the presence of the self. Mental health is fairly reflective and conscious, partly through the use of professional supervision. The general side of nursing tends to just cope with stress and trauma, and try to manage it. If work affects you, it is a personal weakness. To date, the general side and midwifery don’t yet know about the value of supervision.

Mental illness in nurses isn’t always recognised or managed well. We have a long way to go before health self cares are routine for nurses. It is no surprise that addictions are so common in health professionals, we self medicate. Nurses, alcohol, war stories and letting off steam are all a part of the culture of nursing. Individuals, the profession and health services don’t have things in place for dealing with mental illness. Doctors tend to get whisked away quickly to get help, but nurses have to fight all the way.
There is often a secrecy around the treatment of nurses with mental illness, maintained to protect them. The can end up being really isolated. When you unpick that, it is based in stigma and discrimination. Nurses are often admitted out of their home area for treatment. I know of some incidents where nurses were actually admitted to the unit they worked in, and they were treated appallingly by their colleagues. Real horizontal violence.

What drives me is having a healthy, effective nursing workforce. Nurses are a valuable resource. When they get damaged, you need to look after them.
Chapter eight: starting anew

What drives me is having a healthy, effective nursing workforce. Nurses are a valuable resource. When they get damaged, you need to look after them.

Gemini

This final chapter of Aroha Mai: nurses, nursing and mental illness is focused on completing this partial exploration of mental illness in nursing in preparation for starting anew. On completion of this chapter, the research moves into the new phase of dissemination through academic publications and ongoing presentations to nurses. This opens the research process and findings to wider scrutiny, providing a contestable platform for new and developing conversations among nurses and researchers.

As the researcher, I too move into a new phase as I develop an academic profile and plan research projects to challenge and advance the findings from this one.

This chapter follows a process of closure wherein the current project is entered into one last time, revisited and summarised in a way that illuminates a visual re-presentation of the research findings (Figure 11). The summary is followed by an analysis of the strengths and limitations of the autoethnographical approach and the future research questions this project has highlighted.

Aroha Mai finds a resting place with a personal narrative about my embodied experience of the research which includes a final vignette.
The Medal Model: a summary

This research began, three years ago, with the aim of addressing the lack of attention previously given to the impact of mental illness on nurses, and of nursing on the mental health of nurses.

The research project illuminated aspects of nursing life that are connected to the experience of mental illness, and are also wider issues for the nursing profession.

The nexus of hyphens that the nurses in this research have experienced cover a range of nursing experiences such as undergraduate education, socialisation into nursing work and the nursing identity, caring, mastery, emotional work, bullying, oppression, othering and colonisation. When the additional areas of having a mental illness and seeking wellness are added to this list, it is clear that the experiences of nurses who have mental illness are complex, distressing and difficult to negotiate.

Nonetheless, the nurses have negotiated these hyphens with varying degrees of success. Their experiences and the literature support the need for radical social change for the nursing profession in order to address the issue of mental illness in nurses. Three key initiatives would promote this change: transformatory education, a programme of conscientisation and supervisee-led clinical supervision.

In summarising the findings from this research, I have adopted a visual re-presentation that is centred on the importance of their registration for the nurses in this research (Figure 11).
Figure 11: The Medal Model for developing an integrated caring professional
This model draws together the conclusions that have emerged from this research project. The inner circle contains features of nursing life, connected by the medal won and worn by Registered Nurses in New Zealand. Caring, mastery, stress, vulnerability and bullying have been consistently described by the nurses in their stories.

The next circle contains wider aspects of the embodied experience of the nurse-tangata whaora. The nursing identity, nursing work, symptoms of illness and seeking wellness all confine and define nursing life when one has experience of mental illness.

The third circle describes the focus of strategies that aim to achieve the goals of a mentally well nursing workforce. Clinical supervision, conscientisation and transformatory education are required across the areas of individual, professional and organisational practice. This workforce of caring professionals, integrated into personhood, is defined in the outermost circle of the model. This outer circle is not confined by lines, but is left open to connect with patients, families, other healthcare professions, personal networks and wider society.

The swirl of colour emerging from the nursing medal and permeating the model is indicative of the dynamic nature of being a nurse who has experience of a mental illness, and the flow of the features among the layers of experience.
**Strengths and limitations of an autoethnographical approach**

The great strength of autoethnography is found in its application to areas of human experience that have not previously been explored. By focusing on first person stories, an autoethnographical approach enables the field of study to be defined by those most affected by it. The utilisation of autoethnography in areas previously addressed only by indigenous researchers (R. Bishop, 2005; Glover, 2002; L. T. Smith, 1998) is in line with notions of *tino-rangatiratanga* and social justice whereby a population’s right to determine for themselves what needs to be studied is aligned with basic human rights. This extends to the ways in which the study is conducted, the processes of dissemination and the ultimate ownership of the research. This self-determination is not as fully developed in the autoethnography literature as it could be because such literature still tends to position the researcher as controlling the process and knowledge generated by research. Although autoethnography begins with the researcher’s story, little attention has been paid to how other participants are accessed and incorporated.

This project has been limited in its application of such empowering ideas in that, although the nurses had control of the content of their stories, they produced them in response to academic requirements and signed them over to me as researcher. Even 64’s artwork was selected by her as being easily replicable in a text, although it remains her property and I only have the use of it for this project. The research findings and dissemination rights belong to me. The move to self-determination could have been accommodated in this research by remaining in contact with the nurses, seeking their approval for the findings and recommendations, and sharing the dissemination processes. This would have been better achieved with a smaller cohort of nurses as co-researchers. Further, it would have mitigated my concern about silencing the nurses’ voices with my own.

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20 Self determination
The inclusion of responsive vignettes and poetry has added a dimension to this methodology that encompasses the emotion and mess which is excluded from more traditional research methodologies. This has added a degree of transparency to the interpretation, because the similar feelings to those of the nurses or their colleagues are deliberately evoked in the audience. This exposure aids in establishing or ruling out resonance, which is an inherent aspect of judging the worth of autoethnographical projects.

A more general limitation of autoethnography is the extent to which the findings of such research resonate with audiences and thereby can impact on their lives. In order to resonate usefully, this research needs to be methodologically sound, as well as evocative, relevant and interesting. I have addressed this limitation by signposting an audit trail, which was discussed in Chapter Three, and continually exposing my research process to nursing audiences for their input and comment. Had I found them to be disinterested or disbelieving, I would have had to revisit my aims and processes. Such interim measures to gauge its value have been encouraging, but the final worth of the project will not be calculable until it is completed and presented for peer review.

**Future research**

This research project has illuminated several new areas for investigation. Of particular interest is the experience of the nursing student and new graduate nurse in relation to the tensions identified in this research. Although I have identified a move to transformatory education as a recommendation from this research, further evidence that relates specifically to the education arena would strengthen this.

A three year, multi site ethnographic study of student and new graduate nurses would provide the opportunity to answer questions such as why people choose to become nurses and whether there are pre-existing issues that render nurses vulnerable to mental illness; the extent to which gendered assumptions and values are included in undergraduate nursing programmes and
whether these contribute to the tensions between education and practice; and how new nurses successfully negotiate the caring-mastery hyphen in the current education environment. An ethnographic study would provide richer data than analysing curricula documentation and interviewing individual nurses, because it would utilise key informants, field observations and focus groups. Such a project would also align with how nurses learn to do or avoid emotional work. The outcomes of this project would inform the nursing profession about the characteristics of the successful recruit, who stays in nursing education and work, and who progresses to become an integrated caring professional in their first year of nursing practice. Moreover, the findings would inform educators about the inadvertent tensions created by contemporary education practices and how to manage classrooms and clinical settings to maximise student achievement.

Further suggested research projects include the issue of what constitutes impairment caused by mental illness in nursing practice. Research into this area could also usefully incorporate an analysis of the impact of mental illness on nursing practice and the incidence of impairment or enhancement of practice as a result of the illness. Such research would also contribute to destigmatisation literature, as assumptions of a connection between mental illness and impaired practice are tested.

Although there are many other opportunities for further research, the final project I am suggesting here relates to expanding the professional focus of the research to explore the experiences of other healthcare groups. For example, literature suggests that junior doctors are the focus of significant bullying (Quine, 1999, 2002), physicians, particularly women, have a high rate of suicide (E. Schernhammer, 2005; E. S. Schernhammer & Colditz, 2004), and dentists experience significant workplace stress (Mathias, Koerber, Fadavi, & Punwani, 2005; Moore & Brodsgaard, 2001). These sources suggest that research into the topic of mental illness
and healthcare professionals is likely to be an issue that would enhance the mental health and self care of groups other than nurses.

**Some concluding comments**

Although the thesis is drawing to a close, nurses continue to live their lives within the nurse-tangata whaiora hyphen. The project aim of creating change for those and future nurses is only beginning. My own understanding of what happens in the hyphen of the nurse-tangata whaiora and what change is required is also only beginning. As I write and speak to more nurses about the project, conversations are begun that will deepen our collective knowledge into the future. Hence, finishing the thesis is merely a resting place to summarise and refocus.

* * *
A resting place

Many years ago, when I was distressed to the point of misery and was the target of bullying on a daily basis, my only hope was the thought that I could leave nursing and put an end to the pain. But my own nursing identity was too important to relinquish. Rather than leaving, I next wished that I had the language and the authority to refuse the distress and force change on my workplace. In the end I was able to do neither, and I changed to a nursing setting where I felt less visible and where I was valued by some of my colleagues, some of the time. That move relieved my immediate distress and enabled me to stay in my chosen career.

One of the satisfactions of working with social justice research is that I have been able to articulate my pain and bear witness to the testimonials of others’ pain. As I have listened to the stories of these 18 nurses and many others, I am reminded that there are other nurses who are feeling that acute distress today. With the publications and presentations that will follow the completion of the writing, I hope to offer a language to those nurses. Perhaps, with a new language, we can create the necessary radical social change.

As I reread my early research journals, I can track my acquisition of this new language. In the beginning I wrote ‘etc.’ and ‘stuff’ to signify places where articulation failed me. In spite of a prohibition of theorising in a concluding chapter, I return to Lyotard (1988) who notes that silences often signify the presence of the differend, wherein bearing witness to the silence enables the development of an idiom. The use of idioms precedes the articulation of new phrases. Lyotard describes the sense of pleasure that attends “the invention of a new idiom” (p.13). This is my pleasure today, and it contrasts markedly with my earlier pain.

As I write these final words, I am loath to leave my work. Accordingly, I will take Art Bochner’s (1997, p.17) advice, “if it’s time to end... tell another story.”

This story, in its first incarnation in an early draft of the thesis, was fictionalised. In this final text, I drop the mask that shields me as ‘other’ and relate for you a dream I believe I was given in my time of greatest need.
Vignette: a cloak of aroha

I went to bed as I had woken, in the grip of a huge coil of barbed wire. The wire, heavy, hard, cold and sharp, filled my head, throat and stomach. I lay down with little expectation of rest, and fell quickly asleep.

I awoke to the call of the karanga, “Aro... ha... mai... ai... ai”21 Maikuku tilted her face to the sky, eyes fixed to the brightest of the stars and voice soaring through the night in quavering appeal to our ancestors. Her voice faded to a whisper. I stepped towards the old woman, who stood waiting for me. I knew her immediately, as though she were my grandmother. But she wasn’t.

I didn’t speak, but felt my barbed wire loosen as I thought,

“I’m lost.”

There are times when a little knowledge is far too much, and with a part of my brain I surrendered to the idea that I’d lost my mind. Psychotic, I decided. But Maikuku still waited.

She was a dark walnut brown, furrowed and wrinkled with a full face moko22. This concerned me. I hadn’t known that women wore full moko. With a mental shrug for my lost sanity, I moved a little closer to her. She smiled.

All the feelings, hurts and worries welled up and spilled over. I cried, but I didn’t need to speak. Maikuku closed the last of the distance between us and laid a beautiful, soft korowai of grey and white feathers over my shoulders.

“This belongs to our whanau, child. I pass it to you with aroha. It will protect you, and you must wear it with pride. It has been worn by many generations of our women. You will pass it on one day.”

21 The karanga is a call of welcome or lament. In this context, Maikuku is asking for the presence of our ancestors

22 Tribal tattoo
I was mildly surprised to understand her Māori speech, but was too entranced by the feel of the korowai to worry. As Maikuku fastened the cloak around my shoulders, I had to straighten my back so the feathers drifted close to the ground without dragging. I was bursting with pride as my fingers stroked the feathers over my breast.

I slept all night, and woke feeling rested and hopeful. The barbed wire, still there, had softened and I could breathe. The cloak of aroha remained a warm weight around my body. The cloak is both intangible and very real; it still protects me and at the same time it challenges me to be the best I can. I have to walk tall, to keep the feathers away from the dust.

Until this moment I had not imagined how I could pass such a gift on, or who I would give it to. But now I can.

This is my gift to you. Wear it with aroha.

* * *

During the course of this study, time has almost stood still. I have been fortunate that I have had no family crises, no inopportune demands on my time and energy and only a few people who wanted to rain on my parade. Yet my children are suddenly taller than I, and my husband almost as grey. It is time to reclaim my life.

I blow out the scented candle that sits beside my laptop for the last time, and gather up the last of the articles and chapter drafts. This room will revert to a spare bedroom in the next few days, and I will revert to my roles as wife and mother. As I do so, I say in a soft voice to the nurses I leave in these pages and the family I have neglected:

Aroha mai.
Appendices

Appendix One: University of Auckland Human Participants Ethics Committee (UAHPEC) approval

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE

16 September, 2004
MEMORANDUM TO:
Jacqueline Kidd
School of Nursing

Re: Application for Ethics Approval

The Committee met on 15 September, 2004 and considered the application for ethics approval for your research titled "Nurses, nursing and mental illness" (Our Ref. 2004/327).

Ethics approval was given for a period of three years conditional on:
1. The Committee requires that the approval wording is included in the advertisement.
2. In the Consent Form, please add the following statement: I understand that the information provided by me will be treated confidentially and no material that could identify me will be used in any report on this study.
3. Please provide the above revisions as soon as possible for inclusion in the next agenda (27 September).

If the project changes significantly you are required to resubmit your application to the Committee for further consideration.

In order that an up-to-date record can be maintained, it would be appreciated if you could notify the Committee once your project is completed.

Please contact the Chairperson if you have any specific queries relating to your application. He and the members of the Committee would be most happy to discuss general matters relating to ethics provisions if you wish to do so.

Margaret Rotondo
Executive Secretary
University of Auckland Human Participants Ethics Committee
c.c. Head of Department, School of Nursing

Jacqueline Kidd
14 Balmerino Cres
Pukete
Hamilton
Appendix Two: Recruitment letter

RESEARCH ON NURSES’ MENTAL ILLNESS
I am conducting research into nurses’ experience of mental illness as part of my PhD studies at Auckland University.
I am a registered nurse in independent primary mental health practice, and I also teach for the University of Auckland.
The purpose of this research is to explore how nurses experience mental illness within the nursing arena, and what impact, if any, nursing work has on their experience. This project will identify strategies for working with, and the management of, colleagues who experience mental illness while in the nursing workforce, and improve knowledge about the impact of nursing work on mental illness.
The research involves meeting with me for three sessions of about an hour. During the first session the nurse will be invited to tell their story, through whatever media they prefer. For example, the story could be simply told to me verbally, or could be undertaken as a journal or diary, artwork, poetry, or music. During the following two sessions, the nurse and I will talk and write about the story and what it means.
If you have had a mental illness while you were working in clinical practice, are mentally well at present, and are interested in participating in this research, please contact me for an information sheet (a medical psychiatric diagnosis is not necessary, but you need to have sought medical, psychological or spiritual treatment for the illness). Absolute confidentiality will be ensured. Please phone me on 0800 1155 23, or email me at Jacquie@hineirahealth.com.

Jacquie Kidd, RN, BN, MN, Auckland
Appendix Three: Request for change to UAHPEC ethics approval

Human Participants Ethics Committee
University of Auckland

Request for Change in Ethics Approval

10 March 2005

Research title: Nurses, nursing and mental illness.
Researcher: Jacquie Kidd
Reference number: 2004/327.
Changes requested: increase in participant numbers and change in data collection process.

Following ethical approval last year, I have placed a letter in a professional journal and asked potential participants in my research to contact me if they are interested in receiving more information about the research. Although I knew, anecdotally, that there are many nurses with mental illness, I had no way of assessing how many nurses would be willing to talk to me about their experiences. I had hoped to hear from perhaps 6 nurses as a result of this first notice, and instead have received 28 responses so far, and 12 nurses have already returned the signed consent form. Nurses are still contacting me, and want to tell me their stories.

I have talked with my supervisor, Dr Mary Finlayson, about this, as it brings up two particular issues relating to my ethical approval.

Firstly, I had indicated a sample size of 9 - 15 participants. I would like to increase the maximum number to 25 participants, please. The increase will make my analysis more thorough, and potentially more representative, although it will present challenges in terms of valuing each story within the final word limit of my thesis.

Secondly, travelling around New Zealand to meet with this number of nurses is problematic in terms of both money and time, as each nurse is interviewed three times. Several of the nurses have suggested that they tell their stories through email, and discuss them with me on the telephone. (These suggestions have been brought up by the nurses without any disclosures from me about any difficulties I might personally face.)

Changing my data collection process from solely face to face interviews to allow for email and telephone interviews would enable me to limit my travel to the main centres, but still collect data from nurses in more distant areas.

In my original application I explained that the nurse participants could choose how to portray their story in the first instance, and some of the respondents have told me that they have diaries or stories already written that they would be happy to share with me. I see the use of email for the initial story as being similar to this. The nurse is able to tell his or her story in their own time and in privacy, and then we will discuss what they have written by telephone. It is important to
note here that we will not be discussing the depth of the nurses’ distress, or the symptoms of mental illness that they experienced, but will be focusing on how they experienced working as a nurse, and what responses they experienced from colleagues and management.

The ongoing wellbeing of the remote nurse participants will be addressed in much the same way as the nurses interviewed face to face. In the first instance, they will have identified that they are mentally well, and are voluntarily participating in the research as evidenced by their response to the advertisement. Process consent will allow the participants to call a halt to their involvement if telling the narrative becomes too hard. As a Registered Nurse with over 11 years experience in the mental health specialty, I am able to assess the impact each interview has on the nurse participant, and will ensure that interviews proceed safely. I will also be able to assess whether it is in the nurses’ best interest to withdraw from the study, even where the nurse is willing to continue. This ongoing assessment will be as achievable over the phone as it is in person, and will take into account hesitations, changes in the tone and rhythm of the conversation, and the way a participant chooses (or not) to address subjects. Nurses will be able to withdraw from the study at any time, and will be able to withdraw their data from the study until two weeks following their third and final interview.

I propose that additional written consent be gained from these participants, as the process they have agreed to has altered.

Thank you for your consideration of these changes.

Regards

Jacquie Kidd
14 Balmerino Cres
Pukete
Hamilton
Ph 07 850 1770
Jacquie@hineirahealth.com
Appendix Four: UAHPEC approval (amended)

14 April, 2005

MEMORANDUM TO:
Jacqueline Kidd
School of Nursing

Re: Change to application

I wish to advise you that the Committee met on 13 April, 2005 and reviewed the request for change to your application titled "Nurses, nursing and mental illness" (Our Ref. 2004 / 327).

The Committee approved the change.

If the project changes significantly you are required to resubmit your application to the Committee for further consideration.

In order that an up-to-date record can be maintained, it would be appreciated if you could notify the Committee once your project is completed.

Please contact the Chairperson if you have any specific queries relating to your application. He and the members of the Committee would be most happy to discuss general matters relating to ethics provisions if you wish to do so.

Margaret Rotondo
Executive Secretary
University of Auckland Human Participants Ethics Committee

cc. Head of Department, School of Nursing
Jacqueline Kidd
14 Balmerino Cres
Pukete
Hamilton
Appendix Five: Participant Information
Sheet (Amended)

PARTICIPANT INFORMATION SHEET (2)

For remote participants

Project title: Nurses, nursing and mental illness

Researcher name: Jacquie Kidd

I am a registered comprehensive nurse, and a PhD student with the University of Auckland’s School of Nursing. Thank you for indicating an interest in participating in this research. Please note you are not obligated to take part in this research, it is voluntary. Should you choose to participate my contact details are at the end of this information sheet.

This research seeks to understand more fully the recognition and management of mentally ill nurses in the nursing workforce, through narratives told by the nurses who have experienced mental illness. Further, the research will explore if issues related to nursing as a profession, or aspects of nursing work, trigger or exacerbate mental illness in its members.

The research will involve participants in the remote equivalent of three interviews of approximately 1 – 1 ½ hours. The aim of the first interview is to generate a narrative about the experience of being mentally unwell while in clinical practice. It is important to note here that the focus of the narrative is on your personal experience as a nurse doing nursing work, and not on matters such as clinical competence or clients’ experience of your nursing care.
This initial narrative will be sent to me via email or post. Narratives can take many forms, including diaries, journals, a written story, or a piece of artwork. We will discuss the form of your narrative by phone prior to you sending it to me. If posted, these narratives will be returned to you at the completion of the second interview. If you have emailed me your story, it and all correspondence between us will be deleted from my inbox and hard drive at the completion of the negotiated narrative. I will not keep copies of any data except for our narrative.

The second and third interviews will occur via telephone, at my expense, or by email. The initial narrative will be discussed and analysed jointly by you the nurse participant, and me the researcher, resulting in a “negotiated narrative”. I will later analyse the narratives looking for patterns and contradictions, and taking into account what has been written about nursing and nurses, and about mental illness. The research will result in a published thesis, and will also be the subject of several articles for professional journals and conference presentations. Please note that all personal information will remain strictly confidential and no material that could personally identify you will be used in any report on this study.

You are free to withdraw from the project at any time without giving reasons, and you may withdraw your data from inclusion in the research until two weeks following your third and final interview.

No audio taping of telephone conversations will occur.

The narrative will be in written form, and will be done during the second and third interviews. This mutually agreed analysis will be the data on which I base my research, and is the only data from the interviews that I will keep. Names and identifying features will be removed from the narrative as it is constructed, in order that your identity is protected. The negotiated narratives will be stored in a locked cabinet in my home, and will be published in the thesis as appendices.

Your ongoing emotional and psychological safety is very important to me. You must feel mentally well in order to participate in the research, and I will ask you to confirm this. The narrative that you choose to share for this research may arouse painful emotions for you, as you recall a period in your life that may have been difficult, so we will discuss how to meet your individual and cultural needs throughout the research process.
In addition to this, you will have a therapist of your choice available to you, with two sessions paid for by me should you require this additional support.

As mentioned above, all personal information will remain strictly confidential and no material that could personally identify you will be used in any report on this study.

If you have any queries regarding this study please contact myself or my supervisor, Associate Professor Mary Finlayson, using the above contact details.

You can contact the Head of the Nursing Department, Associate Professor Judy Kilpatrick, at the University of Auckland, Private Bag 92019, Auckland. Phone 09 373 7599 extension 82897. Email j.kilpatrick@auckland.ac.nz

For ethical concerns contact: The Chair, The University of Auckland Human Participants Ethics Committee, Office of the Vice Chancellor, Research Office, Level 2, 76 Symonds Street, Auckland. Tel: 09 373 7599 extn 87830.

Jacquie Kidd
14 Balmerino Cres
Pukete
Hamilton
Ph: 0800 11 55 23
Email: Jacquie@hineirahealth.com

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 16 SEPTEMBER 2004 TO 16 SEPTEMBER 2007 FOR THREE (3) YEARS. REFERENCE NUMBER 2004/327.
Appendix Six: Consent Form

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS

Project title: Nurses, nursing and mental illness

Researcher name: Jacquie Kidd

I have read and understood the Participant Information Sheet relating to this research and I agree to take part in the research. I have had the opportunity to ask questions and have them answered. In addition, I understand that I am free to withdraw from the study at any time, and to withdraw any data traceable to me up to two weeks after I have participated in the third and final interview.

- I accept/do not accept being audio taped during the first interview
- I understand that if I have chosen to be audio taped, the tape will be returned to me at the commencement of the second interview
- I agree/do not agree to the use of email and telephone as an alternative to face to face interviews
- I understand that any personal material provided to the researcher as part of my narrative will be returned to me at the completion of the second interview
- I agree/do not agree that my narrative may be included in the doctoral thesis

I understand that the information provided by me will be treated confidentially and no material that could identify me will be used in any report on this study.

Signature ___________________________________________ Date ____________

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 16 SEPTEMBER 2004 TO 16 SEPTEMBER 2007 FOR THREE (3) YEARS. REFERENCE NUMBER 2004/327.
Appendix Seven: Consent Form for use of art

Held for a period of six years

Project title: Nurses, nursing and mental illness

Researcher name: Jacque Kidd

I have provided copies of artwork to the researcher, and understand that it will be used in the PhD thesis when it is published. This consent form specifies additional areas where the art may be used by the researcher.

I understand that the art will only be used in connection with the research when it is being presented or discussed, and that I will not be identified other than by the nom de plume I am using for the research.

Please delete any conditions you do not wish to accept:

- The art may be presented on a slide in powerpoint presentations in the University setting
- The art may be included in presentations to professional groups including nurses and researchers at conferences
- The art may be published in professional journals or e-journals as a part of reporting and discussing the research
- The art may be published on a professional web page where the research is featured (for example the web page of the College of Mental Health Nurses or the NZNO Research Section page)
- The art may be published or presented in popular, non-professional media where the research is being reported or discussed

I understand that the information provided by me will be treated confidentially and no material that could identify me will be used in any report on this study.

Signature _____________________________________________ Date ____________

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 16 SEPTEMBER 2004 TO 16 SEPTEMBER 2007 FOR THREE (3) YEARS. REFERENCE NUMBER 2004/327.


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