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The Significance of Gender to Australian Psychiatric Nursing

Thesis submitted by

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For the degree of Doctor of Philosophy

in the School of Nursing Sciences, James Cook University, Townsville.

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ABSTRACT

This research has critically examined, using a historical method and discourse analysis, some of the many issues related to gender in Australian psychiatric nursing. More specifically, it has explored how gender and gender differences amongst Australian psychiatric nurses evolved, their significance, how they are maintained, and some of their continuing influences and effects in respect to the nature and role of the psychiatric nursing profession.

A major focus of the research has been the explication of the published discourse since 1788 in the context of Australia's social and cultural development, including more recent changes in professional and health service organisations and education. These have also been interpreted within the context of international developments, and have contained lines of inquiry relating to gender, the sexual division of labour, role stereotypes, patriarchy, feminism and the history of psychiatry. Using a discourse analysis and historical criticism, the principal aim of the research is a recovery of the past, which seeks to understand more clearly the meaning of associated discourses and texts so they can be used as a knowledge base and a resource. This will enable the current nursing workforce to use these understandings productively and by adding meaning, to benefit from the wisdom of the past.

Recommendations of this thesis include the need for health services and human resources to be more pro-active in adopting gender-neutral recruitment strategies and in constructing nursing as a job for men, and in embracing a less gendered conception of nursing. It is suggested that recruitment should be targeting people who are suited to the work, emphasising the role function and taking a more egalitarian approach.

Whilst gender is important, it is argued that if we continue to assume that only females can care we are taking a shortsighted view, and that many males provide high quality care.

The thesis recommends that the comprehensive nurse education programmes offered by universities and other educational institutions need to increase the psychiatric nursing components of their undergraduate degrees. This extended curriculum should include the topic of gender, as well as the history of psychiatric nursing. The range of skills that particular genders bring to nursing and the crossover of gender markers might be a useful starting point for this.

This research argues that the comprehensive nurse education programmes in Australia do not adequately prepare nurses to work in mental health settings, and that separate training programmes for nurses working in mental health are to be preferred. Psychiatric nursing is conceived as a specialty, which needs to be treated as such.

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Like so many other students research this work draws from many wells and has been inspired by a number of quite diverse contributors. Of these, my loving parents, who in their own ways taught me to do the best that I could and in doing this have something to say about whatever I did in life and to make and take my own chances by challenging the status quo. My mother taught me to try hard and be the best that I could and my father who taught me to be somewhat 'sceptical' of all things which at times translated to dogmatic. My two sisters who often gave me advice and who had to tirelessly contend with me across our formative years were like my parents instrumental in setting me off on this journey. The other major inspiration to this work comes from the love of my life, my dear wife Fiona who represents everything in so many ways that I am not. Fiona looks for and finds good in everything and everyone even in adversity. She pushed me to complete this work and has been my inspirational guiding light. Fiona helped me with editorial work and tirelessly steered the ship and loved me unconditionally at the same time. My mother in law Eileen who helped endlessly with our new edition and collectively they kept me on track as best they could. I owe so much to them.

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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Preface

In starting this research the writer was interested in the topic of gender and why gender may have been a factor in psychiatric nursing. This interest was borne after having spent some considerable years working in the profession both in England and in Australia. It appeared for this writer that in the face of some criticism about choice of career from his peers that psychiatric nursing was something that he would find easy to do. The notion of a career in nursing being easy to do was because the writer felt that it would be 'second nature' to him and that he had a 'predisposition' towards caring and therefore nursing. Caring was a phenomenon that he had grown up with at the hands of his family and was therefore the feature of nursing known to him and he felt would be easily applied in the clinical field. The writer wondered if there might be a genetic component to caring and that somehow the writer's internal programme was in tune with what was required to be a nurse in psychiatry. On reflection, the writer remembered that his mother was a very caring individual and had provided a multitude of different roles within the home environment that may have been significant in his choice of career. His father was the 'traditional provider' who worked everyday and conformed to the role of being the 'breadwinner' and also the one who delivered any punishments. These roles were very much like the ones being played out across family life in the house next door and were representative of their time and place in history.

On review of these circumstances, consideration was extended to the writer being socialised to care but this view appeared to fall short because the writer had seen a

multitude of other people, both male and female who appeared unable to care and were different to him despite the influence of an array of what appeared to be good socialising agents at their disposal. In light of this, the research sought to look more closely as to why gender had been significant to particular professions but focusing specifically on psychiatric nursing. As a starting point in relation to psychiatric nursing the writer wondered why particular people choose to enter this employment area. The next step was to look at the specific gender of the applicants, as there are a series of factors relational to this issue.

According to Johansson (1998, p.43)

there have always been men and women. As far back as Adam and Eve we have learned to separate the two as if they were God-given differences, or at least gender differences have been seen as essentially inherited. ...As with all institutions, gender is not once and for all constructed, but continuously reconstructed in ways that are not always the same.

Johansson argues, “gender is paradoxical and ambiguous ...from both practical and theoretical standpoints”. This argument suggests that gender stereotypes not only need to be understood in order to make sense of the situation but that they ought to be dissolved, since essentially gender will always mean different things to different people. Gender described, as male and female are not definitive because males and females do not enact their gendered role in the same way. There are a whole variety of different factors, which contribute to this including socialisation, the context in which the role is played in, some biological determinants and a myriad of life experiences.

The significance of gender to psychiatric nursing at first glance appeared a rather complex yet interesting research project because of some of the aforementioned factors where it is difficult to pin this significance to any single or given factor. Despite varying over time and by place, occupational segregation by sex is extensive in all countries, and present no matter how they are economically or politically organized (Anker, 1998). Across Europe, the main policy focus on the reduction of sex segregation in employment has involved ways of getting women into men's jobs (Cross & Bagilhole, 2002, pp.204-5). However, despite several decades of women's expanded labour force participation, women and men still tend to work in different industries. Cross and Bagilhole (2002, pp 204-5) suggest that individuals have feminine and masculine sides to their personality and that because of this one's gender identity can be internally contradictory and in tension. This suggests that these masculine and feminine sides could be employed on an as needs basis within one's social life and therefore one's nursing practice.

The above preface situates this research project. Further to the preface, this research has critically examined, using historical methods and discourse analysis, some of the issues related to gender in Australian psychiatric nursing. More specifically it has explored how some issues of gender and gender differences amongst Australian psychiatric nurses evolved, how they are maintained, and has examined areas of their continuing influence and effect in respect of the nature and role of the psychiatric nursing profession. A major focus of the research has been the elucidation of the published discourse in the context of Australia's social and cultural development, including changes in professional and health service organisations and education. These will also be interpreted within the context of international developments, and

have entailed lines of inquiry relating to gender, the sexual division of labour, role stereotypes, patriarchy and the history of psychiatry. The overriding aim of the research using a discourse analysis and historical criticism is a recovery of the past. This recovery of the past seeks to understand a little more clearly the meaning of particular discourse and texts and is described by Taine (1989, p.1) as recovering from the monuments of literature “a knowledge, understanding and meaning of the way in which people thought and felt centuries ago”.

The rationale for pursuing these lines of inquiry arise from a variety of different personal, clinical, and academic interests, which have developed from previous research, personal interest and clinical experience, none being considered as mutually exclusive to the others. It is clear that limited yet informative accounts concerning the development of related topics such as Australian psychiatry are available (Bostock, 1968; Lewis, 1988), with these accounts detailing Australian psychiatry and tending to take a state focus, such as Victoria (Brothers, 1965), Western Australia (Ellis, 1983), and New South Wales (Garton, 1988), and more specific issues raised by gender have not, thus far, been addressed in any depth. Information, which describes psychiatric morbidity rates, especially details about particular mental illnesses, which appear more prevalent for particular gender groups, is quite plentiful (Leslie and Rosenbeck, 1999; Gold, 1998). Similarly, snippets of information referring to psychiatry and psychiatric nursing practice are contained in many of the historical accounts of general nursing (Lang, 1980; Durdin, 1991; Pearson and Taylor, 1996; Pearson, et al, 1997), but there is a scarcity of information about the two issues together and how they may relate. The history of nursing tends to “concentrate almost exclusively on the study of a female-dominated occupation, created with the

assumption that such a role is inherently natural to the female sex alone” (Mackintosh, 1997, p.232). This thesis will therefore explore and fill a significant gap, or silence, in the existing literature and meets, in this writer’s view, an urgent need for a better understanding of the implications of gender for nursing generally, but more specifically for psychiatry and psychiatric nursing locally, nationally and internationally.

It is intended that this research will be like a journey, which begins by exploring and analysing the available written and visual materials located in archives, libraries, and any other sites, in order to trace the historical development of the key themes. A variety of methods will be used for this task and have been described in some detail by various authors including the notable work by de J Jackson (1989). The interpretive framework together with the literature, which is threaded through the work, will draw on and examine the work of a variety of authors including critical theorists such as Fairclough (1995), poststructuralists, such as Foucault (1978), Lacan (1998), and Giddens (1993; 1994), and the work on gender by Connell (1987), and Segal (1990) and a feminist perspective from Eisenstein (1984; 1991), MacKinnon (1987; 1989) and Butler (1999). The journey will in many ways be self-directing, such that the available literature, which will have many different layers, will be examined and some of the layers will be peeled back to show relevant underlying issues. The peeling back of the layers will highlight the significance of particular issues and an allowance will need to be made in terms of direction by what is uncovered, revealed and located as the research journey unfolds.

The overall purpose of the research is to critically discuss and examine the available

material and in this process produce an account of the evolution and maintenance of the gendered nature of psychiatric nursing in Australia. This elucidation will examine the effect that gender has had, and continues to have, on the nature and construction of psychiatry and psychiatric nursing. This examination will investigate historical archival material, which tends to depict a range of understandings analogous to the practice of psychiatry today. Although taking an Australian focus, the research will critically examine some of the available overseas literature in order to establish to what extent Australian psychiatric nursing and the associated professions have emulated their British and American counterparts. Clearly, there are some significant indications that this may be so, with Australia like so many other countries adopting the initial International Classification of Diseases (ICD 10; WHO 1992) and subsequently moving on to the most recent version of the Diagnostic and Statistical Manual (DSM IV-TR, in Spitzer, 2002) in an attempt to classify and catalogue the complexities of particular mental illnesses. Both of these classificatory systems are being used extensively today and could be viewed as templates to describe and categorise Australian psychiatry. Anecdotal evidence suggests that Australian psychiatry and psychiatric nursing are like a colonial outpost following many of the British and American leads. If this line of argument is well founded then the gendered nature of Australian psychiatric nursing reflects its overseas relations, which is both interesting and significant to this study. Therefore, examination of some of the international issues related to gender will be included in this study to add depth and provide a cross reference to the issues raised about Australian psychiatric nursing. Additional information from staff involved in many of the professions related to this study and generally across health care teams will be included, and should generate a comprehensive account of psychiatric nursing relational to gender.

Although the research will not focus directly on these specific questions it will seek answers to specific areas such as ‘Why are there more male psychiatric nurses than females?’ Why does psychiatric nursing attract more males than females? Questions such as these do not have a simple one-line answer; quite obviously there are a variety of interwoven factors at play, and one reason is not mutually exclusive to the others. It is envisaged that issues such as gender, socialisation, sexuality, patriarchy, economics, language, risk management, text and issues of control are all likely to be significant. Clearly, there are many socially constructed elements to the questions posed above, and initial evidence suggests that concepts such as roles, prescribed roles and role scripting may play an important part in understanding these social constructions. Therefore, this research has used much of the available information and literature to investigate more recent issues relational to psychiatric nursing, although to place many of the more current issues into their particular contextual perspective will require an examination of the earlier history of Australian psychiatry more generally to see how the past may have been significant to some of the issues today.

Another question that arose concerns the function played by the discipline entry requirements of nursing groups and individual professional groups in training schools and universities and the educational pathways that these educational institutions entail. Specifically, this thesis examined what courses were available, to whom the courses were offered, how the students were selected, and the part played by gender. It has also examined the more recent movement of nurse training to tertiary settings and the impact this change has had on psychiatric nursing in particular. This examination looks at the factors that linked particular social roles and occupations

with gender, the subsequent sexual division of labour, and the impact of these processes on Australian psychiatric nursing and related professions.

As the methodology selected to investigate these issues is an historical discourse analysis no formal literature review is used. Instead the literature review was an ongoing exercise throughout the study, and the writer constantly returned to the literature to cross check particular themes and issues. By reviewing the history of a particular topic one captures both the points of note and the silences in the available material. Extensive searches of the available literature have brought forward and highlighted numerous articles relating to a variety of perspectives on gender, psychiatry and psychiatric nursing. The literature does not appear, however, to contain any significant or in-depth examination of these together, except in the cases of the gendered nature of psychiatric ill health and mental illness morbidity rates, which are issues falling outside the scope of this thesis. Gender itself as a topic is readily available in the literature, and it was felt prudent to have as clear an understanding as possible of the issues, themes and current discourse surrounding this topic. The researcher's journey seeks to understand how gender and gender differences evolved amongst Australian psychiatric professionals, especially psychiatric nurses, their impact, and how they are maintained. With this in mind, the writer explored the following key topics; sex, scripts and gender roles; the sexual division of labour; self as a repertoire of different masks or selves; social learning theory; genetics and game playing; the realities of employment taking into consideration power, patriarchy and capitalism and text, language, discourse and deconstruction, also, the role and subsequent tensions based on gender which have emerged such as teamwork across multidisciplinary care, the role played by

professional organisations, the trade union perspective and the different performance criteria played out by different gender(s).

Taking an overview on the topic of nursing generally it is fair to say that much of the literature depicts nursing as a caring profession, and on that basis 'genders' nursing because it also identifies females rather than males as more natural care-providers. This depiction can take many forms in the literature, and there has recently been a strong trend toward concepts of nursing which entail some sort of sympathetic understanding (Griffin, 1983; Peden-McAlpine, 2000) or compassionate morality (Von Diete & Orb, 2000), an I-Thou relationship (Buber, 1987; Hanson & Taylor, 2000), tenderness (Miller & Zamora, 1990; Wakefield, 1999), respect for self and others (Kelly 1990), spirituality (Clark et al 1991; Kendrick and Robinson 2000), and empathy as a moral duty (Olsen, 1991; Morse, et al 1992; Kunyk & Olson, 2001). Although many of these authors may not explicitly do so themselves, it is easy to enlist cultural stereotypes of femininity and link their depictions of nursing exclusively to females. One way, in which this link appears in the literature, is the invariable use of the term 'she', when referring to nurses. This is an issue that will be discussed within the body of the thesis.

I have added a brief précis of each chapter to direct the reader across and through the research.

Chapter two examines and describes the particular methodology used to explore the thesis topic. The intent in this chapter is to allow the data to 'speak' by adding meaning and understandings rather than being just a chronology of facts and figures,

which tends to add little to the discourse. The methodology chapter outlines the use of a 'storytelling' perspective in which the researcher uses a collection of events or moments, including photographs and anecdotal information, which are often left open to question and therefore often contain some uncertainty in the literature. The chapter also looks at the number of other methodologies, which were available to examine this topic and why a critical historical discourse analysis was selected "to put meat on the bones" (Bostock, 1968, p.5). Putting meat on the bones encourages the past to penetrate and inform the present and obversely that the present is an outcome of the past, suggesting that they are both important and not mutually exclusive to each other. The researcher believes that our understanding of the present is increased significantly by this looking both back and forth and by the adding of meaning and what the meanings mean, or their significance to what historically preceded it allows the history of psychiatry to be more significant, informative and a future source of wisdom. Similarly, that being able to review the literature of earlier times and examine it now by subjecting it to analysis on the basis of present day values has been productive towards professional growth and practice.

A critical discourse analysis was selected because literature tends to resist physical decay and is not subject to memory after being written, or Chinese whispers. Once written it requires a reader, a person educated to transform its pages of print into a mental experience by adding their meaning and understanding.

Chapter three outlines the history of psychiatry showing that to date, this has not been recorded at any depth and has a lack of clear defining boundaries especially in relation to Australia. The literature suggests that unless directly involved in some

aspect of psychiatry, the general public tended to ignore it, make fun of it or casually refer to it in passing by attaching it to other more benevolent or charitable activities. This strategy used in the hope of hiding both its seriousness and the impact it may have had on themselves, sufferers and the sufferer's family. Similarly, 'madness' was often viewed as possession, usually by the devil or, as being touched by God. Much of the literature depicts the history of psychiatry in Australia and any understanding of mental illness like its English or American counterpart, which tended to link mental illness to metaphysical beliefs. The chapter examines further how Australia began its life beset with some of the problems of the older English world. Amongst these problems were the difficulties and treatment of the insane. In order to understand Australia's background in regards to psychiatry and psychiatric nursing it is necessary to encompass the bigger international picture and thus know what was happening in other countries and how these happenings were in themselves significant and influential in Australia. In the first instance, Australia depended on many of the English and American leads as it began to consider psychiatry and psychiatric care and many of the ideas about mental health and the building of facilities to cater for mental ill health relied on their English and American counterparts, which were some 12,000 to 13,000 miles away. This often meant that ideas were often slowly implemented rather than being considered on their usable merits.

The English experience showed that from 1760 onwards, workhouses were built and these institutions were used as dumping grounds for the dependent and different of all descriptions in England. Similarly, the passage of Treatment and Poor Law Legislation was instrumental in the shaping of services for those considered insane in

England and were indirectly responsible for the structure of services in Australia. This chapter argues that at times administrative arrangements tended to suit the administrators rather than those for whom they were supposed to care for. The treatment of those considered insane was at times harsh in both England and Australia and the usage of Bridewells, benevolent societies and private madhouses add their own dimensions to this argument. The private component of this section outlines the usage of the insane for financial reasons rather than any philanthropic endeavour.

This chapter also highlights how events such as the illness of George III in England changed how the general public thought about insanity moving away from the term insanity to the more benevolent term mental illness. This change shifted away from more custodial pursuits of the history of psychiatric care and the respective roles of keeper or attendants, to the more therapeutic regimes and the subsequent movement toward nurses and nursing and therefore dealt with some of the significant gender issues which had been significant in earlier years. This shift meant that ‘madness’ had almost become respectable and a condition that might happen to anybody. This is of course of incalculable value in the general acceptance and movement of ‘insanity’ to ‘mental ill health’. It indirectly took ‘mental illness’ into peoples homes and caused much discussion about what it was and could be. The Australian experience quite clearly followed these changes at the hands of some very important and influential figures (notably Tucker and Norton Manning).

Chapter four takes an in-depth look at the people who worked with the insane and some of the gender complexities often associated with this work. First, it examines

the rulebooks, which were produced to outline the specifics of a rather difficult job and in this examination touches upon some of the masculine/feminine roles which were expected, in fact unofficially encouraged by the medical superintendents and head nurses which went to more housekeeping and custody/firmness and safe keeping roles for specific genders. Across this examination the writer has included some of the more contemporary views, which deal with issues of gender balanced against the roles of male and female nurses. Also, prescribed gender roles, genetic scripts, scripted performances, which often serve as guidelines to the particular contextual enactment of a given role. The chapter then moves to consider 'self' as a repertoire of different masks or selves, which suggest that individuals of both genders can adopt multiple roles which can be and often are employed across nursing in the provision of nursing teams and services. This provision shows how newcomers to a profession such as nursing learn to 'fit in' by taking up ascribed requisites to accommodate. This argument has been extended to show that gender is also subject to these ascribed prerequisites and that in the case of males entering nursing, their ascribed male prerequisites carry them through to do well in a profession, which is for the most part traditionally female. Masculinist agendas/qualities which are usually attached to provider roles at home are then used in the workplace often giving males better career opportunities than females (in a hierarchy) as they incorporate some of the natural masculine qualities such as challenge, drive, achievement and competitiveness to their position. Many of these qualities are not features of being female and therefore may be considered shortfalls to female success.

The chapter then considers schema socialisation and some of the changing roles brought about by philosophical and ideological shifts in parental, economic and other

roles at the beginning of the twenty first century. These shifts include changes to the sexual division of labour and many of the intricacies of the changing job market and the roles that were considered to be traditional in the late 1940s, 50s and 60s, along housekeeper versus provider lines. These role changes are informed and influenced by a whole series of factors such as the changing economic markets, feminism, welfare provision, female contraception, World Wars and a more open view about career choice. Men and women choose nursing for a whole series of different reasons in the same way that men and women may choose engineering. The more traditional division of labour now appears less important and males and females now employ and take on different roles/rules in their daily lives. All of these shifts/changes are informed by issues such as power, patriarchy and capitalism and more recently a shift in how society uses issues such as text, language and discourse.

Chapter five deals with the construction and nature of psychiatric nursing in Australia looking back across the limited history of the profession to see if past events had been significant to how psychiatric nursing is practiced now. Some of the notable issues across this chapter include the selection of psychiatric nursing staff (across history and now) and how this appeared to be a rather difficult proposition. The absence of a generally agreed upon criteria of what constituted a good attendant/keeper/nurse with many in Australia other than those who were convicts being selected on the basis of being willing, thought of as upstanding citizens and were often selected because of some previous philanthropic endeavour rather than having any practicable skill or experience. Clearly, the fear and stigma that insanity evoked in the general public, and the perception that insane people were violent and dangerous was significant in early treatment arrangements of the insane and a reason

why people did or didn't readily seek employment in this area. Alternatively, the provision of small wages or rations actually began to raise the possibility of more people actually becoming involved in work with the insane with the view that any employment was arguably better than starving to death. An aside to this was that often convicts before the courts for offences committed in the colony, were often sent to work in the hospitals as a punishment. These issues lead onto the training of asylum attendants because how those considered insane were treated began to shift from a more custodial to therapeutic oriented regimen despite many of the staff being criminals according to indifferent laws. Initially people without any education were often used to attend the insane, then domestic servants were employed to care and with time attendants were required to undertake training with the medical superintendents and others seeing the value and benefit of educated help relational to patient outcomes, staff retention and the smooth running of the asylum. These measures were instrumental in shifting the care from custodial to more treatment orientated regimes and attendants rather than simply fulfilling a custodial role, were expected to have an understanding of why, where and how particular conditions might arise and be seen in the asylum environment and what they might be able to do about these conditions. Often this posed difficulty in some quarters of the general public as education in these areas was often in short supply. Because of this services were often gained from elsewhere and many doctors and head attendants were recruited from overseas.

The second part of this chapter deals with the history of mental health nursing contrasting Australia with international developments in England, America and other countries and suggesting that from a mental health nursing perspective, little clear

historical information exists, although issues surrounding the care of the insane are often subsumed within other areas of discourse. Some commentators point out that historians have not rushed to investigate and examine the nursing care of the insane, pointing out that the history of psychiatric nursing is considered unglamorous, unromantic and has little appeal.

The chapter then looks at some of the asylums in Australia highlighting one particular institution as a template to give readers an overview of the available resources across Australia. The first recorded institution in New South Wales was an establishment at Castle Hill, which began taking in-patients in 1811. In 1825 Castle Hill was replaced by the Liverpool Lunatic Asylum, which ceased to exist after 1838 when its place was taken by an institution at Tarban Creek, later known as “Gladesville”. In Tasmania the first asylum, erected about 1829, was at New Norfolk. In South Australia the original accommodation was a house situated on the Eastern plains taken over in 1846, which when the present Parkside Mental Hospital was built became known as the old asylum. Other states such as Queensland (Woogaroo Lunatic Asylum first opened in 1864) and Western Australia (Fremantle Asylum first admitted patients in 1857) were notably slow in following the lead set by both Victoria and New South Wales being nearly fifteen years later before similar accommodation was erected. Obviously, population, particular circumstances, finances and demographics would have played a part in this. When these aforementioned institutions were being considered and built, Victoria was known as the Port Phillip District of New South Wales, which then was under the control of the New South Wales government. At the beginning of Australian settlement there was obviously no provision for the mentally ill other than gaol like (lock up)

accommodation. Patients were herded together with other criminals; some of the inmates were selected in exchange for a variety of undescribed favours to look after new patients and in return for caring for them were often granted a remission of their sentence (being for the most parts criminals themselves). In 1845, the New South Wales council appropriated £1,000 towards the erection of a new lunatic asylum to be placed in the vicinity of Melbourne this would be known as Yarra Bend. The chapter then outlines some of the recruitment issues of local people, which proved difficult, and often asylum officers had to advertise nationally to secure what were described as suitable staff. The choice of staff often went to self-sufficiency of the staff member rather than the prospective staff member having any particular skills in this area of work. The institutions in themselves attempted some form of self-sufficiency where asylums attempted to provide services without burdensome costs attached. There are many issues about staff and their employability across the history of psychiatry with the suitability of males versus female attendants being one in particular. Some of these issues were driven by the rapidly changing face of the care provided for the mentally ill, with many of these changes being made as a result of public pressure being applied. This public pressure was driven by concerns over safety issues rather than concern about the overall care of those deemed to be insane or mentally ill.

Chapter six looks at the more recent issues relational to psychiatric nursing and examines the significance of gender in psychiatric nursing from a more current day perspective. This process allows us to look back from the vantage point of the present. The last twenty to thirty years in mental health nursing have seen immense changes taking place in the philosophy, organisation and delivery of mental health

care in Australia and overseas. These changes were in part driven by financial, political and employment issues that placed some burden on how mental health nursing was then practiced on the particular government of the day. The changing focus of mental health nursing in both England and Australia has been instrumental in how the professional groups, especially nursing, practice and exist within the mental health arena and this chapter has explored some of the philosophical underpinnings, ideology and driving forces behind some of these changes. This exploration has shown that a series of interrelated factors including gender have collectively played an instrumental and significant role in how these changes have been played out in mental health nursing generally.

Some commentators suggest that we have reached a crisis in mental health care due to a series of changes brought about initially by early 20th century governments being unsympathetic and unresponsive to the need for reform within mental hospitals and mental health. This reform stemmed from the fact that respective governments in England and Australia were not addressing the escalating demand, and subsequent costs, for services within mental health arena. This escalating demand driven by spiralling inpatient and outpatient numbers, with patient admissions always seeming to outstrip patient discharges had cost as its hidden agenda.

The filling of nursing positions with untrained ancillary staff was not well understood by either the English or Australian nursing unions of the day or the nursing profession generally, and that the direct implications for using mental hospitals primarily for the accommodation of the elderly and those considered to be chronically ill was rather short sighted. This meant that acute psychiatric care was

being gradually shifted to general hospitals with this compounding the gender mix issue and was instrumental in the movement of many mental health nurses following these patients into acute care areas which were always seen as more appealing professionally from a career perspective.

The Australian picture of mental health nursing paints a very similar picture with evidence suggesting that the mainstreaming of mental health has not had a huge effect on the issue of stigma in fact some evidence would suggest almost a negative result has been achieved (Chan & Rudman, 1998, p.144). Once again these issues do not appear to have affected the consistently low number of comprehensively trained graduates choosing psychiatric nursing as a career option. In fact some of the aforementioned arguments may have acted as a deterrent in themselves to graduates looking for psychiatric career options. The comprehensive programme may have inadvertently 'feminised' psychiatric nursing as by weight of numbers 94% of the under graduates are female and of that 94% some choose psychiatric nursing as a career choice.

Some commentators argue that psychiatric nursing has been experiencing an 'identity crisis'. This crisis is brought about by a whole series of factors including biomedicalisation and education issues and these have lead to a steady decline in numbers of those showing interest in psychiatric nursing and the recruitment and retention of staff. Because recruitment and retention has been affected fewer males are moving into the area of psychiatry preferring to take options in more general orientated areas. The empirical evidence from the Nurse's Board of Victoria (NBV) shows that in 2002 there were 67,434 females in practice with 6,058 males. The

chapter highlights that the Australian picture demonstrates that there have been very significant and poorly thought out changes to the ways in which psychiatric nurses are recruited and trained. The trajectory of these changes was sealed over 25 years ago, when professional nursing organisations expressed support for changing to ‘comprehensive’ courses located in the tertiary education sector. The decisions with the benefit of hindsight have been instrumental to the deleterious position of psychiatric nursing today.

Chapter seven looks at some of the gender issues and how they are influential or factored into the Australian nursing education scene. The chapter considers many of the for and against arguments put forward by academics and practitioners about the comprehensive nursing programme now on offer across Australia and where these directions are taking the profession. Registered Nurses now complete their undergraduate degree and are able to practice as a beginner in an array of different clinical areas including psychiatry. This means that graduates have in theory a little knowledge about everything but really an in-depth knowledge of none. The chapter looks at how university based courses are offered and describes them as being inflexible and that the assumption that the provision of psychiatric nursing across what is an essentially general nursing course is flawed. These arrangements will not attract the numbers of quality staff members required to fill speciality positions in psychiatry. Similarly, the staff members who attempt to offer quality teaching and learning in these speciality areas are quickly ‘burnt out’ by lack of financial support, large workloads, the financial difficulty associated with providing quality supervision for undergraduate students and their inability to place students in quality clinical placements across a shrinking deinstitutionalised nursing environment. These points

suggest that the current undergraduate curriculum is not comprehensive in nature and that the current programme is inadequate in preparing graduates well, for beginning practice in psychiatric nursing. These factors are complicated by the onset of fiscal imperatives and downsizing with many universities now trying to cost cut across courses, and the mental health nursing segments have not been excluded from these, resulting in a dilution of mental health content. Many commentators suggest that not only is the preparation of undergraduates for beginning practice in mental health nursing inadequate, but some university based nurses actively discourage students from considering mental health nursing as a career option. All of these issues go to recruitment and retention.

Chapter eight summarises the research by looking at the key factors outlined across the critical discourse analysis, which blend together to complete a rather complex picture. Some of the emerging themes have been discussed which demonstrate that gender has had a place in the development of insane/mental health/psychiatric nursing over the evolution of the profession. Some of these features have been created across the changing nature of how the profession of nursing has evolved over time but more especially the changing format of nursing education across and within the last twenty to thirty years. Gender is quite clearly a topic unto itself and the arguments, which put forward the view that women are devalued and exist in a devalued way across their work in the context of a patriarchal society, have some significance and merit. In the context of this research the feminine traits of nurturing, caring and dependence exist in stark contrast to the masculine characteristics of strength, aggression, dominance and self-control. How these factors and some of the incompatibilities of masculine and feminine sex role identities have played out in a

workforce where more males are now entering the nursing profession, makes one wonder about how men adapt to nursing's feminine sex role, and how the influx of men in a female dominated occupation impact on female nurses themselves. These points, coupled with the gender assignment of the custodial nature of psychiatric/mental health nursing across history have now been changed by the evolving comprehensive training packages offered in Australia and in other countries where mental health/psychiatric nursing are now firmly attached to general nursing. These changing perspectives have moved the usual entry features into mental health/psychiatric nursing and now offer an array of different demographics to either gender, both who maybe considering mental health nursing in the future.

CHAPTER TWO

METHODOLOGY

2.1 Introduction

This chapter examines and describes the particular methodology chosen to explore the thesis topic. Examination of the available discourse throughout the thesis related to the topic has shown what information already exists and has clarified some of the hidden layers of literary significance, giving meaning to this evidence. Articulation of the data allowed the information 'to speak' by adding the researcher's own meanings and understandings. Rather than catalogue a chronology of facts and figures that would produce a rather stale archival viewpoint, this methodology, from a post structuralist standpoint seeks to allow the data to be viewed from and through the meanings and understandings of the author's own present day interpretations. The methodology also combined the use of cultural artefacts, journal articles, photographs and some anecdotal information to add different perspectives and a depth of understanding to the available topic area. The history of psychiatric nursing is not a rational, clean-cut sequence of events, rendering objectivity difficult. These different perspectives therefore add an interesting dimension to the available data.

According to Roberts and Taylor, (Roberts and Taylor, 1998, p.309), "history is viewed as logocentric, a source of myth, ideology, and prejudice..." They suggest that nothing that has gone before can be taken as fact or truth because of its association with human interpretation. Research methods and processes are thus rendered impotent as records of events over time. With these thoughts in mind, time itself is rejected as chronological and linear, the modernist understanding of which is oppressive, measuring and controlling of one's activities (Rosenau, 1992, p63).

Roberts and Taylor (Roberts and Taylor, 1998, p.310) argue that truth claims are difficult to establish and are therefore a form of terrorism, that “threaten and provoke, silencing those who disagree, thereby making research tantamount to a terrorist activity”. They suggest that this terrorist activity really means that words, images, meanings and symbols are presented as if they constituted a ‘fixed system of meaning’, and as representations, sceptical postmodernists reject them because they do not allow for diversity. All of these claims make the choice of methodology difficult. Unless one can find a methodology, where the author can offer tentative insights whilst facilitating the reader’s interpretation by allowing them to add meaning to their interpretation, one may find research such as this almost impossible. Using the chosen methodology of historical method and critical discourse analysis allows this research to have a ‘storytelling’ perspective, in which the researcher uses recollection of events or moments that are often ‘left open’ to constant questioning and uncertainty in their depiction in the available literature. The use of individual narratives adds some depth to the particular points being researched.

2.2 Choice of Methodology

Although a variety of different methodologies are available to investigate these particular topic areas, such as historiography or phenomenology, a combination of historical method and critical discourse analysis was chosen. A qualitative methodology was selected because the writer felt that this would allow for a more in-depth examination of the available material which by its very nature would be difficult to empirically measure and replicate along the lines of cause and effect. This also allowed the research to be relative, context dependent and open to interpretation by both the researcher and the reader. The research topic areas are part of the whole

context of the issue being explored and are not founded on absolute claims. They are qualified in words and provide insights into the possibilities of the findings and are specific to the phenomena under study. Grounded theory as a methodology attempts to try and make sense of what people say about their experiences and so therefore proved unsuitable for the context of this research question. Phenomenology as a method has a lot to offer both nursing questions and the lived experiences of their patients. For this research question the lived experience of psychiatric nurses in relation to gender would have proven a rather interesting and productive field of inquiry but may not have encompassed the broader historical and contextual aspects of the question being examined which this writer thought may be important. Ethnography, as a research method looked interesting and the ‘portrait of the people’ known as mental health nurses would most certainly prove to be a productive and useful exercise. Ethnography, however, is primarily concerned with the present and of course this makes on-the-spot observations of any of the cultural antiquities of psychiatric nurses or nursing over the years virtually impossible. Historical research appeared to be the way to go forward for this study, to help discover new knowledge about what was happening in times past in relation to how they are perceived and interpreted now, give meaning to the profession as it is practiced today.

The choice of a historical method and critical discourse analysis methodology allowed the available information to be in a way self-informing, such that the information gained have been the building blocks in one sense and the mortar in another, each adding perspectives as they are drawn from a variety of different sites and resources. This form of methodology aims to read the available literature as it was originally read, with a view to understanding the original meanings in their

particular context. Obviously, there are some philosophical problems with aspects of this particular methodology. Dewey, (1964, p.36) for example, argues that all history is necessarily written from the standpoint of the present, suggesting that it is the history, which is contemporaneously judged and deemed important as it is recounted in the present. He rightly points out that it is these views, or present interests of the historian that determines how a particular history is selected, documented and more importantly interpreted and given meaning. Foucault (1965) argues that there is no sense of forward movement or progress in the history of ideas, only discontinuities. And the ideas of one era are not necessarily an improvement on those of the past, only different. These views are consistent with post-structuralism and state quite clearly that each historical timeframe has its own way of thinking, and that a retrospective look back at particular timeframes show that formal and elaborate systems have been constructed or used that enable people to learn from those that have preceded them, such as books, journals, educational and cultural systems and more recently universities and computer data banks. Lovejoy (1964, p.29 & pp.35-37) takes a slightly different point of view by saying that when an historian gives an account of a past period of time or of a particular society, the selection of what should be deemed important should not be governed by what seems to be important to him or her, but by what seemed important to other men and women in the past. This becomes a problem of objectivity as determined by the historian's own values or even the values of his audience or society, which of course are taken into account when determining or guiding the selection of what is important. Often those involved in events have no idea of their significance in the long term.

History is not objective, because the historian often cannot observe the subject

matter. Historians can sometimes observe artefacts and are often able to conduct experiments on human or other remains. They may also have accounts of past events by being able to view films, look at photographs and drawings. But, generally, because a “historian’s documentation of the past is fragmentary; because he must select even from this partial record; because he must arrange his materials in reporting his results; because in employing organizing concepts he imposes a structure on the past that it never really had; because the events he is interested in involve ethical and aesthetic considerations; because no historian, in any case, can bring to his work a neutral mind” (Beard, 1964, p.21).

Barracough (1964a, p.20) takes a more conciliatory line and supports the view taken in this thesis that by looking at the past and interpreting and adding meaning to the data allows the information to have its own voice by adding this writer’s understandings. Barracough (1964b) extends on this by saying that in historical study, we should appraise past ages, if we form an opinion about them at all, by their own standards, and not by ours, giving importance and meaning to what was important then, and not single out only the phases and incidents that seem significant now. This will be difficult because it would be hard to ascertain what was important then from an objective point of view. However, this method has allowed the writer to look back from the vantage point of the present adding an interesting dimension to this historical discourse analysis.

2.3 What Evidence Exists for a Historical Discourse Analysis

The first research task for this thesis was to establish what evidence or information exists that might help address the research question. The second was to analyse,

interpret and give meaning to the evidence, seeking some authenticity and then assessing the information for its significance to the case at hand (Windschuttle, 1994 p.219). Obviously, this necessitated an informed interpretation of the forthcoming data, requiring the exercise of personal judgement as to what has counted as relevant data or been significant in terms of evidence. This interpretation allowed the data to speak for itself, but the data's voice has only been heard through the writer's understandings and interpretations, such that it assumed meaning by that understanding (Holmes, 1997). The intention is to offer a valid, plausible and meaningful account of events, which have gone before, which accords with the available evidence but is also more understandable and allows present day readers to add their own understandings and meaning to the evidence. Bostock (1968, p.5) describes this as "putting meat on the bones" bearing in mind the dearth of available material. Initially, the writer proposed to investigate the topic areas by attempting to understand the historical information. This understanding would be gained by taking a current 21st century perspective rather than by allowing the information to 'speak' for itself. To recreate history as it was, would be by reporting the facts only, but if this approach had been adopted, the accumulation of data or the cataloguing of facts would have resulted in a rather stale, archival view of history which would then only shift the interpretation of the information to any given reader. The two tasks are somewhat antithetical.

Therefore, in line with more contemporary views, the information is interpreted and given meaning by the researcher or writer allowing other readers to benefit from these understandings. The readers would then apply their own particular interpretations of this writer's understanding and give meaning to these

interpretations. The application of their own intellectual and attitudinal options and interpretations would be subject to their own time and place and their own ideologies and biases (Holmes, 1997, pp.32-35), subject to the meanings that this writer gives to the facts, and so on and so forth. Bostock (1968, p.5) also touches upon this point in saying that

...the historian in such an atmosphere inevitably has opinions on the motives and manner of his subjects. As the reader will have the opportunity to study the same material, he has a legitimate claim to both facts and opinions. He wishes to know not merely a recital of events but also an analysis of relevant factors and their possible application in contemporary thought.

In this sense, and by using this methodology, objectivity becomes rather difficult (Windschuttle, 1994, p.136) and moves, using Foucault's analysis, to encourage historians to be 'political activists' with all knowledge exuding power. Windschuttle (1994, p.136 citing Foucault, 1971) argues that Foucault suggests that the aim of traditional history is to discover in the past a pattern, or a rational sequence of events. This aim is impossible because there is nothing constant or universal in either human nature or human consciousness. Foucault (1971) argues that "different historic eras cannot relate to one another, and a new era is not born within and nurtured by its predecessor. A new era, or 'episteme', simply appears in a way that cannot be explained" (Windschuttle, 1994, p.137). Foucault suggests further "history does not display any pattern of evolution, because the past is nothing more than a series of discontinuities or unconnected developments" (in Windschuttle, 1994, p.137). Holmes (1997) takes the view that everything in history has to be seen from a particular perspective, with historic facts not being allowed to stand on their own. He states that facts alone cannot speak rather we make them speak by interpreting them to any given audience and ourselves. Foucault's (in Windschuttle, 1994, p.137)

argument suggests that historical facts cannot stand on their own because the media, language and formats we use to express and describe these facts are always interpretive. They are persuaded and manoeuvred by particular ideology and bias. Holmes (1997, p.30), in a similar fashion, reminds us that historical research should be as accurate and reliable as possible. Reliability and accuracy derive from the historian's interpretation of the information, and this exercise of personal judgement relational to the data is unavoidable and intrinsic to the enterprise of history.

2.4 Clothe the Bones in Flesh

If history is concerned with past human actions of societal significance as described by Mandelbaum (1938) then to clarify and analyse the significance of the human past relational to the thesis topic that of gender and its significance to Australian psychiatry, will prove rather elusive and difficult. If the onus on the historian is to explain why things are the way they are, and not just to establish facts but also to understand them, then this writer would prefer to take the position advocated by Hempel (1959, p.348) who offers historical explanation as "...showing that the event[s] in question [were] not a matter of chance, but [were] to be expected in view of certain antecedent or simultaneous conditions". The expectation, not being prophetic or divine, is then based on rational scientific anticipation. Some of the more insightful commentary on history offers different yet contrasting thoughts. Foucault (in Danaher, et al 2000, p.98) for instance, suggests history is not always predictable; in fact, in many ways, it is unpredictable because it stands outside of logic, is not linear, is not a complete fixed entity and contains many absences, silences and coincidences. In contrast, Foucault (Danaher, et al 2000, p.98) encourages us to think of multiple, overlapping and contesting histories. Danaher, et

al (2000, p.97) suggest we progressively reconstruct the past in order to serve the interests of the present...the nineteenth century did not occur between 1801 and 1900, but rather is an ongoing invention that has been subject to revisions and reconstructions through each subsequent era. On the other hand, Karl Marx (in Collingwood, 1946, pp.122-3) suggests that there is some internal logic to history and that history contains patterns, and is not a number of different parallel histories (economic, political, artistic, religious) but one single narrative that proceeds logically, and that individuals could/can change or intervene in history.

The literature (Brothers 1950 & 1965; Bostock 1968; Cummins 1968; Garton 1984; Lewis 1988) depicts the troubled background of the mental health care provided in Great Britain and the burgeoning nature of the overall problem. Other literature (Carpenter, 1986; Nolan, 1993; Nolan and Hopper (1997 p333) suggests that transportation to the colonies would prove to be doubly beneficial to the authorities in Great Britain. Often the removal of people regarded as troublesome, or bad and therefore mad, and because of this, difficult to place would be transported to the colonies. This also emptied the English gaols as well as disposing of the insane (Bostock, 1968, p.9). The whole exercise maintained social order in light of significant costs to those in Great Britain and there were increasing numbers of people deemed to be mentally unwell. Ellis (1983, p.26) reports that the cost of keeping a patient in an asylum in Western Australia was £42 per head per annum, compared with the equivalent cost in England, which was 'something like £200' (Ellis, 1983, p.26). These figures may have been significant to those in Great Britain making the decision to transport people who had committed minor stealing offences to the colonies and in this process attached bad to mad.

Recent commentary suggests that the study of the history of mental health care has been enjoying a revival in both the United Kingdom and more generally in the Western world across the past three decades (Nolan, in Newell and Gournay, 2000, p.28). Nolan suggests that being able to appreciate the history of one's profession could complement and enhance one's practice with keener insights, and enable practice to be more proactive.

The view offered by Nolan suggests that being able to review the literature of earlier times and examine it by subjecting it to analysis on the basis of present day values will be productive towards professional growth and practice. The intention in using methods such as these will, as Bostock (1968, p.5) suggests, allow individual readers to 'clothe the bones in flesh, bring dead men (sic) to life' and hopefully make vanished scenes reappear with much more clarity which is the remit of a discourse analysis. Clarity in the reappearance of the vanished scenes allows both the researcher and the readers of the research to review the discourse in a new light and subject these new understandings and their meanings to their own interpretations and understandings. This broader conception and analysis has included text that has been written and also spoken discourse, so that, for example, the words used in conversation or their written transcripts constitute a text and have added some depth to specific points.

By widening the discourse analysis, and in keeping with the broad range of sites available, texts other than linguistic texts have been examined. Cultural artefacts, journal articles, photographs, hearsay and anecdotal information have been included where appropriate, as they add another valuable dimension to the research.

Fairclough (1995, p.5) argues that the aforementioned view of texts has its dangers because its extension can often mean that the results become rather nebulous. This point is relevant and was borne in mind by the writer as the research unfolded. Fairclough argues further that texts in contemporary society are increasingly polysemous and have many meanings, taking a broader conception within discourse analysis, where a text may be either written or spoken discourse. This view is valid and allows more meaningful information to be drawn from a wider source of data, for example combinations of language with other media such as photographs, drama, television, diagrams and anecdotal accounts/information. It would appear obvious that to rely on information drawn from available documents as advocated by Cushing (1996) and to accept them uncritically would not be particularly wise. The notion of allowing data to 'speak for itself' is interesting as the way data is interpreted and given meaning through the historian or reader can be said to verbalise a particular view. To suggest that we can only allow the information to speak for itself is interesting, as factual accounts of an incident or happening which may give readers the date of the incident as an example may not be precise in other areas (that a fire burns is in itself factual). Other variables, however, are not considered and this perhaps precludes any real substance, human understanding and therefore meaning that can be drawn from the available data. The facts assume meaning and significance once they have been interpreted or expressed. Using a discourse analysis under these guidelines fits well with the oral tradition which is often espoused by those in nursing as being central to the profession (McRobbie in Street 1991 p27). The aim in this thesis has not been to gather objective information but rather to further the understanding of human meanings, and in this process gain some intrinsic understanding from the inside, unlike the natural world where we tend to impose

extrinsic understanding (Windschuttle, 1994).

2.5 Hidden Layers of Significance

Using a discourse analysis with a critical focus revealed amongst other things the hidden layers of significance lying beneath the obvious, taken for granted surface that is often taken for granted. Lupton (1992, p.147) argued that looking critically at the use of language in accounts of verbal communication such as newspaper reports and/or archival information exposes at some level the power structures and, more importantly, dominant ideologies in societies. In using a critical discourse analysis, this work incorporated the work of a number of critical theorists, poststructuralists and feminist writers focusing on specific areas as they are identified in archival, statistical, general literature and recorded interviews. Uncovering material by this means and adding meaning to the data gave directional pointers to the research and were instrumental in peeling back the layers of information and exposing new information and directions in the overall process. The critical perspective, which this particular method entails, has been selected because it incorporates one of this writer's preferred focal points. It helped develop a clearer understanding of how the current situation arose, how it is maintained and what are the important factors that surround and sustain it. This textual evidence has enriched the analysis, which included a social and cultural focus, and is partly linguistic and partly intertextual. This scrutiny should indicate how links between one text and another occur and what significance this holds for their form and content. Gaining information from the aforementioned sources has not precluded other sources of data during the course of this study. Anecdotal evidence has been a most valuable resource, which cannot nor should not be ignored. The incoming information has revealed a variety of different

themes, some obvious and others that were initially hidden that have been drawn out and added to the material and knowledge base of the research. In this, the commentator's particular perspective has been made more context and observer specific: the perspective has been made more explicit by acknowledging the speaking subject as inevitably positioned within a socio-political framework. Omissions and silences from texts have been identified in this process, as both implicit and explicit meanings have been uncovered by peeling back the layers when dealing with the content. The methods used for this study have been consistent with the research aims.

Bearing all this in mind, the research has investigated, examined and analysed the written and visual materials located in archives, libraries, and a variety of other sites, in order to trace and understand the historical development of any key themes that arise within the material. A variety of methods are available and could have been used for this task, but the clearest definition and/or guide which summarises the approach adopted has been described in some detail by the notable work on historical criticism and the inherent meanings of texts by de J Jackson (1989).

de J Jackson's (1989) position on historical research entails in basic terms an interest in the recovery of the past. He advocates the significance of attaching literature of the past to the time in which it was written suggesting that readers need to be careful of 'taking for granted' one's understanding as comprehension would be impaired or transformed if one was ignorant of the social context in which specific literature is written. Reading past works of literature in the way in which they were read when they were newly written is what most naïve readers suppose they are already doing. de J Jackson (1989, p.3) argues that "...experience makes one increasingly aware of

the discrepancies between the original readings and subsequent ones, ...suggesting that these discrepancies are so great as to be beyond repair". de J Jackson (1989, p.5) suggests a corollary to the aim of reading past works of literature in this manner and by suggesting that historical criticism is not an end in itself but a means to other ends. It is certainly possible for a historical critic to be a historical critic and no more; like scholarly editing, the activity can be intellectually and even aesthetically satisfying in itself. But establishing the original meaning of a text, like establishing the original wording of a text, is normally undertaken with a view to providing reliable materials for all other kinds of criticism to work with.

The interpretive framework for this study has drawn on the work of a variety of other leading authors including several critical theorists and poststructuralists, such as Foucault, Lacan, Habermas and Giddens, alongside writers on gender such as Eisenstein and Segal, and feminists such as MacKinnon (1987; 1989) and Hartsock (1983). The purpose of the research is to critically discuss and examine the available material and in this process produce an account of the evolution and maintenance of the gendered nature of psychiatry and psychiatric nursing in Australia. The research has elucidated the effects this has had, and continues to have, on the nature and construction of psychiatry, psychiatric nursing and other psychiatric professions.

2.6 Adding Meaning

Other research methodologies could have been used to examine the aforementioned issues, such as an interpretive and/or hermeneutical approach. The intricacies of the research topic in addition to the mystique and fascination of the topic of psychiatry in general, means that a huge variety of interpretations and understandings can be

arrived at. Every attempt to interpret and understand and, in this process, add meaning will be conditioned by the contextuality of both the interpreter and the text as discussed by Linge (1977, p.xii). In this view, any text as understood in the broader sense of a created work will be interpreted from a specific historical position, arguably that of the socio-cultural position of the reader. This would mean that the particular text needs to be read and recontextualised in what could be described as a different horizon to that in which it was originally created. This is very similar to discourse analysis and goes toward putting 'meat on the bones' as described by Bostock (1968, p.5). de J Jackson (1989, p.4) argues that readers of past literary work should be careful "of not distinguishing meaning from significance". In this instance de J Jackson refers to the meaning the work conveyed to the reader and not what the meaning or the significance of that meaning had for any particular reader at first or later". Both methods appear able to externalise or materialise the original author's intellectual intent as text. The meaning attributed to that text by readers is obviously somewhat dependent on what might be described as contemporaneous understanding. Ricoeur (1981, p.139) clarifies this point in saying that writing is the initial division between intent and signification, what Gadamer called 'the matter of text' (cited Ricoeur, 1981, p.139). Here, the text is set free from the horizon of the author who adds meaning, and it can then transcend the author's horizon. Gadamer's work (Gadamer, 1976) is particularly interesting in this regard, where he sought to attach the notion of horizon to what he describes as an historical consciousness. According to Gadamer (1976), there is an uninterrupted historical horizon linking the past with the present (as described by Annells 1996, p.707). He argues that as the horizon of the present, which he states is constantly changing, comes into contact with the historical horizon there is a linking or "fusion of horizons". This fusion of horizons is

a way of describing how the new understandings emerge. Each interpretation by a reader or researcher would reflect the unique fusion of the horizons of an historical consciousness with a historically situated text.

Locke (1977, in Nolan, 1992/93 p.131) adds that the past penetrates the present and obversely, that the present is the outcome of the past. This suggests that the past and present are both important and not mutually exclusive; they are dialectical and informative to each other. Our understanding of the present is improved by looking back and by the adding of meaning to these reflections. For this research these meanings allows the history of psychiatry to be more significant, be more meaningful therefore productive and a future source of wisdom.

This line of thinking and analysis has some similarities to the position put forward by Holmes (1997) who suggested that interpreting and adding meaning to a particular discourse allows historical data to 'speak', by allowing the data's voice to be heard and given meaning through the writer's understandings, hence, a fusion of horizons.

2.7 Resisting Physical Decay

By examining the literature we can become both informed and educated by history. For some, this seems a difficult concept to grasp but when one analyses the statement and examines the available literature relevant to a particular topic area it appears to be true. The basic idea that past works of literature can survive the passage of time undamaged is subject to a variety of different schools of thought, notably our own response to such work and our understanding of what the data, book or work conveys. This is situated by the understanding and subsequent meanings the reader

attaches to the work, and would be subject to the speculations about what may have prompted these understandings and would also need to take into account the environments of both the author and the audience which are not mutually observable as would be the case in a conversation. de J Jackson (1989, p.37) highlights this point by using the work of the poet Coleridge, saying “[t]he man who reads a work meant for immediate effect on one age, with the notions and feelings of another, may be a refined gentleman, but must be a sorry critic.” The sense of presentness of a past work of literature, and its power as a vehicle to allow the reader to recapture the moment, is arguably one of literatures’ greatest strengths. de J Jackson (1989, p.21) argues that in regard to meaning, speech acts have the advantage of being familiar to us all, both in our capacity as speakers and in our capacity as hearers. They have the further advantage of being relatively simple, even if “inconveniently various”. He states further that “the most obvious discrepancy between a statement and a work of literature is one of scale and hence of complexity” (de J Jackson, 1989, p.21). These thoughts were significant for this writer when considering the use of a critical discourse analysis for this research project. Using a critical discourse analysis was in part realised because literature tends to “resist physical decay because, like music, it is only partly complete as a physical object. It requires a reader, a person educated to transform its pages of print into a mental experience” (de J Jackson, 1989, p.38). de J Jackson argues that in ascertaining the value of any past literature we as the readers are often deceived ourselves because we do not bring to it the experience that is required for its imaginative or intellectual realisation in its own time. Instead, we tend to bring the experience that is required for the realisation in our own particular time. Within this analysis by de J Jackson, the experience and the literature lose something in that only fragments of the earlier true experience survive. According to

de J Jackson (1989, pp.38-9), the only “true decay that can afflict literature is invisible; it is within ourselves ... it is not the objects that have decayed but the readers”. The suggestion here is that readers may not feel decayed but as readers of past literature we are demonstrably decayed because we do not bring to it the experience that it required for its imaginative or intellectual realization in our time, an experience in which only fragments of the earlier experience survive (de J Jackson, 1989, p.38). This was important in the selection of de J Jackson’s (1989) work, dealing with historical criticism to look at this particular research question because it remains consistent with reader centered approaches ushered in by post structuralism. de J Jackson suggests that our sense of the literary past arises from our observation of discrepancies between the world it depicts and the attitudes it conveys.

With these points in mind this thesis has looked at some of these discrepancies. The examination of the significance of gender to Australian psychiatric nursing reveals a limited yet diverse range of data, although much of this data is anecdotal rather than textually based. Of the works available some speak to specific periods of time, others speak of particular geographical areas. The intent of this research reflects the changing attitudes towards those who society deems to be mentally ill. As illustrated in the following chapter the attitude depicted in the literature portrays the general public’s view towards mental illness as one of a changing indifference. The insane were often housed and locked up in gaols giving the people who worked with them a custodial role in their keeping. Over time, this custodial keeping moved to a more therapeutic caring regime but still retaining a similar underlying focus, that of an ‘out of sight out of mind’ policy.

Gender, as a social construct, plays an important role in nursing *per se* with the role of nurses being significant in how nursing is viewed by the general public and similarly, how those deemed mentally unwell are and should be taken care of. The position argued in this thesis is that gender is genetically scripted and then overlaid onto a set of social circumstances that provide and embody standards by which others joining the professional group ascribe to by ‘fitting in’ with the set role. A critical discussion and examination of the available material throughout the body of the thesis has produced an account of the evolution and maintenance of the gendered nature of psychiatric nursing in Australia. Although this examination has focused on more recent events it has also transversed across earlier historical periods showing how other accounts and archival material has been informative and interchangeable with contemporary understandings. Although taking an Australian focus the research has critically examined some of the available overseas literature taking in a more global perspective to establish to what extent Australian psychiatric nursing and the associated professions have emulated the British and/or American psychiatry models.

The path of mental illness leads backwards to the beginnings of Australian settlement and the efforts made by those pioneers who were instrumental in placing foundational stones to hospital treatment in place of custodial asylum care. This movement reflects the changing attitudes towards those considered mentally ill described by Ellis (1983, p.xvii) as moving “from nuisances who had to be restrained and cared for in custody, to sick individuals who could be treated and who could maintain or regain their places in an increasingly complex society”. The path of mental illness is also reflected in the staff and their individual contributions to mental health, their collective nature as a group of professionals and some of the factors at

play which determined why people select mental health nursing as a discipline or career pathway. Much of the next chapter highlights some of these intertwined features and examines a brief history of psychiatry which contextualises the role of the people who work with those with a mental illness.

2.8 Summary

The discussion in this chapter has presented an overview of the methodology used to investigate this topic area including some of the background information relevant to the study. The looking both backward and forward encourages people to benefit from the wisdom of the past.

The chapter notes the range of methodologies that could have been used to investigate the thesis topic. Because the history of psychiatry and, in particular the history of psychiatric nursing, is not a rational, orderly topic or sequence of events, the researcher decided to use a critical discourse analysis which allowed the limited available textual data to speak by adding the researcher's own, contemporary, meaning and understandings. A critical discourse approach was selected in preference to other methodologies because the researcher felt that this would allow the subject matter to be investigated in more depth and would produce informative and usable data, rather than a dry, archival catalogue of facts. It has been argued that de J Jackson's (1989) position on historical research, which entails an interest in the recovery of the past through contemporary interpretation, is a useful way of approaching this study. The methodology is believed to offer the best opportunities for generating a valid, plausible and a meaningful account of past events, which accords with the available evidence but also allows present day readers to add their

own understandings and meaning to the evidence.

The next chapter presents a brief history of psychiatry, which includes psychiatric nursing. This history makes linkages between the nursing care offered in other parts of the world, especially England to demonstrate the similarity of approaches across the world.

CHAPTER THREE

THE HISTORY OF PSYCHIATRY

3.1 Introduction

The history of psychiatry and the nursing care of the mentally ill in Australia have not been recorded well and in any great depth. Psychiatry by its very nature, and by the picture it may conjure up to the general public, has remained a rather elusive, almost mythical and a consistently fascinating (Bostock, 1968, p.5) topic. Despite this fascination only a limited number of authors have chosen to examine this area beyond a cursory glance, perhaps much to do apprehension and incogitancy. Many authors refer to a history of psychiatry rather than examine a history of psychiatric nursing. Shorter (1997, p.ix) describes the history of psychiatry as being like an ‘uncharted minefield’ with both literary and anecdotal evidence, suggesting that the richness and abstract nature of the sources make it almost possible to demonstrate anything by using selective quotations. It is hard not to agree with this opinion as one researched this unlimited topic area which tended to still retain much of that special mystique today. The lack of clear defining boundaries highlights one aspect of the difficulties faced by using a historical discourse analysis to research the thesis topic. Psychiatry as a subject is shrouded in mystery. Adding to this mystery are topics such as diversity, culture, myth, convention, ideology, established order and significant difference which all highlight many pathways which prospective researchers can travel. Each of these pathways involves different philosophical perspectives, adding complexity and in essence further clouding an already

nebulous picture. One could argue, taking the position advocated by Shorter (1997), that the history of psychiatry in Australia does tend to rely on a whole series of anecdotal quotations, with a significant dearth of what could be described as quality literary information being available. History of course is not just the repetition of certain facts, which by being repeated and written about attain a sense of factual permanency. Nor by continued repetition should a fact collect strength and take on a different, more sustainable meaning. As an example, using repetition in the formation of family names where for instance Robin's son can by repeated usage become the surname known as Robinson with the process tending in this way to sustain, take on a slightly different meaning and reinforce itself. This writer argues that history is partly constructed or reconstructed and given meaning(s) in this way. The history related to Australian care of the insane/psychiatric nursing is of course not as extensive as its overseas counterparts with Australia only being settled in 1788. Clearly, many of the leads related to the care provided for the insane in Australia have their beginnings in English and similar overseas institutions.

Bearing in mind these limitations, this research contains primary and secondary data selected from limited available resources, notably university data bases, the Archives of the Royal College of Nursing Australia, the State Library of New South Wales (by proxy), the Fischer library of the University of Sydney, the University of Melbourne Library and a whole series of personal collections and original official reports.

Bellaby and Oribabor (Davies, 1980, p.147) capture quite simply the position this writer has chosen to take with this research in moving toward understanding more clearly the

gendered nature of psychiatric nursing. Bellaby and Oribabor suggest that whatever final judgements one draws, new interpretations and meaning can be drawn from old material provided the questions one starts with are different. In terms of difference, using a historical method and a critical discourse analysis and by critiquing the available archival material allows the data to be viewed in different and more distinguishable ways. This interpretation allows the data to 'speak' for itself, but the data's voice is heard through the writer's understandings and by adding meaning to this interpretation draws out more distinguishable points. These interpretations need to be balanced against the questions asked such that they assume meaning by that understanding (Holmes, 1997).

To fully understand something as complex as the history of psychiatry and psychiatric nursing, individuals, groups and organisations, including governments often construct interpretations and imply particular meanings, and within this process sometimes manipulate the truth to suit their own particular needs and ends. This was largely the position promulgated by the so-called antipsychiatry movement (Szasz, 1960; Foucault, 1961 p.276; Shorter, 1997, p.272). The antipsychiatry movement in both England and Australia, attempted "to change psychiatry from within by taking an existentialist approach that argued for the valuing of human experience in preference to treating the label under which the patient was controlled by the dominant medical hegemony. Antipsychiatry was a different way of viewing mental illness or, asking different questions which freed up patients by enabling them to exist as human beings rather than being seen and related to as patients or labels that were devoid of any social, cultural and

personal attributes” (O’Brien, et al 2001, p.4). A different view described by Nolan (citing Carpenter, 1986, p.15) is that the Victorian image of the asylum was still prevalent in the mid 1980s with “asylums...likened to...public sewers designed to cleanse cities of moral filth, unobtrusively removing it to a distant place where its threat to decent society could be contained”. “Asylums, because of this view, were seen by the general public as punishment-centred bureaucracy[ies]” (Nolan 1986, p.15) and this research argues that this view was determinant in the gender and demeanour of prospective applicants for employment.

3.2 An Ignorant General Public

Unless directly involved in some aspect of psychiatry, the general public in countries around the world tended to ignore its existence or casually refer to it in passing by attaching it to other more benevolent or charitable activities. Many choose to make fun of, or be amused by those who are mentally ill, in the hope of hiding both its seriousness and the impact it may have on themselves, sufferers and the sufferer’s family. Similarly, ‘madness’ was often viewed in the eighteenth century as possession, usually by the devil or, alternatively, as being touched by God. People were often spoken of as being insane or as lunatics and thought of as idiots, and were invariably scorned, often tried by the courts and punished as witches or warlocks (Jones, 1972, pp.4-9). Historians tended to record insanity based on these archetypal symbols and in this were not especially interested in those who delivered the care.

3.3 Understanding of Mental Illness

Much of the literature depicts the history of psychiatry in Australia and an understanding

of mental illness like its counterpart in England by the common view of the time, which tended to link mental illness to suspect metaphysical beliefs (Lewis, 1988, p.1). Insanity was considered as being part of a larger group, which included vagrancy, petty criminals, the physically disabled, and pauperism. Insane people were often not recognised as a separate group, which required special accommodation and care. As Lewis (1988, p.2) notes, “the varieties of insanity from which they suffered were more easily defined as medical conditions, the preserve of a new type of medical specialist”. “The mad-doctors not only provided specialist care but usually administered the asylums which housed their patients” (Scull, 1979). The adoption of the medical model in psychiatry across the world for the treatment of the insane was to remain dominant for the next hundred years and probably still sets the scene at varying levels today (Lewis, 1988, p.2) and the implications of this were/are considerable. Not only were the insane physically isolated from the rest of the community, in being housed in facilities outside of the town structure, but this belief went further to propose that medicine and geographical asylum could help to restore sanity. Moreover, insanity itself was conceptualised in a new way moving from being thought of in vague cultural terms attached to metaphysical beliefs it became a disease category or an entity with an underlying pathology, which would be understood better, it was assumed, with the advancement of medical science and nursing care (Lewis, 1988, p.2).

Nolan (1990, p.3) suggests that in more recent years there has been a plethora of new ideas, fads and fashions about care in general, and provision for the mentally ill in particular. He rightly points out that “it is easy to fall into the simplistic trap of adopting

a condescending attitude towards the past as we view it from the enlightened theories of the present". Hunter and McAlpine (1974; 1992/3) extend this point by arguing that to consider the past as wholly primitive and barbaric would and should be considered erroneous, and that the history of the care of the insane revealed that many examples of good patient care were delivered on the back of profound and intelligent humanity. Anecdotal evidence from the 1960s and 70s support this view.

Those old arrangements were so much better than how we practice psychiatric nursing today. At times it was a bit rough and ready but we cared about our patients treating them as people rather than as the illness they suffered from (Ward, 2001).

3.4 An Australian View from England

English principles and practice in the late eighteenth century and across the nineteenth century continued to be influential in the Australian colonies but law, the administration and systems of care were gradually shaped by the colonial experience at first by the penal character and autocratic government of the early settlement and later by the values of a confident bourgeois society (Lewis, 1988, p.1). Lewis suggests that the 'principles and practice' and the 'law, administration and systems of care' were separate whereas it would appear that the two are in many ways intimately linked. Lewis (1988, p.1) argues that the shaping of the approach, which was essentially English, was templated on the context of the colonial experience. The limited depiction in the literature (Bostock, 1968) suggests that it could almost be the other way round and that the adoption of British laws and administration systems, were modified with the actual practice being quickly changed to suit the Australian situation taking into consideration location, size, geography, environmental issues, climate and inhabitants. These changes were quickly accepted in the absence of any suitable alternatives because there were no government

officials to carry out the laws, or arbitrate their suitability in any way. There were limited physical facilities in which to detain prisoners or the insane, no judiciary in rural areas, a country policeman was often 'the law' and the insane were at the mercy of local officials. There was a custodial basis to the care, which was usually provided by males was connected to an 'out of sight out of mind' philosophy. These arrangements describe the rather haphazard beginnings and nature of psychiatry in Australia, but clearly demonstrate how their construction was initially built on the English template.

Lewis (1988, p.1) suggests that lunacy law and administration as well as the systems of care devised for 'lunatics and idiots' were, like so many other cultural and material artefacts, originally imported from England. Bostock (1968, p.9) expands further on this point saying, "Australia began its life beset with some of the problems of the older world". Amongst these problems was the treatment of the mentally ill or those described by others as lunatics or idiots and not fitting in or adhering to the social norm or more importantly the ascribed acceptable behaviours (Porter, 1991). In order to understand Australia's background in regards to psychiatry and psychiatric care, it is necessary to encompass the bigger picture and thus know what was happening in other countries such as England and the United States of America, and how these happenings were in themselves significant and influential. Australia tended to depend on many of the English and American leads as it began to consider psychiatry and psychiatric care and many ideas about mental health and the construction of facilities to cater for the mentally ill relied on their English and American counterparts some 12,000 to 13,000 miles away. This point is well illustrated in the English neo-classical design of some of the prison

buildings, gaols and the initial and contemporary designs of some lunatic asylums prepared by the then colonial architect William Lewis (1834-7), which is perhaps best illustrated in terms of the design proposed for Tarban Creek (Gladesville) in Sydney, with Lewis simply adapting existing British plans for Sydney and Parramatta (Kerr, 1989). For attendant/nurse training, the 'red handbook' introduced to Australia by Williamson in 1885 certainly had an English flavour to its contents.

3.5 Conditions in England during the 18th Century

Psychiatry as a topic is represented from an English perspective by considering the care/help that was delivered at the facility popularly known as Bethlem. Bethlem has an extensive history, built in 1247, and representative of many of the Australian facilities incorporating the range of mental health services commissioned to provide mental health care in Australia. Bethlem has always had its defenders and attackers. Since some of the early records of the hospital have now been destroyed, records are largely dependent on partisan accounts of the treatment at this time. The *Story of Bethlehem Hospital*, published in 1913 was written by the chaplain of the hospital (O'Donoghue, 1913) who outlined a range of issues related to hospital life which included the using of inmates at Bethlem as a source of amusement for the general public who payed for this entertainment. This payment probably went to the attendants. A poem which was said to describe life at Bethlem and quoted by historians of the hospital which appears in the official history (Jones, 1972, p.14), was written by J. Clark in 1744, and was sold to visitors:

... to our Governors, due praise be giv'n Who, by just care, have changed our

Hell to Heav'n.

A Hell on earth no truer can we find than a disturbed and distracted mind.

... our learned Doctor gives his aid, and for his Care with Blessings ever paid,
This all those happy Objects will not spare who are discharged by his Skill and
Care.

Our Meat is good, the Bread and Cheese the same, our Butter, Beer and Spoon
Meat none can blame. The Physic's mild, the Vomits are not such, But, thanks be
prais'd, of these we have not much. Bleeding is wholesome, and as for the Cold
Bath. All are agreed it many Virtues hath. The beds and bedding are both warm
and clean, Which to each comer may be plainly seen, Except those rooms where
the most Wild do lie.

The usage of inmates to raise money perhaps speaks of how trivially those that were deemed insane were sometimes treated and that indirectly insanity had a marketable value to some who chose to be neglectful.

The most famous representation of these conditions occurs in the eighth scene of *The Rake's Progress*, which Hogarth painted in the incurable ward in 1733. It shows two fashionable ladies watching the inmates without a visible sign of compassion. The Rake lies on the floor, practically naked, and with his head shaven, while a keeper manacles his feet and another, or an apothecary, examines his head (Jones, 1972, p.15). Excerpts such as these perhaps summarise how the general public felt about insanity but do little except deter the general public from being involved or change their understanding of what it would be like to be an inmate of a facility such as this and served only to make people wary of what insanity may entail. Manning (1880) makes similar reference to conditions across the care offered in New South Wales in Australia. Similarly with these depictions in mind, it would be difficult to understand why people would consider working in facilities such as this, which contained people deemed to be insane. These pictures of asylum life would more likely have acted as a deterrent to people interested

in becoming attendants or nurses.

Digby (1985, p.4) takes up the issue of insanity having a marketable value in saying “[f]rom the mid seventeenth century onwards, certain individuals began to make a living from insanity through their organisation of private madhouses. But it was not until the middle of the eighteenth century, when there was an appreciation that the mad could be managed, rather than brutalised, that a different kind of provision for the insane could develop”.

Jones (1972, p.16) talks about the quality of some of the attendants who worked at Bethlem Hospital who were questioned about a series of financial scandals concerning the misappropriation of patients money and goods and also receiving payment from visitors who were amused by the mentally ill. In 1752, a pamphlet entitled *Low life: or, One Half of the World Does Not Know How the Other Half Lives*, accused the keepers of stealing food and personal possessions from the patients. In 1772, the House Governor himself was dismissed for obtaining large quantities of provisions from the buttery for his own personal use. Some of these particular points have something to say about both the social conditions that attendant staff lived under at the time and also about their calibre and suitability for their position in attending/caring for the insane (Hopton, 1999; Smith, L. 1999, p.6).

“Patients are ordered to be bled about the latter end of May, or the beginning of June, according to the weather,” stated Dr Thomas Monro in evidence before the Select

Committee of 1815”, in England and after they have been bled, they take vomits once a week for a certain number of weeks; after that, we purge the patients. That has been the practice invariably for years, long before my time; my father handed it down to me, and I do not know any better practice” (Jones, 1972, pp.15-16). The control of the Monro family over the medical treatment of the patients at Bethlem was “complete and unchallenged, and consisted in an unvarying and indiscriminate use of weakening agents to reduce violence, coupled with the frequent use of mechanical forms of restraint” (Jones, 1972, p.16). Most patients, male and female, appear to have been kept in a state of near or complete nakedness, either because the authorities would not provide clothes or because the patients might destroy them (both for financial reasons) and in the eyes of the authorities were less likely to escape unclothed. Bedding usually consisted of straw for the paupers and unclean patients, since this was cheap, accessible and easily cleared away when fouled. Tucker (1887) from an Australian perspective makes many references to the keeping of patients both in and out of seclusion and the using of straw, straight jackets and attending patients who were often near naked demonstrating that practices in one country were often followed worldwide for example his report refers to straw bedding and restraint being used at Couradsberg Hospital, in Stockholm, Sweden, Eichberg Asylum, in Germany, Marsens Hospital, Fribourg in Switzerland, Charenton Asylum, Charenton, in France, Whau, Auckland in New Zealand, and Callan Park Mental Hospital in Australia. Similarly, Dax (1981 p261) describes treatment in Victoria, Australia where a range of treatment provisions were provided for a range of insanity conditions which were caused by smoking, love, religion, hardship and misfortune. Australian life was also put forward as a causative factor in that sunburn,

alcoholism, bush madness, flogging and malnutrition were all itemised as contributing factors. The care offered was very basic.

Cowering in a corner upon a heap of straw sat his unfortunate mother, the complete wreck of what she had been. Her eyes glistened in the darkness for light was only admitted through a small grated window-like flame, and as she fixed them on him, their glances seemed to penetrate to his very soul. A piece of old blanket was fastened across her shoulders, and she wore no other clothing except a petticoat. Her arms and feet were uncovered, and of almost skeleton thinness. Her features were meagre and ghastly white, and had the fixed and horrible stamp of insanity. Her head had been shaved, and around it was swathed a piece of rag, in which a few straws were stuck. Her thin fingers were armed with nails as long as the talons of a bird. A chain, riveted to an iron belt encircling her waist, bound her to the wall. The cell in which she was confined was about six feet long and four feet wide (Jones, 1972, p.16).

All of these issues must have had a bearing on the applicants (male and female) wishing employment in these areas both in Australia and overseas. Many applicants were drawn from the lower class and similarly were not usually well educated and usually had no experience in these areas. Many took employment in these areas because this type of employment was better than unemployment and starvation. While casual visitors who paid for admission and came only for entertainment were welcomed, serious and responsible visitors who wished to observe and ameliorate conditions often did not include medical practitioners who were often forbidden to see the patients for fear that they may interfere. Accounts such as these from Bethlem demonstrate some of the underpinnings to the profession of mental health care. Also, the notion of handing down skills between family members over generations probably meant that both good and bad skills were passed on and may have been significant in the calibre of applicants seeking employment in these areas. It sounded as though family members may have been taken as attendants first before others in providing help to those deemed insane.

It is easy to overstate and be critical of the authorities at Bethlem. They provided care and treatment of a kind when this was otherwise unknown and the authorities had no precedents against which to test their methods. The reality of the situation is often not stated and working at an institution for the reception of violent patients can never be easy or a pleasant place to work. Also, however enlightened the policy of the authorities, there will always be inmates who suffer through delusions of persecution, depression, or squalid habits that defy the most patient and sustained attempts at cleanliness; but the available evidence shows that the policy of the authorities, even by eighteenth-century standards, was far from enlightened (Jones, 1972, p.17). The keeping of the insane was difficult and a long way from being thought of as treatment and it appeared to represent more an “out of sight out of mind” (Lewis, 1988, p.191) phenomenon.

Nolan (1993, p.45) argues that the emergence of the asylum system was in response to threats posed by problems of the lower class, involving both moral and paternalistic attitudes. Nolan (1993, p.45) suggests that there was “increasing power of the State over the lives of individuals in the mid-19th century”

...asylums wrapped their aims in medical rhetoric, as state-funded institutions their purpose was essentially social and lay in welfare administration.

Nolan (1993, p.45) argues that the “idealists who had hoped that the newly built institutions would be hospitals where mentally ill patients could be protected from the hostility of society, were rapidly disillusioned. Scull (1982, in Nolan, 1993, p.45) suggests social class may well have contributed to this issue suggesting that self-righteous humanitarian attitudes held by 19th century upper class Evangelicals and

Benthamites were really the views that the dominant class had toward those lower down the social structure. Evangelical rhetoric tending to conceal class interests. Since the establishment of the asylums and the advent of carers to work within them, attendant care (or nursing) has always found itself sandwiched between those in pursuit of scientific certainty in the diagnosis and treatment of mental disorder (perhaps representing male gender values), and those whose pragmatic approach to psychiatric institutions has seen them merely as centres for the dispensation of welfare (more so the female gender perspective)(Nolan, 1993, p.5).

3.6 Workhouses

In 1740, the population of England was approximately five million; this represented a significant population increase. The production of food and wealth generation did not keep pace with the increasing population, resulting in widespread poverty, starvation and physical and mental disease (Nolan, 1993, p.31). By 1774, pauperism and genuine poverty, as distinct from habitual vagrancy, had assumed alarming proportions in England. From 1760 onwards, more workhouses were built as these institutions tended to become “dumping grounds” for the dependent of all descriptions (Henriques, 1979, in, Nolan, 1993, p.31). There is probably no other period in English history in which the social classes were so clearly divided. A book entitled *An Account of the Workhouses in Great Britain* in the year 1732, compiled apparently from official returns, gives a vivid picture of the treatment of the poor at this time (Jones, 1972, pp.17-18). The rich, who had to pay the rates, were obsessed with the idea that institutions for the poor must be run as cheaply as possible. The guardians of the workhouse in the parish of St George’s,

Hanover Square, for example recorded with some pride that as a result of the 'frugality of management under Honourable Persons' they had succeeded in reducing the cost of maintenance per head to the sum of one and nine pence halfpenny per week. At Maidstone, the Poor Law authorities were satisfied that 'very great numbers of lazy people, rather than submit to the confinement and labour of the Workhouse, are content to throw off the mask and maintain themselves by their own Industry'. 'A Workhouse,' they added, 'is a name that carries with it an idea of correction and punishment' (Jones, 1972, p.18) and with this in mind workhouses were managed based on the philosophy that "inmates were poor because they were idle and therefore were in need of reform" (Nolan, 1993, p.31).

It is impossible to assess accurately the number of insane people who were housed in these institutions and who abided by this stringent and corrective nature but it would be quite substantial. In England, the parliamentary committee of 1807 came to the conclusion that the previous year's estimate of one thousand seven hundred and sixty five people was a gross under-estimate and in 1828, the figure was put at nine thousand. Even allowing for the increase of population in the late eighteenth and early nineteenth centuries, it would be safe to say that there must have been four or five thousand people suffering from psychotic disorders or mental deficiency in workhouses before 1789 (Jones, 1972, p.18).

The emergence of the asylum system in England was significant and indirectly attached insanity to pauperism and vagrancy, similarly, because of the custodial nature of

management of the insane attached insanity to criminal activity, mad therefore bad. These arrangements in many ways suited the social structure of late 18th and 19th century England, which tended to think that destitution should be controlled by the removal of pauper lunatics into asylums. The building of the county asylum at Stafford in 1818 “next to the county gaol provided an example of this mad therefore bad issue. The arrangement permitted ... some degree of common administration between the two institutions, thus minimizing expense” (Jones, 1993, p.61). The removal of pauper lunatics into newly built asylums was to provide the indigent with the necessities of life becoming in this process a witness to the State’s humanity with the provision of food, medicines, and recreation and even free burials should the person die (Nolan, 1993, p.46). Asylum care began to move from treatment “*en masse*” with little variation according to individual cases to a more moral management position across the eighteenth century. Walk (1961) explains that moral management attempted to replace the usage of physical restraint. Many of the hospital superintendents saw moral management as a soft option believing it encouraged patients to remain insane and idle as it was based on recipients and the attending staff being taught the necessity of leading an ordered existence (Nolan, 1993, p.42). This tended to shape the staff employed where the moralistic (softer) approach was more in keeping with females. According to Dax (1981 p258-61) this was very similar across Australasian psychiatry (although at a different time) where treatment in asylums was administered, developed/delivered in a close working relationship with poor law institutions, work factories and benevolent society homes. The teachers of this ordered care were the attendants under the direction of the medical profession. The new asylums in both England and Australia were almost

immediately overwhelmed by large numbers of ex-workhouse inmates with chronic illnesses (Nolan, 1993, p.47).

These numbers were fairly substantial and the concern here is the fact that this problem existed, yet was hardly recognised in the literature except by passing it off as insanity being a more acceptable malady than that of pauperism. The significant fact in this is that insanity or insanity in workhouses was hardly recognised. The *Account of Workhouses* in 1732, which included returns from all the principal Poor Law institutions in the country, mentions them in only two instances, and then in passing. There was no special administrative practice for dealing with pauper lunatics as a class, with pauperism having reached alarming numerical proportions in 1774, so treatment often depended on the policy or lack of policy of the local authorities and this of course suggests that care was mostly nonexistent or very basic (Jones, 1972, p.18). Once again, each case was not managed on its individual merits, rather they would have been grouped together and classified as all the same – insane, therefore to the workhouse.

3.7 Treatment and Poor Law Legislation

The basis of Poor Law legislation was the Act of 1601, which stated that unpaid overseers of the poor were to raise money ‘weekly or otherwise by taxation’ in each parish for the relief of its own paupers. This position is interesting because this meant that parish funding usually harnessed any care that was offered, which was invariably at a minimum. Many parishes often used the workhouse as a weapon by way of threat, to deter the poor from seeking relief at all (Jones, 1972, p.18).

Jones (1972, p.18) argues that the great failure of the Poor Law lay in the apparent inability of its administrators to distinguish between the 'impotent poor' who could not work, and the able bodied poor who would not. Conditions varied greatly from parish to parish, but the number of authorities was so great, and the administrative area of each so small and cumbersome that it was impossible for most of them to devise a workable system of classification, which would allow for differentiation in help or treatment. Similarly, these arrangements tended to suit the administrators rather than the people being helped and were instrumental in the employed workforce attracting a lower calibre of applicant (Hart, 1997, pp.37-38). Staff was often drawn from the same sections of society as the paupers, and often exhibited the same kinds of unruly personal behaviour, which was then believed to contribute to insanity (Carpenter, in Davies, 1980, p.135). From an Australian perspective the staff were mostly drawn from the settling convict population.

Jones (1972) describes a scheme for the more sympathetic provision of the 'impotent poor' in England being put forward by the Earl of Hillsborough in 1753; he proposed that county hospitals should be set up. Such a scheme would have been impossible to put into practice without great financial outlay and an extensive reorganisation of the whole framework of poor relief (Jones, 1972, p.19). Fiscal rather than sympathetic oriented concerns were often decisive. Once again these conditions/arrangements would have made some difference to the calibre and suitability of selected attendant staff that chose to work under these arrangements. Nolan (1993, p.47) argues that attendants occupied the middle ground between doctors and patients. Socially and intellectually, attendants

were considered far inferior to medical staff, but their closeness to patients made them highly influential in the patients' lives. Attendants in the mid 19th century (1850s and 1860s) represented cheap labour and were expected to deliver a range of skills that their backgrounds and lack of training made almost impossible to implement. The limited literature suggests that Australia reflected a very similar picture (Smith, T 1995; 1999).

3.8 Medical attention

The provision of medical attention to the insane is often presented in the literature as a troublesome concept, and mostly an afterthought. The provision of control or containment had little to do with the provision of good medical intervention. Jones (1972, p.20) addresses some of these issues. At St Albans, the Guardians recorded with pride that the sick and insane were nursed mostly by women paupers, thus saving fifteen to twenty pounds a year in apothecaries' bills. 'There are many workhouses,' wrote an official at Winchester, 'where medicines are dispensed; but they are generally given without the advice of a doctor. Where medical attention was provided, the general practice was for the contract to be farmed out to the local doctors, and the lowest tender automatically accepted. The doctor or apothecary gave nominal attention to all paupers, providing his own drugs and medicines, for a sum of twenty pounds a year.' Since a degree of physical debility would render the more troublesome lunatics weaker and thus more amenable, it is unlikely that any sustained attempt would be made to restore them to robust and violent health (Jones, 1972, p.20).

On a more positive medical note, despite the fact that in most workhouses no attempt

was made to separate the mentally disordered from the other paupers, for the benefit of either class. Some of the larger workhouses possessed infirmaries, but these appear to have been mainly used for those suffering from infectious medical and contagious diseases, such as smallpox and syphilis and limited attendance/care by women keepers. The records of St Peter's Workhouse (from 1696) in Bristol show that it was one of the very few venues where those who were considered mentally ill (pauper lunatics) were treated as a separate class, and almost certainly the only facility in England where prospective sufferers received treatment as distinct from confinement (Jones, 1972, pp.20 21).

Insane patients were placed in separate wards almost from the first with early regulation recommending that 'the lunatic wards be floored with planks' presumably because stone floors were more injurious to the patients' health. Any medical attention required was provided by local physicians, who gave their services without payment. A regulation of April 1768, laid down that medical attention was to be provided to the 'Frenzy Objects' once a week, and also 'such objects as shall from time to time be brought in by Warrants of Lunacy' (Jones, 1972, p.21).

St Peter's in Bristol had a different policy standing in contrast to that of almost every other Poor Law authority in England. It established three principles foundational to the later development of county asylums: they were, the care of the insane should be the responsibility of the parish or township in which they lived; they should be treated as a separate class, their living conditions being adapted to their special needs; and, they

should receive treatment, not punishment. Although these principles appear to be a very good starting point for the treatment of the insane, they seem to have been ignored in practice (Jones, 1972, p.21).

3.9 Bridewells

In England Bridewells, or houses of correction, received vagrants and beggars and these groups often contained people who were insane and who could not be convicted of any crime save that of wandering or refusing to work. They also housed a number of petty offenders of the kind who under the modern penal system would probably have been placed on probation. The chief distinction between a gaol and a Bridewell was that in the former the inmates were responsible for their own maintenance and for the payment of gaolers' fees, since the gaolers were generally not in receipt of a salary. Many prisoners were forced to remain in gaol as debtors long after the original sentence was served. Arguably, this produced a system where the means often justified the ends, as prisoners often would have had no way of paying their debt. In a Bridewell, the male officials received a salary, and the Poor Law authority was responsible for the maintenance of pauper inmates, who were released at the end of their term of imprisonment (Jones, 1972, pp.21 22).

The patients or inmates are commonly referred to as 'objects of charity'. John Howard's Report on the State of the Prisons (1777, in Jones 1972) found that hardened criminals, shiftless vagrants and petty offenders were often confined together with the insane. 'Idiots and lunatics ... serve for sport to idle visitants ... where they are not kept separate

[they] disturb and terrify other prisoners and inmates'. No care was taken of them, though it is probable that by medicines and proper regimen, some of them might have been restored to their senses, and to usefulness in life (Jones, 1972, p.22). These comments show over time a slight shift away from the more custodial philosophy and movement toward considering 'the insane' as treatable. This would have been significant in helping people decide about career options relational to working with the insane. Kennedy (1982, p.51) argues that in many ways charitable activities in Australia could boast some kind of British antecedent. In Australia, Kennedy (1982, p.51) notes that the problems faced by Colonial Victorian charity appeared to be "less serious than the vast and intractable mass of destitution confronting British charity". The Australian equivalent to the English workhouse was probably the Benevolent Asylum and although legislation was often not in place for workhouse systems Victoria and New South Wales had many such organisations. Workhouses were home and shelter for aged and worn out men and women, patients dismissed from hospital with nowhere to go, deserted wives, widows with children, wives of prisoners, unmarried mothers, imbeciles, blind people disabled for life, dying cancer patients and people otherwise destitute or starving (Kennedy 1982, p.64). New South Wales had similar benevolent asylums, which offered services to the deserving/undeserving poor and appear to have in many ways been fashioned on their English equivalents. One of the prime functions of this facility was the disciplining of the homeless poor in an attempt to accustom "inmates to an institutional and ordered existence" (Kennedy 1982, p.64). The benevolent activities of these asylums were instigated for the most part by the philanthropic activities of women in both the English and Australian experiences. Philanthropy "emerged as a major

activity for high status women, or ladies ...philanthropy ...was a means whereby ruling class women attempted to exercise control over working class women and children” (Godden, in Kennedy, 1982, p.84). Often the linkage or entry point for philanthropy for women was the church and Windschuttle (cited Kennedy, 1982, p.12) argues that women performed “more familiar roles in colonial society – as housekeepers and caretakers, nurses and midwives”. Some commentators put forward arguments that suggest philanthropic endeavours were an ideal which allowed women (but also some men) to bridge or jump class barriers (Kennedy, 1982, p.5) and these views may be determinant in why females and males chose association with these areas and this initial association may have progressed to an emerging employment choice.

3.10 The Reform Movement

The reform movement in England began imperceptibly, through what might be described as a series of apparently disconnected events, each of which aroused the public interest in some aspect of the treatment of the insane. In 1744, dangerous lunatics were specially considered in a revision of the vagrancy laws; in 1763, the general public was alarmed by revelations concerning the conditions in private madhouses, and a movement to obtain statutory control was initiated; in 1789, the nature of the King’s illness became generally known, and because most people had some concern over the King’s sanity the topic was open for public debate and the topic of madness was widely discussed in a context which excluded the attitude of moral condemnation. It was scarcely possible, at least in Tory circles, to assume that the head of state was being punished for his sins (Jones, 1972, p.25).

It is doubtful whether many people in the eighteenth century sensed the connection between these events; for, as we have seen, the idea of insanity as a single social factor had not yet been evolved. It is only in the light of later developments that these happenings assumed a relevance to each other. The King's sanity was instrumental in bringing the topic out into the open, being discussed more openly and humanising the process. This change was instrumental in making mental illness more readily understood by the general public, but despite this, most remained apprehensive.

3.11 Lunatics under the Vagrancy Laws 1744

A parliamentary committee was set up in 1742 to consider the treatment of 'rogues and vagabonds' and the revision of the vagrancy laws. The perennial problems of vagrancy tended to be reviewed every thirty or forty years through the sixteenth, seventeenth and eighteenth centuries. By 1744, the population movement to the industrial north and midlands, and the cumulative effect of enclosures, was exacerbating the problems. The 1744 Act (Jones, 1972, pp.25-26) which resulted from the committee's recommendations, began:

'Whereas the number of Rogues, Vagabonds and other Idle or Disorderly Persons daily increases, to the great Scandal, Loss and Annoyance of the Kingdom ...' It no longer included wandering scholars (a Tudor Act' refers to 'all psons (sic) calling themselves Schollers going about the country begging') but it included Persons who threaten to run away and leave their Wives and Children to the Parish...Persons found in Forests with Guns... All Minstrels, Jugglers...All Persons pretending to be Gypsies, or wandering about in the Habit or Form of Egyptians'.

Lunatics under this Act (1744) had been attached to the band of marital defaulters, poachers, travelling showmen and other nomads described in the 1714 Act. That Act provided for their detention, restraint and maintenance, but not for treatment as none of

any note really existed. The importance of the 1744 Act rests in the fact that it added the words 'and curing' although despite the addition of these words it did not in fact specify particular methods by which treatment and/or cure could be carried out (Jones, 1972, p.26). A step forward nonetheless.

Under the 1744 Act, anyone could apprehend a vagrant, and the local justice of the peace was directed to order the payment of a reward of five shillings to the informant. This of course made the apprehension of vagrants or those considered insane something of a novelty and of course could often mean that people may be apprehended who were say under the influence of alcohol, eccentric or just different. Similarly, the attached fee often meant that this system was likely to be abused by some for profit. Normally, vagrants were sent on a single magistrate's warrant to a Bridewell 'there to be kept to hard labour for any time not exceeding one month'. The point of incorporating a special section concerning lunatics was probably less to secure treatment for them than to exempt them from the penal clauses applicable to other vagrants.

Section 20 of the Act reads as follows:

It shall and may be lawful for any two or more Justices of the Peace where such Lunatick or mad person shall be found, by Warrant under their Hands and Seals, directed to the Constables, Churchwardens and Overseers of the Poor of such Parish, Town or Place, to cause such Persons to be apprehended and kept safely locked up in some secure Place ... as such Justices shall appoint; and (if such Justices find it necessary) to be there chained.... The Charges of removing, and of keeping, maintaining and curing such Persons during such Restraint (which shall be for and during such time only as such Lunacy or Madness shall continue) shall be satisfied and paid ... by Order of two or more Justices of the Peace, directing the Churchwardens or Overseers where any Goods, Chattels, Lands or Tenements of such Persons shall be, to seize and sell so much of the Goods and Chattels, or to receive so much of the annual Rents of the Lands and Tenements, as is

necessary to pay the same; and to account for what is so sold, seized or received at the next Quarter Sessions; or, if such Person hath not an Estate to pay and satisfy the same, over and above what shall be sufficient to maintain his or her Family, then such Charges shall be satisfied and paid by the Parish, Town or Place to which such Person belongs, by Order of two Justices directed to the Churchwardens or Overseers for that Purpose (Jones,1972, pp.26-27).

This section has several significant points, and its omissions also convey information about the treatment that the insane received. The clause which deals with causing such person to be apprehended is interesting in that the legislation implies rather than states that the local magistrates, who possessed neither legal nor medical training, were held to be sufficient judges or diagnosticians in relation to the existence of a state of insanity or otherwise. No medical certification was necessary. It should be pointed out here that responsible medical certification was hardly possible until after 1858, the date of the Medical Registration Act. The idea of using two or more Justices of the Peace to organise detention was rather rhetorical, since in practice the warrant for the detention of a vagrant under the other sections of the Act required the assent of only one magistrate. The provision of a joint authority in the case of the insane may have been designed to prevent individual magistrates from indulging in a purely personal grudge against an inconvenient neighbour by using their powers under this section. Similarly, the researcher would suggest that the acquisition of land and chattels was a fairly common occurrence and may have been influential in whether or not a person was deemed to be insane or otherwise.

The notion of a safe and secure place sounds with the benefit of hindsight almost paradoxical in that a 'secure place' was often a gaol or house of correction, since these were the only places which possessed the means of preventing the inmates from

escaping. Under these conditions, security was paramount and the safety aspect probably referred to the safety of the general public rather than the safety of the person concerned. The clause concerning the removal of the person who was not a resident of a particular parish in which s/he was apprehended is interesting because the insane person would/could be removed to her/his legal place of settlement, if this could be established, so that the responsibility for her/his maintenance might devolve on the latter parish. Once again, arrangements had a pecuniary rather than therapeutic interest attached. The secretive, underhand element arises because insane people could be shifted to different locations without a great deal of thought, caring intent or administrative rigor and could contain a variety of hidden agendas.

Under the Act, the intent of keeping, maintaining and curing was not well provided for, as no machinery was set up for curative treatment or medical attention of any kind. The only form of treatment apparently envisaged was that of mechanical restraint in the form of chains. Referred to by Cummins (1968, p.9) taking a later Australian (New South Wales) perspective from 1788-1855 as

...the chaining and manacling of troublesome patients, the keeping of them in a state almost of nudity, sleeping on filthy straw, the mixture of melancholics, and persons merely subject to delusions, with gibbering and indecent idiots, the noisy with the quiet, the total lack of any proper sanitary arrangements.

However, the Act did make it possible to send patients to special accommodation where this was provided. This provision within the Act placed the onus of judgment about the patient's level of sanity on the gaolers or the justices. Two social dangers were implicit in this unsatisfactory clause: a person who regained his sanity might be confined indefinitely if he offered resistance when chained, or fell foul of his gaoler; alternatively,

a person suffering from a cyclical condition, the course of which is separable into distinct and recurrent phases, might be released during a lucid spell, to become again a public danger soon after his release. Further to this a legal check was to be kept on the administration of property appropriated by the gaolers, overseers or church wardens to satisfy these maintenance charges, but no provision was made for any safeguarding of other property belonging to the insane person during his or her confinement under the provision of this Act. Therefore, it was entirely probable that unscrupulous relatives or attendants without fear of legal action might seize such property (Jones, 1972, pp.27-28).

3.12 Private Madhouses

Many of the smaller, private madhouses in Britain and Australia were frequently run as family businesses, often employing several generations as staff. This is of particular interest as the notion of business relational to health often meant that profit was the defining feature of the exercise in care with the provision of “merely the basic necessities of life” (Nolan, 1993, p.29). It would appear that the insane and associated finance(s) were a constant source of discussion in government circles. Insanity and finances rather than insanity and care, the former seen as important, the latter often ignored. Significantly it was some nineteen years before the vexed question of the insane was again raised in Parliament, and then in connection with the private madhouses. On this occasion, it would appear that there is the first hint of outside pressure being brought to bear on the House of Commons in relation to this subject (Jones, 1972, p.28). The public interest was aroused by two cases in which a writ of Habeas Corpus had been issued as a means of liberating the inmate of a private madhouse suspected of being

wrongfully detained. This procedure had in the past been mostly unsuccessful, since many devices such as changing the patient's name, using secret cells, which could not be detected by an investigator, or declaring that the patient had escaped, could be used to defeat it. Jones (1972, p.29) suggests that the usual practice was to require that the relatives and a physician appointed by the Court should be given access to the patient in the madhouse, in order to ascertain whether a state of insanity really existed. If they reported that the patient was sane, the proprietor of the madhouse was then required to produce the patient in court.

In *Rex v Clarke* (1762) the attempt to serve a writ of Habeas Corpus was defeated by an affidavit from the appointed physician that the patient, Mrs Anne Hunt, was in an acute state of mental disorder, and had in fact been sent to the madhouse on his own advice. The interest aroused by the Clarke case caused a growing degree of public concern that was fanned by the publication of a now famous article in the *Gentleman's Magazine* of January 1763 that read,

[w]hen a person is forcibly taken or artfully decoyed into a private madhouse... he is, without any authority or any further charge than that of an impatient heir, a mercenary relation, or a pretended friend, instantly seized upon by a set of inhuman ruffians trained up to this barbarous profession, stripped naked, and conveyed to a dark room. If the patient complains, the attendant brutishly orders him not to rave, calls for assistance, and ties him down to a bed, from which he is not released until he submits to their pleasure. Next morning, a doctor is gravely introduced who, taking the report of the keeper, pronounces the unfortunate person a lunatic, and declares that he must be reduced by physic. If the ...victim offers to argue against it by alleging any proofs of sanity, a motion is made by the waiter for the doctor to withdraw, and if the patient, or rather the prisoner, persists in vindicating his reason, or refuses to take the dose, he is then deemed raving mad; the banditti of the whole house are called in, the forcing instruments brought, upon which the sensible patient must submit to take whatever is administered. When the poor patient thus

finds himself deprived of all communication with the world, and denied the use of pen and paper, all he can do is to compose himself under the unhappy situation in the hope of a more favourable report. Any composure under such affliction is immediately deemed a melancholy or sulky fit, by the waiter, who reports it to the doctor in the hearing of the despairing prisoner, whose misery is thus redoubled in finding that the doctor prescribes a repetition of the dose, and that from day to day, until the patient is so debilitated in body that in time it impairs his mind ... What must a rational mind suffer that is treated in this irrational manner? Weakened by physic, emaciated by torture, diseased by confinement, and terrified by the sight of every instrument of cruelty and the dreadful menaces of an attending ruffian, hardened against all the tenderness's of human nature...(Jones, 1972, pp.29-30).

This article contrasted this situation with conditions in the public hospitals and concluded with an appeal to parliament to frame regulations designed to prevent the imprisonment of sane people, and parliament responded on the 27th of January by the appointment of a Select Committee of the House of Commons (Jones, 1972, p.30). Interestingly, it shows how cornered the position of those described as insane had become. All attempts at pleading sanity were scoffed at and taken as signs of madness in themselves. Also, the reports regarding the person said to be insane to the said doctor were taken as true and accurate when in fact they were probably without scientific fact or truthfulness. The person making the claim about the patient's sanity was no more skilled to make that observation than any other person. The fact was that the word of the proprietor was accepted because it meant that detention would be ongoing, which meant peace for the authorities and profit for the keeper of the private madhouse. Only a few "engaged the part-time services of a physician and the number of staff was kept to a minimum. Conditions were generally such as to promote mental disorder rather than cure it" (Nolan, 1993, p.29).

The Select Committee report makes interesting reading. The members found it necessary

to proceed with extreme discretion, since London madhouses confined the relatives of many prominent people, and also because a number of well-known members of the medical profession had financial interests in private madhouses. Allegations concerning the private madhouses revealed that persons had been confined there on the representation of relatives without adequate medical examination, and that they were prevented from communicating with the outside world, being denied visits from friends and the use of writing materials. Many questions were left unanswered and the impression left on the reader is that, although the Committee was bound to investigate, it did not want to investigate too deeply for fear of what it might find (Jones, 1972, p.31).

3.13 Regulation

It was eleven years from the time when the Committee made its report to the time when provisions limiting the power of ‘madhouse’ proprietors became law showing how difficult framing legislation relational to insanity had become. Even then, the opposition of the legal profession was such that the provisions for enforcing the regulations contained in this Act were so ineffectual that it remained inadequate. It did not apply to pauper lunatics in madhouses, to single lunatics, or to public subscription hospitals. The preamble ran:

Many great and dangerous Abuses frequently arise from the present State of Houses kept for the Reception of Lunaticks, for Want of Regulations with Respect to the Person keeping such Houses, the admission of Patients into them, and the Visitation by proper Persons of the said Houses and Patients: and whereas the Law, ... is insufficient for preventing or discovering such abuses... (Jones, 1972, p.31).

The rules were clear with no person being able to take charge of more than one lunatic for profit without a licence. This legislation obviously considered that the current system

had been used and abused my many and therefore it contained many consequential provisions such as a keeper who refused to admit the Commissioners had to forfeit their licence. Notice was to be sent to the Secretary of the Commissioners by the keeper within three days of the reception of a patient (Jones, 1972, p.32).

The Act applied only to a limited section of patients, but even so, had many weaknesses. The most glaring of these was the omission of any power by which the Commissioners might refuse to grant licences on the grounds of ill treatment or neglect of patients. A keeper would forfeit his licence if he refused to admit the official visitors; but as long as he admitted them, whatever the conditions, they could take no action except that of displaying their reports in a place where few could see them and none would have their attention drawn to it (Jones, 1972, p.32).

3.14 The Significance of the 1774 Act

The 1774 Act appears to have been constructed for reasons other than the health and welfare of those described as insane, having what appear to be ulterior motives, which satisfied the interests of the private madhouse proprietors. Even if the visitation envisaged by the Act had been carried out systematically and conscientiously, the proprietors of private madhouses would have remained almost as free from the fear of legal penalties as before (Jones, 1972, p.33). The Act said nothing on the subject of the medical supervision of patients, diet, overcrowding, mechanical restraint, or deliberate brutality of treatment. Its primary purpose was to provide safeguards against illegal detention, but it failed even in this simple object, since there was no means of forcing the

proprietor to comply with the orders of the Commissioners (Jones, 1972, p.33). The drawing up of this legislation had proven rather difficult; notwithstanding, it had attempted to put some regulatory safeguards in place that would oversee the safe keeping of people detained in private madhouses. The following points show that although the provisions of the Act were administratively weak, the Act of 1774 served a purpose by the provision of overriding principles related to lunacy.

1. Licensing by a public authority of private institutions run for profit.
2. Notification of the reception into such institutions of a person alleged (note the wording) to be insane.
3. Visitation by Commissioners, whose method of appointment was prescribed by parliament.
4. Inspection to ensure that those wrongfully detained were released, and that those rightfully detained were treated with humanity.
5. Supervision by the medical profession (Jones, 1972, p.33).

It was many years before these points were covered by more effective legislation. As in most areas of social reform, the reformers themselves were not aware in these early days of what they wished to achieve and some aspects of the provision of legislation were a little on the all encompassing side. This often meant that as one set of laws was found to be inadequate a new set of laws was designed to cover the deficiencies of the old and this was instrumental in the emergence of a more coherent policy and tended to set the scene for the ongoing administration of mental health (Jones, 1972).

3.15 The King's Illness

The true nature of the King's illness did not become public knowledge until 1788, when his condition became so incapacitating that he became incapable of carrying out affairs of state (Jones, 1972, p.34). The King's doctors were not optimistic about a swift recovery

with the fate of the administration hanging precisely on this point. If the King's illness lasted more than a few months, a Regent would have to be appointed. The obvious candidate for the Regency was the Prince of Wales, and Jones (1972) suggests that some of his adherents were concerned that, once he was established, his first actions may be politically unwise as he may install an administration who would have their own interests rather than the country's at heart. Jones (1972, p.33) footnotes that Macalpine and Hunter (1969) were concerned that the King's symptoms and the public reactions to them were symptomatic of George III actually suffering from a rare metabolic disorder known as variegated porphyria. However, George III's contemporaries believed his condition to be a mental illness and assumed that it was likely to be hereditary (Jones, 1972, pp.33-34). Nolan (in Newell and Gournay, 2000 p.30) believes that the madness of King George III was highly fortuitous in turning the tide of neglect, cruelty and exploitation against the mentally ill and government finally stepped in to enact legislation to improve the situation for this highly vulnerable section of the population. The concern about the monarch's mental health (described as mental health rather than sanity/insanity for the King) required another and more optimistic opinion of the King's state of mind (Jones, 1972, p.34). The treatment of the King speaks volumes for the contemporary view of insanity; one party wanted him cured as soon as possible, and the other would have been glad to see that cure delayed but neither protested that the monarch should not be subjected to indignities of the treatments offered at that point in time. By the end of 1788 the King's sanity was being openly discussed in clubs and coffeehouses by the general public. This had one good and lasting effect as for the first time, mental illness and its treatment formed a significant topic of public discussion. The subject, both its good and

bad had been brought out of concealment in a way that defeated the past conspiracy of concern and silence (Jones, 1972, p.35).

The King's eventual recovery seems to have been greeted with relief and satisfaction by the general public. Similarly, the effects on lunacy reform of this first attack suffered by the King are intangible, but nevertheless real. The sympathies of the nation were with the sufferer, and the note of moral condemnation, which had previously characterised all approaches to the subject, was entirely lacking. Nobody suggested that the King was being punished by heaven for his sins; nobody regarded him as being possessed by the Devil. Madness had become a respectable malady – one that might happen to anybody; and, which is even more important, one, which was susceptible to treatment and capable of cure (Jones, 1972, pp.37-38). This is of course of incalculable value in the general acceptance of what would be described as the movement of insanity to mental ill health, taking mental illness into people's homes causing much discussion about what it was and could be. It also made working with the mentally ill more acceptable.

The King became ill again twelve years later in February 1801 and then again in May of the same year. He struggled on with ill-health until 1805 when at sixty-seven years of age his sight began to fail, making it increasingly difficult for him to live a normal life. The final descent into illness from which he did not recover came in 1810, brought about by the death of his favourite child, the Princess Amelia. A Madame D'Arblay reported that the King imagined himself to be conversing with angels, and the slow drift into religious delusion may have been a merciful end to a troubled reign (Jones, 1972, p.38).

The Regency Bill became law in 1811, and the King lived on until January 1820, through more than thirty years of intermittent illness. Notable features about the phrasing of this obituary notice were the avoidance of the words 'mad' and 'madness', and the substitution of 'mental darkness' in a context which linked it with the King's physical blindness; and secondly, the description of an insane person as 'this brave and honest man'. This marked perhaps the beginnings of a considerable shift of opinion (change the discourse which changed the view) since the days of the witchcraft trials (Jones, 1972, p.39) and was the catalyst of placing the monarch's illness into some sort of more general public and friendly banter. As the King's illness had stretched across the time of Australian settlement from 1788 - 1820 one would presume that the more open discussions which centered on and around mental illness would have travelled across to Australia with both the transported convicts, the crew and their keepers.

The overview of the care of the insane from the late seventeenth century makes it plain that there had been considerable activity in improving the care of people suffering from insanity before the passing of the Lunacy Act on the 4th August 1845. This is not to underestimate the importance of the Act that heralded a new era in the care of mentally unwell patients. One of its main architects was Lord Shaftesbury, the great humanitarian reformer, who for forty years chaired the English Lunacy Commission and acted as chief spokesman for the Lunacy Reform Movement. He believed that a more comprehensive asylum system was needed to replace the rather haphazard mixture of private madhouses, public asylums, workhouses and prisons, which were at that time providing accommodation for those considered insane (Nolan 1992/93). According to Nolan

(1992/93, p.134) Shaftesbury's speeches to the House of Commons implied, by using terms such as patient, doctor, treatment and cure that his proposed asylum system would be more akin to a hospital network. He suggested that this similarity of provision for the mentally and physically ill was appropriate because mental and physical illnesses were largely similar. Although this was a view not held by many it could be argued that Shaftesbury's beliefs were innovative and appear almost out of kilter with what might be described as contemporary thinking at that time. The movement toward more remedial and therapeutic interventions was a step in the right direction and significant in the history of care to the mentally ill. Shaftesbury's overall intention was that institutions, which embraced the liberal and humanitarian philosophy advocated by the York Retreat and people such as Tuke in 1813, would represent a new and different system (Digby, 1985). He wanted to create not only different establishments where the scientific study of mental illnesses could be pursued more readily but also a changed philosophy where remediation was appropriate. In this, Shaftesbury wanted to see the adoption of the reformist practices at the Retreat applied nationally (Nolan, 1993, p35). The emergence of the asylum system reflected the increasing power of the State over the lives of individuals in the mid-19th century. Baldwin (in Nolan 1993 p45) sees powerful political and economic forces behind the growth of the asylum system. Its justification on moral grounds was the bringing of aid to deranged and powerless people. These arguments were weak because of the total disregard for the freedom of the individual which the system embodied tended to contradict its appeal to humanitarianism. There were some similarities within the advance of the Australian asylum system.

The changes to both the philosophy and how those with mental illnesses were treated is not fully described here but there appears to be no clear individual issue except those described above which clearly delineate when the custody of those described as being insane was changed to embrace the care of those considered mentally ill. Many of the aforementioned reforms were commissioned well before the settlement of Australia in 1788. Many of these reforms were accepted and implemented without question by those who were administering the colonies in Australia.

3.16 An Australian Perspective

Bostock (1968, p.5) speaks of the history of psychiatry in Australia as being founded on, and more to do with, the difficult problems of administration and certification. In terms of background, Bostock (1968, p.9) suggests that the overall

...conditions in Australia from 1788 to 1850 must be regarded not merely against the background of contemporary events in England, America and the Continent, but also against that of pioneering difficulties in a virgin land.

Clearly, the treatment, management and care of the insane were in some ways callous and ferocious (Bostock, 1968, p.9). In a similar fashion to mental health care treatment overseas, the treatment can certainly be described as a little rough and ready. Bostock (1968, p.8) illustrates this point speaking of patients

...being bled in the latter end of May according to the weather; and after they had been bled, they take vomits once a week for a certain number of weeks; after that we purge the patients. Bostock talks of restless and excited patients being [often] secured by chains ... with a particular patient being secured by being placed in a collar which encircled his neck, while being confined in movement by a pole at the head of his bed. Similarly, an iron frame passed over his shoulders, with apertures for the arms at either side. Finally, a person with a mental illness could

be chained by the ankle to the foot of the bed.

Australian psychiatry in the hands of Norton Manning 1867, 1875 and Tucker 1887 sought to look at what was being offered overseas in an attempt to emulate good psychiatric practice in Australia. Good practice at that time sought medical control of asylums for the insane and was viewed by Lewis, 1988, p.27) as being instrumental in the setting up of “specific training of nursing staff”. Norton Manning who was appointed as medical Superintendent of Tarban Creek asylum in 1868 was commissioned by the Australian Government to tour asylums both overseas and within Australia and report on his findings. Manning was particularly critical about the condition of the Parramatta asylum suggesting that “the buildings at Parramatta are utterly and completely unfit for the purpose for which they are at present employed (Manning 1868, in Smith, T. 1999, p.15). Manning went on to say that no amount of money would render them adequate, and that the asylum should be abandoned and a new asylum should be erected. Manning also suggested that many new asylums should be constructed more particularly in country areas (Smith, T. 1999, p.15).

Aside from the issues concerning the buildings, which housed the mentally ill, Manning was also concerned about the staffing profiles at Gladesville and Callan Park hospitals. With the improvements to the hospital buildings and accommodation, there also came a substantial revision of the rules to be ‘obeyed’ by the staff. These staffing profiles encompass many gender perspectives, which have been instrumental to the shaping of psychiatry and how it is practiced today. The next chapter incorporates the topic of gender and looks at some of the staff and staffing issues which were significant to the

overall profession by using some of the more recent literature/arguments and balancing the history of psychiatry with some of the emerging thoughts and tensions of today.

3.17 Summary

This chapter has looked at many facets of the history of psychiatry, demonstrating that over time the general public moved from being ignorant about mental ill-health to becoming a little more involved and more knowledgeable, with the ill-health of King George III in both England and Australia being a catalyst for this change. The chapter looked at the English experience and treatment arrangements, and highlighted some of the limited resources that were available, but which were still influential in the care of the insane in Australia. The chapter examined Poor Law arrangements in England, which was difficult to interpret, and the moral management of people who were often deemed to be different rather than classed as 'insane'. A whole series of different housing arrangements for the mentally ill were noted, including private mad houses, Bridewell's and workhouses, which were all seen as dumping grounds for those people not meeting social expectations. The last part of the chapter looked at the Australian experience of mental health and the influence of the English experiences to these arrangements.

The next chapter examines the nature of those who worked in the old asylum system and gradually moves toward the mental health services of the present day. It considers, as part of this examination, the various roles the people who worked with the insane were expected to fill.

CHAPTER FOUR

PEOPLE WHO WORKED WITH THE INSANE

4.1 Introduction

This chapter looks at the people who worked with people deemed by others to be insane, and demonstrates that this choice of occupation was for a whole variety of reasons not always the possession of the necessary skills required to help. In June 1885, a new rulebook at the Hospital for the Insane, Parramatta, Sydney entitled ‘Rules for the Attendants, Nurses, Servants, and Others’ was published under a Doctor Godson’s name. This rulebook was in many ways similar to rulebooks published overseas at other asylums and outlined in detail the requirements of the day-to-day handling of the insane. According to Smith, (T 1999, p.20) this particular book of rules (or roles) was encouraged and guided by Dr. F. N. Manning. As general rules, these attendant handbooks reflected the philosophy of the hospital to which they were attached and, within this, often the person in charge. The person in charge was the medical superintendent, but, Smith, (T 1999, pp.16-17) alludes to others including the “Master Attendant” and “Matron” who were considered powerful in their own right running some asylums. Often behind the day-to-day management arrangements of the asylum the medical superintendent had to deal with a sometimes difficult and officious Board of Governors. Similarly, the Lunacy Department exercised strong and direct control over the asylums (Smith, T. 2002) so the philosophy of particular hospitals reflected a host of different views relational to the care of the insane. The medical superintendent was always a male and more often than not a doctor and so often attendants/nurses were to

operate according to arguably one side of the gender divide and often the keeping of patients was exactly that, custodial. These points from a gender perspective show that medical (male) dominance of public asylum management had become the generally accepted norm (Smith L. 1999, p.59), although anecdotal evidence would appear to suggest that the master attendant (who was also male) and the matron (female) in heading specific sectors had absolute rule of their particular areas. In 1885, the remit of the attendant was described by Smith, T. (1999, p.21) as the “treatment of persons suffering from defect or disease of the brain affecting their mental powers”. The aim of “all persons engaged in its service must therefore constantly bear in mind that it is a hospital, the object and aim of which is recovery...” (Smith T. 1999, p.21). It is noteworthy to consider here that ‘treatment’ rather than ‘keeping’ was the term used by Smith, (T 1999).

4.2 Two Separate Roles

Attached to the rules were that the “essential qualities in an attendant or nurse which distinguishes two separate and different roles, (see Fig 1) are patience, gentleness, and firmness, with constant perseverance in all efforts to induce the patients to work, to join in recreation, to take food and medicine considered necessary...It is absolutely necessary that attendants and nurses should observe the peculiarities and character, and take personal interest in the patients under their care, since it is only by becoming acquainted with their habits, tendencies, eccentricities, and delusions that they can manage them properly or can hope to adapt themselves so as to influence them for good (Smith T. 1999, p.21). Although the superintendent had overall responsibility for house

management, some aspects fell to the matron. She had delegated responsibility for oversight of the care of the female patients, the supervision of the female staff and management of the domestic aspects of asylum life, such as food preparation, cleaning and laundry, all very much in keeping with the role of female outside of the asylum in Victorian England and Australia. Often the rules described infer a therapeutic preference/regime which according to more recent literature encompasses a role in keeping with a more female orientation, whereas at other times the notion of firmness and making or inducing one's patients to work suggests the usage of a more masculine approach on the part of the nurse. This adds weight to the arguments advanced later where one gender can incorporate the usual gender markers of the other gender when required.

The term “mental nurse” ... “was not widely used in the 1920s ...female staff were frequently referred to as asylum nurses, male staff were known as attendants...” (Nolan, 1986, p.15).



Fig 1: Attendants and nurses posed in front of the Chronic Block, Mont Park. (Bircanin & Short, 1995, p.11).

Nolan (1993, p.6) states that during the 18th and early 19th centuries, the term ‘keeper’ was applied to those entrusted with the care of the insane. He suggests that keeper referred both to the owner of the house in which insane patients were cared for, and to those employed running such houses. The term implies that those who looked after the insane both restricted access to them and controlled the movements of patients in more a protective capacity. Further, Nolan argues that with the emergence of the asylum system after 1845, the term ‘attendant’ was preferred as it indicated a more humanitarian approach to care. The attendants, according to Nolan (1993, p.6), attended to the institution, keeping it clean and tidy, maintained order by controlling inmates, and ensured that there was sufficient farm and garden produce to render it viable. Attendants were considered to be the medical superintendent’s servants, with primary responsibility to carry out his orders. Yet these aforementioned duties suggest that both males and female attendants/nurses were required and expected to fulfil role expectations or gender markers usually associated with the opposite gender.

Without being date specific, Nolan (1993, p.6) suggests that from the mid 19th century, female attendants were generally referred to as ‘nurses’, although the men were still called attendants. Nolan suggests further that, by the end of the century, nurse had become a neutral term used for both male and female carers. These issues, which describe sex, script and gender roles appear to have changeable boundary definitions, which is perhaps what the role of a psychiatric attendant/keeper/nurse actually entails. Some of the classic feminist works, such as those by Chodorow (1978) Eisenstein (1982) and MacKinnon (1987; 1989), also underpin and support themes relating to sex and

gender roles in much of the literature and hint at more loosely defined or extended gender roles where one gender incorporates some of the usual gender markers of the other. This is especially so in and across disciplines/cultural groups/organisations, such as anthropology (Bateson 1947; Mead, M. 1950), biology (Ruddick 1989; Wearing 1996), feminism (Chodorow 1978; Eisenstein 1984; Tong 1989), sociology (Evans 1988; Edwards 1989), nursing (Game and Pringle 1983; Short and Sharman 1989; Jolley and Brykczynska 1993), teaching (Wearing 1996) and psychology (Burman 1990), which deal with specific topics within the field. Some of these works examine issues of gender almost as though it were a commodity, with a specific and uncontentious meaning, which is framed in ways that suit each author's purposes. Notable exceptions to this include Melia (1987), Segal (1990) and Wearing (1996), who use earlier seminal publications as springboards or vehicles for their own research. This seems particularly wise, as much of the literature has a tendency to advance or promote gender as having specific boundaries and meaning, and in this fails to draw out or acknowledge many of its extended, contentious and more complex features.

Most definitions described above posit or assume that gender is a specific role defined by a particular person's biology and value system, and that their interplay places individuals somewhere on a sliding scale, with 'male' and 'female' being the two definitive poles. For the sake of clarity the different ways of looking at gender and biological sexual identity would be wise. If a dimensional view were taken it would see biological sexual identity as a spectrum, with the majority of individuals being located at the poles (Connell 1987). This study suggests that across nursing and more specifically psychiatric nursing the two definitive poles which locate a particular gender have

incorporated markers which are usually associated with the other gender which tends to blur these distinctive markers. A similar model could be conceived in relation to the social construction of sexual identity, or gender, which entails certain roles which are embodied and reinforced by dominant social thinking and mediated through approved 'scripts' or behaviours. Similarly, a categorical model would in difference see biological sexual identity as falling into two discrete categories, with dubious or transitional cases being viewed as damaged, incomplete or an unhealthy version of one or the other (Connell 1987). The two models discussed here outline some aspects of the division between male and female roles. If one looks at psychiatric nursing and takes the dimensional view, most attendants and nurses would sit comfortably at the ends of the spectrum being defined by their individual titles and other similar boundary markers, such as males working with male patients on the male side of the asylum and females working with females on the female side of the asylum. Similarly, the categorical model would recognise the specific groups but would see any deviation from these categories as problematical with consequences attached. For instance evidence of homosexuality may lead to dismissal from the facility or being castigated by ones contemporaries. Maggs (1987, p.117) adds a dimension to this saying "...the more gentle and womanly, the better the nurse. Now as the woman becomes a little mannish, as is the tendency of the present day, she spoils her usefulness as a nurse. The best male nurse is effeminate and is good accordingly as he approaches a woman in his characteristics".

The dimensional view was once the preferred way but more recent thinking and a movement away from the gender poles to include feminism and the changing of the division of labour suggests a more fluid understanding of sexual identity maybe

necessary.

4.3 Biological Features

The roles or points on the sliding scale are defined by historical and socially constructed means such that whatever it is assumed one is born biologically, one must immediately adopt, conform and fit into the accepted or prescribed gender role (Kandiyoti, 1991). For the most part, these arguments suggest that gender is a socialised, constructed and historical role, in which members are prescribed, or ascribed, a particular gender role identity. In other words, various social characteristics are overlaid onto the substratum of male and female biological features. Because of this construction, gender is inexorably linked to the natural physical features of an individual, and thus the characteristics attributed to an individual on the basis of gender are also rendered as ‘natural’ or biologically given (Wearing, 1996). In the case of treating the insane, history shows that a custodial approach to this work meant that males were more employable. Their biology equips them to be stronger, faster and more assertive, and these were prerequisite to the job. From a biological perspective, Willis (1995, p.143) argues that

...the terms male and female refer to both an individual’s sex and their gender. ...Gender is a social concept; sex on the other hand is a statement about a person’s biological and physiological characteristics as well as a behavior. As a behavior, people are said to come together to have sex. As a characteristic individuals are born with a set of sexual organs such as a penis or vagina, as well as chromosomes and reproductive organs that define them as male or female.

Definitions such as these, although rather limiting, reflect how society constructs gender concepts, such as ‘male’ and ‘female’, ‘feminine’ and ‘masculine’. Hence, biological determinism or the inherited genetic script becomes not only socially constructed but also socially ascribed and for the most part accepted as the given as it is played out in

everyday life. More recent literature is beginning to challenge the claims that biological differences are the only key determinant of gender differences. This changed thinking has directed attention toward a variety of other factors such as power, patriarchy, role scripting, social construction, social roles and gender relations. The areas of sexuality, economics, family commitments, context and circumstances, different realities, discourse, text and language, selection of employment, career pathways and professional roles are all affected by biological differences. These differences are only factors among many, which in practice often interact and overlap with individual factors being instrumental in how others are enacted, for example family commitments shaping how the selection of employment is made and then employment factoring into a persons social role and sexuality. From a nursing perspective Chur-Hansen (2002, p.198) argues, “individual factors have been significant in how patients are now becoming more accepting of nurses other than the traditional female”. With patients now moving from the singular preference of wanting the gender of their nurse to be the same as their own when the nursing care is of an intimate nature. To becoming much more accepting of either gender when the clinical scenario is not emotionally invasive.

The argument that gendered roles are determined exclusively by biological difference is significant, and it might reasonably be asked where this line of thought might take us. Chan (1995) argues convincingly that the biological nature of the human body not only determines the physical characteristics of an individual, but also is instrumental in shaping particular behavioural patterns. Behavioural patterns could/would then be instrumental in shaping career pathways or choices of employment, for example it would

seem more logical that males would undertake employment that involves the usage of strength and females would at face value appear more suited to child care activities. These particular thoughts are the more traditional arguments about gender and the sexual division of labour and have been soundly refuted by many different sections of the community but for the purpose of this research can be used as a starting point.

4.4 Scripting and Biogrammar

Chan's argument, using the work of Tiger and Fox (1972, p.11), suggests that genetic structures are relevant in what the authors describe as 'human biogrammar'. Human biogrammar is a genetically based programme, which predisposes the human being [of whatever gender] to behave in certain predetermined ways. Tiger and Fox (1972) argue that these particular behaviours are inherited from our primate ancestors and include, for example, male aggressiveness and dominance, and female caring and subservience. These are the unavoidable manifestations of an inherited genetic script. With Chan (1995, p.11) suggesting that

...the existence of these behaviors offer[s] strong support for the notion that human behavior can be genetically determined.

This genetic script could be assumed to be instrumental in how the individual may go about their life, and would be significant in their relationships, their sexual identity and orientation, their general demeanour and the sort of person they turn out to be and the career they select. This line of argument would also suggest that males or females would each be more inclined, along with their inherited script, to undertake or choose various occupational pathways in preference to others. Their genetic imprint would have much to

do with the type of work they select and how they would manage their individual and family circumstances. This view would suggest that a person would be predisposed to undertake caring work because of a combination of their genetic script and the active socialisation process which would be going on in the family home. Similarly, this would also add weight to the suggestion that a child would most likely be caring because its parents were, both being arguments, which could go to recruitment and retention issues in nursing generally and psychiatric in particular post 2000.

This literature suggests that there is a scripted view from both a genetic perspective and a social perspective, which moulds and determines the way one would and could act in relation to nursing, from either a masculine or feminine perspective and then from a nursing perspective. Kimura (1992) and Walsh (1997) argue that the scripted element of these points suggests that gender differences or gender identities are somehow wired into our biology. Here, the idea of a scripted performance which deals with both gender and roles is interesting and would mean that everything we say and do is part of a scripted and gendered performance.

Goffman employs a "dramaturgical approach" in his study, concerned with the mode of presentation employed by people or actors and their meaning in the broader social context (1959, p.240). He suggests that interaction is viewed as a "performance", shaped by the environment and audience, constructed to provide others with "impressions" that are consonant with the desired goals of the actor. The performance exists regardless of the mental state of the individual, as persona is often imputed to the individual in spite of his or her lack of faith in or even ignorance of 'the performance'. Goffman uses the

example of the doctor who gives a placebo to a patient, fully aware of its impotence, as a result of the desire of the patient for more extensive treatment. In this way, the individual develops identity or persona as a function of interaction with others, through an exchange of information that allows for more specific definitions of identity and behaviour.

According to these points, Goffman (1959) suggests that scripts serve as guidelines, which enable people to know how to behave and act in the different circumstances and roles in which they find themselves. This suggests that certain behaviours, embodied in specific scripts, are attached to specific roles; therefore, specific roles are predetermined such that 'actors' play out each role in a given way, and this entails employees playing out their professional roles. Adherence to these roles gives rise to a 'we have always done it that way' mentality which encompasses both 'right' and 'wrong', in the sense of correct or incorrect adoption of the standards expected in the role. A similar process can be seen in several areas relating to the profession of nursing, including education, registration, and clinical practice. For example, standards of nursing competency are used as benchmarks to determine whether a student nurse's progress is acceptable and whether, upon graduation, they may register as a nurse. In a clinical nursing practice situation, standards may be embodied in routine, culturally approved procedures, or articulated in clinical practice guidelines. From a psychiatric nursing perspective the risk management strategies, which are in place across clinical areas, are an example of this where suicide as a possible diagnosis is more likely to get admission to the hospital than say an exacerbation of schizophrenia. Similarly, male nurses being asked to escort patients between psychiatric facilities rather than female nurses because of security and

safety concerns. In extending the notion of standards to the area of gender, enables us to see how playing out a particular gender role will persist until the formula of what constitutes a particular gender and role is changed or modified. Although it is hard to draw a clear parallel between the two because nursing and gender are in many ways intimately linked and interactive, where the stereotype of nursing and that of gender have some similarities. Conformity to both the gender and nursing role, or socialisation into either role, is approved or disapproved by the discipline/gender and by acceptance of the person concerned into the group, or the person would be dealt with by institutional means and excluded, marginalized or punished, by being sent to nursing areas which are not considered very popular, for example, or being 'sent to Coventry'. Cultural processes like these help maintain the status quo and mitigate against changes to concepts of gender and the gendering of professional roles. These arguments suggest that nurses could have a repertoire of selves, or a series of different selves played out in different roles. Or the wearing of different role masks.

4.5 Self as a Repertoire of Different Masks/Selves

The body, and its gender, is the medium through which this discussion and the subsequent discourse are centred. This writer argues that the body and subsequent role of the general nurse is socially defined and that this definition is significant in relation to how gender and the nursing role is perceived, examined, understood, and deployed in everyday life. The role of the psychiatric nurse relational to general nursing is different. It is viewed with some suspicion by members of the general public because of its attachment to psychiatry. Many think that psychiatric nursing is a job rather than a professional discipline, that custody is the defining feature of what this job entails and,

people that work in psychiatry can be “strange” (Robbins, 2001). Connell (1987) argues that the body becomes a social agent as if from pure nature, or from some standpoint outside society. The body as used, the body I am, is a social body that has somehow taken on meanings, whether intended or otherwise, rather than conferred them. A male body does not confer masculinity on its owner; it receives masculinity or some fragment thereof as its constructed social definition. The body, in this sense, without ceasing to be a body, is taken in hand, and scripted, transformed or played out in social practice, and the role expectations fulfilled by its owner. This view draws on the work of George Mead (1863-1931), who argued that the self develops through social interaction with others, using the body as its vehicle or medium. Short, et al (1998) extend this line of argument using the work of George Mead in viewing self-concept or self-image as a picture or lived impression an individual has of him or herself. This picture of self refers to one’s identity, and this identity establishes what and where a person is in social terms and situates, defines or casts a person as a social object (Stone, 1975, p.82). Further, this picture of self also establishes a set of values, or attitudes and perceptions that an individual has about their own self that is influential in their actions or how they may respond to the actions of others. In this, when one has identity one is situated or recognised as a social object by the acknowledgment of participation or membership in social relations or groups. Therefore, these arguments suggest that others in a group need to establish a person’s identity by locating that person as a social object within the group, and by using the same words of identity that a person may appropriate or use for him or herself, as in completing the necessary competencies to be able to register as a nurse This is an interesting view because it suggests that a person has to live the role of a

particular gender in order to fully realise and understand it. However, it might be argued that no one could never actually fully understand their own lived gender role, and that a person probably only ever enjoys a partial understanding of their own gender role, as well as the other gender role, and the various associated identities. This understanding allows us to function and participate in a given society rather than remain as individuals who are detached and socially isolated from the other gender(s). This commonality and shared understanding are more significant and extensive than areas of idiosyncrasy and difference and implies that individuals have little control over the 'fitting in' arrangements which appear to take place. Warelow (1996a, p.35) argues this point by examining some of the roles in multidisciplinary teams, and suggests that individuals moving into professional disciplines are required to learn

...the ways of the group or society in order to become a functioning participant. This process entails the establishment of boundaries on a person's behaviour. I have argued that for disciplines to become accepted members of any multidisciplinary team they have to conform and 'fit in' and take up certain prescribed, discipline specific roles.

4.6 Teamwork

Taking the multidisciplinary perspective into consideration highlights some of the tensions that exist between not only professional disciplines but also gender across the disciplines within psychiatric nursing. Warelow's (1996a, p.35) argument suggests a pecking order arrangement between disciplines, which disciplines seem to adopt almost as though it is the accepted way. Newcomers 'fit in' with the status quo without challenge as highlighted by Stein's (1967) doctor nurse game playing research. Female nurses seem to naturally assume a one down position to male doctors without question. Nursing activities are seen as and are invariably linked to the history, status and activity

of women (Miers 2000; Miers 2002). Similarly, the literature depicts gender and specific gendered attributes for women (such as caring) and with men (such as authority). These depictions are culturally created and determined and often go unchallenged. Miers (2002, p.71) puts forward an analysis of gender order which she describes as a system in which the division of labour, sexuality and power relations all influence both men and women (Connell, 1987). Miers suggests men and women can be seen as constrained by hegemonic masculinities through expectations about the body, about sexuality and about social roles. These expectations have particular significance for nursing as they portray the notion of 'good women', views of females as sex objects and constructions of heterosexual masculinity (Miers, 2002, p.71). There are of course some contradictions between societal gender roles and the work that males and females might ultimately do or be expected to do in their employment roles. Male nurses often completed domestic type duties such as ward cleaning and female nurses were often drawn into apprehending patients threatening to abscond. These are indeed contradictions but represent the ability of either gender to incorporate the gender markers of the other gender in context dependent situations. In these arrangements females by adopting more usual male gender markers appear more able to assert themselves becoming politically more active and achieve a higher ranking in the pecking order and in these arrangements are often more successful in their position and in promotional achievement. Evans (1997, p.226) argues this point further adding that male nurses often use strategies to separate themselves and their masculine sex role identity from their female colleagues and the feminine image of nursing itself. Evans suggests that the small number of men in the profession of nursing occupy a privileged position in relation to their women counterparts. Males push for

professional autonomy and move toward positions that practice more independently whereas women appear to enjoy working together and operating within teamwork structures (Evans, 1997, pp.226-231).

This supports the view that the role is genetically or biologically prescribed or determined and the person then fulfils or lives out the expectations of the social role. Goffman (1976, p.75) suggests that human beings possess a created or assumed essential nature or personal nature, a nature that can be discerned through the natural signs displayed or given off by them and which are employed to fit their social surroundings. Goffman, using a dramaturgical analysis, argues that a person's individual self is constructed and maintained through validation by others (Brissett and Edgley, 1975 p.55). Goffman (1959) describes the flexibility of role taking as being akin to putting on a series of masks or presentations appropriate to given circumstances. In this argument, gender is viewed as a socially scripted dramatisation of a given culture's idealised view of feminine and masculine natures (Lorber & Farrell, 1991). Goffman (1959) argues that we are all beings of multiple roles; that a person's 'true self' is changeable, and is displayed in each particular situation or context. According to this view, a person is a collection of masks worn and played out according to the given social script. Therefore, a person's true self is a social and scripted performance, which is played out differently in different circumstances, and which entails gender identity. Brissett and Edgley (1975, p.56) suggest

The self is social not only in the larger connotation of the world but also in the idea that a person's sense of individuality is situationally specific. Different situations occasion the establishment of different selves. In this sense a person's sense of individuality is plural, not singular.

This view is supported more recently by Zaejian (1998 p31) who suggests that we all have different personas that we apply to different situations such that a person's self is not carried from situation to situation, rather individuality would be constructed around the context and the audience in which the persona was enacted and the performance took place.

4.7 Trade Unions

In line with the views expressed above concerning teamwork and gendered identities come the interrelated issues of professional organisations and trade unions. Professional organisations and trade unions in regard to psychiatric nursing have changed significantly over the last twenty to thirty years. Over the history of psychiatric nursing the trade union movement was dominated by men with masculinist agendas usually attached to provider roles. The Asylum Attendants Association in England was more interested in staff rights and their interests and was often involved in working condition issues. The professional organisations like the Royal College of Nursing in Australia had similar agendas to the male oriented trade union movement. The last twenty plus years has seen some movement from this masculinist agenda where political issues have manoeuvred psychiatric nursing and their remit now considers what might be described as issues that consider both genders. For instance union movements and professional nursing organisations are now considering extended and paid maternity leave and job share positions. In saying this psychiatric nursing is now not as unionised as it was as both genders change their overall perspectives of the roles they provide in clinical practice with males

preferring to specialise and create what Evans (1997, p.228) describes as “islands of masculinity” within the profession. These islands incorporate nurses moving into areas such as psychiatry, anaesthesiology and intensive and emergency care areas attached to what might be described as masculine prerequisites such as strength, technical prowess, autonomy and cool headedness. Therefore, the adoption of masculine roles and safety within a female occupation.

Goffman (1959) argues that we have a repertoire and vocabulary of manageable fronts or selves, which we use across a multitude of settings. Just as the British would know the tune of God Save the Queen and Australians would know the tune of Advance Australia Fair or Waltzing Matilda we prepare and deliver responses. Personality trait definitions or fronts become collective, normative terms, or common understandings in a vocabulary. Thus social fronts or selves are almost institutionalised. Others anticipate and base their expectations of what constitutes ‘me/you’ from the stereotypical, stock traits ‘we’ project; examples of this would be male, female, nurse, doctor, psychologist, and car dealer. When we take on a new job role for example an expected front is already waiting in the incumbent's workplace. We perform the job and ‘take on’ or ‘fit in’ with the front that comes with it. This is significant in terms of workplace culture and expectation.

Morrall (1995, p.133) supports this point in relation to nursing and suggests that:

...individuals who enter the nursing profession should be aware that they are indulging in a socially prescribed ‘performance’, which moulds their behaviour. That is, individuals who adopt the identity of ‘nurse’ follow certain pre-set rules and socially acceptable [and defined] patterns of behavior. These rules have been prescribed by various social institutions for example the government and nurses’ statutory organizations, as well as through the everyday interaction that nurses conduct with colleagues, managers and service users. Consequently, it can be argued that nurses are not really free to decide on their actions in the practice

setting or indeed, in any other situation. They are constrained, to a significant extent, by the parameters that are associated with their occupational role.

Similarly, Melia (1987, p.127) adds an interesting dimension when she says that nursing students from her research show:

Fitting in constitutes a major part of the students' behaviour. First they concentrate their efforts on getting on with the ward staff, and second on the actual business of patient care. In this way, the students spend three years learning to 'pass' in both the service and education segments of nursing.

Her findings suggest that new staff can be role-socialised to 'fit in' not only with practice expectations but also with the ethical ideals of the group they are entering. Nursing practice under these criteria is determined by the scripted element of the group.

4.8 Gender Schema

Bem (1993) adds a further dimension to this argument, arguing that gender roles arise as a result of developing what she describes as a 'cognitive gender schema'. The idea of a cognitive gender schema is consistent with a social learning theory approach, in which children are regarded as learning or developing a schema by observing their parents and carers. In adopting, implementing and practising the schema, it becomes the approved way of behaving, thinking and feeling and in this sense assumes a normative function, distinguishing right from wrong or correct from incorrect. In this way, for example, it would be more likely although difficult to empirically prove that caring parents are more likely to produce caring children. The socialisation of a child in terms of gender of course, tends to be an idealised view in the eyes of the child's parents and of course the realised way or result can often be at odds with the original intent. Added to the position of an inherited genetic script in terms of gender comes the issues of social role. Social roles have played an important part in many sociological and psychological

understandings of sex and gender roles. Specific role analysis is documented in many sections of the literature as a major feature of 'structural functionalism' (Shaw 1981; Mead 1934), which was an influential theoretical paradigm in the 1950s. Functionalism, or the view that all social arrangements serve a purpose or have their own distinct rationale, would argue that gender differences arise because of their functionality. A central feature of Parsons' (1951) analysis of the social system was the concept of role, or a set of expectations governing a person's particular position in the social system. The accounts offered by Mead (1950) and Parsons (1951) have been appealing and significant, but with the benefit of more recent research on sex roles it could now be seen as rather limited. This more recent research (Morrall, 1995; French, 1995, p.185) offers an analysis dealing with gender and gender relations as a social, cultural (Wierzbicka, 2002) or life script (Adams, 1992), in which some people learn and enact scripts, and particular cultural aspects of scripts suggesting for this research that gender is in itself socially arranged, and played out in line with stereotyped and the expected behaviour or role 'norms' of that gender naturally following on. These role 'norms' become over time deeply seated and reinforced in our conscience whatever their origins may have been. This post-Parsonian line of scholarship and its intellectual context helped amongst other things to lay the foundation for a variety of feminist orientations and writings in the late 1960s which moved toward developing and deploying a feminist concept of sex roles and then moving on to encompass gender roles (Wollstonecraft, 1967; Myrdal & Klein, 1968). It also connected social structure with the formation of specific personalities, whereby the specific role is learnt, internalised and enacted from an individual's earliest days. If this is an accurate account of human behaviour, then males and females become

masculine or feminine by learning and ‘fitting in’ as described by Melia in relation to nursing in 1987, with the specific role that is genetically assigned to them or the role that they learn and is usually reinforced from their parents or carers. This role is then operationalised to fit one’s life circumstances suggesting that both the social construction and biological determination of a person’s gender are given. This form of discourse and its analysis appears to have been instrumental in placing men and women in what is seen to be specific but different places or positions within society or, more simply, at the opposite ends of the bipolar continuum.

4.9 Social Learning Theory, Genetics and Games

A genetically inherited script, with its origins in ‘biogrammar’ as described by Tiger and Fox (1972), works alongside ‘social learning theory’ (Bandura, 1977), which argues that some aspects of gender roles are learnt from parents, peers, teachers and significant others and are replicated by adherence to the role. Melia (1987) suggests that nursing conforms to this model in that it has its newcomers ‘fit in’ to the system whether good or bad, keeping the cultural stereotype intact and maintaining the status quo.

Society continues to expect certain specific behaviours from boys and girls, male and female genders, including the role of a nurse, and is instrumental in ensuring gender conformity, and adherence to specific behaviours. People unable to conform tend to be labelled as non-conformers, colloquially the individual will be described as a ‘troublemaker’, ‘not a team player’, ‘a square peg in a round hole’; they may be excluded and treated as outcasts, or even seen as sick and deviant. On the basis of non-

conformers being labelled in such ways, one may question how diversity and change is possible within a social system, which tends to expect specific set professional and gender roles. Changing attitudes and practices occur and are possible as a result of cultural shifts which are usually brought about by events such as earthquakes or similar catastrophes but are often related to individual reformers and radical thinkers who challenge the status quo and because of these qualities often facilitate change over time to entrenched issues and can facilitate these movements. From a nursing perspective, there have been many cultural shifts over time with the introduction of university-based education programmes, different pedagogical strategies, the advent of an array of technological equipment and some rather interesting fiscal funding formulas, but really despite some of these strategies facilitating change none of these have been attached to any one nurse in particular. All of these issues bring about cultural shifts in how nurses nurse and how the socialised role of nurse is enacted in clinical practice. This of course reinforces the view that policy and funding issues do and will impact on the individual and how that individual plays out their particular roles.

Minor changes to cultural groups such as nursing and gender groups would allow individuals to change masks and assume the possibility of different selves. This change would probably occur over time, as society appears reluctant to accept change that happens quickly, having shown some reluctance to accept the changing role of men, for example, and those who become “househusbands” or “sensitive new age males”. These terms arguably reflect society’s ambivalence and scepticism about the changes to the roles of male and female. The terms “househusband” and “sensitive new age males” are

in a way putdowns or a cynical acceptance of the change of role. Giddens (1992; 1994) taking a similar position argues that men have had an appalling record of cruelty, crime, abuse and egocentrism and must and will eventually change from stone-age animals to decent human beings and in this change befitting a partnership with the far more advanced (culturally/socially/ethically) female of the species. Giddens' advancement of these arguments tends to idealise women and demonise men and this fails to capture the complete picture. Holmes (1994, p.3) argues that "aggressive, antisocial, or uncaring behaviour, as well as sexist rhetoric, are no longer the special province of men and it is as if some women appear compelled to proclaim that they have been [now] liberated from stereotyped female behaviour and attitudes by appropriating what they have criticized in men".

Another line of argument would be that male qualities come as a package, for example if men lose their aggression they will fail in social life; take away their more violent tendencies and you'll take away their motivation, their will to succeed and their competitiveness. Similarly, one could argue that if females lose their gentleness they may in fact interact with the world differently, and would the alternative be better? If women were given or took their chance, they also have the potential to be as badly behaved as men. These arguments suggest that the measure of an individual could be their good and bad qualities collectively, and that society needs to learn to cope with both as these qualities make us human. Further to these points, it could be argued that male aggressiveness and bad male behaviour is nurtured in, or an effect of women's socialisation of their male children, and their menfolk. This line of argument suggests

that males are, to a large extent, what women make them and want them to be. Boughn (2001, p.18) argues that “women are still socialized to think of others before they think of themselves” and suggests that the “time is ripe for socializing students to be proactive, rather than reactive” in fact to take on board many of the male characteristics which allow men who enter nursing “to rise like cream in milk”. Boughn (2001) argues that women rather than resent men for this rise must examine why it takes place. Boughn (1994, 2001) and Boughn and Lentini (1999) suggest “men are clear about, and comfortable with, identifying such practical issues as salary and working conditions as acceptable and reasonable motivations for choosing nursing. Boughn (2001, p.18) argues that because of this women fail to realize their economic and professional power whereas men expect and set up their professional lives to secure them, and eventually attain them.

Bem (1993) argues that gender roles arise out of a cognitive gender schema, with children developing this schema or ‘script’ by observing and learning from their parents and significant others who continue to take up both appropriate and inappropriate behaviours. Social learning or stereotyping sustain certain set roles relational to gender and, as far as changes to these are concerned, parents and others could be instrumental in modelling new behaviours. Different understandings and a collective pro-active exercise would work to change how specific gender groups enact and see their role. This would move to facilitate change to the stereotyped and culturally acceptable view.

4.10 Feminism

The feminist literature (Leipert, 2001, p.50; Tong, 1998) claims that pro-activity as a

gender group has been successful in changing views regarding the role of women in society at large and the depiction of patriarchal arrangements holding the more dominant position. Not surprisingly, this has been a long and arduous process with much pain along the way for many of the participants; nonetheless, this journey could be seen as a significant start. These commentators have argued that masculinity needs to be redefined in socially acceptable ways with these different ways needing to be discovered by men and that feminists have tried to hijack the process for their anti-male agendas.

All the theories reviewed so far have assumed that gender along with other elements of identity is something the individual internalises in some deep, meaningful and profound way. The individual thus becomes congruent or 'fits in' with the outer society. That is, we know we are male or female; we know the gender expectations our society places on maleness and femaleness; and whether we like it or not, we conform from the inside out that is, we adjust our selves to match social and cultural expectations.

Eysenck's (1947) research on trait theories is particularly interesting in this regard, with his theory of personality including a consideration of its genetic and environmental basis, and the application of the theory to life experience. Beginning in the 1960s, he influenced professional geneticists equipped with the most advanced methodologies of plant and animal genetics to analyze data on personality and intelligence. In these studies, he suggests genetic factors contribute 50% of the variance in a person's personality. Interestingly, he argues that genetic factors were found to contribute roughly 50% of the variance to a variety of social attitudes like prejudice, authoritarianism,

religion, and conservatism. This linkage of genetics to social attitudes and predispositions might suggest linkages between genetics and caring, and similarly, genetics and the filling of gender related roles involving specific social attitudes such as nursing. Initially this work proved quite persuasive but there has been substantial literature, which critiques Eysenck's work taking a variety of counter positions especially in relation to the area of sociability and the replicability of findings (McNeilly and Howard, 1991). Similarly, Eysenck's first model (1957) had significant changes made in the second model (1967) with little correlation between the two, with the second one not accounting for some things that were included in the first.

Eysenck's theories (1957; 1967) which deal with environmental factors operating to make family members different from one another which may include prenatal events, accidents during birth, illness, and the luck of having a good or a bad teacher fitted well with this writer's line of inquiry which has promoted that we all can fulfill different roles or operationalise different selves. The shared environmental factors making siblings similar include sharing the same parents, the same home, the same food, the same schools, the same friends, and so on went straight to the gender scripting area discussed earlier. But, as Eysenck (to some degree) and others who critique Eysenck's work (Hall, et al 1997) have discovered, these between family variables turn out to be relatively weak influences on personality in the long term, but are links nonetheless. This argument suggests that personality development is more a long-term business, which develops over time rather than something, which is set at or before age of twenty.

Goffman's views (1959), using a more postmodern perspective has some similarity to those of Eysenck. Goffman describes 'multiple masks', in which individuals can employ or adopt a mask in one situation and an opposite or different mask in another. These masks or role are employed by attaching the mask to the circumstances or context, or as Shakespeare (Act 2, vii) would have it, "All the world's a stage, and all the men and women merely players: They all have their exits and their entrances; And one man in his time plays many parts". A role cannot exist without other roles existing, because it is shaped and contextualised by these other roles. The role of 'male', for example, cannot be a role without the role of 'female' against which it can develop, compare and contrast. Similarly, the role of mother cannot be played out without the role of child, where legitimacy of one role is balanced against that of the other. All roles, in this sense, legitimise and reciprocate all others (as in Turner, 1975). From a nursing perspective the legitimacy of the nursing role as a professional activity, is balanced against that of medicine, which enables medicine to present itself as masculine/rational and because of this gain power and privilege (Davies 1995, p.61). This adds to the claims already made that there is more to the argument than men and women simply being seen as radically and fundamentally different.

These arguments represent a powerful emerging theme, partly in response to feminism, which now suggests that males still hold what is regarded as a privileged position but this privileged position is now being questioned (Connell, 1995; Kerfoot & Knights, 1998). It is widely claimed in feminist literature, from an array of perspectives including psychological, interpersonal, cultural and socio-political, that males and females are fundamentally different, and associated research tends to address issues about how

society accommodates and deals with these differences. This position advances the view that there has been some movement, or a shift, reducing the power of males and increasing that of females. Walsh (1997, p.33) advances similar ideas, adding an interesting disclaimer by suggesting that social scientists are now agreeing that the evidence suggests that men and women are much more alike than they are dissimilar. This evidence also suggests that the differences within each gender from a role perspective are much greater than between the genders which are highlighted by the arguments put forward in this thesis about the adoption of the usual gender markers associated with the other gender in the roles played out in psychiatric nursing. This point is also raised by Dominelli and Gollins (1997, p.396), who argue that in considering men, power and caring relationships, power is a complex phenomenon that is and needs to be negotiated between social actors. In respect of such negotiations, it is their findings that no one party to any given interaction is either all powerful or all powerless, and individual parties of both genders should be able to exercise some control over the negotiations in regards to their gender. They use male carers as an example (p.397), suggesting that they are in a difficult, ambiguous position in relation to power because power is organised constitutively along different dimensions in different contexts. Male carers therefore choose to play out power in different ways. Power 'over' is utilised by the male carers, or is the 'expected norm' in the public arena of their waged employment, whilst simultaneously they can struggle with being 'powerless' against their own potential subordination as male carers doing what is described as women's work. This argument suggests that men can use power in different ways and can be affected by different and contrary forces, according to the situation and its context.

Hence, power is more a fluid entity, which is constantly (re)created and (re)negotiated through different interactions and becomes a constantly shifting set of circumstances (Dominelli and Gollins, 1997). This position has similarities to those suggested earlier when describing the term gender which also appears to have some fluidity in our understanding of its construction with it being constantly recreated, renegotiated and played out in life from a variety of prescriptive selves in roles and how the roles are enacted and attached to everyday life. If this theory is correct, then we can extend this view to include women using power in different ways, once again dependent on the situation and its context. In terms of nursing, one of the best examples is described by Stein (1967) who examines some biological explanations of the sexual division of labour, whereby patriarchy as a system of social relations between men and women, promotes men as being dominant. Within the health care system doctors are mostly male, therefore with the above argument, dominant and consequently the controllers of domestic labour, which is mostly female.

4.11 Sexual Division of Labour

More recent literature highlights some of the issues of gender roles promoting what is known as the 'sexual division of labour' in which each sex becomes associated with particular tasks or job roles (Savage, 1987). These tasks, such as housekeeping or breadwinning, are attached to the cultural concepts of the behaviour generally deemed appropriate for men and women. These behavioural differences are assumed to be genetic in origin and are therefore viewed and lived out as being the way it has always been, and have come to be regarded as largely unchangeable. In the context of this

research the male attendant role and the female nursing role are portrayals of these divisions. As Savage (1987) so rightly points out, while men and women are biologically specialised for particular reproductive roles and both have an unmistakable genetic and physical makeup, these factors most certainly do not fully determine the specifics of individual behaviour. This view is at odds with the genetically inherited script advocated by Tiger and Fox (1972) but would suggest that the genetically determined script is played out or enacted within the person's social environment. Savage (1987) argues that there is a significant and continuous interplay between the individual and their social environment and this would support this position being put forward here. This view is particularly appealing where Goffman (1959) talks about the notion of people having multiple selves and the ideas expressed in his research suggest that the condition known as dissociative identity disorders or multiple personality disorder may have some significance and something to offer in gender research and social role theory where people can be said to be/to have different personalities and play out these personalities without in most cases each personality knowing or being affected by others. This writer would suggest here that humans have the potential to play out different roles in different sets of social circumstances and this would fit well with the gendered nature of some types of work and employment (for instance males in nursing and females in security where there is a predominance of the other gender making up the total workforce). Clearly, there is also a link between employment, patriarchy and capitalism (Aungles and Parker, 1992, p.39) and many employers would probably argue that males are more employable over time than females because of childbirth and child rearing issues which they would argue can get in the way of productivity. Employment and capitalist

imperatives both bring in a whole series of other issues and contributing factors. It might be asked how issues such as gender, patriarchy and particular roles have been constructed and played out in non-capitalist societies. For example how exactly does capitalism contribute to the gendering of social and particular work roles? It would appear that in most cases, social circumstances and finances are relevant to the particular professions or employment people seek to attain. The genetic scripting which helps to shape a person's behavioural patterns (Tiger and Fox, 1972) would be significant here in moving individuals to areas of employment that suited them and then the social determinants would come into play where earning an income to support ones family is necessary. In one culture the idea of women as coal miners would seem rather strange whereas in the former United Soviet Socialist Republic this would not have been remarkable. Similarly, employing women in the role of hunter and provider would be viewed as undertaking a natural role in some primitive societies, but would seem strange and paradoxical elsewhere.

Stein (1967) extends this argument further using the doctor-nurse relationship in clinical practice as an example,

...the traditional dominant-subservient relationship between doctors and nurses has remained unchallenged for many decades. Rooted as it is in status differentials, the position of women in society, with differences in education and remuneration, and nursing seen as an adjunct to medicine (Stein, 1978, p.107). Lack of serious challenge in any form has thus maintained the status quo. Rather they prefer to engage in doctor-nurse games. These interactional gambits allow nurses to exercise some control and a measure of decision-making, while at the same time accede to medical authority. Nobody feels threatened and peace is maintained. ...The rules and object of the game are that the nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive. This is done in such a way to make her recommendations appear to be initiated by the physician (Stein, 1978, p.109). The

cardinal rule is that open disagreements between players must be avoided at all costs (Stein, 1978, p.110).

These arguments highlight the double-bind in which nurses find themselves, whereby the historical construction of nursing, their culture, the gender issue and the disclaimer that open disagreements must be avoided, hold nurses and nursing powerless, or less able to act. Competing claims mean that they often feel uncomfortable questioning or challenging the doctor but still feel that they ought to do so. Ferguson (1985, p.88) describes power as not generally associated with nursing, with many nurses feeling uncomfortable with the idea of power and empowerment. This notion is based on nursing being predominantly a female workforce employed in hospitals that are widely acknowledged as male-dominated power structures. This line of reasoning champions the stereotype and gender-socialisation arguments put forward by Salvage (1985), Koziar and Erb (1988) and Leipert (2001), who describe a society in which female activities, exemplified by nursing, are seen as less important than those of males. These arguments go to key performance indicators regarding the performance criteria of what constitutes a good nurse. Gender differences across this issue suggest that the provision of good quality care might be more satisfactory for women whereas climbing the career ladder seems more important for males. Similarly, males work more so in the “fast paced high tech” areas (Evans, 1997, p.228). Jobs that are more masculinized by the advent of medicine. The female issues include their role of child rearing and family responsibilities and so female nurses often prefer more ‘hands on’ nursing at base grades levels as was the case with Division 2, Enrolled Nurse registration.

4.12 Power

Daniel (1983, pp.191-2) insists that power is related to prestige and that “sexism ...ensures men predominate in the most powerful occupations ...female occupations occur at the middle to lower levels of prestige”. This argument needs to be balanced against nurses (women) being viewed as doers and carers, and men being viewed traditionally as thinkers and planners and more technical/manual workers. From this perspective, women are socialised to raise children, as nurturers, and men socialised to provide for the family. Boyd (1982, p.187) extends this point, saying “[t]he man ...power(ful), brave, patient and kind. The women, hard working, gentle, a life of service, offering herself wholly to caring for the male”. This exemplifies what Boyd described as the ideal relationship between men and women within Victorian society. More recent literature (Boughn, 2001) considers the issues, which surround the reasons for males and females choosing nursing as a profession, and suggests that a long-anticipated nursing shortage is looming on the health care horizon. Boughn (2001) points out that to alleviate this shortage, more men, as well as women must be persuaded to choose nursing as a profession. For nursing education and the health care industry to respond to the current enrolment crisis and the concomitant predicted shortage of nurses, it is imperative that the motivations, needs, and expectations of the young women and men already attracted to the profession be better understood.

4.13 Career Choice

Although women and men today enjoy more freedom in making career decisions than in previous eras, the sexes are still largely concentrated in gender-specific professions

(Kesselman, et al 1999; Rotello, 1998; Ruth, 1998). However, both women and men do sometimes choose fields traditionally dominated by the other gender. Nursing is a case in point, with the Annual Nurses Board Report for 2002 showing that the proportion of males in nursing across Victoria (Australia) has remained fairly constant over the past seven years at 8%. In 2002 there were 67,434 females in practice with 6,058 males, a slight increase in both groups. Gender inequity in nursing remains. While the number of men in nursing continues to be small, men nonetheless were the fastest growing segments between 1986-1996 with the number of male nurses increasing by 17.1% compared to a 6.7% increase in females over same period (AIHW 1999) - it is noted however that the AIHW (2000) report indicates that this increase was not sustained in 1997. The number of men entering nursing does not match attrition, therefore careers in nursing need to generate an increasing interest amongst females utilising different approaches than those that attract men. As well, different approaches are needed to attract females and males from different age groupings.

Furthermore, research studies that examined why men choose nursing (Boughn, 1994) and why women choose nursing taking a more general nursing perspective (Boughn & Lentini, 1999) have found areas of both congruence and dissimilarity between the genders (from Boughn, 2001). Boughn's study (2001) revisited data gathered in the mid 1990s from two previous studies in order to compare and contrast why women and men selected nursing as a profession. The original studies employed a grounded theory approach (Glaser, 1992) emphasizing emergence versus forcing of the data. The narrative responses from both groups of students speak vividly to the question of why women and

men choose nursing. The comparison highlighted that caring attitudes varied little between the two groups. Some of the factual evidence that came from Boughn's work showed that the pursuit of power was a significant factor and that there was a difference between how males and females pursued this issue. Skevington and Dawkes (1988) discovered that men desire job promotion and advancement significantly more than do females, citing in support the work of Dassen, et al (1990) who suggest that more men than women aspire to become head nurses. Balanced against these points was a pattern of females failing to identify practical matters, such as finances, as indicators for choosing an occupation. The suggestion here is that women's lack of interest in practical motivations for example salary and working conditions may be grounded in a long history of financial inequities related to career choice. Another way of looking at the same issue would be to argue that women are less concerned with pay issues because many tend to be married to men who are the primary breadwinners, with the money from the nursing position being a second income. Men, because of social expectation are more concerned about money as they fulfill their role as the actual or future breadwinner. Similarly, in terms of traditional role performance, men play ambitious, power-seeking roles, with success for men being culturally defined in terms of their ability to have power and create wealth. This is different for women with success being measured by her ability to marry a man who is powerful and wealthy. These facts are consistent with the observation that occupations dominated by women have historically had lower median annual earnings (Boughn, 2001). Similarly, Ratcliffe (1996, p.393) argues that the importance of geographical mobility and its use as an exclusionary criterion in career progress is significant. Ratcliffe proposes that men are over represented at the top of the

nursing hierarchy, and suggests that women have a propensity to make lateral moves whereas men make more linear career moves upward in the career market (using the work of Hunt 1991). The other important factor discussed in Ratcliffe's work in looking at general nurses career progression is the differential rate of progress between males and females and the breaks taken by female nurses when they have children. Career breaks, it is suggested, delay promotion because of time spent not working and because many women return to work on a part-time basis. However, research by Davies and Rosser (1996, p.390) indicated that very little of the average time taken to reach nursing officer/supervisor level was due to women taking career breaks. The average time taken to reach nursing officer grade for men was 8.4 years compared with 17.9 years for women. The average time for women with no career breaks was 14.5 years, compared with 22.7 years for women with career breaks. These figures are significant and show that females are waiting a longer time for their management posts in comparison to men. Also, of note from Ratcliffe's (1996) work is his suggestion that men may progress more quickly up the hierarchy because that is what they want to do, whereas women prefer to remain at the bedside. However, it could be countered that this is short sighted, as Davies and Rosser (1996), for example, cast doubt on the thought that male and female nurses have different career aspirations. Their research suggested that neither men nor women were particularly interested in taking the nursing management career route. Anecdotal evidence from students and research by Happell (1996; 1998b; 1998c; 1999) indicates that often undergraduates choose nursing because they could not get into their preferred course; were using nursing as a stepping stone into a preferred course; fulfilling someone else's wishes (usually parents or, "Mum was a nurse") and some give a more sweeping

statement such as “I want to help people”. This evidence clearly is indicative of very few students choosing nursing because it’s a good career choice.

4.14 Scripted Performance

Stein’s (1967) work explored some further interesting areas, notably game playing in the clinical situation, which could not really be discounted in relation to this research, cutting as it does across gender and power issues. Game playing, as described by Stein (1967), Salvage (1985) Porter (1992) Adamson and Kenny (1993) are an attempt by both sides of a power differential in relation to patient care to mediate the role of the other party such that each side undertakes ‘games’ in order to maintain a working relationship in health care areas. This game playing is akin to responding to the other party in a way that is considered outside of the professional role of the discipline involved and goes to some of the issues articulated by Berne (1964) who suggests a response from a particular ego state. Butteril, et al (1992, p.169) also offer an interesting analogy when they describe individual team members from different disciplines as having expertise and charismatic power, both of which they suggest can be used to upset the balance of power within a group/team. Their expertise and charisma can challenge the team leader and leads to healthy competition by influencing the thinking and actions of other team members over and above that of the team leader. These powerful assertions started to suggest a more liberated, egalitarian team functioning but this freedom was quickly captured by the authors, saying that the team leader in this case, the psychiatrist would\should harness the team members’ charismatic and expert power and direct it toward the team’s objectives. Berne (1964, p.171) offers an interesting point in relation to game playing, which is

elucidated by Stein (1967), namely that game playing is passed on from generation to generation, and that because of this and because it has a “historical matrix” it would take at least five or more generations to change. The unnerving part of Bernes’ hypotheses as far as nursing is concerned is that any member of the group\culture who attempts to change the game will tend to be “extruded” (Berne, 1964, p.152) or forced out. It would be interesting to know how many nurses have seen this in clinical practice, and how many have left nursing because of it.

The notion of a scripted performance for both the gender role and for life in general, relates to the dramaturgical model offered by authors such as Goffman (1959) and Holmes (1992), who suggest that human beings have the ability to play out more than one ‘self’ and more than one role. This thesis also suggests that we all have a repertoire of different selves, which we can play out in a myriad of roles determined, and often scripted and shaped, by others. Psychological theories have something to offer in this regard with scripting and the notion of self, or ego states, forming the basis of transactional analysis. Many of the more recent articles (Waldekranz-Piselli, 1999) about transactional analysis articulate the view that the self can adopt different roles, or ego states, which are played out in different sets of circumstances, including physical and mental illnesses. Transactional analysis proposes that a person can move into or adopt different responses or ego states to suit particular circumstances. Parent, Adult and Child are all created scripts, or responses, that people employ in dealing with a myriad of physical and emotional circumstances (Thunissen, 1998; Waldekranz-Piselli, 1999). However, people may not to be limited to just three ego states or the created responses that can be played out from the adoption of these ego states in given circumstances.

Transactional analysis assumes that each person has within them a playback system comprising three ego states which can be played out in interactions with others (French, 1995, p.191).

The transactional analysis model suggests to this writer that, apart from assuming the three different ego states of Parent, Adult and Child, individuals are also able to assume different gender roles/schemata in delivering their transaction, message or response. French (1995) touches upon this point, saying that because individuals usually respond without conscious thought automatic behaviours occur. This suggests that particular responses are out of the person's control, and that gendered responses are, at least partially, predictable.

These different scripts or responses are often played out in given roles relevant to specific social contexts and circumstances. As an example, the role of the psychiatric nurse from the 1920's would have been precipitant or instrumental to how nursing is practiced today. The role then has similarities with how graduates in psychiatric nursing practice nursing today. In the 1920s, the nurse's role was likened to that of a 'Jack of all trades', ... with large numbers of attendants being employed by superintendents and used in a multiplicity of ways, being able to turn their hand to different skills, many of which were not related to nursing (Nolan, 1992/93, p.133). Therefore, the notion of caring may not have been as important as other skills when staff were selected for employment.

Most of the attendants are artisans who work with the patients, do all the repairs and anything requiring attention. The shoemaker takes chief charge of the 1st

Male Convalescent Ward as well as overseeing the shoe repair shop. The mason takes charge of the 2nd Convalescent Ward; he is glazier, painter and decorator. The tailor assists in the 4th or Epileptic Ward at meal times and in the evenings. The 5th Ward has two attendants: the junior takes charge of the barrow men and assists in all excavations and wheeling of earth. It is only by such arrangements that any asylum can be conducted efficiently (Annual Medical Report of the Worcester Asylum 1851, in Nolan, 1992/93, p.135).

In enacting these different trades or roles, nurses often assume a whole series of different roles and play out the one(s) they believe, fit with the requirements of the job, rather than being based on any skilled intervention as a requirement of their patient care. This is particularly important when considering how gender, educational requirements and professional issues are determinants affecting entry to the profession of psychiatric nursing. Morrall (1995, p.141) touches on the multiple self-areas when he describes the work of Burns (1992), who uses a dramaturgical model to suggest that an individual has a series of selves, and uses the analogy of a Russian doll, describing an inner and outer social self. He suggests that the inner self lurks inside the outer self, and helps the individual to distinguish between his/her self-image and the misconceptions of himself/herself, which he/she feels his/her behaviour must be sowing among others.

This position is particularly appealing bearing in mind the previous arguments and perhaps the notion of two selves does not fully describe what could be the total or full self. The Russian doll is a doll that has another similar doll, which fits inside, which has another, which fits inside that doll, which has another doll, which fits inside, and so forth. The position taken in this thesis is that gender is one role balanced against many other roles with none of the many other roles being regarded as finite, nor set in any formalised way as being the only role that an individual could enact. Most people could

recall a time when they have crossed what could be best described as the socially constructed line and displayed different types of behaviour(s), which would be described by others as different and not fitting their social norm. Behaviour such as this is generally frowned upon because being different can lead to stigmatised or marginalised responses from others. This crossing of the socially constructed line could be applied in a whole variety of different circumstances, in regards to gender, employment or sexual orientation. The implications of this, according to Morrall (1995, p.141), is that what an individual nurse considers to be the core of themselves is moderated by the many rules and expectations associated with the socially constructed role of nurse. The idea of a core self is rather complex as one could consider core as a role in itself. Becker (1963, p.32) argues and extends this point by saying that individuals have a “master role or traits”, which takes over other roles in an individual’s life. That a person may have a series of interlocking roles such as father, husband, doctor, socialite, Christian, and/or many others. The main focus of ones life maybe for example the role of a doctor and society tends to see a person in terms of this master role, rather than in any of the others, many of which the person concerned may be having difficulty with. The auxiliary roles in this sense can be viewed as problematical to the master role with Becker arguing that in the case of a doctor society expects “him to be upper middle class, white, male and Protestant. When he is not there is a sense that he has in some way failed to [fit] the bill”. Becker extends this view in saying if a person is a criminal all the other auxiliary roles can be and often are assumed by others to be problematical in regard to this one master role. That a criminal could not or would not be any good at being any of the auxiliary roles such as father, husband, doctor, Christian and so forth. Taking into

account the arguments above perhaps we are all people who have more than one auxiliary self and these selves are shaped by the contexts within which we deliver these auxiliary roles but are harnessed by the master role, which overrides this process. This thesis argues that in fact we have an almost endless series of selves, which can be applied to given sets of contextual circumstances almost at will by people in relation to their life circumstances. These selves which this writer argues are genetically pre-determined, then socialised and then learnt or fostered through a whole series of factors to do with cultural norms, fitting in, ones social circumstances, ones context, family and many other auxiliary factors. Arguably core self is lived out around gender where a person plays out the learnt self which is arranged by conforming or fitting in with an accepted contextual and societal definition. Psychoanalysis may have something to offer here where the analyst seeks to inquire about who their patient is or find details about the patient's inner self or selves.

Most sociology simply assumes that self and society come together in some way. Symbolic interactionism for example arises out of theories of the self, but sees the possibility of a kind of split between inner self and society. We communicate with others not self to self, but instead through symbols that we share. What we communicate with these symbols may represent our inner selves, but often they represent social expectations that are external to ourselves. Like actors, we play roles. We learn the appropriate lines and we deliver them, and for the most part we hope that we deliver them effectively. But we do not necessarily internalise them or become them.

Goffman talked about social interaction as "dramaturgical" and as "performance." Social

interaction is a matter of learning roles and acting them appropriately. This does not mean there is no inner self, but it does mean that there can be a disjuncture between the inner self and actions displayed by the person. Within this concept of social interaction, there is little room for disagreement, as potential roles are relatively fixed, and it would be hard for people to escape them. People in subordinate or marginalized social positions are cast in 'deviant' roles and cannot really escape them; the stigma of their social position shapes the nature of their communications with others. There is huge pressure on people to perform their appropriate roles in an appropriate manner, and people who do not may find themselves marginalised and often placed outside the realm of effective communication by the group they are involved with/in.

Butler (1999) argues that it is a mistake to assume that gender is a kind of entity based in some way on the sexed body. She argues that it is better to understand gender as a relation among socially constituted subjects in specifiable contexts. In other words, there's no fixed script for gender; people create it in and through their social relationships in the particular times and places in which those relationships occur. This view argues against the ideas of human biogrammar and genetically based programmes put forward by Tiger and Fox (1972) and goes to a more fluid interpretation of sexual identity and gender.

Butler (1999, p.25) argues further that '...there is no gender identity behind the expressions of gender; ... identity is performatively constituted by the very expressions that are said to be its results.' In this process of performing gender, or any other aspect of the self, people create and re-create themselves'. Butler therefore tends to depict gender

as an act or a performance, a set of codes or markers rather than a core aspect of essential identity. It would be unwise to suggest that middle ground on this matter should be taken as sexual bodies are material objects and nature differentiates more or less consistently the male and female body and their physiological functions. Most would probably be firmly located on this middle ground.

This middle ground rather than the usual bipolar distinctions of gender has been significant across the evolving profession of mental health nursing. The traditional roles played out by specific gender are always seen as a natural relational to the context and time frames in which they are enacted. Power is often attached to the specifics of particular gender roles and usually appears as a central theme when issues of gender are addressed in the literature (Connell, 1987). This is especially so when feminist writers describe power and some of the surrounding issues together (Eisenstein, 1991; MacKinnon, 1987; 1989) and focus on gender and its social construction. Eisenstein (1991) argues strongly that we, as a society, and perhaps all societies, need to move beyond obsessive polarity and pendulum swings between sameness and difference, and instead develop new ways of considering gender in its social, economic, political contexts, which tends to move us back to that middle ground discussed earlier. The gender issues in the history of psychiatry go to an array of staffing issues but also need to be considered in the context of time where gender considered differently.

4.15 Can Behaviour and Roles be Determined by Roles?

In returning to the history of psychiatry, Manning's views on staffing issues are depicted in Smith, (T 1999, p.21) which examines the rule book for attendants and nurses authored

by Dr Godson but refers to these rules being authored by the respective medical superintendent and the whole exercise being overseen by the “guiding hand” of the Inspector General of the Insane (Norton Manning). The overriding position offered by the rulebook suggests that patients should not be punished but rather encouraged by kindness. Attendants and nurses were to be cheerful and punctual, giving attention to orders and show kindness to patients. Non-adherence had consequences for employees, who were liable to be penalised, castigated or imprisoned. The rulebook clearly articulated the power vested in the male Superintendent (McDouall, 1911), and epitomised some of the realities of employment, encompassing power, patriarchy and capitalism.

4.16 Realities of Employment: How Gender Works with Power, Patriarchy and Capitalism

This returns to more recent understandings of gender by looking at power, patriarchy and capitalism. MacKinnon’s (1987; 1989) work is particularly interesting in this area because she suggests that the central issue in gender is the unequal distribution of power between men and women. Power usually appears as a central theme when issues of gender are addressed in the literature (Connell, 1987). This is especially so when writers who deal with feminist issues describe power and some of the surrounding issues together (Eisenstein, 1991; MacKinnon, 1987; 1989) and focus on the social construction of gender (West and Zimmerman, 1991). This discourse serves an ideology that covers domination and clouds over some of the more obvious reasons and neutralises many of the quite obvious disparities. Eisenstein (1991) argues strongly that we, as a society, and perhaps all societies, need to move beyond obsessive polarity and

pendulum swings between sameness and difference, and instead develop new ways of considering gender in its social, economic, political contexts. Clearly, what authors such as MacKinnon (1987; 1989) and Hartsock (1983) alert their readers to is that the sameness-difference dichotomy is securely anchored in a liberal bourgeois notion of feminism which simply makes room for women in pre-existing male structures. This position could be described as positive but begs the question of whether women should or could conform to the roles determined by the male bastions of patriarchy. The notion of conforming to a set of specific roles is touched upon by Warelow (1996a) who, by using the work of Mead (1950) and Parsons (1951), suggests that people, in this case professional disciplines, learn the ways of particular groups or societies in order for them to become integrated and functioning participants. People in this case 'fit in' to the prescribed or defined role.

Notwithstanding these views, obviously females working in mental health settings have bridged the gap between what was a male dominated profession because of the custodial nature of the work and have moved to a more therapeutically orientated structure or female endeavour. This movement also involved male psychiatric nurses moving to work on female wards where both respective groups can bring into play gender markers usually associated with the other gender. This movement had its beginnings in poorhouses, workhouses, Bridewells and asylums to employment areas which were not usually associated with both genders but now are equally well undertaken by either gender where in this case custody has shifted to therapeutic care and those more punitive male activities have been replaced by other more female skills/roles.

Wearing (1996) suggests that the differences between the sexes are the most interesting yet frustrating and enduring division of society. Understanding these differences psychologically, culturally, interpersonally and socio-politically would be productive and helpful in understanding why society is constructed in the way that it is. The literature tends to depict and advance the idea that women are, as a definitive, subordinate to men because they are somehow internally programmed (Walsh, 1997) or responsive to a genetic link (as per Tiger and Fox, 1972) which is instrumental in this process which programmes both sexes for their prescribed roles as wives, mothers, husbands, fathers and arguably nurses. This internal programming would appear to be the adaptive force that moves women and men to fit the social norm or accepted role set of their prescribed gender. Within this process, there is some persuasive explanation of why people are somewhat unquestioning of these prescribed roles and with the exception of the critical theorists, most appear to accept the overall role construction. However, this programming is still instrumental in moving women [and men by association] to “fit in” (Melia, 1987) with what is often described in the literature as an inherently inferior role (Tolsen, 1977; Connell, 1987; Segal 1990). This is suggestive of accepting a predetermined script about gender, which most choose not to acknowledge or question because gender and gender roles are often attached to power relations and are usually viewed and depicted in the literature as being natural or given. These thoughts are consistent with ideas and discourse which suggest that one’s physical make up, genes, hormones, and reproductive instincts, can channel and shape, yet limit one’s skills, one’s social life and more importantly one’s personality. Clearly, biological factors for the most part distinguish a female as being different to a male; her potentiality to bear

children and feed, both significant aspects, which she may not choose to use but yet still, will keep her biologically female and different. Mathews (1984) argued strongly that the biological polarity of male and female is by no means clear cut, alluding to the many variations in anatomy, hormones, and chromosomes which she felt need to be considered along a continuum. All but a small percentage of people fall into the extreme points or poles which society deems to be male or female, quite a few people fall in between these defining poles. Some of these 'few' maybe people who suffer from chromosomal abnormalities or gender identity problems, with these conditions being considered statistically abnormal and really do not inform a theory of human sexuality, except to stand as exceptions which prove the rule. Mathews (1984) argument takes this point further highlighting that somewhere in between the definitive gender poles fall a range of bodies, such as hermaphrodites and transsexuals that are not clearly either female or male. To either side of this argument are bodies that are recognisably male or female, but lack certain, prescribed, yet crucial aspects of maleness or femaleness, or carry significant characteristics of the opposite sex, such as eunuchs, impotent men, infertile women, hirsute women and breasted men. These arguments are encompassed by Holyoake's research (2002) when he describes soft masculinity in male nurses and Boughn and Lentini's (1999) study describing harder female nurses who incorporate the usual gender markers of the other gender. Similarly homosexuality, with the passage of time and the changing shape of social relations, is becoming more socially acceptable, talked about, depicted and recognised in the media and seen as more a natural than unnatural occurrence. With more common usage of the term, significant media exposure and changing perceptions comes acceptance or changes in how people think about the

issue. Within the health care professions males can often be depicted as homosexual (Savage, 1987, p.76) because by entering what is usually described as 'women's work' he is usually expected to demonstrate 'feminine qualities'. Anecdotal evidence speculates that health professions provide some individuals the opportunity to explore their own personal health issues, and by extending this line of thinking further could include exploring their own sexuality. It would appear that some homosexuals feel safer working in health care settings, especially psychiatry, where social norms are seen and viewed differently to those recognised within the general public and are certainly to some degree safeguarded from the prying eyes of the media. Further to this research study, anecdotal evidence suggests that males entering largely female occupations could be said to have failed in a man's world and that now only a female world is available to them. Man is further emasculated by taking on work that by its very nature is described as female and means he has to be or is expected to be caring and gentle and incorporate the prerequisites of the role. This could be described by its very nature as anathematous to the gender expectations or the social norm. It may also be that homosexual people disregard what are usually described as the social norms, or that this is just one of their selves which they choose to play out, practice and perform in their lives for a whole variety of different reasons. This or any other particular self may be more comfortable for a person to use rather than some of the other available selves a person may have at their disposal.

Vancarolis (1998, p.497) refers to the notion of other useable selves when she talks about 'dissociative identity disorders' or 'multiple personality disorder', which involve the presence of two or more distinct and alternate personalities or others in a single

individual. These other personalities, or what are described as ‘sub-personalities’, can recurrently take control of a person’s behaviour. Varcarolis’ summary suggests that each sub-personality has its own pattern of perceiving, relating to, and thinking about the self and the environment. Each is considered to be complex, with their own memories, behaviour patterns and social relationships, which can dictate how the person acts when that personality is dominant. Each can have different names and can be a different race, religion, or sex/gender and have different sexual orientations. Sometimes, one personality is dominant and aggressive, another passive and recessive, others can be both passive and aggressive. Varcarolis (1998, p.498) refers to the personalities having their own distinct “selves”, having different names, different dominant hands and a different sounding voice, and with each fulfilling different roles, independently of each other. Having the potential to enact different personalities with their own inherent schema adds weight to the position offered earlier where the enactments of different roles or selves were offered as possibilities within the role of a psychiatric nurse.

By subscribing to the view that scripts are predetermined and then learnt, we are saying that particular scripts can reflect dominant discourses, with males being depicted as strong and fulfilling provider roles, and females depicted as nurturing and taking on childcare roles. Particular professional roles are often chosen by prospective applicants, which are clearly known at the outset to be a role, or job commonly undertaken by a particular gender. Although occasionally individuals choose professional roles not generally associated with their own gender, scripts are strengthened by their continued widespread usage and adherence, such that they sustain and strengthen the gendered

nature of the role. This continues despite the opinions of the person fulfilling the particular role. Yudkin (1979) summarises these claims, saying that the exclusive and exhaustive biological segregation into male and female that is part of commonsense is more a demand of acceptability within our culture. These biological and genetic bases of gender are widely described in popular culture as being 'perfectly healthy' and 'natural', for example, with polar definitions of what constitute 'man' and 'woman'. Anyone who appears to fall between these poles is viewed not only as different, but also possibly as deviant and unacceptable.

Waters and Crook (1993) argue that social change is significant in a woman's family life and general functioning and that a woman's public role together with the changing social, economic and political position of women outside the family sphere continues to portray women's subordination to men. They encapsulate the view that the limits imposed not only by families, but also by society, enforce a secondary status on women, who collude with the process. Grimshaw (1980) argues that each gender develop, fulfil and ascribe to given contextual roles relational to their families, including child bearing/support, and childrearing or matriarch/patriarch, their employment status, provider/patriarch or caregiver, and economic or pecuniary interests. This must be significant in the sort of employment available, sought and occupied by particular gender groups, their levels of education, the economic well being of the family and the current school of thought driven by parental (and societal) expectations of the day.

The psychoanalytic perspective tends to focus on anatomical differences between the genders as represented in the unconscious mind. It suggests that each gender regard the

other's reproductive and sexual abilities with elements of envy, jealousy and fear. These emotional factors are perhaps symptomatic of both the animosity and attraction between the two genders. The learning perspective on the other hand advances, albeit at times somewhat cryptically, that gender differences in personality and behaviour are learnt and internalised and therefore socially prescribed. These differences are not just natural differences in themselves but are socially constructed with some of the defined differences being taught, normalised and treated differently in infancy. From a slightly different perspective, sociology demonstrates that roles themselves determine how people act and feel, and how in particular circumstances people adopt what is socially constructed, or socially acceptable. Characteristics of this socialisation process include men and women, learning the ways of the group/society in order for them to become functioning participants. This process entails the establishment of boundaries or specifics, which surround a person's behaviour(s), so that sex role differences are indirectly perpetuated not only by genetic arrangements, but also by social considerations such as institutions, especially marriage, family life, the media, the church, employment, by disciplines, by economics, by the needs of society, and by patterns of power. Over time this perpetuation can alter the mindset of particular individuals, leading them to fulfil a role constructed by others, acting in accordance with another or others' wishes. Quite obviously, many of the perspectives overlap and could be seen to be interwoven, rather than mutually exclusive.

4.17 Different Realities

Wearing (1996, p.ix), argues that men and women construct, live out and participate in very different realities in their everyday lives. The 'living-out' of these realities concerns

so many things related to their existence and being: their clothing, families, upbringing, employment, ambitions, even their own definitions of happiness or their gender role. This writer would stretch Wearing's definitions further to suggest that the construction of specific social realities means that no universal or singular definition of a specific reality in relation to gender and sex role exists. Wearing (1996), quite rightly in this writer's view, argues that it is hard to imagine a society in which the only differences noted between the sexes are the act of sexual intercourse and the consequent gestation, birth and suckling of infants for women. This view which could be described as "anatomy is destiny" which is described by Wearing (1996, p.4) as being the view taken by Sigmund Freud and as being a pivotal issue in the functionalist view that gender differences were a natural outcome of biology. This position as alluded to in the literature tends to make up a good proportion of the discourse concerning gender issues. Gender, then, is often depicted as a rather elastic and inclusive term, which can be stretched by definition in all sorts of different directions. Gender is sometimes depicted as a commodity, which can be shaped to suit so many different circumstances or contexts. Freud adds a dimension to this argument suggesting that boys/males grew up in the knowledge that their strength and physique, in particular the possession of a penis which was seen as representative of power, gave them more of a strength, provider and leadership role. Further to this, Freud argued that all women behave as emasculated men and that feminism may be viewed as an adult version or expression of penis envy. These views immediately differentiated the male gender as being more powerful and give women an entree into the world of men and an access to male power. In contrast to this, the female was seen as deficient or deviant because she was anatomically different or

lacking a penis, and her whole psychological make up is based around somehow trying to compensate for this deficiency. In its time the doctrine offered by Freud was readily grasped and became prescriptive for parents and educators who reinforced gender differences both within and outside the family (Wearing, 1996 p.4).

Chodorow (1999, p.10) argues for an alternative theory to Freud's psychodynamic construction of masculinity and femininity. Her argument entails the sexual division of labour and childcare in which separation from mother can lead to different implications for male and female identity. Chodorow's theory suggests that primary attachment to mother can lead to blurred boundaries for girls who grow up needing to compete in other close relationships. Chodorow suggests that boys have to make a double separation from the mother, first as a separate child and then as a male child. The male child subsequently lives in a constant tension about either separation or loss of masculine identity and independence. This would suggest that separation would be more difficult for same sex pairs such as father and son, mother and daughter. Kozier and Erb (1988) and Warelow (1996a) touch upon some of these aspects when they look at some of the professional issues that surround the nurse-doctor relationship within health care teams and some of their professional boundaries and working issues/roles.

Chodorow (1988) believes that girls identify with their mothers and are able to do so well into adulthood. As a consequence their socialisation is about connection, emotions, affection and care. Chodorow argues further that boys on the other hand must separate from their mothers so that gender identity is characterised by loss and separation. As a consequence to this boys and men seek achievement rather than connectedness. Giddens

(1995, p.45) argues that socialisation has the potential to repeat itself with succeeding generations as girls see their mothers nurture and boys see their fathers achieve. These features are significant in many of the professions within psychiatry; it suggests to the researcher that roles are therefore situated identities, almost assumed and relinquished as the situation demands. Following this, some roles, and some professions are already gender marked, such that special qualifiers need to be added to highlight the difference that is already biologically evident. Exceptions to the social norm, such as female doctors and male nurses, are added as being an anomaly to the rule. Using these features and viewing the issue in its historical context, and examining cultural/anthropological perspectives shows how particular professions and their make up can be socially constructed and at some level gendered. Many professions have been seen as essentially open and undifferentiated by gender. However, in most societies, many jobs are still very clearly divided into men and women's work. Holroyd, et al (2002, p.295) argue that

“... professions such as medicine and law are male-dominated and women are less well represented. Women have only entered the training programmes for these professions following determined campaigns by feminists in the last few decades. ...Similarly, female-dominated professions such as teaching and nursing have also excluded males under such gender assumptions”.

Holroyd, et al (2002, p.295) argue that under these arrangements men have been shown to “emphasize their masculinity and distance themselves from their female colleagues, in order to legitimize their employment in female jobs”. In contrast, women entering male-dominated professions are usually far more constrained in their responses to such biases.

Holroyd et al (2002) argue that

emphasizing femininity may have limited benefits for women in an occupational

structure defined and controlled by men. Men have been shown to monopolize positions of power in the working environments and can make decisions about employees that favour other men. Thus, men are rewarded for emphasizing their differences from women whereas women are typically penalized for emphasizing their differences from men.

These arguments suggest that specific roles are and can be played out because of these arrangements in different ways (Bird, 2003, p.579). That males working in the nursing profession can accomplish the given role of nursing, yet within this process maintain their masculinity. This may require some modification on their part of how they play out their role but would suggest that this may be instrumental in how they manage to do well and advance upwards from a promotion perspective. Females entering psychiatric nursing can often deal with some of the more volatile aspects of the job being able to use their more gentle approaches to their advantage.

“...Sally is only small and rather mild mannered, yet she managed to talk a rather aggressive Mr.K down very easily” (Bolton, 2001).

The ability to do this often takes the patient by surprise, as they do not expect assertive behaviour from a female or someone who looks meek and mild. The ability to de-escalate potentially violent exchanges with hostile patients is usually a role that would be allocated or assumed by a male.

...forensic psychiatry clinic in Canada ... would rather employ female nursing staff members ... in male patient only facilities. This decision because ...feel that women are ... better at defusing and de-escalating aggressive ... more successfully ... more quickly than males by the approaches that they use. That just the presence of females is calming in itself (as per Chapter 6).

In multi-disciplinary health care teams nurses, doctors, in fact all disciplines learn the social rules and roles not only along gender lines but also the gendered social rules and role

of the group and or discipline of which they are part (Kozier and Erb, 1988; Shalinsky, 1989). These rules and roles tend to promote women as avoiding or being less interested in the pursuit of achievement and power which men are encouraged to attain (Vance, et al 1985). The role appears to be socialised and accepted by the profession of psychiatric nursing although more recent research suggests that males are beginning to examine some of the cultural meanings of their identity in mental health/psychiatric nursing finding a “soft masculinity” (Holyoake 2002 p33) within the role of male nursing issues and similarly, females finding that societal expectations about having children and settling down into marriage are perhaps not quite as persuasive as they perhaps were earlier since the baby boom days. Similarly, in terms of role performance, traditional roles are beginning to be replaced and although men to a large degree still play ambitious, power-seeking roles, with success being culturally defined in terms of their ability to have power, earn money, create wealth and achieve the literature suggests that females are now beginning to move into more breadwinner type roles with the advent and acceptance of different societal gender roles. These changing gender roles or the incorporation of the opposite gender markers see a blurring of employment opportunities and the take up of what were exclusively single sex occupations.

Characteristics of the socialisation process include people learning the ways of the group or society they are part of in order to become an accepted and functioning participant. This process entails the establishment of boundaries on a person’s behaviour. This writer has argued that for disciplines to become accepted and functional members of any multi-disciplinary health care team they have to conform, fit in and take up their certain

prescribed, discipline and gender specific roles (Warelow, 1996a). This writer would add that disciplines assume a pre-set or prescribed role in relation to the other disciplines, with anecdotal evidence suggesting that this is done almost at a subconscious level. In terms of particular disciplines within the health care arena, the nursing literature (Smith, L 1987; Heenan, 1991; Crepeau, 1994) often depicts the (male) doctor as the team leader, and chooses not to analyse why this is the case or what benefit it serves in terms of patient care. Brearley, et al (1978), argue that the most powerful team members direct the contributions of the others, with medicine being dominant, and nurses being submissive in proportion to their seniority. Nursing authors (Gilgun, 1988; Katzman, 1989) tend merely to describe the dichotomy between medicine and nursing rather than offer any solution. They tend to stereotype the nursing role as 'handmaiden' or as an adjunct to medicine, with the rhetoric implying that female occupations such as nursing are secondary to that of males (Daniel, 1983). Related to this are games that particular professions play to maintain their standing within the institutional pecking order. Stein (1967) argues that the 'doctor-nurse' game highlights the dominant-subservient relationship between the two disciplines, and extends this point to include the relationship between the two sexes. Clearly, there are significant benefits attached to the playing of these games for both parties, in that peace is generally maintained and the nurse has some measure of control and decision making within the health care setting tacitly approved by medicine in the name of good patient care. The game, later revisited by Stein, et al (1990), now suggests some movement from the position originally advocated by Stein in 1967. These changes are associated with nurses beginning to assert themselves both socially and politically, and becoming more proactive within the health care environment. Other disciplines have correspondingly shifted their focus

somewhat and now see nurses and nursing in a slightly different light as more powerful and more worthy of respect. By adopting some of the ascribed usual role markers associated with males (power, assertiveness, ambition and aggression) nursing has now been more able to change its position regarding its role with other professional disciplines within the health care system. These changes show that, in the eyes of the general public, males and medicine are dominant, and more prestigious and therefore more powerful than females and nursing (Daniel, 1983; Crepeau, 1994). These factors, before and after the changes noted above, have been significant and have been instrumental in adding some proactivity to a nurses role, with 'militancy' 'within the ranks' being now considered, adding weight to the many nursing concerns expressed by nursing groups/organisations. Females now occupy a different position seeing that the seeking of further education, collaboration in terms of practice, militancy and taking on some of the gender markers of the other gender have not only significance in their career advancement, but also their role within multidisciplinary teams and also changed lifestyle opportunities. These changed arrangements which incorporate essentially more masculine qualities harnessed with the perception by the general public of nursing as a female oriented profession have arguably worked in favour of nursing as it attempts to move beyond the gentle caring depiction in the media (Clarke and O'Neill, 2001 pp.351-59; Jennings and Western, 1997 pp.277-282). Militancy and the collective will of nursing have been instrumental in getting more satisfactory patient/nurse ratios recently in general nursing areas and similarly the Blair report (2000) outlines a range of significant improvements across an arbitrary log of claims relational to nursing conditions of employment. The psychiatric component of the report added some decisions, which the commission hoped, would deal with recruitment and

retention issues and the general low morale of the profession as a whole. The conditions of employment ranged from improvements in salary, leave entitlements and enterprise bargaining amendments. Females incorporating masculine gender markers have moved general nursing away from the gentle caring depiction noted above and similarly females in psychiatric nursing away from a secondary status (see Pontin 1988) within multidisciplinary teams. With males incorporating female gender markers have brought more an acceptance of what Holyoake (2002 p33) describes as “soft masculine performance” which has been significant in moving psychiatric nursing away from the hard out of sight out of mind philosophy.

The powerful position of medicine as described above tends to oppress other professional disciplines. Wilson (1970) endorses this point using the doctor as the model, saying that “...each variety of health worker gauges his/her status and professional selfhood in terms of how closely s/he approaches the doctor on a scale of privilege [power] and responsibility”. Wilson’s (1970) argument links well with Daniel’s (1983) scale of privilege and power and from a nursing perspective captures what Speedy (1987) describes as nursing’s (female) attempt to achieve parity with medicine (male). Hayes and Patterson (1975) further this point, saying that students modify their verbal behaviour according to status differentials within multidisciplinary teams, and in this sense other disciplines are silenced. Perry (1986), writing from a nursing perspective, concurs with this view saying that nurses are socialised into accepting “taken for granted” cultural practice norms, institutional rules and routines, which enable them to participate willingly in their own domination, without even recognising it.

These points are of particular interest to this research and suggest that power and prestige are interlinked. This link means that power brings prestige to the particular profession and the general public has already attached the prestige to the powerful position. This ascription of power and prestige to the position rather than to the person would maintain this inequity. Warelow (1996b) argues that

...the patriarchal system dovetails with these points in that medical dominance and nursing's role in relation to medicine appears almost self-sustaining, such that both parties choose to undertake games so as not to openly confront each other. Stein argues that nurses engage in clever although often self-defeating strategies for the sake of their patient care and so as not to rock the 'we have always done it that way' boat. This view tends to promote medical (male) dominance with it being seen as natural and unchallengeable (reified) and advocates the prevailing masculine ideology, which is significant in the socialisation of both males and females and hence nursing and medicine as respective professions. Hearn (1987) and Speedy (1987) both argue this point further by suggesting that nursing in its desire to attain full professional status, is still struggling with this issue because it regards the process of professionalisation as being dominated by male ideology, with the whole process being considered one of the bastions of patriarchy. Ferguson (1994) adds weight to this argument using her study of organisations to suggest that the patriarchal model of power 'emphasizes outcome over process, hierarchy and centralisation over equality and participation, commanding over facilitating, technique over intuition, possession over sharing and conformity over dignity'. This position tends to accept biological explanations on the sexual division of labour, whereby patriarchy as a system of social relations between men and women, promotes men as being dominant and therefore the controllers of domestic labour (Warelow, 1996b).

4.18 Patriarchal and Feminist Underpinnings

These gender markings and identities encompass some patriarchal and feminist underpinnings. The term 'patriarchy', like the terms 'male', 'female' and 'gender', have meanings that are difficult to define. If one looks at the definitions one gets a string of other words which, when one adds ones own values, sentiments, bias and understandings, tend to confuse the issue further. It could be argued that these different meanings and their minor variations may be connected to the way in which a given

society, given genders, and furthermore given groups and professions within those societies, understand, perceive and relate to specific language and text. If this is so, then the word patriarchy could be described as somewhat enigmatic. According to Lerner (in Wearing, 1996, p.21), the term patriarchy has a “narrow traditional meaning”, derived in part from Greek and Roman law, in which the “male head of the household had absolute legal and economic power over his dependant female and male family members”. Patriarchy dealing with these hegemonic, legal and economic considerations, the labour process, and the sexual division of labour and power, needs to be understood in terms of workplace control. This is mostly related to capital and output, which tend to go hand in hand, rather than by gender dynamics alone. Over the last two or three decades, issues about the sexual division of labour and the allocation of specific employment roles to specific gender groups have proven troublesome to those in human resources and those employers who are selecting a person for a specific job without gender being a key selection criterion. The literature indicates that issues of gender are central to the control of the labour process. Game and Pringle (1983) suggest that control has three distinct forms: simple control, which is direct and where power is invested and exercised by an individual; technical control, in which technology controls individuals relational to their work; and, bureaucratic control, in which control is embedded into the workplace environment, and where control is exerted by adherence of the paid employee to sets of rules, procedures and job descriptions. Each of these forms of control appears to have some patriarchal disposition or elements attached to them. Defining patriarchy, like defining gender, has many variations, which depend on particular ideological contexts, specific interests and the particular inherent perspective and beliefs attached. Patriarchy

could be described as a structure or system of social practices and beliefs that gives some men power over other men, and all men power over women.

Farrell (1993) argues that the feminist movement is fundamentally deceptive, with the term being filled with falsehood, foolishness and inaccuracy. The argument suggests that feminism and the feminist movement have almost a social bias against them which implies a rather singular entity with more recent feminist literature suggesting that because feminist thought is more diverse and heterogeneous and moves toward describing “feminisms” and “feminist movements” reflecting the emergence of a more pluralist perspective (Butler, 1999; Robinson, 2003 pp.129-37). In this, the notion that describes women as powerless and as victims is fundamentally wrong because women live longer, have more control over personal wealth and make up a good percentage, above half of current college graduates. Farrell (1993) also suggests that male power is really a myth and that this assumption tends to keep men and women apart. Farrell (1993) contends that we do not really need a women’s movement or a men’s movement but rather a gender transition movement one that requires men to speak up so ‘those’ women can hear. Farrell suggests that dialogue is the key, so that love and communication would engender a more egalitarian society.

One of the aims of this study was to gain a clearer understanding of the extent to which patriarchy has shaped, and is continuing to shape, Australian psychiatric professions, especially psychiatric nursing. What is significant in the literature in relation to this area of investigation is that despite the many variations, perspectives and vagaries that the

examination of gender, patriarchy and the sexual division of labour bring forth there appears to be nothing significant or inherent in any particular job or profession that make them either singularly male or female. This suggests that gender expectations of employment, their stereotyped and prescriptive natures, and the division of labour, are gendered in many ways, and both historically and socially constructed. Kandiyoti (1991, p.104) argues that the term patriarchy is overused and under theorised, but even with these two disclaimers the term often evokes a monolithic conception of male domination. This in itself obfuscates rather than reveals the intimate workings of culturally and historically distinct arrangements between the genders. Ardern (2002), in his research into nursing matrons, says

...writing a book about nursing [more specifically matrons] means writing a history about women only, just as writing a book about physicians would mean writing a history involving men only. Well into the twentieth century heads of nursing were all female, answerable to heads of medicine still always male.

Ardern (2000, p.15) argues that women as healers have not perhaps been as well documented in the literature, as they could have been often remaining “silent healers”. This lack of acknowledgement is described as “not surprising as prior to the twentieth century, men wrote all histories and sciences, thus providing only male interpretations and descriptions”. Other literature would suggest that there are histories of nursing, including eulogistic accounts of the work of individual nurses that recount particular congratulatory achievements especially in the United States of America (Nutting and Dock, 1907; Strachey, 1938; Seymer, 1949; Wymer, 1954; Huxley and Grant, 1975).

Another dimension to this argument is brought about in some of the feminist literature where MacKinnon (1987; 1989) and Hartsock (1983) argue strongly that males, as

sexual beings, tend to emphasise the sexual dimension of their power over women. The focus of this work is away from the workplace setting, and concentrates on the family and private life, and deals with issues such as incest, pornography and rape. This tends to single out areas that would not include/involve the vast majority and therefore one could be critical of this perspective. The available literature dealing with and connecting issues of sexuality and power is somewhat divergent and arguably serves other agendas such as personal, psychological, political and populist rather than be offered as a convincing explanatory account. Feminists such as MacKinnon think that power is an expression of male interests and tends to refer to and advance an overall structure of male domination. This view, along with other feminist work, argues also that women have power but this is either a commodity that is often not used or a learnt skill that allows women to achieve in a male dominated world. This tends to undersell the position of women in what is today becoming a more egalitarian society as women are also sexual beings and within this have power in their own right, power over males.

Writers such as Foucault (1965) argue that power is directly counterposed to any idea that it is a function of overall relations between rulers and the ruled. Foucault (1965) believes that where there is power there is resistance that this resistance is inside power rather than exterior to it, and can be used as a developmental tool in power relations between men and women. Foucault (1965) argues that gender relations and construction are a process involving strategies and counter strategies of power. If one chooses to use the Foucauldian argument that gender is not just a way of positioning individuals or groups in society with respect to their biological features, then surely we need to look at and encompass other issues such as the following. The positioning of individuals as

proposed by Foucault (1965), which is determined by masculine or feminine categories or typologies is about gender influencing and directly affecting an individual's access to many key areas such as education, work and professional employment opportunities, wealth, politics, and available resources. If we accept that gender is socially constructed, and hence persuasively viewed by males and females as in some way natural and true or just the way it is, then we must also accept that this is the only way it can be. In doing this, we inadvertently subscribe to the views put forward by Foucault (1965) that generally the rules of a particular discourse adhered to by certain groups in a society tend to exclude other versions of reality such as behavioural learning, parental modelling and social roles. The literature abounds with evidence that the discursive framework that is "the feminine" is secondary to that describing the masculine, and is hence relegated to a subsidiary position or totally excluded.

The social constructedness of gender has been the challenge and subject of debate for many authors (for example Chodorow, 1978; Weedon 1987; Connell 1987; 1995; Bird, 2003), who have all sought to uncover how women's secondary status and oppression was more social, cultural and political than biological. By building on the work of Gatens (1983) and using a post structural analysis, Wearing (1996) argues that accounts of gender and gender relations are internally inconsistent and mutually contradictory. Leyser (2003, p337) argues that simply possessing a gendered set of expectations is "not sufficient to establish a masculine" or feminine identity. Leyser suggests that gender is a performance and that people must do gender which "implies an interactional process whereby men and women simultaneously display gender and obtain knowledge about what is an appropriate gender display for each particular context".

4.19 Text, Language, Discourse and Deconstruction

Much of Western literature generally and nursing literature in particular tends to use the words gender and sex almost synonymously in the same fashion that the literature uses the terms she and nurse as if all nurses are female or the accepted norm. Evans (1988) suggests that both words, and their derivatives, are good examples of how language and meaning change or can be adapted by authors to reflect and facilitate cultural shifts and particular preferred meanings. Language and text therefore can be viewed as a way of classifying or as tools for the classification of, our experiences of and in the world in different ways and at different levels. Lee (1992) points out that language is a functional instrument imposing structure on our perceptions of the world. An argument could be mounted which suggests that language, text and discourse can also distract and confuse the reader, making meanings obscure by being at times cryptic and because of this difficult to interpret. Discourse and competing features of discourse are used in the body of this text to denote a cluster of meanings that are systematic reflexes of a specific way of making sense of the world. Language which considers gender is very interesting because the question of perspective appears to be bound up with social identity and this social identity embodies a number of issues relevant to this study, such as social class, the sexual division of labour, gender and ethnicity. The place of gender in this debate has a twofold interest; firstly, sexist discourse; and, secondly, how language is used by different genders. Sexist discourse, according to Lee (1992) supporting the work of Lakoff (1975), embodies a pervasive ideology, which tends to differentiate, marginalise, exclude and downgrade women. If this is correct, discursive practices are ideologically applicable to the social circumstances and must be significant in the socialisation of

gender relational to specific social realities, or the way individuals perceive their worlds. Furthermore, recent discussion that relates to politically correct language adds other interesting dimensions to this area of study, such as the problem as to what we should call a male registered nurse: would mister sister suffice for example? In fact, the very notion of referring to a male in nursing as a “male nurse” is significant because a female in nursing is not referred to as a “female nurse”. Lee (1992) quite rightly points out that the lack of a sex neutral third person singular pronoun in English is problematical. The significant absence of a singular, non-gender orientated term for people in general in the English language means, amongst others, that certain, biased ways of speaking become the accepted and therefore prescribed norm. This socially accepted norm, continued usage bringing change, contains male oriented meanings and ideologies, which appear somewhat resistant to change. The maintenance of the status quo according to some areas of the literature, especially some of the feminist work, is because some of these male orientated meanings and this ideology are very powerful and to change this would mean subscribing to an equal relationship with females. At the moment the more dominant position held by males would be difficult to give up, and some of the literature ponders over the alternatives wondering if they would be any better. Many different cultural factors influence the way in which men and women communicate. Similarly, different languages such as Vietnamese, contain many gendered words which when spoken alter other words and their respective meanings. The French language contains nouns, which have a gender identity, and change the form of associated verbs and adjectives. Therefore, what and how someone says, and what someone means, may be subject to a variety of different interpretations. The English language, despite the points

made by Lee (1992), could be described as largely gender-neutral.

The aforementioned arguments provide an interesting forerunner to the comparison between male and female discourse. Gender differences in communication have been referred to as cross-cultural communication reflecting differences in the beliefs and practices of men and women in the way in which they relate to their worlds (Schuster, 2000, p.34). Lakoff's (1975) work identifies what are described as grammatical and phonological features, which characterise women's language or female discourse, demonstrating its difference. An analysis of Lakoff's work suggests that women's speech is consistent with their socialised and constructed gender role; that is, it is softer, gentler, polite, less intrusive, and contains more adjectives of approval and sex exclusive markers or specific linguistic features. Lee's (1992) work also questions and analyses some of these points and attempts to draw some of the more contentious and debateable points together. Lee argues that if one accepts that there are separate discourses for male and female and if there are features in a given language used by both male and female, but some features used more often by women than men, then this must be significant in how this would influence and socialise gender. Similarly, one might puzzle over what effect this would have on the 'fitting in' with the allotted role of a particular profession or occupational group. It would mean that new members would pick up the language and assimilate these features into the role. Lee (1992) suggests that the properties which characterise Lakoff's (1975) somewhat disparate features as a discourse have to do with the fact that these features are often interpreted by readers as homogeneous. This interpretation suggests that like sexist discourse, the characteristics of female discourse derive from, amongst other things the social disadvantage of women and is in this sense

a language of diffidence or powerlessness. Further studies by Lakoff (1975), West and Zimmermann (1977) and Maltz and Borker (1982) suggest that gender difference in the English language and in text are not necessarily marked by grammatical and phonological features but more by distinct discursive practices. Here, women are said to ask more questions and use positive minimal responses more often (such as “mm hmm”). Women are more likely to adopt strategies of silent protest after being interrupted, and often allow themselves to be interrupted more often and more readily than men. Women are also less likely to use direct declarations than men and less likely to dispute, and tend to allow and follow conversational leads more so than their male counterparts. These particular features are suggestive of power differences and most certainly demonstrate the socialised gender features, which are significant in males being different to females, by socially structuring the power relationship between the sexes and describing and assigning to men control of and over females. These particular arguments also suggest that because they adhere, in a general sense, to these socialised features then they adopt the female orientation to cooperative and more agreeable strategies in the use of language, which is different to that of males who lean towards a more competitive discourse style. Clearly, one can extend this argument across so many areas of the nursing profession and by subscribing to the views of Leyser (2003, p337) which argue that contextual circumstances shape “gender as a performance” then gender as a variable in psychiatric nursing raises some interesting points. Males and females in psychiatric nursing fill two separate roles, one which encompasses the caring side of their nursing or the more feminine role and one which essentially upholds risk management issues, security of others and general control seen more as the male features of their nursing.

These two roles are interchangeable and not mutually exclusive but can be employed based on the context of the problem being faced at the time. Traditionally the risk management, security and control areas are usually dealt with by males and the more caring and empathic roles are usually carried out by females. This dilemma also impacts on the role status assumed or prescribed within multi-disciplinary health teams, where ones gender is often an unspoken factor when health care interventions are decided/allocated. For example a contact made by relatives of an aggressive patient would probably be allocated to a male nurse/case manager rather than a female. Similarly, a patient with postnatal depression admitted with a child would probably be allocated to a female nurse. These positions are deceptive as according to this research individuals have the ability to adopt the usual gender markers associated with the other gender and so the circumstances of given psychiatric situations shouldn't make any difference as individuals could employ their 'softer masculine side' of their 'harder feminine side' dependent on the situation. Employment in psychiatric nursing in the past (in contemporary mental health services) could be expected to reflect similar divisions of responsibilities based on gender. These sexual divisions of labour tended to be portrayed right across the board as the work undertaken by male and female nurses in psychiatry tends to be different from their general nurse counterparts with mental health institutions (in the past) going out of their way to make sure that females are not left on their own in circumstances where their safety might be compromised and male nurses allocated work areas where their integrity wouldn't be compromised. The division of labour is significant in promotion, staff allocation and health and safety issues with resources being allocated often on the basis of gender. Often males would be promoted to

refractory wards and females of merit allocated to more deskbound jobs such as staff allocation, rosters and clinical management. These points have a historical and present day perspective but also go to the different language formations used by males and females and how these have made a difference in how they both use socialised gender themes and power differentials and what purpose/benefit this has served over time. Anecdotal evidence from student nurses on their clinical rounds in psychiatry talk of some nurses being “battleaxes” and “aggressive” (Bolton, 2001) toward other staff members and use horizontal violence or bullying seeing this as a way of getting their job done.

...Nurse X was really aggressive toward student Y. She’s a real battleaxe. She didn’t give student Y a chance. She was in her face I thought they were going to come to blows...(Bolton, 2001).

These points can be indicative of why and how men and women choose or select particular professional roles. Further to this, it shows why men and women remain in particular positions and how both prestige and gender are instrumental in setting particular role boundaries. Under these parameters gender conforms to constructed and preset boundaries, set and in many ways regulated by others. The doctor and the nurse are not only gender socialised but also role socialised to act, perform and function along certain defined and ascribed roles (see Stein, 1967; Stein, et al, 1990; Kirchmeyer and Bullin, 1997). Conforming to these stereotypes, rather than seeking to challenge the power base of the medical and other professions in health care and multi-disciplinary team settings has perhaps been more comfortable for some nurses. The public stereotype of the nurse involves seeing the nurse in the role of the doctor’s handmaiden or assistant. The sequelae to this are the general public’s tendency to treat nurses that way when they

themselves become patients (Salvage, 1985; Stein, et al, 1990; Salvage, 1992; Warelow, 1996a; Bushardt, et al, 1987). In this way, nurses tend to fulfil the role expectation of both their gender and their profession (Kirchmeyer and Bullin, 1997), although few studies examine these issues together. From a psychiatric nursing perspective because of the higher distribution of genders across the profession perhaps the handmaiden metaphor is less of an issue and that the division of labour along gender lines related to the role of domestic servants/service is more in-keeping with the psychiatric nursing role. Kirchmeyer and Bullin (1997), examined gender roles and how these roles played out in their natural work settings. They suggest that most gender role research has been concentrated in studies involving laboratory tasks and using college students. This is problematical because, as subjects, college students give only one perspective and most certainly one limited by their age (Dimitrovsky, et al, 1989). The Kirchmeyer and Bullin (1997) study used 86 nurses from four specialty teams (12 emergency, 27 operating, 25 intensive care and 22 psychiatric nurses) at a university-based hospital in Canada. The data was collected using a questionnaire, the gender role scales were measured using 30 items from the Bem sex-role inventory (Bem, 1974), with these scales being shortened by 5 items in order to meet the request of the research site to keep the questionnaire as unimposing as possible for busy nurses. The femininity scale was shortened by dropping shy, feminine, softly spoken, childlike, and easily convinced, the masculine scale was shortened by dropping self-reliant, athletic, masculine, acts as a leader and willing to take risks. The educational level ranged across the spectrum from novice to experienced. The shortened scales appear to have taken the weight and rigor from the study and this writer would think that taking out the obvious tends to cloud the picture even more so.

Similarly, it would be difficult to see how these results could be generalised to other areas bearing in mind the usage of only one university based hospital.

4.20 Occupational Fit

Another twist in the empirical study conducted by Kirchmeyer and Bullin (1997, p.78), who investigated the relationships between “occupational fit and success” among Canadian nurses working in emergency areas, operating theatres, intensive care units and psychiatric areas was that the study demonstrated that even though the nurse’s gender roles appeared rather androgynous, what was found to be valued and rewarded in clinical practice was really the more masculine components of their day-to-day work, especially those areas which dealt with patient focus, assertiveness and the voicing of opinions. The study also suggests that a scaled high femininity score (using the Bem Sex Role Inventory, 1974) was associated with little experience, whereas a scaled high masculinity score was associated with higher pay and a higher contribution to group problem solving. Kirchmeyer and Bullin (1997, p.78; Bird, 2003) suggest further that by examining gender role relationships with work attitudes and organisational culture that what was clearly shown was that gender roles represent rather complex self-identity schemata. Also, those key findings using “occupational fit and success” as a measure showed that only those high on the femininity scale predicted a level of organisational commitment and the value of this commitment to the hospital. Similarly, only high masculinity scaling predicted the hospital leadership value, and androgyny predicted values of innovation, change, patient focus and efficiency and team relations. This empirical study uses three theoretical models to consider gender roles 1) the congruence

model, 2) the masculinity model, and 3) the androgyny model with all of these models offering a distinct line of thinking about the effects of gender roles in what are described as traditionally female occupations is a little difficult to generalise across nursing as a profession but, most certainly demonstrates some significant findings in support of earlier arguments advanced by this study. The psychiatric nurses who were examined in this study could be said to represent a slightly different group to the emergency nurses, the operating room nurses and the intensive care nurses, by virtue of the fact that their individual profession has a higher proportion of males within its workforce than the others. The literature (Arkkelin and O'Connor, 1992; Gauthier and Kjervik, 1982) tends to advance the view those feminine traits such as being kind, gentle, self-sacrificing, submissive and dependent form the common stereotype of nurses in general. However, Kirchmeyer and Bullin (1997, p.79) find this view somewhat disturbing and say that "...given changes to nursing practice with nurses now acquiring more education and taking on greater responsibility than ever before, the accuracy of this stereotype as a reflection of well-functioning nurses becomes suspect". Clearly, the evidence suggests that males are well suited to the profession of nursing generally and psychiatric nursing in particular and within their nursing role can employ all of the qualities which are usually associated with those of being female. This combination of skills increases masculinity in females and increases femininity in males with the result being more well balanced practitioners.

Kirchmeyer and Bullin's (1997, p.79) findings are not only interesting but also challenge the common stereotype of nurses put forward in most of the literature. The study showed that of the 86 respondents of which only four were males most scored as high on the

masculinity scale as they did on the femininity one. The argument here suggests that this adoption of higher masculine roles indicates that both genders are able to adjust their functioning and role within a given gender to suit their particular work environment. In this sense fit the organisational and occupational context and structure in which they find themselves employed. Thus, gender roles represent complex self-identity schemata. This study showed that associations with success indicators such as pay and contribution to group problem solving supported the masculinity model. Masculinity appears to both yield financial rewards for nurses and to meet the current demands of functioning through the often mobile nature of employment in nursing and healthcare teams. Hence, even though the nurses endorsed masculinity and femininity equally and indicated rather androgynous gender roles, what predicted success in this traditionally female occupation was masculinity (Kirchmeyer and Bullin's (1997, p.90). These authors go onto say that their results have practical implications for the recruitment and future education of nurses as it would appear that feminine traits such as compassion and understanding are perhaps not quite as relevant as they once were and may not yield financial rewards nor help the nurse to compete for attention in group problem solving. If independence, assertiveness, ambition and analytical ability are critical to nursing practice, then they are skills, which must be encouraged in individual nurses and incorporated into the societal view of the nursing occupation and educational preparation programmes.

In light of the preceding arguments, Gatens (1983, pp.143-160) claims that sex or gender distinction are artificial and socially constructed, that although gender is a biological phenomena it can also be somewhat plastic, and shaped to conform with gender identity rather than identity being inevitably shaped and determined by biology. This particular

line of thinking is contrasted against the patriarchal view, which tends to valorise the male body and constructs the female body labelling it as 'other'. This notion of other is included in Todorov's work (1985) and is favoured by structuralists, and other postmodernists, holding that one group of people define the prevailing system of normality or convention in such a way that other values and people are placed outside the system. Windschuttle (1980, p.39) argues that females often claim that in a patriarchal society they are seen as the other. This is a rather circular argument as the notion of other could be applied to males or females with both feminist and masculine groups applying the term each claiming the right of use. In this construction, the female body lacks a penis and is therefore inferior in strength and represents a metaphorical picture linked to the social value, which is placed on female and male bodies in our society. This position has changed, with the feminist movements of the seventies now being replaced (or replicated) by male movements in the late nineties (Schenker, 1998). Bly (1990), Hagan (1992) and Pleck (1995) argue that history has gone full circle and that with the advent of a more equal, stronger, vocal, assertive and different female lived role comes a society in which masculine and feminine are drawn closer together and, in this, transcend their circumstances.

Balanced against these views, Connell (1987) argues that humans project themselves into their future by their choices; by the way they negate and transcend the circumstances that are given to them to start with. This argument advances the view that a person is manufactured or constructed to act, then play out their 'selves', or an adopted other 'self' in a particular way. This is obviously significant in relation to the term 'born to be a nurse', and fits with the arguments put forward earlier that gender should be

viewed as an elastic concept, fitting many prescriptive and at times different criteria. The issues of gender in relation to mental health nursing are encompassed by some of these points and suggest that women and men fill specific set roles within mental health nursing. Male nurses usually nurse male patients, and female nurses usually nurse female patients. These gender distinctions are now changing.

Young (1992); O'Donnell and Hall (1992) and Game and Pringle (1983) argue that gender is fundamental to the way work is organised, and work is similarly central in the social construction of gender. These views endorse what could be described as a complementary relationship, with one symptomatic of the other. When studying the labour process contemporary authors tend to ignore gender, apart from token gestures about the ways in which management and bureaucracy tend to create disunity amongst the working class by manipulating gender groups, most notably women. Similarly, many employers have difficulty with part time employment, casual work and the dilemmas or problems that women are likely to face regarding childbirth and more recently determinations surrounding maternity leave. Simply arguing that gender is fundamental to the way work is organised appears not to acknowledge that work is constructed to some degree around men and women's biological features. Some work and professions are seen to be more suited to particular gender groups than others, despite empirical evidence to the contrary, such as in nursing, medicine, the armed forces and the police force. Also, work completed by females at home has not been recognised, or seen as important. Child rearing is considered to be part of a woman's natural role and that a woman would be more likely to give up her employment (or take leave) despite

significant pay differences with her male partner (Oakley, 1974; Baldock, 1983). From a nursing perspective, much of the literature advocates nursing as a mainly female enterprise, and tends to equate caring, benevolent actions with nurturance and mothering. Fry (1989) strongly asserts that caring is a feminine value, and links the ethical ideal and attitude of caring to the carer's earliest memories of being cared for themselves. Fry extends this line of reasoning by arguing that this caring attitude is related to the experiences of the carer in relation to the person's mother figure (1989, pp.15-16). Fry's argument suggests that caring, as an ethical ideal for nursing, is learnt from the nurturing experiences in one's own childhood. This implies universalism although mother-child experiences, bonding and individual circumstances would add variables to this particular analysis (Warelow, 1996b). Fry's view which links caring attitudes to being cared for oneself and asserting this as a feminine value seems to preclude the fact that essentially males are also the recipients of care from their mother/parents as babies and during their formative childhoods and this would suggest that this could be translated into distinctively male forms of caring such as particular sexual orientations and paternalism or the caring given by male nurses for people they are looking after. The only difference from either a biological or genetic point of view would be how we socialise particular gender for their roles as male or female (Melia, 1987; Holden, 1991 p.893; Fry, 1995, p.1822). Fry's research since 1989 retains her thoughts that not only are caring central to nursing practice but also a moral obligation and arguably she shifts her thinking (using Noddings, 1984) in suggesting that caring involves behaviour that have moral content and ... can be adopted by both men and women. Fry and Johnstone (2002, p.42) assert that "as a natural sentiment of being human, caring is a feeling and an attitude that is

universal for the whole species ... caring one commonly sees between a mother and child”.

Whitbeck (1984), Noddings (1984) and Gilligan (1982) all focus on the experiences of childbirth and child rearing, saying that the symbiotic relationship between mother and child is significant in respect to the feminist ethic of care and compassion. One could argue that these points are salient, and in terms of a nursing ideal, if caring is only described as being grounded in mothering and if mothering is construed primarily in terms of experiences surrounding childbirth then caring can only be a female enterprise. Lauritzen (1989) notes that caring would be placed squarely on the backs of women, and today in nursing this is obviously not the case. In this thesis, the question arises to whether caring is only learnt from one's own mothering experiences and therefore has no innate or inborn (as proposed by Tiger and Fox, 1972) quality as paraded in much of the nursing literature. Further to these articles, which suggest that specific gender and caring go together, with nursing being depicted as a mostly career oriented calling for women. If this were so, nursing would be considered a domain for women and males wanting to join the profession would be considered as uncaring by virtue of being male.

4.21 Moving to Gender Neutral

In practice, nursing, unlike other occupations, tends to cut across the gendered construction of labour and arguably nursing could now be classified as being more of a male and female profession or a gender-neutral profession. Statistically 7.4% of registered nurses are male (Australian Bureau of Statistics, 1998), with a much higher percentage working in the area of psychiatric nursing. The arguments offered earlier

about males being socialised in different ways to females from day one of life highlights the dilemma that males moving into psychiatric nursing may face as psychiatric nursing has always been considered one of those areas of nursing which has been viewed as being within the male domain because of custodial role definition. Psychiatry, taking a historical perspective, has a significant gendered nature and Haw (1990, p31) touches on this point in saying

...the fact that Hanwell lunatic asylum recruited men, as attendants from the houses of correction suggests that the role of the attendants was still perceived as being custodial.

Similarly, Brown, Nolan and Crawford (2000, p.10) suggest that

...controlling patients in order to maintain a pristine establishment was the major task of nursing staff.

These views are depicted mainly because of the general public's poorly understood notion of what the role of mental health attendant entailed with most believing that it was custodial in nature. Today, the general view of the role of the mental health nursing has much to do with security and risk management (Holmes and Warelow, 1999), which is a view echoed in history and represents societies wish to lock people away that do not fit with socially acceptable and prescribed 'norms' or behaviours. This incarceration requires the provision of what might be described as a socially acceptable custodian known as the attendant and the provision of a protective role that has always been allocated to and within the ascribed mandate of the male, mostly along the lines of strength, security and protection, under the watchful eye of the medical profession. Most of the male attendants were ex-military men and prison warders, or recruited from among the local farming community (Haw, 1990, p.31; Nolan, 1993 p.47; Nolan,

1998/99, p.19). Often recruited for their size and strength, and their ability to carry out orders, with their military (male) type uniforms, evident in most contemporary photographs, which portrays an image in stark contrast to that of the angelic (white starched) one, portrayed as representative of female nurses. Similarly, general nursing has always been given over to the role of the female; with Nightingale (Chatterton, 2000, p.11) being depicted in an idealised way as being angelic, benevolent and offering hope and care in the face of adversity, once again under the watchful eye of the medical profession. The general public appear to have been encultured or socialised into these respective views of psychiatry and more generally to nursing. Similarly, the type of person who may choose or be chosen to look after and seek employment in areas where there are people receiving these types of care and treatment. The literature (Fry, 1989; Cummings, 1995, pp.19-29; Chatterton, 2000, p.11) tends to portray females as being gentle, caring, more person-centred, and empathic and more the deliverers of therapeutic help. In contrast, males are portrayed in the literature (Cummings, 1995, p.27; Williams, 1995) as living out the ascribed role as being strong, providing security, being protective usually toward female co-workers and taking care of the more dangerous aspects of life and offering control. This appears especially so in the psychiatric nursing literature where Williams (1995, p.64) talks of males being hired in psychiatry “because I am a man... [and] due to their presumed physical strength”. In one way those who work in these speciality areas have to contend with how their jobs are constructed and/or depicted by the media and the general public along with the associated myths attached and the gendered nature of their occupation.

Godfrey (1999, p.172) argues that sexuality is an important and integral part of the whole person and it allows individuals to define themselves as it is linked to one's self-concept and general self-esteem. Godfrey (using Foucault, 1978) argues further that sexuality has moved into the home with the development of the conjugal family. This has led to heterosexuality being seen as the norm and in itself natural. This definition has therefore created a general assumption that all people are and should be heterosexual. Further to this thinking anyone outside of this mandate is viewed as different or deviant. This leads to the belief that heterosexuality is both superior and a 'proper' expression of sexuality. In the past homosexuality was seen and depicted in the media as a deviance and was considered to be in the remit of a psychiatric disturbance.

The popular image of nursing through the media and importantly television are that it is mostly a female occupation. With the profession idealised in many ways as a philanthropic, angelic exercise undertaken by females all directed to the common good of society at large. If we agree that this is the view accepted by society generally then how does this view fit with psychiatric nursing, which is generally thought to be more of a male profession. The television or media portrayal of psychiatric nursing is in rather short supply and what is available demonstrating that both male and to a lesser degree female nurses, as in Kesey's *Nurse Ratched* (1962) are usually more concerned with a custodial role and in this exercise can become aggressive and forceful in getting the rules of the particular facility met rather than the provision of any therapeutic endeavour. *Nurse Ratched* for example rules the ward environment by creating uncertainty and scaring the patients as a consequence of upholding the hospital rules. Soon, a new

patient, Randle McMurphy, is brought into the ward. The institution and its patients would never be the same. From him, the other patients are introduced to his world of gambling, breaking rules, drinking and many more surprises. For the first time in the Nurse Ratched dictatorship a patient has challenged her authority. Inevitably, McMurphy's touch of the real world gives other patient's laughter, something to stand up for, courage, a sense of purpose, and hope. Nurse Ratched is perhaps the inflexible archetype of a psychiatric nurse in the early 1960s, more interested in upholding rules rather than caring for patients. One wonders how relevant such portrayals are to real practice and are they in any way useful. It would seem that however close the nurse Ratched portrayal is mirrored in reality this depiction of asylum care and the role of psychiatric nurse was very persuasive to the general public (see Chapter 6).

Anecdotal evidence from students after their clinical placement in psychiatry differentiate their psychiatric placement from any of their general nurse placements in saying

... psychiatric nurses are different, they seem more laid back, are always interested in looking through issues, tend to read something in when it is not sometimes there. They tend to nurse differently...they seem to take a more punitive approach almost ...do as I say (Robbins, 2001).

Masculinity and femininity and their social construction cannot, in this writer's view, be understood apart from the wider concept of gender. Segal (1990) suggests along with many other authors that gender should be understood as the individual, cultural and institutional ways in which biological sex is given social existence and arguably acceptance in any particular context. Foucault (1978), Lacan (1998), and other discourse theorists argue that masculinity and femininity refer neither to a collection of traits, nor

to some set of stereotypical, prescribed roles. Their arguments suggest that what constitutes masculinity and femininity refers to the effects of discursive practices and conventional ways of conceiving and representing reality, which serve to produce and represent sexual differences in specific contexts of knowledge. In this sense discourse tends to set up contradictory positions for male and females by somehow giving it voice, undermining any coherent and individual sexual identity, whilst in the process setting up sites for resistance and struggle which only serve to highlight and further the differences. This suggests discourse also oppresses the male gender and is not mutually exclusive to females. Differences from what might be described as 'normal' in terms of gender sexuality are the areas noted more readily in the literature. Foucault's (1977) interest was in why certain ways of thinking and speaking became acceptable in a given society whereas others did not and it would appear that Foucault felt that discourse was deterministic and more than just linguistic construction. His arguments suggest that discourse is one way of encompassing or capturing a specific reality or social understanding. That in essence discourse was a way of talking and thinking about a reality or a set of understandings or common assumptions that has something to do with how individuals understand and attempt to make sense of their specific worlds.

From a nursing perspective the discourse of nursing suggests that it is "gendered work" (Muldoon and Reilly, 2003, p.93). Essentially it is a profession that belongs to women and this view is traced from the "traditional, taken for granted role of women in providing informal care for children and ill and dependent relatives..." (Muldoon and Reilly, 2003, p.93). The discourse doesn't say very much about why females assume this extended role beyond that of nursing and suckling children so obviously biological

factors relational to roles are significant in deciding which gender takes on certain role functions. The contextual circumstances would reinforce these biological prerequisites with roles being traditionalised to certain genders relational to the circumstances in which they arose. Male nurses would therefore be expected to carry out more secure and custodial pursuits in psychiatric nursing rather than females. The discourse suggests strength would be useful, therefore all patients in psychiatric facilities are aggressive therefore males would be better psychiatric nurses.

These arguments tend to dispel the theory that the source of women's oppression is male power in general, but more because of specific issues such as class and capitalism adopting more the orthodox Marxist view that are described in detail by Busfield (1996). Busfield argues this point further saying that capitalists have an interest in subordinating women into domestic labour, for domestic labour supports, in fact, encourages and sustains capitalism through the reproduction of labour power, which ensures a continuing healthy labour force over generations. These arguments persuasively suggest that domestic labour benefited the male, and could be described as a hidden cost to capital. Domestic labour in this sense can be and would be viewed as valueless; in fact if one analyses the rather wide and at times divergent views in the literature, it usually depicts that women are viewed as having a natural, unquestioned responsibility for the rearing of children. They bear, suckle, and take on most of the accompanying household tasks, with patriarchy and capitalism being the benefactors. These views and this line of opinion are often not clearly explained or articulated in the available literature, in fact, one could argue that they are almost purposely omitted from the literature. These omissions arise because they are viewed as being too difficult or awkward to question or

analyse in any depth, therefore, the status quo is maintained with males remaining dominant and women dominated. One could argue that in the late 1990's with the changing of the more traditional and accepted roles in which physical strength is no longer considered a key value in wage earning along provider lines, with these roles moving toward being much more interchangeable. Physical strength under these arrangements is less of a key determinant in the appointment of particular employment roles and this is therefore significant in relation to the position and to those who may apply and most certainly to those who are appointed. The issue of strength is somewhat paradoxical as it is usually portrayed as a masculine feature, yet nursing does require strength and stamina, moreso in general nursing areas, with some hospitals employing a group called "the men", who are trained in lifting, and employed on call to attend to those lifting jobs which save nurses back problems. Alternatively, many hospitals now adopt a 'no lifting' policy and machines are now used to manoeuvre patients. Strength would arguably prevent strain injuries and "bad backs" yet is not prerequisite to employment in general nursing. Some commentators (Holmes 2003a) believe that this issue has been played down because it was too late to change nursing to a male occupation, it would also deter new recruits, and it might lead to countless damages claims. This movement toward the interchangeability of roles will mean that gender roles and the more traditional roles accepted for males and females would be different. This change would be seen and talked about in a different light and would be instrumental in developing a changed, or different discourse and incorporated by the media and other powerful institutions and probably reversed. An example of this was referred to in Chapter 6 where females were employed to de-escalate anger in a forensic

psychiatry unit in Canada where the feminine skills of caring and understanding were now being seen as more productive in de-escalation than more assertive, punitive and masculinist approaches. This changing position suggests that a biologically based sociology of work is emerging. Gender inequalities are not specific to capitalist societies, however, and this suggests that capitalism and patriarchy cannot serve as single explanations of the gender divisions within both labour and society.

Clearly, the attachment of management to good order fits well with the ascribed roles of males and female in the late 19th century and similarly touches upon the sexual division of labour, which ascribes domesticity to the role of the female. Tucker over one hundred years ago (1887, p.21) spoke of the visible influence of female attendance to the male wards, where the “general household work, the bed making ...and to see that patients are properly and tidily dressed ... their presence imparts a home like character to the wards; and if they are the right kind of women, their tastes and instincts supply many little home-like and inexpensive additions to the surroundings of the patients, enhancing their comfort and contentment, and consequently conducing to their recovery”. Many of these points suggest that the wisdom derived from his overseas survey must have been productive on his return to Australia for both himself and some of his contemporaries and that some of the meanings that Tucker has attached to sections of his report suggest he was both significant in the overall history of psychiatry and importantly could see the value of different roles (both professional and gender) within the overall provision of mental health care. Wright (1999, p.153 citing Abel Smith) suggests that from the beginning of the nineteenth century nursing amounted to “little more than a specialised form of charring”. Wright adds that there is “an intimate relationship between domestic

service and the emergence of a nursing profession'. Wright (1999, p.154) argues further that during the second half of the nineteenth century in England "women increasingly found themselves recruited to asylums, hospitals and poor-law infirmaries, where older habits of "service" were molded and transformed within a new medical milieu". Wright suggests that women moved from domestic service to institutional nursing often being promoted quickly and graduating to higher status and more lucrative positions. Women often stayed shorter periods of time in the asylum, gaining experience and accumulating funds before moving onto another institutional job or getting married. Wright (1999, p.155) suggests that these conditions meant "mid-nineteenth century asylum nursing, thus, offered unparalleled opportunity for working class British women".

4.22 Finances

Personal finances are a significant factor relational to personal and social life. Income can also shape the meaning(s) and functionality of the gendered division of labour and our understandings of the terms and role of femininity and patriarchy. Mathews (1984, p.47) argues that in terms of the labour market, women and men in Western Industrial societies have been and are segregated, working in different occupations, different times and different places. Mathews' argument suggests that in terms of tools and technologies and considering the material forces and the processes significant in the production of living, women and men had, and still do have, different access, training and skills and opportunity. If this line of reasoning is correct then both their expectations, circumstances and experiences of work, and their consciousness of the economic and social orders that women and men inhabit and live out would be different. Mathews

(1984) argues that these worlds obviously intersect and affect each other and suggests the possibility that some women live their working lives closely aligned to and with more masculine frameworks. If Mathews' work is valid then arguably the opposite could apply whereby men in some areas of employment, notably nursing and clerical work may live their lives closely aligning their employment to a more feminine framework. This is particularly interesting, bearing in mind the radical arguments put forward by feminists such as MacKinnon (1987; 1989) and Hartsock (1983) and those on gender and gender schema (Connell, 1987; Wearing, 1996; Walsh, 1997), which tend to steer away from this suggestion. Mathews' (1984) suggests that fewer men live their lives both socially and in their employment close to the feminine framework, which is difficult to understand when one considers the more recent changes in gender roles, the increasing number of males entering professions such as nursing, and of females entering the medical profession and the armed services. Matthews (1984, p.47) reminds us that over the last century the position of the gender boundary, or the line of demarcation between the male and female economies has altered dramatically, becoming elastic at times and suiting a whole variety of different circumstances and hidden agendas surrounding economics, roles and the sexual division of labour.

4.23 Finances, Working Conditions and Training

From an Australian historical perspective Manning, as Inspector General of the Insane, who was president on the Governing Council had made repeated attempts to get a training programme recognised by the Australasian Trained Nurses' Association (ATNA) but this was not successful until 1911 (Smith, T. 1999, pp.22-3). Manning appeared to

recognise that there were additional benefits in getting informed staff to work with the insane and was therefore interested in their working conditions. The formal training programme of mental nurses over a two-year period had been offered at Gladesville in the mid 1880s (McDouall, 1911; Smith, T. 1999, p.23). Manning was also involved after his retirement with the training of nurses and the hours they worked, and insightfully saw that the use of female nurses with male patients had the support of both the male and female staff. He found that “the patients were cleaner and better dressed, the ward neater and more cheerful” when female care was involved (Smith, T. 1999, p.24), and employing female nurses was seen as a progressive step. According to Smith, T. (1999, p.25) and Schultz (1991), Manning also had much to say about the working hours and annual leave of attendants, and was quite vociferous about some aspects of their working schedule. At times he condemned how unreasonable attendants were in their claims over working conditions, yet as a general rule appeared quite supportive of the efficiency of the staff, whom he felt worked well in poor conditions. It was also on his suggestion that the Lunacy Acts were framed, with new hospitals erected and older ones remodelled (Schultz, 1991, p.326). The staff in institutional settings were reorganised, as was the system under which they worked, with senior officers now selected by him, indicative of how strongly he felt about the role of the attendant and patient care. His work made an early provision for females to more readily undertake the care of the insane.

Tucker’s (1887) world survey of asylums also adds a dimension in regards to staffing issues working in asylum care. In prefacing the staffing issues, Tucker (1887, p.17) talks about the moral treatment of the insane suggesting that moral treatment is “even more important than medical treatment ... being considered universally applicable and more

likely to be successful...” Tucker also provided proforma details (p.895) of many of the asylums he visited in both Australia and overseas, itemising applicable pay rates to male and female keepers and attendants. There are several United States reports in which he notes that female attendants pay rates started at two pounds eight shillings and four pence, and rose to three pounds eight shillings and fourpence per month, and that the male attendants pay started at exactly that amount, rising to a possible four pounds. This meant that a female attendant could never earn as much as a male, even though the pay increases were potentially greater. All men started at a higher salary than women, but they had only a small increase before reaching their pay ceiling. It would appear from Tucker’s accounts that physical strength was equated with the provision of security from males, and this was one factor taken into account in regard to the inequitable pay scales. Similarly, males in early Victorian society were attached to the provider role and females to childbearing. Because pay was such an important factor in the provision of living standards these differences would have some bearing on applicants to work in these areas and their suitability.

Further to these pay scales, Tucker (1887, p.21) speaks about the influence of women’s work in staffing asylums, he mostly refers to the role of physician but included some aspects of the general household work provided by attendants. He stated that “lady physicians ...in the treatment of the female insane is attended with many beneficial results ... lady physicians commonly set an example of neatness and order which soon become adopted on the male side, and a wholesome emulation is thus set up, highly beneficial to the institution and its inmates”. Tucker goes on to suggest that “the

softening influence of a refined woman is very great there can be no doubt, and the introduction of such influence in the treatment of mental disease, particularly on the female side, and the regular visitation of the lady physician on the male side, has a very soothing effect and is conducive to good order and good management in the wards”.

These points suggest that despite the discourse suggesting that a particular gender might be better suited to a particular role often the practice belies the theory. For example women bring other roles to psychiatric care that are as equally useful as the controlling features that the strength of men may offer. This argument could of course be as applicable to males and caring as anecdotal evidence from students might suggest.

I was preceptored by Bob (pseudonym) today and we looked after his patients. He was so different to Sally (pseudonym, the nurse) from yesterday. He introduced himself to his patients and me. He laughed at times, was sad at others and he seemed as if he was really bothered about Mr S. He actually told the patient about his own family situation and linked it to the patient’s problem...amazing (Bolton, 2001).

4.24 A Cultural Perspective on Gender

This cross over of gender specific roles is taken up by Savage (1987) where she draws on the work of Margaret Mead (1950), and describes particular cultures where gender or specific gender roles are considered differently and the more traditional Western gender roles are in many ways reversed. Mead (1950) describes experiences in Samoa, and Savages’ (1987) findings from New Guinea, where both men and women in one area are described and encouraged by their culture to be gentle and nurturing. In another area, the Mundugumor of New Guinea expects both sexes to be equally assertive and independent. Savage (1987) describes another group of people from New Guinea, the Tchambuli, in which the women are expected to be aggressive while the men fulfil more

caring roles. If one subscribes to these different and non-traditional views, then these differences suggest that men in these circumstances are more suited to domestic tasks and women the breadwinning role. As these groups subscribe to essentially the same roles played out by Western culture but change the social role or stereotype of the gender undertaking the more traditional roles, of provider (breadwinner) and carer (nurturer) roles, this would add weight to views highlighted by Kimura (1992) and Walsh (1997) that scripts serve as guidelines, which enable people to know how to behave in certain situations and in specific roles. Almost as though specific genders have their biology wired to act in certain predetermined ways, which suggest that certain behaviours may have genetic links. This view is endorsed by Chan (1995, p.11 citing Tiger and Fox, 1972) who argues similarly that human biogrammar is a genetically based programme, which predisposes human beings of whatever gender to behave in certain predetermined ways.

4.25 Gender Stereotypes

These views are similar to the gender stereotype arguments put forward by Harnack, et al (1998) in which specific roles are said to be culturally set and traditionally determined. This argument adds another interesting dimension to the more recent changing attitudes of gender role definition contained within the ideology of 'sensitive new age males' and radical feminism, and in this process to "turns the stereotype, or perceived norm, upside down and inside out" (Berk, 1985) as being non-conformist. Savage (Shore, 1981) suggests that sometimes gender concepts are at odds with the distinctions traditionally drawn between men and women in Western societies. For the most part, Shore's (1981) work is consistent with research completed by Walsh (1997),

suggesting that all men are understood to have some feminine characteristics, which they adopt and play out in daily life, and all women some masculine characteristics. From a nursing perspective this tends to illustrate how difficult entry and acceptance to the nursing profession was for males despite evidence that males have an “equally valid historical role within the occupation” (Mackintosh, 1997, p.235), but their contribution has been “marginalized by their tendency to work in areas of nursing where limited historical research has taken place for example asylums, military services and private associations (Mackintosh, 1997, p.235)”. This particular historical ethos has been based on the creation of a respectable female occupation and the assumptions attached to that, which portrays naturalness for the caring role as the arena for female work (Mackintosh, 1997). The idea that each gender has characteristics usually associated with the other could prove beneficial to each side of the equation. For example in psychiatric nursing many of the males provide high quality nursing care and still assert a proactive authority when required which suggests that this balance would be productive and useful across the profession. Female psychiatric nurses also provide good quality nursing care and are beginning to see that those more competitive male qualities are useful levers in regards to their nursing care of difficult patients adding perhaps another micro skill to their repertoire.

These views also support Walsh’s (1997) argument that males and females are more similar than dissimilar and support the positions adumbrated by Mead, M. (1950) and Savage (1987), which suggest that gender roles can be reversed. Shore adds that some men are recognised as having more developed female elements in their personalities than

most others, to the extent of being given a special status or a third gender category lying between the polarities of 'male' and 'female'.

Similarly, some of the issues highlighted in the feminist literature have focused on male strength and power in terms of being the economic provider and, conversely depict the caring nature of women as secondary and because of this portrayal under the control of the male in an oppressive way. This depiction is characterized by a myriad of political and secondary agendas (Eisenstein, 1991; MacKinnon, 1987; 1989). The overall thrust and analysis of these suggest that certain roles are allocated on the basis of biological sex and that this sex role allocation is functional to, and determined within, a balanced, given or constructed social order. Savage (1987, p.16), for example, argues that like sexuality, gender can be looked at from two different perspectives having both social and individual aspects, these being the more public gender role and the private gender identity. Gender role is described as the set of attitudes, characteristics, and behaviour within a particular culture, which accompanies biological maleness or femaleness. This particular view incorporates any publicly displayed or demonstrated behaviour consistent with the culturally determined, dominant and approved views of masculinity or femininity, which equate masculinity with maleness, and femininity with femaleness (as per Jung, 1982; 1989). As pointed out by Savage (1987) gender is an area in which the biological and social often become confused. This confusion arises because if gender identity is described as the inner experience of gender or the personal ascription of or definition of masculinity or femininity, these views may not always correspond with cultural and stereotypical gender roles often referred to in the literature. More recent

argument (Butler, 1999, p.7) challenges the dichotomy between sex and gender and critiques the epistemic assumptions underlying previous forms of feminist theory. It deems this discourse to be short-sighted because traditional gender roles have been modified within cultural contexts, so that males and females are now employed across different occupational groups for example female security guards and male nurses, and there has been some minor shifting away from traditional sexual roles and 'acceptable' sexual relations.

The feminist literature suggests that since the 1900's there have been some alterations to the construction and filling of social roles. These alterations appear to encompass a significant shift in thinking (Overholt, et al, 1985; Lorber and Farrell, 1991) brought about by a whole variety of interlocking factors. These factors include, but are not limited to, World Wars, changes in and to the sexual division of labour, changes in the control over sexuality by contraception, an overall increase to the cost of living, and the movement of more women into the workforce and males into 'house husband' type roles, often determined by financial remuneration. This movement has a variety of interchangeable factors, which include simple economic considerations, birth control, the feminist movement, governmental changes of policy and the move toward recognition of equal rights and subsequently equal pay.

All of these factors have changed and added different dimensions to the role of both genders and how each perceives, and is perceived, in relation to the other gender. These perceptions have had a significant hearing in much of the available discursive literature (Gamarnikow, et al 1983; McNeil, 1987). Much of the discourse (Connell, 1987, p.49;

Kozier and Erb, 1988) suggests that social roles are adopted by the adherence or following of the role of one's parents with a 'mother/daughter' and 'like father like son' theme, and also other significant adults.

In contrast, some of the literature advocates a context specific nature to the allotted roles, whereby variations in relation to a person's sexuality are mostly frowned upon as 'deviant'; that is, they are seen as unacceptable and genetically different. Clearly, some of the views expressed above are now becoming somewhat dated, and more recent feminist thinking and practice have been instrumental in changing some of these views by helping to remove barriers to this line of thinking taking more postmodern or poststructuralist positions which challenge the dichotomy which were previously drawn between sex and gender. These barriers encompass legal, psychosocial and economic matters, and their removal opens the public world to women and arguably allows a more bipartisan examination of gender and gender issues. The challenge to the socially constructed nature given to the myriad of gender questions are that gender is a question of difference and also, that gender difference is a consequence of politics and power.

4.26 Summary

This chapter has examined some of the factors, which surround people who chose to work with the insane. The chapter highlights the two distinct roles and incorporates the biological features considered natural to both. It looks at many different factors that influence the roles adopted and played out by individuals such as scripting and biogrammar, power, the sexual division of labour, feminism, patriarchy, genetics and gender schema, career choice, occupational fit, text, language and discourse, finances

and stereotyping. Examination of these factors preface the Australian experience whereby some of the preceding arguments have been significant in establishing the way in which specific professional roles may have evolved and are maintained, what part gender played in those processes, and what influence and effect gender factors have had in respect of professional control amongst the Australian psychiatric nursing workforce. Parts of this chapter have examined whether a person's allotted role is somehow genetically determined and cognitively scripted into their life and mindset, described by Willis (1995, p.145) as a schema or mental map of what gender roles are and what they entail. This cognitive theory regarding gender and different roles suggests that a person's social role(s) is/are predetermined and this role(s) is/are played out, self fulfilled, or lived by the person concerned. This issue will be examined more closely, with a view to showing its relevance to the research, namely what impact gender has made on the construction and nature of psychiatric nursing in Australia.

CHAPTER FIVE

THE AUSTRALIAN EXPERIENCE

5.1 Introduction

This chapter moves to understand the construction and nature of psychiatric nursing in Australia. To do this one needs to place the contextual circumstances into some sort of useable perspective. To this end, a dialectical review of both the history and contemporary viewpoints has been used. Australia is a huge country, where geographical and contextual factors such as heat, distance, lack of water, transport problems, isolation, homesickness, conflict with the Aboriginal inhabitants and much uncertainty, amongst other things, were significant in the day-to-day life of the early settlers (Bostock, 1968, p.14). There were also difficulties associated with understanding people of another culture, a people whose habits, customs and spiritual rituals were unlike any previously encountered. Bostock (1968, p.19) in describing the hard life experienced by the early settlers adds that the “paucity of historical information about mental invalids” is important and in some ways explicable under the hard conditions of frontier life. He suggests that man’s first objective was to survive, so little time or opportunity was given over to the keeping of detailed records. Similarly, many of the earlier settlers chosen for transportation to Australia because of their petty crime in England would not have been good record keepers, and in fact most could not read or write. Attendants and nurses were drawn from this stock.

Bostock (1968, p.14) suggests that if “the mass consciousness is devoted to the difficulties of a mere existence, there will be little surplus enthusiasm for the handicapped

of mind or of body". Clearly, men and women of the past had and set some rather elaborate and interesting ideals as they looked into their respective futures. The point made by Bostock, that little surplus enthusiasm would have been available for the care of those who were mentally unwell rings true and is perhaps still indicative of psychiatric care today, and they were consequently considered a low priority, financially and emotionally. The transported convicts, and the lunatics alike, tended to be surreptitiously locked away for both the colonials and the English, who already had a burgeoning mental health problem in their own country and were intent upon transporting some of their difficulties overseas. The distinction between the convicts and the insane, or the bad and the mad, is rather cloudy and it is hard to see either the general public or the administrators differentiating conceptually between the two with any great certainty.

Under such circumstances, the organisation and administration of care offered to those who were considered to be insane would have proven rather difficult. The fact that, in many cases, the people who provided the care were considered to be mentally ill themselves and, according to the limited historical records, often had criminal records, this would have proven rather troublesome to those administering the health care facility and one would think to the prospective patients themselves (Schultz, 1991). The care they gave would have been limited by today's standards, but on the other hand, people willing to look after the insane would have been hard to find. Often, the care given would have been determined by, and fallen on, the shoulders of the man in charge, and this again is difficult to assess because there were so many variables involved. The literature usually depicts a male medical officer overseeing the care given but often the

gender/identity of the provider of the care is uncertain although Schulz (1991 p3-11) and Brodsky (1968) usually refer to male attendants or keepers and to females providing domestic type assistance.

Knowing who was in charge and to whom attendant staff could turn to for guidance, must have been troublesome exercise. In the absence of people who were able to provide quality care, those selected were often of questionable reputation with little skill in dealing with insanity. Many of the staff were people who had little past experience in managing the insane in England.

The first nurses were convicts, as were the other servants of [the] hospital the warders, gardeners, boatmen and whoever else were considered necessary to provide the most crude [of] care for the unfortunate sick. Because no provision had been made to include attendants or assistants for the hospitals, such persons had to be drawn from the convict population; and because the needs of any hospital were considered to be of low priority those least able were detailed for service there. And the fewest possible were used (Schultz, 1991, p.3).

Pearson, et al (1997, p.21) suggest that prior to 1870, “the assignment of nursing as a paid, predominantly female occupation within the hospital staff is not apparent. Before the First World War, the tasks of nursing in hospitals were performed, as often by men as by women. ...duties involved in the care of patients in hospitals ... under the category of nursing ... were performed by staff other than female nurses, such as wardsmen”.

5.2 A Good Attendant

Selection of staff wherever psychiatric nursing was practiced was a difficult proposition. Nolan (1993, p.47) states from an English perspective that, “there were no generally agreed criteria as to what constituted a good attendant”. In Australia the majority other

than those who were convicts (Brodsky, 1968, p.17) were selected on the basis of being willing, often 'seen as' upstanding citizens and were selected because of some previous philanthropic endeavour rather than being experienced or having any practicable knowledge. The title of upstanding citizen and the issue of being involved in previous philanthropic endeavour drew females (usually middle to upper class) to this type of work/activity. Hart (1997, p.37) referring to England, states there was an urgent need for people willing to work in the asylums but, from the outset, containing costs was a paramount concern and over time this point appears to have proven significant in relation to the selection of staff to work in asylums. Wages were poor, being roughly equivalent to those of the lowest paid agricultural labourers and domestic servants, and the conditions were described as arduous (Hart, 1997, pp.37-38). The situation in Australia with convicts providing care to the insane was similar to the English counterpart (from 1810) where only a few asylums were in operation. This care mirrored the provision of rather basic care in England where drunken staff, who were often offenders, usually from the lowest classes, insanitary conditions, starvation diets and basic treatment options were provided. This situation improved in England after the reforms driven by Shaftesbury, including the Lunacy Act of 1845 and then accordingly in Australia in the late 1840s with the copying of the county asylum system in England. The introduction of the medical Superintendent also followed leads that had been instituted earlier in England.

Schultz (1991, p.3) highlights the Australian picture in saying that convicts were not paid, receiving rations only... The convict population was divided into three classes. The first, the most able and reliable class, were detailed to the more essential works of building the colony. The less able or second-class of prisoners were used in the hospitals ... convicts

of the third class, under supervision, were engaged in the heaviest labour.

This needs to be seen in the context of the lower classes at that time. Not being paid/paid well was akin to the life of domestic servants (Haw, 1990, p.34) but receiving rations for the provision of care to the insane was better than starving and having no job at all. These arrangements were probably no worse than other industrial societies of the time and were similar to England and America, and were a fairly good option in the context of the Colony's dreadful employment conditions. Clearly, the fear and stigma that insanity evoked in the general public, and the perception that insane people were violent and dangerous was significant in early treatment arrangements for the insane and a reason why people did not readily seek employment in this area. The provision of small wages or rations actually raises the possibility of why more people did not volunteer to work with the insane with the view that employment was better than being hungry, bearing in mind the "lengthening dole queues and darkening economic" circumstances (Nolan, 1986, p.23). Recruitment efforts for suitable attendants were seen as failures before 1800 in England (Digby, 1985, p.141), but improved over time thereafter. These improvements in England were driven by slightly higher remuneration for attendants, the improved treatment regimes introduced by Tuke at 'The Retreat' in 1815 (Smith, L. 1999, p.34) and the gradual introduction of tuition/advice on handling troublesome patients relational to the job role just prior to the introduction of training across England in the mid 1800s (Digby, 1985, p.148). This training often entailed occasional lectures rather than any course of classroom instruction (Nolan, 1992/93, p.136).

Because of the difficulty in attracting suitable people to work with the insane in these facilities and because such a low priority was attached to the provision of health care and those who provided it, often when sentencing convicts for offences committed in the colony, Magistrates often sent them to work in the hospitals as punishment. This must have been influential to others considering a role as an attendant/nurse. Governor King, in his record of female convicts, referred to the well behaved being selected by the industrious settlers, who made themselves useful in domestic concerns, in raising stock and becoming involved in agriculture. The worst class, he said were employed at the woollen and linen 'manufactories (sic)' and the rest were distributed to public employments as nurses at hospitals...(Schultz, 1991, p.3).

There are differences of opinion depicted in the literature regarding those that worked with the mentally ill. The literature nationally and internationally generally describes workers as asylum attendants rather than nurses and describes both difficult and arduous employment circumstances, but mostly conditions in keeping with those of other lowly paid agricultural labourers and domestic servants in England.

The day often started at 6am and finished at 8pm and staff had only one day off a month when they were allowed out of the asylum. In common with the patients, men and women were segregated. Unsurprisingly, staff turnover was high and standards of care low. Training was seen as an answer. Enlightened doctors had already been giving lectures to attendants and the first training was introduced in Scotland in 1856 where reforms were pioneered (Hart, 1997, pp.37-8).

5.3 Asylum Attendants and their Training

There are quite a few references to attendant/nurse training across the literature with a particular focus on England. Nolan (1992/93, p.135) refers to inaugural lectures from

doctors at Bethlem and Hanwell in England from 1823, and Simpson (1980) refers to the first organised course for attendants starting at the Crichton Royal Hospital in Dumfries, Scotland in 1851, and from then on spreading rapidly throughout the country. Much of the literature that looks at asylum attendants and their training tends to refer to the English experience although some of the sections highlighted below encompass both the English and the Australian perspectives. Digby (1985, p.140) described the asylum attendants as for the most part the “hidden dimension” of the asylum system, whose work was not well recognised. Similarly, Hunter (1956), who attached some praise to the work of asylum attendants, rejected what was described as the “traditional image” of asylum attendants as being indolent, unimaginative and without compassion. Hunter emphasised the significant advancement in the care of the insane in the 1860s, and implied that these improvements were not just because of the advancement of chemotherapy, new psychological theories or different methods of restraint, but were due to the genuine concern for human suffering and oppressed people given by asylum attendants. Walk (1961) also comments that a history of psychiatry that did not include psychiatric nursing was incomplete. Russell’s (1983, in Nolan, 1992/93) work insists that the asylum attendants were the backbone of the asylum system and embodied the spirit of the institution in which they worked. In a similar fashion, the spirit of the institution was also embodied in the person in charge, invariably the doctor/physician.

Doctors often conducted the training of attendants and nurses in England, Australia and America. Many of the asylum Superintendents believed that if psychiatry was to be effective it required skilled attendants, and this view was instrumental in many asylums

offering their attendants some basic instruction. Nolan (1992/93, p.135) suggests that the hope was that this training would not only impart knowledge and help attendants develop a workable skill base, but would also teach correct behaviour so as to compensate for any deficits of education or upbringing that attendants might have suffered. Nolan (1992/93, p.135) and Haw (1990, p.36-53) suggest that prior to 1823 no formal training for attendants was available. Probationers would be placed on a ward under the charge of an experienced attendant and were expected to learn through day-to-day experience (Hopton, 1999, p.364) almost like an apprentice. They were guided prior to 1851, with the introduction of attendant training in Scotland and to other areas shortly after this date utilising idealised statements promulgated in the attendant handbook, introduced in 1885 (Nolan, 1992/93, p.137) that was divided into chapters dealing with ...

- a) The body, its general functions and disorders.
- b) The nursing of the sick.
- c) The mind and its disorders.
- d) The care of the insane.
- e) The general duties of attendants (Nolan, 1992/93, p.137).

The handbooks are often referred to in the literature and their date of introduction appears to have started around the mid 1850s, with Haw referring to a manual of duties for ward attendants dated in 1846 (Haw, 1990, p.37). The idealised statements contained in these handbooks were very all encompassing and set a high standard of what the Justices of the asylum expected from them. Generally speaking, attendants needed to be active, punctual, scrupulously 'cleanly' and ready to render help whenever required, and distinguished by personal neatness and undeviating propriety of behaviour. Over-riding these ideals was the disclaimer written by Dr Campbell the medical Superintendent of Tarban Creek, Australia in the late 1840s, which suggested that attendants

...must be present at meal times to divide the food. It is their duty to prevent violence and to soothe the temper of such as are likely to be aroused; remembering always that the insane are without reason, the attendant should conduct himself kindly to them, speak mildly, and never in an angry tone, and if he has occasion to interfere, his manner should always be gentle and calm, but determined, without hurry. The attendants must never ...threaten, swear at, or strike a patient, or of themselves apply restraint of any kind. If it were necessary to overcome a violent refractory patient, the attendant should not attempt it alone, ...ask for assistance; or, if a case of emergency should arise, rendering it necessary for the safety of the patient, or others, to apply restraint, it must be immediately reported to the Superintendent (Smith T., 1995, p.6).

The attendant of each division must observe the patients carefully and report daily to the Superintendent the state of the appetite, the nature of excretions, the habits of patients, and any mark they may detect on the person (Smith T. 1995, p.6). These rules appear to represent the instructions provided by this particular asylum and it appears that under the auspices of particular State Departments different asylums varied their rules accordingly.

These rules of 1848 have really stood the test of time in regards to mental health nursing in Australia. Many have been added to and clarified further, some completely modified. The important sections that refer to proper and careful observation and the accurate reporting of the patient's condition both their mental and physical health have become the basis on which all following rules and regulations for carers of the mentally ill were written right up until the early 1960s (Smith T. 1995, p.6).

The training of staff who cared for the mentally ill began in 1888 at Gladesville Hospital following the onset of training for general nurses in New South Wales in 1867 (Smith T. 1995, p.15). Smith (T 1995, p.15) cites the Inspector Generals' Report of 1888 and speaks about "the importance of training the attendants and nurses for their special duties

...Drs. Sinclair and Chisholm Ross have delivered courses/lectures, and special instruction as to their duties to classes of nurses and attendants". Further influences on attendant training came from Dr Thomas Kirkbride, at Pennsylvania Hospital in America where in 1843 he introduced a course of instruction for his attendants.

Resident physician John Conolly at Hanwell asylum in England between 1839 and 1843 (Haw, 1990, p.40) talked about the desirability of training for attendants/nurses referring to the English situation but his views coincide in many ways with views put forward by Norton Manning, Inspector General of the Insane in New South Wales, Australia. Conolly felt that training would be instrumental in improving the usefulness of attendants if pains were taken to show them the reason for the many duties required of them. Similarly, an understanding of the causes, diagnosis and the treatment options used in dealing with people deemed to be mentally ill (see Fig. 2) included basic elementary anatomy and physiology, first aid, general medical and special mental nursing.

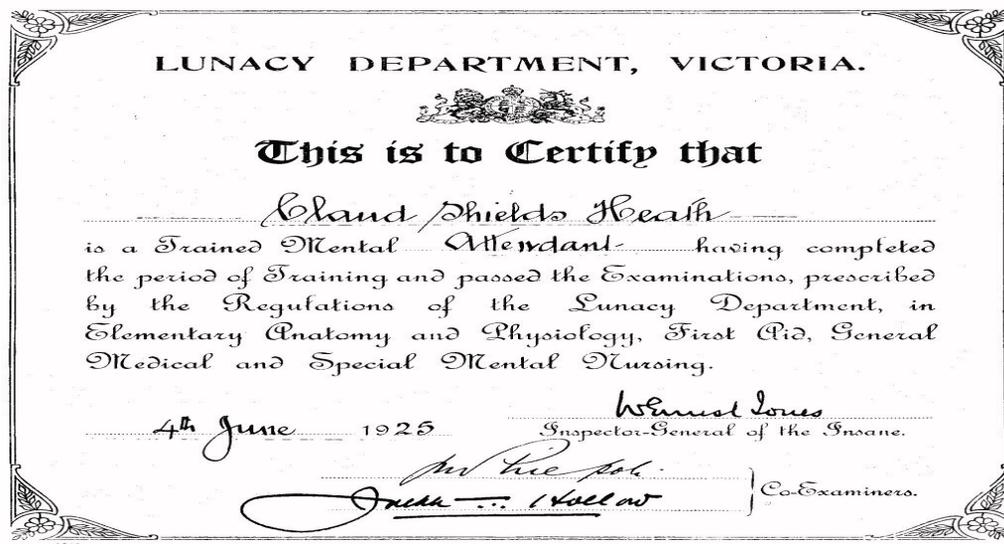


Fig 2: Certificate from the Lunacy Department

The absence of training for attendants at Hanwell asylum (Haw 1990, p.40) was not the exception but more the general rule relational to mental and general nursing in mid Victorian times.

Nolan (1992/93, p.136) also notes that the famous British alienist, “Dr. Henry Maudsley, and the pioneer of asylum design in the United States of America, Dr. Thomas Kirkbride, were both advocates of educating attendants and attendant training”. Both encouraged high quality training, which appeared to be attached to the quality of patient care. The proliferation of separate, asylum-based training schemes for attendants meant that there was considerable variety in their structure and content, with most being directly linked to the enthusiasm of the medical Superintendent. The subject matter, as well as the style of teaching, depended largely on the particular interests and abilities of the doctors who taught the courses and also the idiosyncrasies of particular geographical areas.

The training often entailed occasional lectures rather than any course of classroom instruction although this was dependent on the particular asylum, and changed over the next few decades (Nolan, 1992/93, p.136). The underlying agenda to the introduction of training was that trained staff worked harder and were more skilled at managing patients. They also had a deeper sense of loyalty to the institution, which of course translated to staying longer and increased cost effectiveness (Nolan, 1992/93, p.136). This meant that rather than attendants simply fulfilling a custodial role, they were expected to have an understanding of why, where and how particular conditions might arise, how they could be seen in the asylum environment, and what they might be able to do about them.

Williamson (1885, in Smith, T. 1995) published what appears to be the first textbook for nurses and attendants in Australia. This book, entitled *Lectures on the Care and Treatment of the Insane: For the Instruction of Attendants and Nurses*, was a major turning point for nurses and attendants, for Australian psychiatry generally and for patient care in particular. Smith (T. 1995, unnumbered) suggests that it recognised that nurses and attendants should be seen less as domestics or labourers and more as a body that should and could be educated and aware. From a staffing point of view, bearing in mind the poor quality of applicants entering this type of work at that time, the training may have been a useful recruitment tool and seen as particularly appealing to some potential applicants (of both genders). On the other hand, training would have been seen as problematic and acted as a deterrent to those who could not read and write well, and to others who may have had mental health problems themselves. An aside to this argument is put forward by Nolan (1993, p.53), suggesting that attendants were often hired on the basis of them having less initiative and independence of spirit, so they would more readily conform to the asylum regime. This view suggests two different levels of discourse where the rhetoric of the one provided by the head nurses or medical Superintendent is very different to the actual practices and attitudes of those who work at the patient care levels.

Some of the points raised above are encapsulated in the following passage from a Dr Henry Rayner, later Medical Superintendent at Hanwell asylum as he addressed the annual meeting of the Medico-Psychological Association in Glasgow in 1844 (Nolan, 1992/93, p.137)

...I have been so strongly impressed by the improvements occurring in the most unhopeful cases as a result of the bestowal of special care, that I have come to regard training as having a direct relation to care.

5.4 Was Custody Best?

Despite these improvements public asylums still tended to be “custodial institutions governed by a complicated legal code concerned only with excluding lunatics from society at large and confining them...in secure and remote surroundings” (Chatterton, 2000, p.13). These custody arrangements were instigated despite the initial optimism on which public asylums were founded, becoming like workhouses and increasingly functioning as places of last resort providing custody rather than care and successful treatment (more the role for men, both within and outside the asylum). This confinement was aimed at preventing the people from harming themselves or others, which probably reflected more of a moral obligation, fuelled by Christian values as well as the fear of lunatics. Secondly, the confinement protected the insane from exploitation by families, employers and criminal gangs. This protection from being exploited was provided at a time when those who had jobs (adults and children) were often literally worked to death with profit for employers being the only concern. The State in confining the insane made considerable effort initially to make these arrangements tolerable with the provision of a cleaner living environment, cooked meals, clean linen, basic employment and pastimes (housekeeping roles reserved for women, both within and outside the asylum).

This provision became impossible to sustain after the 1860s as numbers for these services swelled. Although training had offered some hope to the emerging profession, staffing issues were always problematic in terms of recruitment, retention and the quality

of some applicants.

Some of these staffing issues appear to have been difficult in many different spheres of asylum care, and Bostock (1968, p.28) recounts that almost all the staff at Castle Hill asylum in Australia were convicts being neither skilled nor plentiful in number, and that this was borne out by the number and frequency of escapes. This suggests that the selection criteria for staff both nationally and internationally was rather haphazard and not decided upon because the applicant had the required skills but more on being willing and available. Bostock (1968, p.27) suggests that nobody really cared and that a “blind eye” was given to the pressing problems within mental hospitals pre 1830. He suggests that it was easy to “ignore the evils of overcrowding, inadequate treatment, the lack of staff and scarcity of provisions and equipment”. Blame was often levelled for these shortcomings on the Superintendent who could be publicly admonished or dismissed ... the system often being whitewashed and look[ing] pleasing to the eye (Bostock, 1968, p.27). The Superintendent often deflected this blame onto attendant/nursing staff. Earle (1967, p.50) adds a dimension to this point which most tend to overlook in saying

...the Superintendent’s task is not an easy one, and if he lacks the necessary personality attributes, he may fail in his high purpose. The hierarchical system puts a great deal of responsibility onto one man, and that may lead to negative attitudes.

Tucker (1887, p.37, in Earle, 1967, p.50) suggests that Superintendents were often afraid of running risks with patients and asylum staff and resorted to the safe option regarding their patients, keeping them under lock and key in the wards rather than taking a chance with different and more therapeutic approaches. With hindsight, it shows that these

situations were complex, often highly political with very little substantive related literature to both the psychiatrists and planners of the day and to historical accounts of early psychiatry since that time. Bostock touches on this issue in saying (1968, p.5)

...a large section of readers express disinterest or insist that it be touched [upon] with drama in order to increase its emotional appeal. [He suggests further] ...that a bald statement of facts, unless the subject is interesting, quickly tires the reader.

These views do little to address issues relating to the general negativity in both Victorian England and Australia toward people suffering from a mental illness. Deriding or not taking seriously the issues could be seen as one of society's safeguards over something of which they had little understanding and even less control over and very little wish to pursue at any great depth and is instrumental in how mental health services were set up in both countries. Bostock's referral to these issues suggests a rather complacent attitude has prevailed pre and post Victorian times, in fact since the onset of any provision for the insane in both England and Australia.

As a general rule and often depicted in the literature, men and women holding key administrative posts in both the colony and more particular in charge of institutional settings chose to take a dismissive (Kerr, 1988; Smith, L 1999, p.5) attitude to the care of the insane. The task of looking after the insane was viewed more as a custodial role rather than a caring, curative or therapeutic measure. To suggest that the general public did not care about the insane is, however, somewhat misleading. The issue was not that the general public was 'uncaring', as pointed out by Bostock (1968, p.5) Garton (1982, pp.138-166; 1988, pp.98-113) and Brothers (1965), but that the problem of insanity was a difficult one to deal with. Significant revenue was certainly directed by governmental decree toward the building of large institutions to house the insane. This direction of

money toward the problem tended to be the government's answer to the situation, which in fact it did not understand and for which it did not have alternative solutions.

Bostock (1968) gives a comprehensive overview of the early years of the care of the insane in both Australia and overseas, although like all historical accounts it is dependent upon the records preserved with some sections not clearly described. Although in short supply, some of the early records do incorporate evidence of curative and humane treatment of the mentally ill, although the most graphic literary accounts tend to focus on inhumane treatment for the outcasts of society. This group included "lunaticks and ideots" (Bostock, 1968 p.15), and were considered by some as morally disreputable; were invariably poor, turning in their own support to minor crime and vagrancy (Lewis, 1988, p.1). Lewis (1988, p.1) argues further that criminality and insanity were often linked together or closely associated in the Australian colonies because they had been shaped by the colonial experience, arguing that vestiges of a penal approach to care of the insane could be identified long after the convict system had ended. Lewis (1988) suggests that Australian life in many areas was marked by a dreary custodialism similar in character to that which existed in penal institutions. In country districts, gaols and lockups were used to hold lunatics until well into the 19th century and police and magistrates were heavily involved in the committal process (Lewis, 1988, p.1). This suggests that the safeguards of the law were being employed to safeguard or protect the insane from having their rights infringed by families, aggrieved parties and unscrupulous doctors. Similarly, it suggests that those who were sane did not get pushed into asylums. This suggests that these 'outcasts or vagrants' on arrival in their new land amongst the

first convicts landings were considered as both bad and mad with criminality and insanity being linked together or being seen as representing the same problem or the two issues being perceived as symptomatic of each other. This 'mad and bad' combination has been significant, and as late as the 1880s magistrates committed 60 to 70 per cent of lunatics in New South Wales after being arrested by the police (Garton, 1988, p.1). These facts are significant in how these 'outcasts and vagrants' were viewed and treated both then, throughout history and still at some level today. Lewis (1988, p.1) suggests that magistrates misused their powers of summary jurisdiction to avoid the inconvenience of arranging for admissions to asylums, preferring to imprison an insane person as a wandering lunatic or vagrant and would leave to the keeper of the prison the responsibility for doing something about the insanity during or after their sentence. In my view, this tends to set an interesting precedent and is symptomatic of how care was constructed within psychiatry and mental health nursing, setting more a custodial and punitive framework for mental health care and for the role of the attendant/nurse.

5.5 A Strange Sort of Care

Jones (1972, p.6) recounts an experience in England that illustrates an approach used between 1736-1760 saying "the lunatic was stripped of his clothes, bound hand and foot, immersed in the sacred pool, and then left all night in the chapel. If he managed to free himself of his bonds during the night there was a good hope of recovery" Jones (1972) argues further that if the insane were no longer judicially executed, they were certainly regarded with superstitious fear by the lower classes, often clinging to the belief that harsh treatment, would drive out the devil. In opposition to these views, other literature

(Granville 1877) suggests that Victorian society was actually quite compassionate toward those considered to be insane, recognising the need to spend time and money on services for the destitute, the insane, orphans, unwed mothers, the blind and deaf. In fact, sections of the literature (Jones 1972, pp.3-13) suggest that it became difficult to get an insane person admitted to an asylum “as there was no clear definition of what mental disorder was and certainly no recognition of the mentally ill or handicapped as a category requiring a distinct form of treatment”. Also, because institutions were often full and “overcrowded” (Lewis, 1988, p.9), there was usually little room for anyone but those that were considered genuinely insane to be admitted. The stigma attached to being called ‘insane’ was often so great that authorities only admitted people if it was absolutely essential, and it was very expensive to have people in asylums, so again only the truly ‘insane’ qualified. The other notable point was that admissions were all ‘compulsory’ and the person was ‘certified’, so professionals were reluctant to institute these proceedings unless they were absolutely necessary, and also because there had been legal action taken very early on which meant that Australian asylum doctors were extremely cautious about admitting anyone who was not ‘insane’ beyond all doubt. Holmes (2003b) suggests authorities were reluctant to institute proceedings because of a case in 1843, where a Capt. Hyndman successfully sued Thomas Digby the Superintendent at Tarban Creek asylum for wrongful confinement.

Confinement over time was arranged within a “philosophy of individualism and a policy of laissez faire, popular in the early and mid nineteenth century when economic growth and opportunity seemed limitless and penetrated into the realms of psychiatric

knowledge” (Lewis, 1988, p.9). This change meant that “ideas about treatment of the insane were related to a larger body of ideas about the nature of the individual and of society, and ideas at both levels were congruent with the prevailing social and economic order” (Lewis, 1988, p.9). Similarly, in Victorian England the conception of what constituted ‘madness’ was beginning to change toward the end of the eighteenth century with “madness being seen as less a spiritual disease, in which the mad, possessed by the devil, were sinful or immoral, and more a secular condition” (Digby, 1985, p.1). Secular in this context implies that madness arguably had some room for therapeutic intervention or treatment.

5.6 Skills often Sought from Elsewhere

The general impression from much of the literature (Lewis, 1988, p.1; Bostock, 1968, p.9) is that the Australian experience tends to emulate or be imported from its English counterpart (Lewis, 1988, p.1) with much of the discourse suggesting that in the absence of professional expertise locally these skills were sought elsewhere. Medical qualifications in England were “unstandardized”, and according to Jones (1972, p.6) the title of doctor “bore no settled meaning” until this issue was examined by a Select Committee in 1834. By today’s standard, this is probably an understatement, and as Jones (1972, p.6) explores this issue it brings home what must have been and still is a rather a frightening reality when she states that

“[a] Master of Arts of the Universities of Oxford or Cambridge could still acquire an MD degree by expounding a book of Galen in three written or six spoken lectures [before 1834].

Using the work of Chaplin (1919) she argues further that

“...The Royal College of Physicians and the Company of Barber Surgeons held their own examinations, but the examining boards were completely irresponsible, and the standard was quite low. The Society of Apothecaries licensed its own men, but anyone who had served a nominal apprenticeship as a druggist might set up in his own right and calls ‘himself’ an apothecary. No legal action against the unqualified practitioner was possible, and none of the licensing bodies had any real authority outside the metropolitan area.

In moving to these different arrangements with the care of insane now being both questionable and moving into the hands of medicine and its practitioners, has altered the overall picture, with a slight shift in societal attitude taking place. In this, it was not that the notion of madness was curable that really changed, rather that people thought that the institutions themselves had some sort of therapeutic measure that could help (Shorter, 1997, p.8). Confinement in an institution rather than just removing the nuisance from the vexed family and upholding the social norm could actually make the person better and more responsive to treatment. This period at the end of the eighteenth century could be described as a movement away from tolerating the difficulties of a psychiatric disorder by locking people up, towards a more therapeutic, curative era, in which madness was seen to be containable, managed and treated. These changes in the provision of care now relied on a completely different set of therapeutic mental health skills outside of the custodial role. As the perception of the mentally ill shifted, there was a resulting shift in the qualities seen as desirable in those who were charged with their care with less emphasis on physical strength, and more on humanity and caring. This altered role had greater appeal to females, who could now consider care of the mentally ill as a career choice. Similarly, males who were not comfortable with the custodial approaches to mental health could now allow their “softer masculine sides” (Holyoake 2002) to be

incorporated/integrated into their care by adopting or playing out the role which are usually those qualities depicted or associated with being female.

Despite the points above and the passing of the convict era this did not bring to an end the cultural linkage between criminality and mental illness. Lewis (1988, p.1) argues that bourgeois society in the colonies in keeping with the rest of the English-speaking world, valued, at least publicly, the “ideals of self-improvement and moral rectitude”. He suggests that the insane were viewed as social dependants and the State institutions to which they were committed were a constant charge on the public purse. Part of the treatment for this social dependency was in “creating habits of good behaviour” (Lewis, 1988, p.13). Often, however, the patients’ well being was subordinated to the needs of the institution, and what Lewis (1988, p.13) describes, as a pervasive custodialism tended to develop. Many of the facilities were overcrowded and provided gaol-like accommodation, they were often managed with inadequate medical establishments, attendants who were untrained, often personally unsuitable and too few in number.

5.7 History of Mental Health Nursing

From a mental health nursing perspective, little clear historical information exists, although issues surrounding the care of the insane are subsumed within other areas of discourse. Nolan (1992/93, p.131) encompasses this point in saying that “[h]istorians have not rushed to analyse the evolution of the nursing care of the insane”. He points to both sparseness of data and lack of funding for relevant research. Carpenter (1985) quite rightly claims that the history of psychiatric nursing is unglamorous, unromantic and has

little popular appeal. The history of psychiatry generally alongside the history of mental health nursing has not been seen or described as a philanthropic endeavour and has very little relevance to the general public, this of course an issue which goes directly to recruitment and retention issues in mental health nursing where as a career option it is not seen as particularly appealing or a worthy professional career. Nolan (1992/93, p.131) suggests that now there is recognition of the need to be aware of the past, to study, analyse and apply any lessons learnt from it. Locke (1977, in Nolan, 1992/93, p.131) speaks of how the past penetrates the present and obversely how the present is the outcome of the past. In a way suggesting that they are important, not mutually exclusive, at times dialectical and of course informative to each other. Our understanding of the present is clearer by this looking back and forth and by adding meaning (and what the meanings mean) to what historically preceded it allows the history of psychiatry to be more productive, useful and a continual source of wisdom. Nolan quite rightly argues that our understanding of the study of the history of mental health nursing and history generally is not merely a reconstruction of the past but an analysis, or the adding of meaning of how the past became the present. Nolan (1992/93, p.131) suggests that this change of awareness has been amongst other things brought about because of the stimulus provided by the antipsychiatry movement in the 1960s and 70s. He argues that some of the

...central figures of the movement [were] Laing, Szasz, Sedgwick Cooper and notably Foucault [who] were sceptical of received wisdom which [appeared] to comfortably view the history of psychiatry as a straightforward [and rather] benign process.

Nolan (1992/93, p.131) suggests further that

...Foucault's anti-establishmentism has inspired psychiatric nurses to ask why history has been so ungenerous to them despite their having been at the centre of therapeutic practice for the last 150 years. Why is so little known about mental nursing in the past? Why have mental nurses become the orphans of history? Nurses are now aware that having a history confers [some sort of] legitimacy; inclusion in the history of others implies subordination. [He argues further that] ...history is not solely concerned with the great and the powerful; it is also about the middle and lower rank whose central role has been misrepresented and underestimated. We are now beginning to realise that the history of psychiatry is only one aspect of mental health care.

This changed view advocated by Nolan asks mental health nurses to set their own agenda rather than be an agenda item for others. In this process we begin to see that the history of mental health nursing is most important as a baseline from which to launch change. These views suggest that psychiatry and mental health nursing may need to look backward as a way of moving forward and learn from both the strength and weaknesses of what has gone before. This research suggests that the wisdom gained along the way will be a useful and workable tool as we tackle the difficult issues facing psychiatric nursing in the 21st century.

Clearly, mental health nursing has received much less attention from historians than its general counterpart but it is clear that mental health has some special qualities which set it apart from its general equivalent. Chatterton (2000, p.11) suggests "imagery and reality can thus be dissonant" which is the view this writer puts forward in saying that mental health nursing is only seen as useful when the profession becomes militant and threatens strike action (as male gender markers) which gets the profession into the media spotlight and noticed. The shortfalls of the system are then paraded around the media and quickly forgotten. This lack of interest holds true across the history of the profession and has been

significant in the recruitment of staff to the profession. Brothers (1965, p.10) highlights the “indifference view” held by the general public toward mental illness in saying that the care of the insane was “purely custodial”. Concern only arose when someone from a person’s own family was involved.

5.8 Asylum in Australia

The first recorded institution especially for the insane in New South Wales was an establishment at Castle Hill (Brothers, 1965), which began taking in-patients in May 1811. In 1825, Castle Hill was replaced by the Liverpool Lunatic Asylum, which ceased to exist after 1838 when its place was taken by an institution at Tarban Creek, later known as “Gladesville Mental Hospital”. In Tasmania, the first asylum, erected about 1829, was at New Norfolk. In South Australia, the original accommodation was a house situated on the Eastern plains taken over in 1846, which when the present Parkside (Glenside) Mental Hospital (1870) was built became known as the old asylum. Other states, such as Queensland (Woogaroo Lunatic Asylum first opened in 1864) and Western Australia (Fremantle Asylum first admitted patients in 1857), were notably slow in following the lead set by both Victoria and New South Wales being nearly fifteen years later before similar accommodation was erected. Obviously, demographics, and population would have been significant in this.

The overriding view held by the general public in relation to mental illness tended to take an ‘out of sight out of mind’ perspective. The ‘out of sight’ issue was more to do with the general public not wanting a mental health issue on their own doorstep, and the general public often attached mental ill health to criminal activity as is often depicted in

the media then and now (Welch 1998). Often there were no suitable premises available to house those who were mentally ill and this became a difficulty for people generally. Finn (1888, p.518) highlights this issue where he encompasses this 'overriding view', which has been problematical across the history of psychiatry but more so in the late 20th century.

...there were no buildings to use for a prison barracks and the Government was so niggardly that it shrunk from incurring the outlay necessary to provide a substantial receptacle for the safe custody of criminals/insane. But the influx of Bounty Immigration, and the exodus from the British Isles, decided the issue, and Fate finally pronounced that the future Victoria should be unsoiled by the contagion of a penal colony.

Finn's (1888b, p.519) suggested that the local community wasn't entirely happy with being landed with a 'prison contingent' being added to the local population. Finn's work suggests quite rightly that people were shipped to Australia under the name of emigrants but were simply convicts who had obtained pardons by agreeing to leave their home country for political reasons rather than the wish to travel. With these aforementioned points in mind, which tended to place mental illness into a more day to day and realistic although unfair context, and attached badness with madness it was clear that at the time of the early colonisation of Australia the general public's attitude towards people with mental illness was largely one of relative apathy (Brothers, 1965, p.10). The mad-bad connection is fostered on views such as these with society tending to accept the two as being mutually inclusive and this would/has set a very dangerous agenda for how we think and see mental illness today. The care of people was for the most part purely a custodial exercise which of course, in the eyes of the general public equated with being good risk management and being safe and justifying the exercise under the guise of

normality. These points of course go straight to the subject matter of gender and how specific gender might be enticed or otherwise to the role of mental health nursing. This, coupled with the necessity of newly appointed colonial administrators to keep their general expenditure to a minimum, did little for either the future or well being of those considered to be mentally ill. Similarly, one could argue that herein lays the benchmark of health care being delivered by attempting to save money, with economics rather than good health care and staffing being considered more important. At first, people with mental illness were small in number and most were perceived as different and generally ignored. The notion of being diagnosed as insane was a rather speculative exercise and more often than not had nothing much to do with symptomatology or circumstances. The speculation referred to above and relational to mental illness suggests that the categories admitted under the heading of mental illness could depend on a whole variety of factors including the person's financial circumstances, their cultural background, their language difficulties which may have all contributed to them being misunderstood, treated differently because their heritage would have socialised them differently therefore their response to the new country would/could be interpreted as other than normal. There was no special provision or accommodation for those considered insane and most were housed at the various gaols and lock-ups, and occasionally, what were considered to be the less severe cases were cared for in the make shift hospitals. But, with the passage of time as the numbers of those with mental illness increased, other means of accommodation had to be considered and provided as risk management and safety had become more attached to the general public's view of those perceived to be suffering from a mental illness. Gradually, requirements became so great, that institutions for the

special care of mentally ill patients were considered and erected in all of the colonies. This in-keeping with similar thought patterns and practices of those overseas and the subsequent building of institutions which had become the popular way of housing mental illness in the country of origin (mostly England) of many of the settlers. Nolan (1992/93, p.132) describes the newly built institutions as proud edifices, often in beautiful countryside which he suggests were an expression of civic pride and the nation's determination to care for its weaker members and geographically distanced the mentally ill. Nolan argues that it was believed that those who designed the new system and the institutions believed that fresh air and open spaces outside the city or town were essential requirements in dealing with and treating the troubled mind. The provision of a suitable environment for caring to take place had been an essential aspect of the caring work done by Florence Nightingale whilst in the Crimea in 1854-56 and may have been instrumental in the design of hospitals and institutions after that time. Most certainly, according to Nolan's account which cites the clinical practice of Dr. Nathaniel Cotton who in 1764/5 administered a 'private madhouse' in St Albans. Cotton believed that

...in order to heal the sick body ... troubled spirit, clients needed the gentle touch of nature as represented at his particular madhouse by the beautiful grounds. Clients benefited from the best that civilised society could provide in terms of a comfortable and stimulating environment. A congenial and dedicated staff could only create such an environment.

These beliefs of course have gender implications for the staff in the provision of this comfortable and stimulating environment. The poet, William Cowper described humanitarian care as "an affectionate watchfulness...with patience and gentleness...with ...protective and tender care" (Nolan, 1993, p.28). These descriptors were related to the care offered by a male attendant, yet at first glance they are qualities usually associated

with care provided by a female. These points would suggest that gender is not a set role and that either gender can harness those markers usually associated with the other gender.

5.9 Yarra Bend

Yarra Bend was the first recorded asylum for the mentally ill in Victoria, Australia and was completed in October 1848. The gaols and lockups had set an interesting precedent, with Yarra Bend having custody as its first mandate. These custody arrangements encapsulated risk management and the general public's concern, rather the provision of other health related services. This of course would have some influence on the type, quality and gender of those who applied for work at this institution. Prior to Yarra Bend, the neighbouring and older colonies of New South Wales, Tasmania and South Australia had already made special provision for those considered mentally ill.

The exact site of the earliest places of confinement in many states is at times somewhat obscure ... unclearly articulated in much of the available literature. Originally, gaols were called lock-ups; the first in Victoria being part of a thatched slab building in Spencer Street, Melbourne, used by Captain William Lonsdale in his role as colonial administrator as his office and quarters (Brothers, 1965, p.11).

Early in 1840, the first real gaol was erected. Known as the Collins Street West gaol, it was situated on the north side of Melbourne. Although undoubtedly the first gaol of any substance, Garryowen (in Brothers, 1965, p.11) describes it as "little more than a rough and tumble sort of an affair, sub-divided into three compartments" and serving a variety of different needs; there were also two small cells for solitary confinement (Finn, 1888a, p.185). Here, according to our author, the first attempt was made to assist the Colony's lunatics. In speaking of them, Garryowen (Brothers, 1965, p.11) says: "...originally the

provision made for the unfortunates afflicted with insanity was, after committal by the police bench, to be immured in some part of the wretched gaols of Melbourne". Sometimes separately, but often mixed with the other prisoners, and herein lies another strand to the argument, concerning the attachment of badness and madness and the implication that they were in some ways the same. When the incommensurable brick prison was erected in Collins Street West, a small wooden apartment was attached to it as a lunacy ward, where unfortunate patients would be stowed away to live or die, or recover, their outcome very much in the hands of a rather incomplete system, their progress a matter of chance, as anything like proper nursing or attendance was out of the question (Finn, 1888a, p.425).

In speaking of the gaols Garryowen states that "...in the old times the death rate at these Melbourne institutions was of an infinitesimal character, and spoke volumes for the skill and endeavour of Cussen, the colonial surgeon and the humanity of Wintle, the first gaoler" (Brothers, 1965, p.12). We can assume from this that Dr. Cussen and his staff had made a significant difference to the health and overall care of those considered to be mentally ill (Brothers, 1965). Although Cussen lived only twelve years after his arrival in Australia, he (Brothers, 1965) was to make a significant mark in the Colony. He was considered a champion in the cause of the medical profession and in 1845 he helped to form and became president of the first Port Phillip medical association. Apart from these achievements however, of greater importance is the fact that in visiting and tending to those at the gaols he became the first person to render any of what could be described as tangible forms of health care or aid to the mentally ill. This is of course significant in

itself as it arguably demonstrates the movement from more custodial care to treatment and is significant to this writer's research.

The new metropolitan gaol finally reached completion in 1845 and both prisoners and patients were transferred from Collins Street. Also referred to as the Eastern, or Russell Street gaol, and later referred to as the Melbourne gaol, it was here that shortly afterwards an event of psychiatric interest took place (Brothers, 1965, pp.13-14). The following description is one of the amusing parodies referred to earlier where the incident in itself adds nothing to the overall meaning or understanding of the issue being described or psychiatry in general but rather could be considered humorous and amusing. I'm not sure whether interesting or humorous should be the adjectives used to describe a physical attack on a medical officer by a person suffering from a mental illness but nonetheless Garryowen, (in Brothers, 1965, p.13) who witnessed the incident, describes it...

In 1845, Dr. Cussen was attacked and nearly killed in my presence... Professional duties led me to the new gaol. ... There was then no Yarra Bend or any other lunatic asylum, and the gaol had to serve the purpose of what is now termed a hospital for the insane of both sexes. There was a dangerously demented woman confined in one of the cells... and on the invitation of the doctor, we accompanied him to see how this particular patient was getting on. The patient ...Mrs. Lee, ...apparently went mad under certain pecuniary reverses sustained by her husband. Being considered a dangerous lunatic; she was 'camisoled' or bound. Her arms were made fast but her lower limbs were under no restriction. ...as the cell door was opened by a turnkey who stood behind, Mrs Lee sprang forward and the doctor being the first person to enter was dealt such a kick in the abdominal region as to knock him... a half-back somersault, and fall flat on the floor. He was removed in a state of semi-unconsciousness.

Significant in this narrative is the unpredictable and at times dangerous nature of

working with the insane at that time. This depiction from the literature demonstrates that in the absence of good chemical therapeutic agents and suitable housing for people considered insane the provision of care/help would have been difficult and not particularly appealing to those in the general community. As an employment choice under these arrangements many would have been reticent.

Until the completion of Yarra Bend there was no lunatic asylum in Melbourne, so there remained no other alternative but in most cases to transport the more violent and difficult patients to the institution in Sydney. This was the asylum at Tarban Creek, which apart from the Tasmanian asylum at New Norfolk was the only other institution of a similar kind in Australia; hence the more deteriorated and difficult patients from Queensland were also sent there on occasions. Transportation of lunatics or those who were mentally ill, apparently affording the people of Melbourne no small amount of interest and amusement, with such events invariably being highlighted in the "Port Phillip Gazette" (Brothers, 1965, p.14) were not viewed with favour by the leaders or government officials of the Colony finding explanation rather difficult. Moving towards eventual separation for Port Phillip, they trusted that soon a separate lunatic asylum might be established.

In 1845, the New South Wales council appropriated £1,000 towards the erection of a new lunatic asylum to be placed in the vicinity of Melbourne (Brothers, 1965). Eventually, as the institution neared the finishing stages, some concern arose within the general community. An article published in the Argus on the 29th February 1848,

sounded this concern in declaring that the building now in the course of construction on the Yarra above the falls at Dights Mills, which is intended for the lunatic asylum, will soon be completed.

Two months later applications were called for the positions of Superintendent, Matron, and the other members of staff. Mr. George Watson, a retired military officer from Sydney, was appointed Superintendent, with his wife Mary appointed to act as the Matron. The “Argus” criticised Latrobe’s choice of Watson stating that there were others who were well qualified for such an undertaking within the Colony but Watson’s past experience as a clerk at Tarban Creek was doubtless significant in the reason for his appointment. All positions being filled, with Dr. Cussen to act as visiting medical officer, the Colonial secretary at Sydney was informed, and requested to sanction the following appointments (Brothers, 1965 p15): -

Superintendent	Mr. Watson	£100
Matron	Mrs. Watson	50
Medical Officer	Dr. Cussen	54.18.0
Male Keeper	Geo. Fisher	40
	Wm. Bryace	40
	D. W. Donovan	40
Female Keeper	Elizabeth Fisher	25
Cook	Mary Bryace	30
Laundry Woman	Katherine Heley	20

As was often the case the matron was the wife of the Superintendent. It is interesting to note here several factors, which have some bearing on staff profiles and the gendered issues relational to psychiatry. The appointments mentioned above clearly show the differences being offered in terms of wages for what are described as male and female

keepers, with the male keeper earning nearly twice as much as the female equivalent. In fact the female keeper according to the aforementioned legend earns considerably less than the cook. The other notable point is that this particular staffing profile shows that asylum staff had an inordinate amount of family connections across the overall workforce. The number of marital couples or “husband and wife teams” (Nolan, 1992/93, p.133) seems to have been quite high and adds a dimension in regards to the gendered nature of psychiatry. Interestingly as shown in Brothers (1965, p.15) some of the husband and wife teams were employed to complete the same job, yet were entitled and remunerated in different ways. The male was employed as an attendant (male keeper) and enjoyed a higher rate of pay at £40 per annum. The female was employed as a keeper (a nurse) earning some £25 per annum; yet male or female completed within their roles similar job requirements. The only notable exception being that males were often used in refractory areas and females often used in aged care arrangements where physical ill health were added problems.

Husband and wife teams ...seem to have been a feature of asylum life in the early nineteenth century, many sharing their home life with the patients in their care. ...Another such couple were Dr and Mrs William Ellis appointed to the Hanwell Asylum in 1831. Mrs Ellis acted as Matron and took upon herself the role of Occupational Therapist; her husband was active in the cause of better pay for keepers and attendants which he hoped would attract more respectable persons (Nolan, 1992/93, p.133).

Nolan (1993, p.48) suggests that Superintendents often asked those whom they considered good employees if they had any children or relatives who might be interested in asylum work. This is in itself significant as the workforce learnt both the good and bad habits from family members. Superintendents knew that staff children brought up close to the asylum would have realistic expectations of the work and would be supervised and

advised by their parents. Dr Ellis was also keen to implement training for his attendants so that they might legitimately be referred to as nurses. In 1836 he published his *Treatise on Insanity* which furnished numerous examples of how good nursing practice could calm disturbed patients and give hope to the despairing (Nolan, 1992/93, p.134).

The literature is scarce in detailing issues, which favour one gender over another in psychiatric nursing, but earlier commentary adds some significant comments about nursing from both male and female perspectives. Dr. Urquhart (1904, p.816) argues for the importance of good and well-trained nursing staff, which he said was instrumental in the “improvement in the treatment of the insane”. In this work, he deprecates the recent movement in favour of female nursing in male wards, suggesting that male nurses were more able to complete the requirements of the job, which included basic catheterisation, heavy lifting, and bathing of men. Urquhart refers to correspondence from a Miss Vernet (the Matron of a National Hospital), which suggests “a man, after a year’s experience here, is equal in capability to many female nurses of two years’ training”. This was obviously a contentious issue at the time but appears to have gained little in the way of commentary in any of the literature.

Most of the attendants at many of the English asylums were recruited from the local population, which of course was similar to the Australian experience but of course from a much smaller community of people who wished to become attendant staff. In Haw’s (1990, p.28) work she suggests that the attempt by officers of the asylum to employ servants of high quality tended toward the idealistic given the poor pay and working

conditions in place at that time. Haw suggests that there was a large gap between the asylum's expectations and the reality of what actually happened. Prospective candidates for positions at the asylums had to produce testimonials as to their good character and a direct communication from their previous employers to see that the candidate does or does not have the peculiar qualifications required of attendants. In listing these required qualities they were to include understanding, benevolence, youth, activity and good temper. Haw's (1990, using the Matron's report 1854) work goes further, suggesting that none but those persons possessing unexceptional moral character, a respectable appearance, fair education, good address and good health, from twenty four to thirty five years of age are eligible as candidates.

5.10 Recruitment

Recruitment of local people often proved difficult and asylum officers sometimes had to advertise nationally to secure suitable staff. Once candidates were thought suitable for a post they were taken on for a probationary period of three months. The new attendant was supplied with a set of keys, a rulebook and a whistle with which to summon help in an emergency. In line with a view advocated by Pinel (Haw, 1990, p.29), in some asylums ex patients were often recruited as staff members. Pinel had felt that employing attendants from convalescent patients would be useful, as they would already be habituated to obedience and therefore easily drilled into a routine. This particular situation was not universally favoured, and some of the county asylums in England took middle ground and instead began to use ex-patients as people who would befriend or act as servants to other patients.

Male attendants came from diverse backgrounds, although Haw (1990, p.31) suggests that many had been in the army and some were turnkeys from the London penitentiaries. This suggests that at that time, the major focus of care in asylums was more custody rather than treatment of the person's mental illness and these skills appeared to override the good character testimonials and of course are noted as more male gender markers. Increasingly asylums functioned as places of last resort, this of course even after the abolition of mechanical restraints. They had become custodial institutions governed by complicated legal codes concerned only with excluding lunatics from society at large and confining them at the cheapest cost in secure and remote surroundings (Chatterton, 2000, p.13). These arrangements appear to have come about because in the absence of other options where no formalised treatment was available and little in the way of public acceptance of lunacy as a medical disorder that was treatable. Despite the funding difficulties for the colonial authorities in these early days the asylums still offered a quality of life comparable to that of many of society's working class. Some of the Superintendents preferred the employment of ex army men, as they were accustomed to a disciplined life and were seen to have the necessary strength and ability to maintain social order in the face of a very difficult group of people suffering from a variety of paranoid, hallucinatory, deluded, confused and often aggressive symptomatology. This preferential selection of staff was still occurring in the late 1950s where custody and containment was the usual mode of treatment just prior to the advent of anti-psychotic medications and tranquillisers.

As one can see from the staff profile listed earlier, the wages paid to staff were not good;

in fact, by comparison to other positions the remuneration was very poor. Many staff members chose work in other areas to pursue better working conditions and wages. Male attendants earned nearly twice as much as their female counterparts and it would appear as though the asylum hierarchy had decided that males were going to be more useful for security and safety reasons than their female equivalents. Some asylums devised a promotion scheme in order to encourage staff to stay, such as at the Stafford Asylum where all female staff started as laundry girls, progressed to becoming housemaids, then upper housemaids and eventually keepers! (Smith LD 1988, in Nolan, 1993, p.48). This promotional structure would have made some aspects of employment a little more attractive as wages rose within the promotional scheme. Haw (1990, p.34), suggests further that full board and lodging also came with the job and asylum work was guaranteed all year round, unlike the seasonal nature of many other manual trades. Russell (1983), however, rightly points out that asylums are not what one might consider as desirable residences, lacking familiar domestic arrangements, with a harsh, quasi-military routine imposed on all staff. This of course akin to many other forms of work at that time with many factories operating with harsh and regimented routines to boost production; furthermore, the harsh and quasi-military routines adopted in asylums addressed some of the concerns expressed by the Superintendents which spoke of attendants being reluctant to carry out the necessary and assigned duties (Boschma, 1999, p.13; Haw, 1990, pp. 26-53) and taking an Australian perspective (Smith T. 1999, p.21).

At most of the asylums, attendants were issued with a booklet that listed their required duties (Haw, 1990; Digby, 1985). These handbooks were very detailed and prescribed

daily duties for every fifteen-minute interval during the day and for different days of the week. Attendants were expected to clean, observe and feed their charges. They were expected to take their charges to chapel regularly and supervise played ball games in the ward airing courts and in the grounds of the asylum. Infirm, suicidal and deteriorated patients who were too ill to leave the wards and required close attention were expected duties of the nurse. Violent patients were secluded by nursing staff, and attendants were required to make regular checks and entries into patient records of this procedure. Patients were kept in locked wards with head and knife and fork counts all part of the attendant's duty.

Another significant issue not well described in the literature is the question of 'why there more male than female attendants'. The most noteworthy point from the literature is that this question is simply answered by factors of physical strength and an increased likelihood of not being frightened by people suffering from insanity and being demonised by Satan. Chatterton (2000, p.13) adds some different dimensions to this view by saying that

one of the major differences between mental health and general nursing [is] the large proportion of male staff.... ...a universal feature of the Victorian asylum, where men were employed to work on the male side and women on the female. Staff were segregated on gender lines just as strictly as patients.

This writer can recall this segregation over a century later as being rather strict and a not to be broken rule. This of course is another case whereby history and tradition right or wrong sets up how we practice today.

Chatterton (2000, p.13) adds further that

this segregation was reflected in each institutions rule book [Hanwell Attendants Rule Book, see Haw, 1990 p35] the East Sussex County Mental Hospital book from 1929 which stated that: No male nurse...shall be allowed to enter the female side, nor any female to enter the male side...any nurse...transgressing this rule, unless a satisfactory explanation is given to the Medical Superintendent, shall be immediately dismissed.

Chatterton (2000, p.13) recounts

the Medical Superintendent as being someone of supreme power almost a God-like figure before whom both patients and staff invariably cowered.

Another reason for there being more males than females in psychiatric nursing stems from an historical issue, and is described by Chatterton (2000, p.14) as the spatial division of the asylum being ‘the great divide which was based on the constructed ideals of masculinity and femininity held by men who designed and ran these huge institutions. Chatterton (2000) suggests that these Victorian institutions were highly paternalistic and reflected the cultural norms of the day. The masculine and feminine roles and the sexual division of labour were defined in Victorian asylums by staff being segregated on gender lines just as strictly as patients (Chatterton 2000, p.13). Pearson, et al (1997, p.22) contradict this point in saying that the decline of male nurses in mental health was associated with “hospital committees’ plans to save money and create hospital revenue. It was cheaper to employ female nurses”.

5.11 A Family Metaphor

Gamarnikow (in Chatterton, 2000, p.13) uses the analogy of the family to describe the situation in Victorian asylums with the Superintendent as father, Matron as mother and the attendant staff as older children. The patients were treated as the younger children,

which is a clear indication of the paternalistic culture and indicative of the pecking order in Victorian life. These points would have been significant in how candidates for a career in mentalhealth may have approached this as prospective employment.

Further to this, Chatterton's work (2000, p.14) suggests that

these public institutions had to be as self sufficient as possible. Carpenter (1988, Chatterton 2000, p.14) suggests the chief criterion of institutional success was not discharge or recovery rates, but keeping the ... cost of maintenance for a pauper lunatic as low as possible. Thus, patients were expected to work, and this had a profound effect on the relationship between staff and patients and reflected the gendered division of labour in society. Chatterton (2000) argues further that while some staff engaged in physical care on the 'refractory' (or back) wards and some supervised patients exercising regularly in the airing courts, much of their time was spent supervising patient labour. Female nurses supervised women patients, who were expected to work in the laundry, cleaning or sewing. Male patients were put to work on the farm, or in the gardens or workshop.

Once again, these points are reflective of the situation in the 19th and 20th century and (into the 1960's) appear to have been significant in relation to male and females taking up career options in mental health. The supervision of patients, either male or female, tended to reflect the gendered sexual division of labour, which was clearly promoted in the relation between staff and patients in mental health facilities at that time. As Carpenter (1986) points out the patients were expected to work, which had an effect on the relationship between attendants/nurses and patients and in many ways reflected the gendered division of labour in society outside of the institution. The day to day job role whether custodial, caring or both had much to do with supervising patient labour and goes directly toward the type of applicant who may have been interested, recruited and subsequently selected for employment. As a general rule female nurses supervised

women patients, who were expected to work in the kitchen, laundry, cleaning or sewing (marrying their gender markers with their job role). Male patients were put to work on the farm, or in the gardens or workshops (which fits the usual gender markers of male). This division of patients reflected the sexual division of labour outside of the asylum/hospital setting where the roles described above were fulfilled by males and females in the general public. These ideals were reflective/representative of the Victorian ways of life reinforced by the asylums, which were considered by Chatterton (2000, p.14) as being “highly paternalistic”. The spatial division of the asylum described by Gittens (Chatterton 2000, p.14) as “the great divide” was based on the constructed ideals of “masculinity and femininity held by men who designed and ran these huge institutions”.

Many male attendants were drawn from the armed services and others had prison service backgrounds. These recruits were usually selected for their size and strength and were more easily selected by their appearance rather than their caring abilities. The selection of suitable staff was important because when Superintendent Watson arrived in Melbourne (Brothers, 1965, p.15), a wing of the asylum had been completed and the order had been sent out for the transfer of patients from the gaol. A more custodial approach was therefore underway and suitable staff needed to be found.

The two forms of admission were by private referral, or on request from the gaol, were outlined in the *Government Gazette*. Firstly, a person could be admitted by the application of a friend supported by two medical certificates, with the petition sanctioned by a Judge (Supreme Court), transmitted to the Governor who issued the necessary warrant, the patients being then admitted. Or, the insane person was given over to the Police. The Police furnished the necessary evidence to a magistrate, who remanded (note the custodial terms) the person for one week, during which time would be examined by two medical practitioners. If the person

was found insane, he or she was committed by warrant [or found guilty of being mentally ill] to the asylum, and moved there [usually from the watch house] when a vacancy occurred. Overcrowding was a constant problem and the custodial aspects of individual cases tended to over ride or compromise mental health issues and the particular person's well being. In this sense, space would be made available depending on the individual circumstances, the financial status of the person deemed (or otherwise) to be mentally ill and the overall nature of the concerns relational to an individual especially if there were any perceived safety issues and risk (Brothers, 1965, p.16).

When finally completed, the Asylum, at this stage only one wing of a single-storey bluestone building and was supposed to accommodate 33 male and 30 female patients. The rules and regulations for the staff employed to oversee the patients were rather rigid and appear to have been modelled on

...the experiences gained at Tarban Creek Asylum. Emphasis is placed on the tasks to be carried out explicitly by attendants, whereas most of the more mundane, and routine tasks would have been unofficially performed by 'trusty' patients (Reischel, 2001, p.15).

To understand more clearly the role of the attendant in looking after patients at Yarra Bend and similar institutions in Australia, one needs to place this role into its historical context. In the 1850's, Victoria had intentions of declaring its separation from New South Wales, based in part on the fact that it had immeasurable wealth in terms of gold deposits outside of the Melbourne capital. Reischel (2001, p.14) captures this in giving his thoughts on the role of those in charge of the Yarra Bend asylum.

In 1850 Victoria has become an independent colony. Edmund Finn, *Port Phillip Herald*, 11th November: 'Glorious! Separation at Last!! ... The long-oppressed, long-buffed Port Phillip is an Independent Colony, ... with the Royal name Victoria, and endowed with a flourishing revenue and almost inexhaustible resources... .' All public offices and institutions to be renamed. The Merri Creek Lunatic Asylum became Yarra Bend Lunatic Asylum.

The 1851 gold rush saw an exodus to the diggings and left Melbourne almost deserted.

Gold fever had lured most of the able-bodied, regardless of calling and profession, to the goldfields. Scores of businesses and shops were closed, and so were most schools. Streets looked deserted except for a steady flow of ... diggers walking up Mt Alexander Road to the discoveries at Ballarat, Bendigo and Mt Alexander (Reischel, 2001, p.15).

Many people who worked caring for the mentally ill also decided to seek their fortune

...Many male staff of Yarra Bend Asylum left for the diggings. In a letter by the Colonial Surgeon Dr John Sullivan to the Colonial Secretary Lonsdale, we read the following: 'All the male attendants but one left the Asylum on 31st December... the nurses have remained. The persons that have been engaged to fill the vacancies are not only inexperienced but of an inferior class. With a view to assisting/training the new hands in the management of the patients it ... necessary to employ one of the male patients as an attendant; this man has been employed before in the same capacity and is likely to be useful as though not in a fit stage to be discharged his mind is sufficiently composed to enable him to manage his fellow patients, besides he likes the occupation (Reischel, 2001, p.15).

Reischel (2001) refers here to a key point in the history of psychiatric nursing that of making do in the absence of suitably trained staff. In this instance he refers to using a male patient as an attendant suggesting his mind was sufficiently composed at that time. Further to this, the attempt to attract staff in the absence of other attendants who were away at the goldfields was met by offering a hundred per cent pay rise. The male patient mentioned above was called Donovan, whose name appears on the original staff list. Being a patient he was not allowed to join the gold rush, besides he suffered from alcoholism. One cannot even remotely regard 'the assistance and measure of training new hands in the management of patients' by Donovan as any form of nurse training (Reischel, 2001, p.15).

These issues were arguably instrumental in changes taking place in the care of the mentally ill. These changes were indirectly as a result of public pressure being applied.

This public pressure was driven by concerns from some quarters of the public but may have probably more to do with safety issues rather than concern by the general public about the overall care of those deemed to be mentally ill. Further to these public concerns there was apprehension about an absence of proper supervision, and that patients had been subjected to coercion and punishment. The shower bath that was to be used therapeutically had been 'turned into an engine of torture'. Physical restraint by means of straight jacket, handcuffs and gloves was liberally carried out by the attendants without sanction from the Superintendent, who is said to have been absent except for a brief morning visit, and therefore attendants had 'unlimited sway in the institution'. Great concern was expressed that patients were allowed to roam aimlessly without any sort of occupation to amuse/interest them. Not only has the destructiveness of lunatics been called into play to such an extent as to endanger the lives of both patients and attendants, but practices of the filthiest, vilest, most immoral, and sinful nature have been generated amongst them, and these to such an extent as to cause your committee to express their astonishment that they should have been so long allowed to exist (Reischel, 2001).

Because of these concerns Watson, the Superintendent was found guilty of inattention to his duties, disregarding the welfare and the comfort of the patients, often leaving a lunatic attendant in sole charge of a ward, and many other offences pertaining to patient care. The inquiry also found him guilty of materially enriching himself by turning Yarra Bend into an extensive poultry and pig farm, using patients' rations as well as those of the Government horse to feed his chickens and pigs, selling his produce to market merchants. Attendant Donovan was found to be a man of 'the foulest conversation, of the

most disgusting habits, and of the most libidinous propensities', of reckless conduct when intoxicated, giving liquor to fellow patients causing excitement and confusion (Brothers, 1965). One must ask, what led to this situation when there were a strict set of rules and regulations? In the case of Castle Hill, detailed orders were given to George Suttor, but he was not able to abide by them because the authorities had let him down. In this case, at Yarra Bend, the authority's watchdog, the Visiting Magistrate was seemingly unfit for his duty, giving an opportunity for Watson and his staff to flout the rules and regulations, and do as they pleased; exploiting the situation according to their own greedy lust without compassion and humanity.

One would think that the inquiry may have produced some change to the practices of the care of the insane, but unfortunately as a result of the inquiry, George Watson was given another appointment or moved sideways, but Dr Embling had been 'turned adrift' and Governor La Trobe pronounced that Yarra Bend was one of the best managed establishments in the Colony (Reischel, 2001, p.17). These pronouncements would of course make the option of working with the insane much more appealing.

Yarra Bend Lunatic Asylum was considerably enlarged as more and more pressure was put upon it to accommodate patients. Finally, the need arose for additional asylums to be built in Victoria. Royal Park Receiving House was created by converting the old Powder Magazine in the Kensington mud flats in 1865, the Stockade in Carlton in 1866, Ararat and Beechworth Asylums in 1867, Kew Asylum in 1872, and Sunbury Asylum 1879. Lunacy wards were also opened in general hospitals at Castlemaine, Geelong, Bendigo,

Woodspoint and Sale (Reischel, 2001, p.17). This of course meant that more employment opportunities were being created for both males and females.

5.12 Summary

This chapter has looked at many of the different yet interlocking themes, which describe the people who worked with those considered to be insane. The chapter has built on the history of psychiatry and encompassed understandings from the literature, which describe and detail what constitutes gender, gender roles and gender scripts. Within this literature, linkages have been made with some of the key features of the research including those of biogrammar, scripts, and the sexual division of labour to show how some of the discourse demonstrates how gender has been important in relation to the history of psychiatry and more specifically psychiatric nursing in Australia. Within this process linkages have been made with the history of psychiatric nursing to demonstrate the linkages to the here and now. This chapter across this process has also discussed how specific roles can be played out in life by the enactment of specific scripts which are genetically determined in the case of gender and then socially played out by individuals in relation to given sets of social circumstances. These discussions argue that the biological gender role which when attached to a genetic script can show that males and females in nursing can act outside of their usual prescribed and culturally determined role/self. Taking a more dramaturgist view would suggest that individuality is a social rather than a psychological phenomenon, which would basically mean that a person's individuality is shared or validated with and by others. This line of reasoning would therefore mean that a person's sense of individuality is situationally specific. Brissett and Edgley (1975, p.56) suggest further

that different situations require the establishment of different selves and that this means that a person's sense of individuality is plural, not singular taking a 'doing is being' perspective.

These roles or selves have an array of factors, which can contribute to their enactment in everyday life, and at times their enactment is and can be complicated by game playing within specific areas and across genders of the multidisciplinary groups or single discipline groups. Added to this the key areas of power, patriarchy and capitalism and some of the more complex areas of employment including relationships with others, which can make a difference in how well an individual may play out and accept their specific role. Some of the literature suggests that people have the potential to play out different selves and that these selves can be determined by a whole variety of factors. Similarly, text, language and deconstruction issues were discussed because some of the discourse that surrounds both gender issues and professions like nursing are and can be particularly persuasive and sometimes the truth and a clear picture of the profession may be lost. The literature subscribes to an almost unquestioning acceptance of conforming to the stereotype where empirical evidence of numbers relational to males entering nursing appear to have made little headway over the last decade.

CHAPTER SIX

THE LAST TWENTY-FIVE YEARS

6.1 Introduction

This chapter looks more closely at the last twenty-five years to ascertain the significance of gender to psychiatric nursing across this time span. The history of psychiatry and the developing role of the mental health nurse are difficult to fully encompass in a single chapter. The intention in examining these two topics in some depth and the switching back and forth between the history and more recent developments is to preface mental health nursing as it has been practiced over the last twenty-five years. This process has allowed us to look back from the vantage point of the present.

The last twenty-five years in mental health nursing have seen immense changes taking place in the philosophy, organisation and delivery of mental health care in Australia and overseas. These changes were in part driven by financial, political and employment issues that placed some burden on the particular government of the day as to how mental health nursing was practiced. The changing focus of mental health nursing in both England and Australia has been instrumental in how professional groups, especially nursing, practice and exist within the mental health arena and this chapter has explored some of the philosophical underpinnings, ideology and driving forces behind some of these changes. This exploration has shown that a series of interrelated issues including gender have collectively played a significant role in how these changes have been played out in mental health nursing.

6.2 Crisis Point in Mental Health Care

Nolan and Hopper (1997, p.333) suggest that a crisis point in mental health care has been reached in England due in part to a series of changes brought about by “early 20th century governments” being both unsympathetic and unresponsive to the need for reform within mental hospitals and mental health. The required reform stemmed from the fact that respective governments in England and Australia were not addressing the escalating demand and subsequent costs, for services within mental health arenas. This escalating demand in both England and Australia was driven by spiralling inpatient and outpatient numbers of patients, with patient admissions always seemed to outstrip patient discharges. There were many reasons for this situation and need to be factored into this equation. The deficit in terms of budget brought about by two significant war efforts (in 1914-18 and 1939-1945), together with the depression and some of the changes driven by the financial burden that Bevan’s National Health Service imposed on the British Government had obviously persuaded British government policy and by association the Australian government in directing its spending toward other areas. These budgetary concerns together with the more comfortable arrangements provided by inpatient care and often coupled with financial difficulties for the person concerned meant that being provided for in an asylum was better than being hungry and pauperism.

People were often admitted for a huge variety of different conditions in the 1970s. Many of the patients did not appear to have treatable mental ill health issues and required respite and a place to stay. Some of the regular staff used to call this ‘bed and breakfast’. Some of the patients admitted to hospitals in both England and Australia in the 1930s,

1940s, 1950s and 1960s remained in hospital for years.

One man had been a continuous inpatient in an English hospital for 66 years. Clearly, the admission criterion of what constituted a mental illness was different then (Ward, 2001).

Anecdotal evidence such as this would suggest that although funding was clearly an issue, overcrowding in hospital settings was more to do with policy issues because with the availability of medication, admissions and overcrowding should have been reduced. The same could be said of the mental health services in Australia across a similar time frame. In England, Nolan and Hopper (1997, p.333) suggest that during the 1950's the "population of mental hospitals stood at 150,000 patients, a number far in excess of what the system could reasonably and humanely accommodate" (Nolan, 1993). This resulted in a steady decline in the quality of living, working and therapeutic conditions within hospitals, and a steady increase in the cost of patient maintenance and care to the point where it was far beyond what had been envisaged by the architects of the English National Health Service. The researcher suspects that Nolan and Hopper's (1997) estimate of 150,000 patients is rather conservative, as Nolan himself (1993) refers to 142 000 mental patients in hospitals in Britain in 1930 and a growing number each year. At the rate of expansion highlighted by Nolan 150,000 patients in the 1950s seems rather moderate. This continuing expansion, according to Nolan (1993 p120), threatened the viability of the National Health Service and was instrumental in the introduction of the 1959 Mental Health Act which was intended to reduce the number of inpatients immediately and to change the course of mental health care provision.

The costs of the overburdened mental health services alarmed Treasury to such an extent

that it insisted on immediate measures to curb spending in and across the mental health sector (Carpenter, 1988). Nolan and Hopper (1997, p.333) further this point, saying that indirectly Treasury managed to contain some aspects of this problem by keeping nursing staff wages low by “the imposition of circuitous pay structures which foiled repeated union attempts to improve them” and by reducing the numbers of trained nursing staff by filling “vacancies with untrained ancillaries” (Nolan and Hopper, 1997, p.333). This often meant that the quality of nursing staff was at times attached to filling the position rather than employing someone who could skilfully carry out the specialist nature and intricate requirements of the job. “The threat to the professional integrity and skills-base of the mental nursing profession posed by this influx of untrained and lowly paid workers in the late 1980s was not properly appreciated by the union body most closely associated with mental health nursing” (Nolan and Hopper, 1997, pp.333-334).

6.3 Gender as a Prerequisite to Employment

Similarly, it may have been a factor in how particular gender perceived and thought of the job as an employment option being more appealing to those without educational qualifications. Parker an Australian Registered Nurse (2001) recounts that when he applied for his first position at a mental hospital in South Australia in 1970 the chief male nurse asked him if he could play football or cricket as the hospital team were to play the top of the league side in three week’s time. Similarly, after ascertaining this particular prospective nurse’s athletic ability he then asked if he could play a musical instrument because the hospital band was short of a trumpet player. Nothing was mentioned about his ability in regard to caring as a prospective nurse or as a potential

mental health recruit, except his athletic abilities in apprehending patients who may abscond. These points were not confined to the mental health systems in Australia. Arden (2002, p.144) recounts the same situation occurring in England some years earlier in the 1960's. This evidence suggests that in the 1960's it was easier to secure employment in mental health for either gender; but that even then recruitment and retention were problematic but for different reasons. These reasons included people having more choice in terms of career options with many choosing not to pursue a career in psychiatric nursing, and that those who organised and administered the psychiatric hospital system at that time saw the profile of the hospital as hinging on both hospital security, and a lack of patient escapes, the melodic chimes of the improving hospital band and the position the hospital cricket and football team held on the respective league ladder. Once again these points go directly to issues that dealt with employment choices where the more custodial elements proved to be persuasive in the selection of one gender over the other.

...the assistant chief male nurse was looking for a fast bowler, a good footballer, or someone who could play a musical instrument; these were the requisite qualities for male nurses of the closed communities of asylums (Arden, 2002).

The employment of female nurses was often linked to the provision of domestic type services with Wright (1999, p.153) saying "an intimate relationship between domestic service and the emergence of a nursing profession existed". Wright (1999 p.154) suggests that a "transformation of servants into mental health nurses" was significant for sketching "a general outline of the rise of psychiatric nursing, ...and work patterns of ...women". Nolan and Hopper (1997) suggest further that using mental hospitals primarily for the accommodation of the elderly and the chronically mentally ill was

initially not recognised as short sighted. These circumstances meant that acute psychiatric care was being gradually shifted to general hospitals and this compounded the gender mix issue and this was instrumental in the movement of many of the most able mental health nurses following these patients into acute care areas which were always seen as more appealing in terms of professional and career options. This movement of acute psychiatric care under the Australian National Mental Health Policy (1992) to general settings under the umbrella of mainstreaming in the early 1990s was said to “put mental health into the main arena” (Clinton and Nelson, 1996, p.146) and was carefully hidden behind what might be described as destigmatisation and improved services and has meant that the issues of mental health care or non-care have been hidden within larger hospital systems and their budgets and generally speaking the services from a nursing perspective have not greatly improved. Mainstreaming or the movement of psychiatric services into the “main arena” has moved what was considered to be a career option for men into the general hospital domain of women as they are largely staffed by females. The movement of acute psychiatric care to general hospitals had been encouraged, in fact almost urged, by a few psychiatrists to achieve more decentralised mental health services closer to people’s family, community and cultural networks and to enhance equity of access. Inpatient care was mostly of an initial reception and assessment type. The patients would then be moved to an acute ward in the psychiatric hospital or discharged with many patients having short periods of stay, usually no more than seven to ten days. Similarly, the movement of acute care to general hospital areas developed because the medics enjoyed the status of being on general hospital sites and often considered psychiatry as a secondary option to general medicine.

In consideration of the above points and because of the general lack of improvement of nursing services, Toynebee (1995) argues that mental health services have deteriorated significantly, with only limited anecdotal evidence (Parker, 2001; Smallgood, 2001) that stigma has been reduced by the introduction of mainstreaming (Summers and Happell, 2003, p.351). With these points in mind the end in this case would not appear to justify the means. Mainstreaming and patient satisfaction rates do not appear to have affected the low numbers of comprehensively trained graduates choosing psychiatric nursing as an ongoing career option. In fact, some of the changes may have probably acted as a deterrent to graduates looking for psychiatric career options. The comprehensive programme may have inadvertently 'feminised' psychiatric nursing or, made it now more available to female nurses as by weight of numbers, 94% of the under graduates are female and of that 94% some choose psychiatric nursing as a career choice. Previously, the majority of applicants were males. Chan and Rudman (1998, p.144) argue that "the process of mainstreaming [has been] detrimental to mental health" because of its effect on nursing recruitment. Huxley (1995, p.323) adds, "...mental illness does require a different approach from other disorders and disabilities, and that mental illness services need protection from mainstreaming reforms" because "specific needs of the mentally ill may be overlooked when funds are allocated". Huxley (1995, p.324) attaches some of these points to staffing issues in saying that the corporate identity of professional groups is often affected under mainstreaming where boundary violations of particular groups within multidisciplinary teams can be problematical. Also, under care/case management arrangements separating assessors from providers causes problems and is of little value to those who are mentally ill. These sort of administrative arrangements ignore the central

importance of the long-term relationship between worker and patient. Similarly, “if you give trained and skilled mental health workers assessment only jobs they will begin to look for more rewarding employment elsewhere” (Huxley, 1995, p.324).

6.4 Identity Crisis

Holmes (2001, pp.379-381) furthers the points articulated in the introduction to this chapter and adds an interesting dimension. Holmes claims that psychiatric nursing has been experiencing what he describes as an ‘identity crisis’. He suggests the reasons for this are not difficult to pin down, forwarding amongst other things the changes in the organisation and administration of services, some changes in the overall nature of the clinical problems being encountered and how they are now treated, the advent of more long term psychotropic medications, and the increased accountability from all areas in the face of ambiguous social attitudes and expectations; he suggests that these points only skim across the many issues and that “the list goes on”. Two of the most significant areas worthy of individual note are biomedicalisation and the many changes to the overall structure of professional education. Holmes (2001) overviews mental health nursing from an Australian perspective but his concerns would most certainly encompass broader national and international issues which appear regularly in the literature (Happell, 1997; 1998a; 1998b, Murphy, et al 1993; National Swedish Board of Health and Welfare 1995; Callaghan, et al 1997; DeMarzo 1990; Wynaden, et al 2000; Wynaden and Popescu 1999a; 1999b).

Holmes (2001) also argues that there has been a massive resurgence in the power of the biomedical establishment, with medicine holding the dominant position within mental

health care, which he states, may have been initially kick-started by reactions against the antipsychiatry movement. Nolan (1992/93, p.131) talks about the antipsychiatry movement, suggesting that a change of awareness had arisen because of the stimulus by this movement in the 1960s. Here the “Whig” view of the history of psychiatry is interesting and is discussed by some authors (Jones, 1972, p.37) in a variety of ways. The Whig view depicts psychiatry as a genuine attempt to help people with and suffering from a mental illness. The Whig view is strongly opposed by Scull (1979) who takes more a critical theory perspective suggesting that there is no such thing as mental illness, making the claim that psychiatrists who suggest that they treat mental illness is rather superfluous. Similarly, as argued by Shorter (1997, p333), Scull seems to suggest that asylum psychiatrists in the 19th century

... sustain the illusion that asylums were medical institutions, they placed a humanitarian and scientific gloss on the community’s behaviour, legitimising the removal of difficult and troublesome people whose confinement would have been awkward to justify on other grounds.

Porter (Shorter, 1997, p.277) tends to take more middle ground but still argues that psychiatry was “an illegitimate form of social control and that psychiatrists’ power to lock people up must be abolished with the abolition of institutionalised psychiatric care...” Whichever position one chooses to accept there are some interesting points in the examination. Scull (1997) takes a left wing approach and argues convincingly that psychiatry is a system for the oppression of the poor and powerless by the rich and powerful. That psychiatry was only troublesome for society and should not be only dealt with as a medical prerogative. Each of the respective positions appear to have points of merit and collectively make interesting reading but none of the positions on their own

can claim real legitimacy which may be why psychiatry holds this indefinable mystique and often defies clear logic.

6.5 Anti-Psychiatry and Media Portrayal

Some notable figures such as Laing, Szasz, Sedgwick, Goffman and Foucault, who were somewhat sceptical of the 'received wisdom', which viewed the history of psychiatry as comfortable, relatively straightforward, and a rather benign process drove this change of awareness. Many of these intellectuals became identified with the antipsychiatry movement (Shorter, 1997, p.274). Foucault (1965) argued that mental illness is a social and cultural invention of the eighteenth century. Szasz (1960) suggested in his book that mental illness was in fact a myth, describing it as "scientifically worthless and socially harmful" (Shorter, 1997, p.274). Goffman's work (1961) was concerned about what he described as a total institution or closed system that infantilised patients and restricted their lives, and that every social arrangement in mental hospitals he suggested pointed to the profound difference between a doctor and a mental patient. He felt that patients had to undergo a series of abasements, degradations, humiliations and profanations and that the time spent in a mental hospital was wasted. Shorter (1997, p.275) in his review of Goffman's work suggests that the underlying assumption was that there was no such thing as a mental illness and that the pretension of professionals to treat it was nothing more than a shameless power grab and that the perception of losing one's mind is based on culturally derived and socially engrained stereotypes. Laing (1960) suggested that sick families were the cause of schizophrenia and that the so-called illness represented a gifted and creative state of consciousness, a sane response to a mad society. The work of

many of these authors took a very similar stance against psychiatry and was perhaps best illustrated in the novel by Kesey (1962) called *One Flew Over The Cuckoo's Nest*. Shorter (1997, p.275) suggests that Kesey's representation of mental illness was very persuasive to many in the early 1960's and their notion of psychiatric illness and mental health was embodied in the central figure, McMurphy. The theme of the novel was one in which McMurphy was locked away in jail a few times and, when he proved too troublesome, was placed in a psychiatric facility and treated as mentally ill. The message, according to Shorter (1997), is that psychiatric patients are not ill; they are merely deviant with bad equalling mad. Shorter (1997, p.275) suggests that Kesey's portrayal "formed the image of psychiatry for an entire generation of university students", which must have been significant to those who either contemplated a career in psychiatric nursing or had been drawn toward it by both the book and subsequent movie which captured many Academy Awards. He suggests that the works of Foucault, Szasz and Goffman were influential amongst university elites, cultivating a rage against mental hospitals and the whole psychiatric enterprise. These very persuasive arguments would have been significant in career choices made by prospective mental health workers.

Holmes (2001) suggests that a continuance of the antipsychiatry movement in the 1970's, was fuelled by much-fêted new drug options, the emergence of more refined genetic and neurophysiological research sponsored by a myriad of powerful biomedical multi-nationals, and this indirectly has placed significant political pressures upon psychiatrists to align themselves more closely with physical medicine and of course the attached funding. For Australians, the biomedicalisation of mental health problematises

and, in this sense, interferes with and changes the role of mental health nurses and the recruitment and retention of nursing staff. Nursing education for psychiatry in Victoria, Australia is now offered within a comprehensive degree package in which nurse graduates are able to begin practice in one of many different yet diverse areas. Psychiatry and aged care were supposed to be the benefactors of this comprehensive degree option and these packages lead to the closure of some of the divisional arms (Division 1 general nurse, Division 2 enrolled nurse, Division 3 psychiatric nurse) of nursing practice (Division 3 closed in 1994), which dealt with these speciality areas. With the benefit of hindsight, a comprehensive programme has a lot to offer with its initial plan being to broaden the overall knowledge base from which graduate nurses could operate. What sounded good in theory for psychiatric nursing was that practitioners were to be exposed to psychiatry and psychiatric nursing practice and some of the causative factors relational to patients across a general nursing programme. Postgraduate options for those graduates showing interest in psychiatric nursing were to be offered. In practice, this has led to a steady decline in the numbers of those showing interest in psychiatry and the recruitment and retention of staff is problematical. Similarly, fewer males are moving into the area of psychiatric nursing preferring to take options in more general orientated areas. Empirical evidence from the Nurse's Board of Victoria (NBV, 2002) demonstrates a drop in Division 3 numbers of 5.3% from 2001 to 2002 and a modest increase of endorsements on division one of 1.7% between the same two years. There has been a small increase in the number of men entering the nursing profession across 2001 and 2002, with a modest 5.2% increase across small numbers, although the Annual Report for 2002 (NBV) shows that the percentage of males in

nursing across Victoria has remained constant over the past seven years at 8%. In 2002 there were 67,434 females in practice with 6,058 males showing a slight increase in both groups. 1994/95 figures show that registrations from other courses or divisions of the register were 190 with a slowly declining number over the next three years (1995/6 - 115, 1996/97 - 55, 1997/98 - 58).

The biomedicalisation of mental health is at odds with the psychosocial and behavioural approaches that dominated nurse training and role definition throughout the 1970's, the period during which many of the present Australian psychiatric nursing workforce undertook their training. Whereas that training made social interaction and therapeutic uses of the self central to their professional role, many of these nurses now see their role in terms of risk management, the management of medication or the maintenance of patient safety, and marshalling and overseeing the services provided by other disciplines. A steady stream of reports and service evaluations and anecdotal evidence in and from a number of countries indicate that attempts to retain an interpersonal therapeutic focus in the face of biomedical hegemony are also undermined by staff shortages, lack of staff support strategies, inadequate resources more from a financial perspective, staff recruitment and retention and poor general facilities (Holmes, 2001). The advent of significant phenothiazine regimes, particularly medications such as Chlorpromazine (Largactil) prescribed for the management of particular psychiatric conditions have obviously had a direct correlation to inpatient numbers in psychiatric hospitals. Holmes (2002) suggests that inpatient numbers were starting to run down in the 1950's after having peaked in the late 1940's and that phenothiazine medication hastened the process

of deinstitutionalisation, which was already underway as treatment options moved toward community, based care including day patient and outpatient services. Similarly, Turner (1993, in Brooker and White), Godin (1996), and Scazufca and Kuipers (1997), all suggest that it also was indirectly persuasive to female nurses to take up community psychiatric nursing roles, in the belief that this represents a therapeutic wing to their job role because it is more treatment orientated rather than inpatient and custodial.

Phenothiazine medication also added a control feature to mental health nursing and because of this made psychiatric nursing much more appealing to female nurses who could administer medication and use their repertoire of de-escalation skills much more readily and in the same way, if not better than male nurses. Further to this, the masculine custodial approach was seen to be outmoded especially with the advent of community-focused programmes. This arguably made mental health nursing a more appealing employment prospect for females and arguably less so for males.

Holmes (2001) argues that under the influence of biomedicalisation and the return of psychiatry to what he calls the medical mainstream, nurses and other mental health professionals find themselves not only uncertain about their roles but also about how to talk and think about their knowledge and practice. If there is no more to psychiatry than the physical, what are they to make of the word 'mental' in the politically correct terminology of 'mental health'? Although there have been spirited calls for psychiatric nurses to clarify these issues in order to help re-frame their professional roles and objectives (Dawson, 1997), it is obviously not possible to resolve long-standing

philosophical conundrums like the mind–body problem, and all that can be hoped for is an operational understanding of such terms for professional purposes.

6.6 Mainstreaming

Psychiatric nursing is not now seen as a speciality area, but more an aside to general nursing, as universities tend to offer an abridged version (at under graduate level) of the old psychiatric nurse-training programme, and as a post-graduate qualification. Similarly, as the large institutions close and mental health nursing becomes more community oriented and mainstreaming attempts vainly to destigmatise psychiatry in the eyes of those with the purse strings this also detracts from viewing psychiatric nursing as a speciality area and of course the mix of male/females who work in and are attracted to the job. The notion of ‘therapeutic use of self’ in relation to patient care when the facility at which one works is secure adds another dimension to this issue and, in short, moves psychiatric nursing further toward the assessment and management of patient risk. Ward (2001) states

...the job is not really the same; we ship them out really quickly these days whether they are ready to go or not. Mental ill health has nothing to do with the decision that is made. Friday afternoon means getting rid of at least two or three patients to make room for incoming admissions across the weekend. We pick the two least likely to harm themselves or others and out they go. Its risk management ... nothing to do with good nursing care and is really frightening. Lots of the nurses document these problems and their documentation is penned in such a way that it covers the nurse from a legal perspective rather than because their nursing care is designed in the patient’s best interests.

It is interesting to note here that according to some authors (Rose, 1998, p.192; Holmes and Warelow 1999) risk management has become the focus of the care provided to those

deemed to be suffering from a mental illness. In this instance, risk management and the thinking behind it tends to transform the very activity of psychiatry. Mental illness has come to be emblematic of the threat posed to given communities by permanently marginalised, excluded, outcast and largely unreformable sectors that require enduring and ongoing management. Rose (1998) suggests further that all zones of potential interpenetration where these dangerous sectors might come into contact with, and prey upon, the innocent public are felt to be the zones of risk - the car park, the shopping mall and so on. He suggests that quasi-penal rules against the habits of incivility such as loitering, alcohol usage and smoking are all measures of control. He summarises by saying that not only those with mental health problems, but also those psychiatric professionals and everyday life itself are governed through madness. The system, he suggests, is a “blaming system” in which every misfortune is turned into a risk which is potentially preventable and for which someone is to be held culpable and therefore open to sanction (Rose, 1998). Risk management in psychiatric nursing can be assessed equally well by both male and female nurses, although at first glance one usually attaches the risk aspects of the job to the traditional role of the male.

Some aspects of these issues are recognised in forensic nursing care areas where there has been a widespread shift away from notions of dangerousness towards the assessment and management of risk. Similarly, in some facilities in England and overseas are single sex facilities and one male forensic clinic in Canada (Holmes, 2002) that chooses to employ female nursing staff, because the managers believe that women are better than males at defusing and de-escalating aggressive and potentially aggressive situations. The

philosophy of the clinic believes that just the presence of females is calming in itself. The suggestion here is that male staff may feel that they have something to prove and allow 'testosterone' issues to get in the way of good clinical reasoning and decision-making skills or one aspect/role within their male gender to get in the way of the other. To solve particular problems of risk, security and patients questioning the rigidity of the rules requires a physical presence which had been in the past provided by the male attendant who stood up to someone or coerced by their presence those who did not comply with a rigid set of hospital rules. Males in this sense had always been seen as more employable in terms of psychiatric nursing, since they were viewed as having the prerequisite physical strength for dealing with difficult and potentially risky patients and situations. Nolan (1993, p.91) addresses this issue when he lists some of the appealing aspects described by mental nurses relational to their work. The males listed having a job, amiable colleagues, sporting facilities, theatrical and indoor sporting facilities as the most appealing aspects of their work, whereas females listed caring for the patients, companionship with/of other nurses, taking pride in the ward, walks with the patients and the weekly staff dances. These points that males valued job security and were not particularly interested inpatient care and females enjoyed making "homes" on the ward (Nolan, 1993, p.94) go directly to the expected, yet different mindset of particular gender roles (Boughn (1994, 2001) and Boughn and Lentini (1999).

Trade unions such as the Asylum Attendants' Association and The Trained Mental Nurses' Association and Asylum Workers' Association in England were more interested in staff rights and their working conditions and argued that balanced gender numbers

across the total workforce relational to the overall psychiatric nursing workforce was important. Later, the Confederation of Health Service Employees (COHSE) in England (Carpenter, 1985) and the Hospital Employees' Federation No: 2 Branch (Faulkner, 1999) and then Health and Community Services Union (HACSU) (Kallasmae, 1999) in Australia instituted equal opportunity legislation which was to address many of the issues, which appear to have been commonplace between the two genders in psychiatric nursing.

The adage that safety is secured by male strength seems at odds with females being considered more able to defuse aggressive situations by using the basic skills which are of course are taught to both male and female students and are basic and fundamental to the profession of psychiatric nursing, which include a basic repertoire of micro skills such as care, reassurance, persuasion, empathy, unconditional positive regard and de-escalation amongst others. Some aspects of this argument fit with the views held by Kimura (1992) and Walsh (1997) who talk about scripts that serve as guidelines, which enable people to know how to behave in certain situations and in specific roles (Goffman, 1959). Almost as though specific genders have their biology wired to act in certain predetermined ways would suggest that certain behaviours may have genetic links. If we contemplate a genetic link to caring this may be a new way of considering this rather complex and not well-defined phenomenon. Chan (1995, p.11 citing Tiger and Fox, 1972) argues convincingly that human biogrammar is a genetically based programme which predisposes human beings [of whatever gender] to behave in certain predetermined ways which could suggest a genetic link to caring or of course uncaring. The

aforementioned arguments may suggest some validity to these positions.

Some of these skills/behaviours/roles are now taught in an abridged version of psychiatric nurse programmes (Professional Development Units, Training and Further Education - TAFE), which advocate in their graduates more an overall repertoire of skills applicable across different areas of nursing. It is easy to see why this would be appealing in theory and from a financial point of view, but in operational practice it has been problematic with recruitment and retention as an abridged version, as with the comprehensive programme are not skilling nurses to function well in these rather difficult mental health areas. Holmes (2001) agrees, arguing that this operational understanding has not yet happened and, in the context of biological psychiatry, the word 'mental' increasingly appears to be an embarrassing archaism. This view is a little one-sided and it could be argued that a comprehensive programme has much to offer nursing students as integrating psychiatry with general nursing educates both groups about mental health issues, nursing care and humanises both the physical and psychiatric aspects of both speciality areas. It also portrays psychiatry as being a little more accessible to either gender as it promotes nursing in a different way to females who see it as a part of nursing which doesn't need to be frightening and to males who see general nursing as a career pathway they can take which is now less of a female 'starched uniform' only option/profession.

Archer (Muldoon and Reilly, 2003, p.94) argues that career aspirations are not shaped by job related factors alone and are often linked to individual differences such as gender role

orientation. Archer argues that an individual's gender role orientation will affect a number of related behaviours, including a person's occupational choice, suggesting "...it is likely that gender role orientation may be more central to career choice than gender itself. In effect, stereotypical sex-typing of occupations exerts a circumscribing influence on the career choices of children, adolescents and young adults because of the [inherent] characteristics of both the worker and the work".

A nurse-training programme, which incorporates psychiatric with general physical and psychosocial issues, offers prospective students a more all-round and inclusive perspective. This in itself promotes the view that mental health issues should not be treated out of the patient's own physical and psychosocial context or in any different way to general issues. If the statistics are correct, then in a class of a hundred students there will be at least twenty of those students (20%) who will be suffering from a mental illness themselves and a growing percentage of students who will know someone who has a mental health problem (Mohr, 2002, p.5). Other literature expresses concern (Happell, 1997; 1998a; 1998b) about the depth of what is on offer in undergraduate Registered Nurse programmes within the university system and whether this process prepares prospective students or graduates well enough to practice safely and competently in both mental health and general nurse areas.

These concerns signify that both practices and the language of the past is being rejected, so too are some of the styles of work, and values. This is difficult for some practitioners because these former ways have played a fundamental role in the personal and

professional lives of nurses, and even though they recognise that these systems and ideas were failing and not considered perfect, they seem to have done what they could to make them work and are correct in attributing much of the failure to forces – economic and political – which are for the most part outside of their control. Whilst acknowledging the need for constant development, many nurses lament the loss of the positive aspects of the system they once knew, especially when they see what has been put in its place and these points go to recruitment and overall retention issues of the profession as a whole.

I trained in the early seventies and with the benefit of hindsight and a few years of wisdom can now see that then it was much simpler than it is now. In a way it was always complex yet simple in another. Caring was done in such a fashion that somehow training was incidental to the exercise, one just sort of new (Kingsley, 2000).

Holmes (2001) also touches on this point in recalling what he saw some three years earlier.

I visited a psychiatric ward in a large general hospital in Sydney Australia . Unlike most psychiatric hospitals, it was a modern building, but the psychiatric ward was a cramped conventional general ward, and the patients were effectively cut off from the outside world. All the symbols of serious illness were evident, including flowers and 'get well' cards...; some of the patients were in dressing gowns and pyjamas, and nurses stood in starched white uniforms, garlanded by stethoscopes and carrying clipboards. I had not seen a sight like that in over twenty-five years of working in psychiatry. Anyone whose professional origins lay in the psychosocial ideology of the 1970's and 80's would have been hugely disappointed to think that this is where we had travelled in the intervening quarter of a century. The effect of such an environment on the thoughts, feelings and practices of nurses is profound. As mental health problems become recognised as common to the majority of the population rather than reserved for a peculiar minority, as the links between physical and psychological states become more obvious, and as popular notions of mental disorders correspond more closely to those of simple physical disorders, there is developing, alongside professional 'mainstreaming', a cultural mainstreaming, which may ultimately succeed in reducing the stigma attached to mental health problems. On the other hand, mental illness, regardless of its aetiology, is ontologically and experientially different from kidney disease or diabetes, and the hope that mainstreaming psychiatric services would help reduce stigma, has only served to heighten the

sense of difference. This is most obvious when in-patient facilities are collocated, as in the hospital ward I just described. Health departments and bureaucrats have sold mainstreaming not primarily on economic grounds, which are in truth the main motivation, but on the basis that they would enable psychiatric services to piggyback on the professional and ideological prestige of general medical services, and thereby obtain vicarious respectability for mental disorders. There is no evidence that this has happened. In fact, recent reports confirm that mental illness is still highly stigmatised, and that mentally ill people are still systematically discriminated against and seen as easy targets for exploitation, mugging, assault and general terrorisation when identifiable in the community.

Holmes (2001) argues that anecdotal evidence suggests that mainstreaming has robbed the psychiatric services of their autonomy and has allowed psychiatric services to be exploited because of the grossly unequal power balance in relation to general medical services. Huxley (1995, p.323) suggests that both workers and clients need protection from mainstreaming reforms and that the unequal power balance with general services has forced psychiatric services to adopt policies and practices that are inappropriate to the special needs of patients with a mental disorder. Most importantly, however, “mainstreaming has alienated people with mental illness from their own subjectivity by insisting, against many aspects of their own experience, that they are ill in the same sense that a person with kidney disease is ill” (Holmes, 2001, p.380). The funding attached to psychiatric services is now considered more part of general funds and Chief Executive Officers simply spend it on ‘politically’ more important areas or, areas where cost/benefit analysis places the service in a good light. This is not usually in programmes attached to psychiatry (Huxley, 1992; Healy, 1992). In view of all these effects, the confusion among mental health professionals as to their roles is hardly surprising. Clearly, operationalising a competency based nursing programme and nursing care itself under costing formulas are destined to fail. The two positions are antithetical (Pitman & Warelow, 2000;

Stockdale & Warelow, 2000) and are indirectly involved in many nursing staff across the gender spectrum, leaving the profession. It could be considered uncaring and unethical, however, to waste precious health resources on aspects of health care, which yield a low return in terms of higher quality and greater quantity of life. It is hard to see, how under either of these arrangements, that mental health and the choice of mental health nursing as a career pathway would be successful.

6.7 Is Deinstitutionalisation a Backward Step?

The sense of professional identity and the operational autonomy that went with being separate from mainstream medical services, the tranquil surroundings and comprehensive on-site mental health services that characterised stand-alone facilities, and the provision of services to people who had a mental health problem but who were not psychotic or at obvious risk of harming themselves or others, have been lost (Holmes, 2001). This is an interesting argument which suggests that there is and was some significant health care merit in the asylum system complete with stigmatising views that abounded by placing main stream psychiatry on the edges of metropolitan life both physically and geographically. What such a system provided was actually more akin to a true 'mental health' service than the 'risk-based psychiatry' forced upon us today by the need to restrict potentially infinite demands on an under-resourced system, despite the politically correct terminology which requires us to be called 'mental health nurses' instead of 'psychiatric nurses' (Holmes, 2001). Many of the people who found refuge in, and treatment from, the psychiatric facilities of the past would today not be considered sufficiently ill to gain access to professional services and, if we were to be accurate,

many of us have become 'mental illness nurses'. Not that there are no genuine 'mental health nurses' precious resources are indeed spent on preventive strategies and mental health promotion but, whilst this is going on, many seriously mentally ill people are left to sleep in shop doorways and roam the streets in rags, or sit alone in dingy rooms of boarding houses speaking to nobody from one month to the next except the person collecting the rent (or the persons welfare cheque).

The other side to these issues include the notion of an 'asylum', not being seen as a dilapidated Gothic warehouse or as an "architectural manifestation of the power of psychiatry" (Morrall and Hazelton, 2000, p.94) but more as a place of comfort and refuge, a retreat from the pain and confusions of everyday life 'in the community', and where professional help is readily available as perhaps (Fig. 3) suggests.



Fig 3

Coton Hill Asylum, Stafford,

Coton Hill Asylum was built in the 1850s and opened in 1854. It was originally built as an extension to the County Asylum in order to house private patients. It was to be known as The institution for the Insane of Staffordshire and the Adjacent Counties.

The hospital was built in a Tudor style on Weston Road, and features included its own chapel, cinema and dance hall, sports facilities, gardens, orchards for growing fruit and vegetables and farm.

The building remained until 1976 when, apart from the chapel and the lodges, it was demolished and the new District General Hospital was built on the site.

Holmes (2001) argues similarly, wishing for the retention and development of a service with a genuine mental health orientation rather than moving to one rationed on the basis of risk assessment, where people are turned away unless they are a direct threat to themselves or others. Sands' (2002) suggests that psychiatric triage is the new frontier of mental health nursing and argues that nurses must break the pattern of the past. It is difficult to argue with this, although to break the patterns of the past means we need to learn from them first.

Kingsley (2001) recalls a story from the place in which he practiced nursing

“... a particular female patient who had attempted to get psychiatric help from the local psychiatric hospital where she was known on several occasions on the same day. The triage nurse had briefly assessed this patient and had thought she was of no risk to either herself or the local community and was more likely to be an ongoing placement problem and probably a continuing management problem. She according to the triage team was not suffering from a psychiatric disorder but did have some personality disorder issues and so therefore didn't warrant admission (according to the triage nurse) to the hospital despite veiled threats about suicide. The patient continued to gain entry to the facility making a 'nuisance' of herself to the triage team. In fact became such a problem to the team that the team actually locked the prospective patient out of the facility, which is quite a turnabout for 21st century psychiatry”.

6.8 Nursing Education

Holmes (2001) speaks of the need of resources to provide a comprehensive service, but mostly argues the need for nursing staff in sufficient numbers, with appropriate skills and the ability to be able to retain these nursing staff for the long-term benefit of the service and its users. Holmes (2001) tends to weave his thoughts on the dominant position of the biomedicalisation establishment into his second concern which he feels contributes to the identity crisis, and this is his concerns about the education of nurses for work with people who have mental health disorders. Concern about the education and training of nursing staff has been highlighted by a number of commentators (Happell, 1996; 1997; 1998a;

1998b, Wynaden and Popescu, 1999a; 1999b; Wynaden, et al 2000). Reischel (2001) adds the dimension of training in respect of asylum care and for the purpose of this research some of his points set the scene for more recent practice. Reischel (2001, p.27) argues that care had changed in the 19th century, with the medical profession being instrumental in instituting training for mental nurses or “doctors creating nurses”. He suggests that for the whole of the 19th century in the Australian colonies, the care for the mentally ill was [now] based on [more] humanitarian principles, following the examples of Philippe Pinel in France (1745-1826), Daniel Tuke in England (1827-1895), and Dorothea Dix in the USA (1802-1887). The chains and shackles were removed. Sufferers were freed from gaols. As an aside, it is interesting to note that at the start of the 21st Century now that mental hospitals are closing that once again the gaols have become places where mentally ill people once again reside. Hospital environments were created, even though in many respects they were rather stark and primitive. Physical restraints in the form of camisoles or modified straightjackets, lock-on boots, head protectors, canvas mittens, were widely used. Medications were not available until the early 20th century, when bromide, chloral hydrate, and paraldehyde enjoyed popularity as a form of chemical restraint. The use of strong purgatives was still as popular as ever. These types of restraint were paraded as treatment options and together with the introduction of training were considered noteworthy and helped in persuading some of the general public into considering attendant/nursing work especially females. Despite the advent of different treatment options and the changing of the name from lunatic asylum to hospital the institution was very much the same, and these new treatments could not succeed without nursing care.

Reischel (2001, p.27) attaches the care of the mentally ill to the work of nurses who were specially trained. This training was arranged, according to Reischel, by “members of the medical profession who had become concerned about the development of a specialized nursing workforce”. He furthers this point in saying that in 1882, a Dr McCreery at Ararat stated:

‘An institution like this should be looked upon as a hospital for persons suffering from certain forms of brain disease. Nurses are required to tend, look after and nurse, and are not warders to guard as in gaol.’ In 1887, Dr Beattie-Smith while at Ararat Mental Hospital in Victoria, Australia recommended a plan to teach attendants, and insisted that they be provided with uniforms. It was Beattie-Smith who also initiated medical teaching at Kew Asylum in 1887 associated with Melbourne University. In the same year Dr O’Brien, Deputy Superintendent at Kew commenced lectures to male attendants on a voluntary basis. This move was strongly supported by Dr Thomas Dick, Inspector of Lunatic Asylums, Victoria, who insisted that lectures be compulsory. In 1889, Dr W C Williamson, MD, Medical Officer at Parramatta, NSW, presented a paper to the Intercolonial Medical Congress of Australasia on the *Training of Nurses and Attendants in Hospitals for the Insane*. In it he states:

‘The question of establishing some system of training for nurses and attendants engaged in the care of the insane in our asylums, is one of very great interest. The subject is an old one revived. Many years ago, close on half a century, the need of reform in the class, character, and education of persons entrusted with this responsibility was recognised. Curiously enough, though our coworkers in general hospitals have made trained nurses what they are, the honour of leadership in the ideas of nursing reform belongs especially to Drs Jacobi and Pinel, two alienists whose names will be forever held sacred as early pioneers in the humane treatment

of the insane. ... 'There has always been a difficulty in obtaining nurses for the right kind of service in our hospitals for the insane. Samuel Tuke, in 1841, describing the trying and arduous character of the work of caring for the insane, writes — "Can it be surprising if it be so difficult to meet with persons to fill properly the post of attendant on the insane, that instances of neglect or abuse so frequently occur?" ... Dr Kirkbride, in the United States, was commenting on the same trouble, and thus defines his conception of an ideal nurse — "A person of high moral character, of good education, strictly temperate, kind and respectful in manners, cheerful and forbearing in temper, with calmness under every irritation, industrious, zealous and watchful in the discharge of duty, and above all sympathetic with those under care. No wonder, the services of such an individual, after proper instruction in the performance of duty, would be invaluable." Nurses of this stamp, however, were not to be had, and I do not think there could have been much at this period to choose between the hospital and asylum pattern.

Williamson saw the value of a more specialised training for those who were to look after the mentally ill and that at times getting suitable people to work in this area had proven difficult (Smith, T. 1999, p.21). Reischel (2001, p.28) attempts more clearly than most to itemise what was involved in some aspects of this training stating that

... 'Dr Campbell Clark, of Glasgow District Asylum, Bothwell, began in 1881 (not without distrust of the result), a course of eighteen lectures to his staff, the subject matter thereof being apparently practical mental nursing, put into as simple a form as possible. The success of this departure was so marked that he ventured onto a second course of lectures, and again the result was most gratifying. The latter series embraced a wider field of teaching, and prizes and certificates were eagerly competed for at the examinations on the conclusion of the course. He stated, as a result of his somewhat varied experience — (1) That too great a barrier existed between officers and attendants; (2) That the mental and moral qualities of the attendants were not utilised as fully as they might be, and (3) That attendants require to be individualised as well as patients. ... We are becoming more and more fully impressed with the idea that the asylum of the future will partake largely of the hospital type.' Williamson goes on to say: 'In America, the necessity of reform in the nursing of their insane, had also been recognised, and for some years had occupied the minds of asylum Superintendents. In 1879, the plan of the McLean Asylum Training School was definitely determined upon. ... In February 1884, a subcommittee of the British Medico-Psychological Association prepared an official handbook for the special instruction of attendants, and since then a considerable amount of literature has been published on the same subject. ... I am glad to say that reform in this direction has not been confined to the few asylums already mentioned. In our own colony [NSW], Dr Sinclair has, at Gladesville, for the past two winters carried out complete courses of lectures and ward training, both for

nurses and attendants.’ He continues to emphasise the development of a nursing workforce: ‘I am inclined to think that in the past the medical officers have put too much faith in the means which they personally brought to bear upon the recovery of their patients, and have overlooked, or have not made sufficient out of the association of the nurse or attendant with the patient (a very insightful comment which tends to fly in the face of more recent commentary).

Williamson (in Reischel, 2001, p.29) suggests further

... If, as there is little reason to doubt, success in the treatment of our insane depends largely on the men and women to whom we confide the trust of our patients, and the fulfillment of our instructions, the necessity of providing the best possible type of nurse and attendant, and of training them thoroughly for their important duties, is evident.’

Reischel (2001, p.29) suggests that all who listened to the Williamson paper agreed that instructions for attendants and nurses were ‘...the thing at the present time in the further advancement of the curative agencies brought to bear on the insane, and ought to be carried out zealously...’

At the same congress Dr Eric Sinclair MD, raised the importance of the establishment of special training wards, in saying

...‘And now the need for improved nursing arrangements being recognised, it is evident that the nursing staff must have some more or less systematic training, to allow of their being able to carry out intelligently, ideas as to improved nursing. A course of lectures, demonstrations, and examinations, will do much to give this; but, unless supplemented by special training in a ward, moulded more after the style of a general hospital than most hospitals for the insane at present possess, it will not make the staff sufficiently good to effect a radical change in the nursing of the patients. I do not for a moment intend to have it understood, that training of nurses cannot be carried out without such a ward, or that the training when completed, will not be of value in its absence; but I do think, that the possession of such a ward will allow for the training being carried out to the pitch of perfection, impossible without it’ (Reischel, 2001, p.29).

Reischel (2001, pp.29-30) talks about some of these issues as being significant in the shift of thinking and practice between custodial and therapeutic nursing care. Lunacy, the state of being 'struck by the moon', was gradually being lifted from the realms of superstition and folklore. It slowly evolved as a medical speciality. The emphasis shifted from purely custodial care to remedial care. Traditional asylums gradually were transformed into hospital environments. By the beginning of the 20th century, the position had changed from gaols, to lunatic asylums, to hospitals for the insane. Lunacy was no longer a crime, but was now being regarded an illness. Medical, neurological, and microbiological discoveries, as well as the emergence of neuropsychology, greatly enlarged the medical speciality. At the beginning of the 20th century it was being realised that medical care had to be complemented with specialised nursing care to be of any value. Members of the medical profession employed in the lunacy departments of the Australian colonies, in the late 1880s, began the task of originating a nursing workforce through specialist training courses. Their aim was to create a remedial, ongoing nursing environment as an extension of medical care (Jones, 1972; Reischel, 2001). These advances appear to have been significant in adding a degree of respectability to the developing profession and went a long way to attracting more suitable candidates to the care of the mentally ill.

Clearly, Reischel's (2001) work is important here suggesting in the first instance that doctors, trained nurses and that the advent of training for nursing staff had indirectly been significant in the movement away from what might be described as custodial care to more treatment orientated and remedial approaches. The next section of his work adds another dimension to this change.

Taking Victoria, Australia, as an example, in 1952 there existed an approved establishment of 1760 nursing staff for the entire mental health services of Victoria, but only 1400 positions were filled. The shortage of nurses was so acute that some services were in danger of closure. The situation was made worse by the practice of “borrowing” nursing positions for artisans and sundry other staff. Many male nurses also preferred working as artisans because of better conditions and pay. So the actual mental health nursing shortage was greater than official figures suggested. The number of qualified mental health nurses remained very low. Two thirds of the nursing workforce in mental health were untrained ward-assistants. Most mental health nurses, up to the 1950s, were living in single rooms on the wards, sharing with their patients the most primitive conditions. Recruitment was affected by these circumstances, as well as by the low pay offered, and there were plenty of work opportunities elsewhere. But within a few years, modern, well-designed and neatly furnished nurses’ homes and hostels had been built in all hospitals. More nurses were persuaded to stay, and new recruits appeared. New style uniforms were provided. The next step was the updating of nurse training. This had been completely disrupted by World War II. Proper lecture facilities were non-existent. One or two human anatomy charts could be found and those were loaned between hospitals. Textbooks were not readily available to mental nurse students until the Office of Psychiatric Services imported the ‘red book’ *The Handbook of the Psychological Society of Britain, Scotland and Ireland* plus a small general nursing handbook in the 1950s. Students could buy both for 18 shillings (in the early 1950’s) (Reischel, 2001, p.50). The red handbook has its origins in Australia dating back to Williamson (1885). There appears to be a whole series of instructional booklets which are described as handbooks

which were produced by the hospitals themselves. This writer has encountered early copies of the red handbook used in Australia during the 1930s and 40s (see *Handbook for Mental Nurses* 1942).

The training of mental health nurses was also significant in regards to overall nursing staff numbers and the number of staff who showed interest in mental health nursing as a career option. The next points (Reischel, 2001, p.50) were significant in this.

Lecture attendance was not compulsory, but students had to clock up a minimum number of lectures before being admitted to examinations. Exams consisted of a six-hour written paper at the end of the first and third year, and a written plus oral exam in the second year.

By 1950, due to inquiries into mental health, the government had finally sanctioned the registration of mental nurses, and the Nurses Board of Victoria began the drafting of regulations to encompass the requirements of the training programme and the exam.

It is interesting to note that linkage between what happened in Britain and what happened in Australia are similar because the immigration policy in place between the two countries encouraged migrants to take up a whole array of employment including psychiatric nursing. The authorities felt they could use immigrants to fill positions within mental health facilities, which often meant using unskilled, and artisan labour. Added to this, the poor conditions, low pay structure and the unsavoury nature of the work continued to make it difficult to recruit staff. The administrators attempted to modify the training packages to complement or make psychiatric nursing a more appealing profession. Reischel (2001, p.51) offers some insight into these areas.

The legislative basis for the registration of mental nurses in 1950 was long overdue, although general nurses opposed it. Outdated views of a distant past, before the origin of more recognised mental nursing in the 1880s, were still being applied, quite ignorantly. Modern training of mental nurses began at approximately the same time as that for general nurses in Australia. The former was regarded as inferior, because it had been attached to the care of those who were mentally ill and this stigmatised relationship was problematical in getting people to seek career option in psychiatric nursing when in fact it was just merely different. Its main emphasis was on psychiatry, psychology, and psychoanalysis, but it included a comprehensive cover of general nursing care, hygiene and nutrition, infectious and fever-nursing; and included the care of the unconscious patient when deep coma insulin treatments became popular. Concessions for general nurse training had been granted for a select few mental nurses since 1931. Some mental nurses went across the border to New South Wales to get a general nursing concession there. During the 1930s depression, many general nurses in the private sector found themselves out of work and some joined the Lunacy Department. Reischel (2001) claimed that these nurses were instrumental in raising nursing standards, but it could be equally well said that they merely complemented mental nursing. The Nurses Board also refused these nurses registration as mental nurses. All were female; male general nurses did not come into existence until approximately twenty-five years later. Had these female nurses been registered, there was a chance that male mental nurses would also have gained access to the register.

In 1952 when Dr Eric Cunningham Dax, Chairman of the Mental Health Authority in

Victoria until 1969 outlined his plans to build psychiatric units associated with general hospitals, and suggested that general nurses should share their training facilities with mental nurses, little did he realise the deep gulf that still existed between the two (Reischel 2000). In 1945, the 7th Nurses' Board agreed in principle to the registration and representation of mental nurses, perhaps stimulated by a renewed interest in psychiatry, the establishment, in 1943, of the Diploma in Psychiatric Medicine at Melbourne University; and in 1944 the integration of the Mental Hygiene Department with the Department of Health.

The Board drafted a syllabus for mental nursing, and began the writing of regulations. Miss Jane Bell OBE, a most influential member of the Board, President of the Royal Victorian College of Nursing, an undisputed authority, steadfastly maintained that any specialisation in nursing must be post-basic to the general nursing certificate. The syllabus was never adopted. The Nurses' Act, 1958, established the Victorian Nursing Council, replacing the Nurses' Board. Its main functions were to hold examinations and appoint examiners, to issue or cancel certificates, determine special courses of training, and take proceedings against offences within the Nurses' Act. The Act was to ensure the maintenance of a high standard of nursing practice, and act as advisor to the Minister on all nursing matters. Agreement had finally been reached with the Mental Health Authority for a register of mental nurses (Reischel, 2001).

Had registration not eventuated at this time, mental nurses would, in all probability, have developed into a separate profession, dropping the title nurse, and adopting some other

suitable name (Reischel, 2001). A mental nurses' association did exist and could well have gained separate control and with the benefit of hindsight this may not have been such a bad option. Reischel (2001, p.52) recounts in a short narrative about the general feeling, which tended to pervade the view of mental health nursing not so long ago.

Some years after the Victorian Nursing Council had been established, at one Council meeting, a very kind, elderly matron of a general hospital came up to me in the boardroom and said: 'It is nice to have you here, but I must tell you we did not want you. We had to take you because of that new nurse's law. Nothing personal, mind you.' So there I was, an unwashed cousin. Of course, Matron was merely trying to point out the reluctance in the past to accept psychiatric nursing as a branch of the nursing profession. Psychiatric nurses were then still regarded as second-class nurses.

Psychiatric nursing has arguably played the role of second cousin to that of general nursing, and tends to have a lower status in the eyes of the general public. Many of the areas of discussion in this thesis go to the reasons why the general public hold these views and in short they are much to do with uncertainty, lack of knowledge, fear, concern, stigma and a whole array of beliefs which are mostly to do with conformity to social norms. The other side to this argument goes to the changing professional role of nursing generally and more specifically the sterling work done by nurses who selected psychiatry as a career option in the past.

Cunningham Dax (1979, in Reischel, 2001, p.62) refers to this point at a seminar on 'psychiatric nursing - past and present' presented at Aradale. Dax, remarked '...the most important change in the profession of psychiatric nursing over past years was its rise in esteem.' He added further that the exercise of initiative was something that the modern

psychiatric nurse was allowed, in contrast to the position 25 years ago. He further remarked that the great number of discharges from mental hospitals was largely due to the initiatives of the nursing staff. Comments such as these were few and far between, but were indicative of the changing face of psychiatry generally and psychiatric nursing in particular. Anecdotal evidence indirectly suggest that these more positive comments are of value to the profession as a whole and although small are numerically positive in attracting staff, especially males to the profession across the early 1970/80's and moreso in 2001 and 2002 (Nurse's Board of Victoria, 2002).

Reischel (2001) describes a whole series of changes in the workplace which were both significant to the professional profile of psychiatric nursing but also more importantly to the patients under the care of nursing staff. Integration was a major part of the process of "normalisation". Normalisation is described as "the process of helping people with a mental illness meet their needs by living as much as possible like other members of the community with access to appropriate housing, a home like atmosphere in which to live, and with access to the same facilities and services as everyone else. Its introduction to Victoria, Australia was brought about by the gradual trend toward deinstitutionalisation, the discovery of psychotropic drugs, and libertarianism of the 1960s. It began in the 1970s and appears attached to the concept of mainstreaming (Clinton and Nelson, 1996, pp.10 11) when hospitals set out to bring about the following changes

- gender mixing of patients
- gender mixing of ward staff
- combining nursing administrations (male/female sides to psychiatric care)
- shedding of outward symbols of authority
- wearing non-uniform like clothing.

All of these issues were significant in their own right, shifting the way psychiatric nursing was practiced and of course within this shift the way patients were nursed. Patients already had the opportunity to mix at various places within the hospital such as the canteen, at church services, hospital dances and outings. Now the geographically isolated male and female sides of the hospitals were mixed, with respective wards side by side, and where possible mixed. Adjacent doors were unlocked during the day and men and women could intermingle (Reischel, 2001, p.62).

6.9 Staffing Policies

Similarly, the single gender staffing policy was changed from that of a completely separate administration for male and female nursing staff. Female nurses could work in male wards and vice versa. This was not achieved overnight, but took time. It met with difficulties because so many old traditions had to be overturned. Staff uniforms were abolished as much as possible, except that gowns were worn for clinical bedside work. Well before the normalisation drive was announced, nursing schools had discarded uniforms in favour of civilian dress. This was criticised by some matrons at the time who saw it as insubordination to their authority. After all, the nursing profession was still conducted along para-military lines, with every member decked out with respective symbols of rank. Female students wore little starched caps, sisters wore white starched veils, and matron's large veils reached down to the waist at the back. Males wore epaulettes with coloured stripes denoting a respective rank on their white coats. Nursing schools and mental health nursing were the first to dispense with nurses' uniforms and to advance to civilian standards of dress without any rank symbolisation, students setting

the example (Reischel, 2001, p.63; Holmes, 2001).

Similar to the ward staffing changes classes were co-educational. This was in contrast to general nursing schools where male students and they were a rarity then, were barred from attending lectures on the reproductive system. In psychiatric nurse training there was no room for such prudishness (Reischel, 2001, p.63). This statement stands as testimony to the difference between general and psychiatric nursing. The differences referred to above go to several points in the next section, in which Reischel points out what he describes as the “emancipation” of mental nurses, which he credits to a Muriel Yarrington. Yarrington was a general and psychiatric nurse who had worked in both England and Australia. The Mental Health Authority appointed her Nursing Liaison Officer, and she also joined the Psychiatric Nursing Working Committee of the Victorian Nursing Council. Yarrington later became an examiner in psychiatric nursing, and was described by Reischel, as the ultimate psychiatric nurse and teacher. The emancipation of mental nurses that had been started in Victoria by Muriel Yarrington, gained a foothold in other parts of Victoria. The self-esteem of mental nurses began to rise. Before, many of these nurses had avoided such questions as ‘What do you do for a living?’ White lies were often offered by those too shy to tell the truth. The new NursesAct, 1958 had begun to improve the status of psychiatric nursing and Yarrington’s personal approach paid dividends in terms of attracting staff (male and female) to the profession.

6.10 Paradigm Change

Chan and Rudman (1998, p.144) believe that current trends in nursing education are

undergoing a paradigm change because of the gendered nature of professional knowledge. They argue that because nursing is commonly perceived as a female occupation, with the corresponding adoption of stereotyped female values such as self-sacrifice and servitude, nurses invariably go on to develop a self-defeating and apologetic nature in their interprofessional relationships. Further to this, nurses may be exhorted to adopt a 'male' paradigm in order to gain academic credibility and social status or be seen to be, and accepted by the profession as, caring. This research argues that males appear able to adopt a feminine side/role to their repertoire of skills (soft masculinity) and females by adopting some of the masculine characteristics (hard femininity) appear to have more success in career advancement and add a valuable dimension to their nursing skill base.

More recent transfer of nursing education into the higher education sector may represent the adoption of 'male' definitions of knowledge, so apparent in the ivory towers of academia which may, however, fail to acknowledge the caring dimension so valued by the users of services and the profession of nursing as a whole.

The number of people entering psychiatric nurse training was always much lower than those entering general nurse training. The male to female ratio in psychiatric nursing was higher since, in general nursing, male nurses were almost non-existent. In 1973, in Victoria, there were 290 students in psychiatric nursing, compared with 5096 in general nursing. The number of trained psychiatric nurses was comparable to that of mothercraft nurses, approx. 1350. There were approx. 24,000 general nurses registered.

Equal pay for male and female psychiatric nurses was granted by the Victorian Public Service Board after the Hospital Employees' Federation No: 2 Branch (HEF2) had lodged a successful claim on the basis that males outnumbered females. It resulted in a flow-on to general nurses, who had been declared a female-only industry and, much to their protestations, were not eligible for equal pay due to the infamous clause 9 of the equal pay legislation. By arguing that psychiatric nursing was part of the nursing profession, the general nurses' claim was strengthened and eventually won.

The reasons for including the above points are twofold. Firstly, psychiatric nursing in attracting more males than females are much more likely to be politically proactive, more aggressive and forceful (Connell, 1983; 1987; 1995), more likely to be internally driven to provide for their family (all male gender markers) and less likely to be dissuaded by ethics in regards to caring (female gender markers) for their patients. Secondly, psychiatric nurses have been traditionally regarded as militant and more industrially motivated in relation to striking a fair deal in terms of pay and conditions of employment for their members. An additional point was that males were paid more for their psychiatric nursing services in comparison to females and also, psychiatric nursing was remunerated better than its general nursing counterpart (Nolan and Hopper 1997; Nolan 1993). These circumstances are perhaps a metaphor for the gender problem.

Reischel (2001, p.65) refers to these points in saying that the industrial officer from the HEF2, rang him stating that

...he had lodged an equal pay claim with the Public Service Board (PSB), and could he be so kind to attend, bringing with him some supporting evidence regarding nurse

training. Reischel recounts collecting just hard facts, keeping the submission clear of any lengthy preambles, position statements and devoid of any waffle. Those facts took up a mere one-and-a-half pages. Points such as: female students have to pay the same examination fees as males, the same registration fees as males, incur the same costs on consumables, plus the fact that there were more male students in the courses in Victoria over the last ten years, and therefore it was a male dominated training scheme, and so on. The claim was heard and proved successful, and psychiatric nurses both male and female would be paid equally from that point on.

The reason for mentioning this at some length is because of the uniqueness of the case compared with similar cases today. There was no lengthy committee involvement, just a phone call or two; no protest marches up and down main city streets with loudhailers, no signed petitions, no position papers, and no judicial redress of any sort. Charitable concessions traditional for nurses in Victoria such as discounted footwear and clothing, heavily discounted train and bus travel, free theatre passes, hostel accommodation, discounted canteen meals did not make it any easier for them to gain overall equitable wage justice. Nurses had difficulty convincing others that they did not want to continue to live on charity, although their meagre pay in the past had led to it in the first place. Organisational representation of mental health nurses has a history of being fragmented. In Victoria, the Hospital Employees Federation No2 (HEF2) represented nurses industrially at the Public Service Board together with all other hospital workers. As a consequence, nurse members sometimes had to take a back seat. The Royal Victorian College of Nursing pledged professional representation, but not industrial representation because of a gentlemen's agreement between the Royal Australian Nursing Federation, Victorian Branch (its industrial arm) and the HEF2. Nurse educators were not represented by HEF2 initially. The Royal Australian Nursing Federation declined industrial representation, and the Public Service Union welcomed membership without

representation.

Joan Christie, a former nursing adviser, Mental Health Authority, highlights aspects of this point in saying

...there appears to be an increasing body of agreement with the idea that it is not exclusively, or even primarily, the psychiatrist who is responsible for the recovery of the mentally ill. In Victoria we now have a therapeutic team concept. Mental health nurses, occupational therapists, social workers and psychologists are no longer adjuncts to treatment, but held just as central to the patient's improvement as the psychiatrist (1974).

Pauline Stockdale, Registered Psychiatric Nurse, writes in the same journal about 'The Situation Today':

'Psychiatric nursing is primarily concerned with interpersonal interactions and only secondarily with nursing procedures, medications and treatment. 'Today the psychiatric nurse is an accepted member of the psychiatric team. S/he is actively engaged in all treatment decisions and programs, with emphasis on nurse-patient relationship therapy, family therapy and community nursing follow-up services. 'New techniques in psychiatric nursing emphasises the importance of the personality and behaviour of the nurse as a factor in therapeutic interaction with patients.'

It is different today, but the issues are similar. The shifts in the early to mid 1970s to psychiatric nursing in the early 21st century encompass many of the same features. Recruitment and retention in relation to the growing number of people developing mental health problems, where best to deal with mental health issues with deinstitutionalisation having already taken place and with the onset of mainstream care in public hospitals which stretch limited resources. It is difficult to suggest the best way forward with these points in mind. To train, educate and retain the workforce with suitable salary entitlements may prove difficult. Many of these features were similarly problematic at the

onset of psychiatric nursing in Australia and the attendant days at Yarra Bend.

6.11 Comprehensive Training

In Australia, there have been very significant and poorly thought out changes to the ways in which psychiatric nurses are recruited and trained. The trajectory of these changes was sealed over 20 years ago, when professional nursing organisations expressed support for changing to ‘comprehensive’ courses located in the tertiary education sector. This included support from the only professional organisation specifically for psychiatric nurses, the Australian Congress of Mental Health Nurses, which endorsed in 1977 ‘the principle of basic comprehensive training’ (Creighton and Lopez, 1982, p.107). In New South Wales, this principle was discussed again early in 1979 by the Minister for Education and the Nurse Education Board, and a committee was established to examine and report on the implications of introducing comprehensive training. In its report, colloquially known as the ‘Pink Report’ because of the colour of its cover, the Committee was ‘unanimous in its support for the introduction of comprehensive courses as the usual way of preparing nurses for registration to function in the health care facilities of New South Wales’ (Grimshaw, 1980, p.57). The most telling comment in the Pink Report, however, concerns the rationale for this position, namely that ‘it is the lack of skills in these areas on the part of many nurses on the general register that is behind the push for a more comprehensive preparation’ (p.30). In other words, comprehensive courses were needed not in order to benefit, improve or bolster psychiatric care, but in order to address what were described as inadequate psychological skills in general nursing, and it was this that was driving the agenda for the reform of psychiatric nurse

education. With the benefit of hindsight and with the passage of time many nursing commentators are now critical of decisions made some twenty-five years ago (Happell, 1996; 1997; 1998a; 1998b; 1999; Clinton, 2001; Holmes, 2001). Within the context of this research no mention was made in the Pink Report about gender issues related to workforce. Its absence is interesting, bearing in mind the historical predisposition of males to work in the psychiatric area in the past.

Similarly, the National Review of Nursing Education Discussion Paper (2001) suggests there has been considerable change mostly across the last 20 plus years, and the discussion paper outlines some of these areas within the context of the review process. One of the most substantial areas of concern is the concept of comprehensive educational preparation for student nurses. The Australian experience, like so many other issues in nursing generally and psychiatric nursing in particular, tended to follow the leads offered by overseas experience, especially those in the United Kingdom and America. Point 1.1.2 in the Pink Report (1980) states that

...It has been the custom in countries where the nursing service of the United Kingdom has been the model followed, that the first preparation for varied fields of nursing (such as mental retardation, psychiatric nursing, general nursing) has led to the nurse's name being placed on the appropriate register.

The Pink Report (1980, p.1) suggests that “the range of registers has varied over the years, and [now] there has been a trend for nursing [staff] to undertake double or even triple registrations, when they [had] felt that the preparation they had undergone for their first registration was not ‘wide’ enough”. Further to these points was the disclaimer contained within point 1.1.3 which highlights the concern about the considerable overlap in the skills and knowledge required for the different registers would indicate that

multiple registrations means there has been considerable waste of teaching/learning time, staff facilities, and money. Little attention is paid to the individual skills learnt under the old regime, in which a depth of understanding could be expected. This depth of understanding was used to benefit patient care and treatment options, and was usually founded on the back of a solid grasp of the topic, which sometimes is not the case under today's comprehensive preparation. Point 1.1.4 (Pink Report, 1980) touches on, rather than addresses this point in any significant depth, by saying that "a comprehensive educational preparation gives clear evidence that within acute general hospitals the psychosocial needs of many patients are not [being] met".

The topic of gender is not seen as an issue by any of the reports available. At times it is noted that the ratio of males to female nursing staff being recruited in the overall workforce in nursing is problematic but generally the supply and demand situation in nursing is paraded as being fairly healthy. The problem would appear to be that the retention rates of qualified nurses who chose psychiatric nursing and stay in this professional area is a major issue. The comprehensive degree programme has staff mobility as one of its rationales/benefits where staff across the gender spectrum can chose other areas more readily should they not be happy with their initial choice. Similarly, multiskilling was one of its perceived benefits where graduates would be able to nurse in a variety of different areas of practice and have a knowledge base to service the requirements of each area. This always sounded appealing but when applied to the clinical field anecdotal evidence suggests it has never really worked.

Nurse X sounded as though she new what she was doing, apparently she's got three registrations, but she's hopeless ...cannot apply it to her practice (Kingsley, 2001).

6.12 Summary

This chapter has examined the last twenty-five years to understand the significance of gender to psychiatric nursing across this time span. Within this examination it has looked at some historical antecedents which have been influential to the thesis topic. The chapter has looked at gender as a prerequisite to employment, the media portrayal of psychiatry, recent changes to the care of those considered to be mentally ill, deinstitutionalisation, more recent changes to nursing education including the introduction of comprehensive nursing courses the interplay of gender issues across these areas and the closure in Australia of psychiatric nursing in its own right. The history of psychiatry and the developing role of the mental health nurse are difficult to fully encompass in a single chapter. The intention in examining these two topics in some depth and the switching back and forth between the history and more recent developments is to preface mental health nursing allowing us to look back from the vantage point of the present.

The next chapter looks at some of the emerging tensions and examines gender and Australian nursing issues taking a closer look at some of the themes and tensions which have emerged.

CHAPTER SEVEN

GENDER AND AUSTRALIAN NURSING EDUCATION

7.1 Introduction

This chapter will examine some of the themes, which emerged in the previous chapter, which examined issues of gender in psychiatric nursing. One of the major themes that proved significant was the introduction of changes to nurse education and training. This chapter will examine education and gender perspectives which are significant in the move across to the tertiary sector.

7.2 Moving to the Tertiary Sector

Before the Committee of Inquiry into Nurse Education and Training (1978) chaired by Sax most Registered Nurse preparation took place in hospitals, although even at that time there were some university courses. Between 1974 and 1983 a range of national pilot programmes set the climate for New South Wales (NSW) to commence sixteen programmes for the education of Registered Nurses in tertiary institutions. These NSW programmes were the forerunners of a 1983 shift from hospital-based training of Registered Nurses in NSW towards what are now university-based programmes. In 1985, compelled by the NSW example, the Federal Labor Government, with the agreement of the States, legislated to transfer all pre-registration nurse education programmes over to tertiary education (Degeling, et al, 2000). At the time, nursing moved into the Colleges of Advanced Education, with the standard qualification being a three-year diploma. The transfer was staged and completed by the end of 1993. The change from hospital-based to tertiary education was made in order to produce ‘a more appropriately educated, flexible

and career oriented Registered Nurse (Department of Community Services and Health, 1990, p.1).

A study by Holroyd, et al (2002) touches on some of these points suggesting that sex-role stereotypes and gender stereotyping in nursing are significant in determining status and the channelling of people into particular occupational roles. Most courses offered within the university curriculum do not discriminate on the basis of gender, with personal interviews not being required to get selection to an undergraduate nursing course. Many secondary school students look at options across the helping professions and behavioural sciences and often select nursing on the basis of their entry score when other options are not achievable. Holroyd, et al (2002, p.295) argue that sex role stereotypes affect the performance of certain occupational roles with some roles being seen as more appropriate for one or the other gender, for example “the feminine characteristics of passivity, receptivity, nurturing and caring in nurses and the male characteristics of aggression, dominance and ambition in the armed forces”. Similarly, gender stereotyping in nursing has meant, “nurturing professions [have] become unattractive to males relative to available alternatives” (O’Heron & Orlofsky, cited in Holroyd, et al, 2002).

Understanding why the shift to the tertiary sector occurred is important to any discussion of the emerging issues in nursing education. In theory, it opened up the nursing profession to more males who may now consider nursing as a more legitimate career option with its curriculum based in tertiary settings. The Australian Tertiary Education Commission Committee of Inquiry into Nurse Education and Training (1978, p.4) listed

the following arguments for a move from hospital-based training:

- the changes in healthcare needs and in systems for supplying health care services;
- the rapid expansion of knowledge and technology;
- the perceived inadequacies of the traditional hospital programmes in meeting the healthcare needs of society and the educational needs of students; and,
- claims that education in a multidiscipline college confers advantages on both students and society.

When elaborating on these reasons, the Committee identified a need for nurses to have knowledge of new technologies, and the behavioural sciences, due to their involvement at crisis points in peoples' lives. They also argued that nurses should be involved in community education for the maintenance of health and the prevention of illness. Other issues of concern at the time were the high levels of wastage from hospital training and the tendency for employment needs to override the educational needs of student nurses. Although many of these reasons sound idealistic, foundationally they were quite sound. Once again, anecdotal evidence from students undertaking the course locally suggest that the elastic and blurred boundaries of psychiatric nursing practice where nursing practitioners need to be skilled in many different areas become problematic for some. In line with this research, the movement of nursing from hospitals to the tertiary sector is seen as representative of movement from the traditional female domain to that of the male. Similarly, the very notion of science conjures up a gender issue since science, knowledge and technology are constructed within masculine paradigms, just as, university settings are, and is more highly valued than treatment or care which are constructed within feminine paradigms and which acquire the lowly status of "women's work" (Overfield, 1987).

7.3 A Comprehensive Course

The Registered Nurse comprehensive course was designed to educate nursing staff who could begin practice in many different nursing areas, in essence to prepare and blur the differences between the psychiatric and general nursing registers. With this in mind, the term multiskilling entered nursing discourse and despite some of its drawbacks one can understand that it does have some place in the overall provision of health care, particularly in mental health. Multiskilling, it could be argued is the application of skills which allow practitioners to practice across a range of different clinical areas and provide a number of different roles which would include mental health. Similarly, multiskilling in mental health could be extended to incorporate the skills which would be more commonly attributed to other disciplines and skills usually attributed to either the male or female gender. This would allow psychiatric nurses to explore the care continuum from a wider perspective (Jones and Norman 1998 p27). Some argue this differently (Clinton and Hazelton 2000c), suggesting that the comprehensive nursing programme which includes multiskilling could actually be detrimental with practitioners being less skilled overall because the Registered Nurse completes their undergraduate degree and is able to practice as a beginner in an array of different clinical areas including psychiatry. This could suggest that graduates have a little knowledge about everything but an in-depth knowledge of nothing. With the benefit of hindsight and in regard to psychiatric nursing recruitment and retention, this has been troublesome and problematic both in Australia and overseas.

There was also an interest in developing a more professional approach to nursing, one

that would drive up the pay and status of nursing. Arguments such as these are generally attached to the militant persuasions of masculinity where fulfilling the breadwinning role related to family life prompts ordinary low/middle class workers to stand up and have their say about their employment conditions. Similarly, with the advent of feminism, the choice of single sex relationships, the higher divorce rates, different birth control measures, the more casual defacto/spousal relationships and the changing gender mix across nursing and by the slow incorporation of the usual gender markers of the other gender nursing (from a female perspective) is becoming much more militant. This militancy has shifted the definitive poles in relation to nursing issues which used to separate the genders. A more gender neutral (see Holyoake (2002 p35) arrangement in nursing is beginning to occur because of these factors. Gender neutral is of course rather deceiving bearing in mind this research which suggests that people can adopt different gender markers and gender markers usually associated with the other gender.

Attaching nursing to university curricula has moved the status of nursing alongside that of other professional disciplines across health care teams (Warelow, 1996a). This is interesting because if one accepts the argument that nursing is predominantly female and that universities are products of a masculinist view of the world, then the introduction of nursing to universities shifts the status quo somewhat and tends to even the playing field within nursing, nursing discourse, the sexual division of labour and the bipolar divisions articulated/depicted about gender.

Some commentators argue this issue differently with Holmes (2001) and Happell (1996; 1997; 1998a; 1998b) both expressing concern about how comprehensively trained nurses

from the university system translate their newly acquired skills to clinical practice. This translation, according to Happell (1996), revolves around new graduates lacking prerequisite confidence and competence levels of beginning practitioners, an issue mostly attached to female graduates who feel theoretically prepared but lack confidence to practice because they often feel afraid. This often excludes females from choosing postgraduate options in psychiatric nursing.

The newly acquired skills required to practice from a comprehensive standpoint in all of the areas contained in the undergraduate degree programme would require that programme to be at least seven or eight years in duration. To increase the psychiatry components of the undergraduate programme would be difficult because programmers of the undergraduate curriculum would wonder what they should take out to include the increase to psychiatry. A postgraduate option would be more viable, as the costs as well as other areas would be largely prohibitive.

Holmes (2001) suggests caution feeling that in the future we may pay a costly price for some of the inadequacies the profession is propagating today. He argues about 'demolition by neglect' were the required care and the financial costs of such care are shifted to families and that instrumentally psychiatric nursing care is not seen as important within comprehensive university programmes and that those who hold the purse strings tend to see psychiatric nursing as more a "common sense" approach which can be taught by anyone. A common sense approach from a clinical nursing perspective is according to the literature Dominelli and Gollins (1997; Walsh 1997; Miers 2002)

usually associated with female gender qualities whereby a more “hands on”, caring, compassionate and gentle approach to clinical practice are seen as useful and prerequisite to good basic nursing care.

Happell (1997; 1998a; 1998b), drawing on her experience in the tertiary sector, wonders about the choices students are encouraged to make from engagement in comprehensive programmes. Happell (1996; 1997; 1998a; 1998b) believes that most students’ tend to adopt the romanticised notions of nursing (‘I became a nurse because Mum was...’) offered by the media in relation to paediatric or emergency departments. This suggests that undergraduate nursing students hold preconceived ideas about the most desirable areas in which to practice nursing following graduation. Wells and McElwee (2000, p.13) suggest that dedicated studies and careful impact statements be undertaken to differentiate the obvious differences between psychiatric and general nursing and also the different nature of the candidates. They imply that the attitudes, and therefore the gender, of young people toward those with mental illness are so important for their impact on recruitment. Mental health nursing, according to Martin and Happell (2001, p.116), is clearly located at the least popular end of the scale as they progress through and complete their comprehensive programmes. Muldoon and Reilly (2003, p.94) suggest, “all student nurses have similar career aspirations – they are hoping to become nurses. In practice, however, certain nursing specialities are likely to be viewed as more or less attractive by women and men. Areas such as midwifery, paediatric nursing and care of older people tend to be regarded as largely female domains. Conversely, critical care, psychiatric nursing and teaching tend to be viewed as appropriate for both men and women”. The

gender arguments surrounding the choice of these specialities suggest that caring would need to be involved in all of these areas but importantly, midwifery, aged care and paediatric nursing all have a mothering, more feminine component to them. Critical care, psychiatric nursing and teaching conjure up different images in the minds of the general public and tend to be associated with men and masculine roles (Muldoon and Reilly 2003).

7.4 Nursing Education in Australian Universities.

The 1994 review of nursing education had as its key objective the assessment of whether the transfer of nursing and nursing education into the higher education sector had resulted in wider and therefore better professional preparation and career choices for nurses. The scope of the 1994 review included many issues in common with those of the present 2001 review, but it did so in a different context, since universities have now had time to consolidate nursing as a discipline and develop some research strength and scholarship. Similarly, Australia can also look to international trends relational to nursing education, in which there has been a shift towards a tertiary-based model in Scandinavian countries, Canada, the United Kingdom and Ireland. Australia has been at the forefront of this shift and is generally regarded as one of the leaders in nursing education (NRNE, Discussion Paper, 1994, p.36). The story is more mixed in the United States of America. The following brief overview of the developing nursing preparation arrangements in a number of countries provides some insight into the international context most significant for Australian nursing (NRNE, Discussion Paper, 1994, pp.36-37). The apprenticeship versus the tertiary model is interesting because, aside from the modes of teaching, each added

another dimension to the gender aspects of nursing in that nurses under the tertiary system are “no longer employees when they first begin their training”. This means that students are not employed by the training hospital as they were under the apprenticeship model whilst they undertake their full time degree programmes and so the ‘full time’ nature of the course requires them to either undertake other employment to support themselves and their families along provider lines and this may be preclusive to both genders, but more so to males, as this is usually associated with the role of the male, although in light of earlier argument this becomes difficult across the genders.

7.5 United Kingdom and Ireland

In England, the Briggs Report (1972) recommended the establishment of an independent system of nurse education to cut the nexus between nurse education and the staffing needs of hospitals. The committee argued that the preparation of nurses using an educational model would improve the clinical content of the nurse education curriculum. In 1986, the British Government supported a phased transfer of nursing education into the tertiary education sector with the first diplomates appearing in the mid 1990s (Degeling, et al 2000). Under ‘The Project 2000’ scheme this transfer continues. These arrangements provide new nurses with a diploma level qualification. Wales, Scotland and Northern Ireland have had degree programmes for nurses running in tandem with hospital training for many years. From the 2001-02 academic year, Wales only offer degree programmes for nurses, and Scotland plans to have only degree programmes by 2005. The system of nursing preparation has been a focus of considerable recent policy debate, and a new structure is being implemented for the regulation and management of nursing in the

United Kingdom (NRNE, Discussion Paper, 1994, p.36). Once again, despite some glowing reports by those instrumental in these changes from hospital to university based training, anecdotal evidence (NRNE, Discussion Paper, 1994, pp.36-40) suggests that neither the transition nor the eventual result are grasped with open arms by the nursing staff on the shop floor.

In Ireland, the 1998 Report of the Commission on Nursing recommended that pre-registration nursing education be based on a four-year degree programme, incorporating one year of employment, with structured clinical placement in the health service. It recommended that pre-registration nurse education be fully integrated into the third-level education sector. This new degree programme began at the start of the 2002 academic year. General nursing, psychiatric nursing and mental handicap nursing developed as separate streams in Ireland, and the Report recommended that three discrete programmes for general, psychiatric and mental handicap nursing be retained. An advisory board has been established to provide advice and set directions in relation to the development of specialist nursing and post-registration education programmes. From the point of view argued above many would advocate for these discrete options finding that the current system is not satisfactory and significantly different from the original prototype, as funding has been chipping away at the process and taking away from the original intention.

7.6 United States and Canada

The United States of America (USA) has a less uniform approach to models of nurse

preparation. Arrangements vary from state to state and this is problematical for both the profession and for students who may wish to travel or move states within their educational preparation. There is still some preparation of Registered Nurses in hospitals in some States, among these Pennsylvania, New Jersey and Ohio, but hospital sponsored diploma training programmes provided less than 10 per cent of new nurses in the USA in 1998 (Aiken, 1998). Programmes producing Registered Nurses include baccalaureate programmes, associate degree programmes and diploma programmes (Fagin, 1997). There is currently evidence that hospitals are selecting nurses with baccalaureate preparation over those with associate degrees (Heller, et al 1999). While it is difficult to categorise nurses in America, they can be described as falling into three main groups: practical/vocational nurses, registered professional nurses and advanced practice nurses (NRNE, Discussion Paper, 1994, p.36). A significant point about nursing in America related to mental health is that psychiatry is a postgraduate speciality. This means that psychiatric nurses are often considered more high status as they can be the first point of contact and in some cases the sole primary healthcare provider as is often the case in remote areas of Australia (NRNE, Discussion Paper, 1994, pp.85-6). They are often Masters graduates and because of this would be very costly to employ for health service providers.

Canada has a mixed model for the preparation of Registered Nurses that involves community college and baccalaureate programmes. The former programmes were instituted in the 1970s and were originally two-year diploma programmes. In 1999, the Nursing Task Force recommended to the Ontario Government that beginning in 2005 the

minimum entry-to-practice requirement for new Registered Nurses be a Bachelor of Science - Nursing (BScN). The Task Force also recommended an increase in the length of preparation for Registered Practical Nurses from three to four semesters (Ontario's Report of the Nursing Task Force, 1999).

7.7 Education and Training Institutions

Universities and training institutions both government and non-government have a key role in defining the discipline and profession of nursing. They perhaps also engage in the development of nursing as an evidence-based profession with this view becoming more acceptable although some consider aspects of evidence based practice as problematical, with French (2002, p.255); Feinstein and Horowitz, (1997) and Hunter, (1998/99) suggesting a cautionary approach should be adopted as the subjectivity of evidence based practice tends to dislocate the research process from the quality assurance processes in nursing at the practitioner level, leading to disenchantment (French, 2002, p.256). The recent changes in responsibility for the initial preparation of nurses recognises the need for high levels of expertise combined with breadth of education, and the articulation of nursing with a range of careers, professional and semi-professional (NRNE, Discussion Paper, 2001 p.35).

Evidence from Price, et al (2001) demonstrates that due to funding cuts and the rationalisation of educational profiles there is an inability to attract quality teachers of mental health nursing to academic positions. Australian universities, despite their achievements in developing nurse education and related research, are less than successful

in preparing undergraduate nursing students for their role as beginning practitioners of mental health nursing as clearly outlined in *The Education and Training Partnerships in Mental Health* (1999). This appears to be similar across postgraduate mental health courses as the take up rate of postgraduate places in mental health nursing courses is also inadequate to meet the future needs of specialist mental health services. *The Education and Training Partnerships in Mental Health* (1999) argues that workforce education and training, a reform of the way services are delivered, the development of intersectoral partnerships and the increasing role that consumers and their carers play in service delivery will all be significant and need to be taken into consideration. Some of these points are also addressed within the *National Review of Nursing Education, Discussion Paper* (2001), published some two years later indicating that “the future directions” of mental health issues are still at the “crossroads” referred to in the earlier publication. These overarching principles suggest that university based courses are inflexible and assume that the provision of psychiatric nursing across what is an essentially general course will attract the numbers of quality staff members required to fill speciality positions in psychiatry. The staff members who attempt to offer quality teaching and learning in these speciality areas are quickly burnt out by lack of financial support, large workloads, the financial difficulty associated with providing quality supervision for undergraduate students and the ability to place students in quality clinical placements across a shrinking deinstitutionalised nursing environment (Clinton, et al 2001; Warelow, 2001).

7.8 Postgraduate

Postgraduate education in mental health nursing also needs significant rationalisation and

reform; and attempts to involve universities and health authorities within partnerships to deliver courses in mental health nursing have not been entirely grasped or successful. Anecdotal evidence suggests that some aspects of any partnership arrangement are “driven by finances rather than by quality educational experiences” (Kingsley, 2001). Similarly, the more common usage of the term ‘mental health’ rather than ‘psychiatric’ gives the exercise a different perspective. It is noteworthy that postgraduate options are more readily taken up by mature age students with a higher proportion across small numbers studying postgraduate psychiatry aged between 35-55 years.

“...Its just bums on seats, most of my psychiatric clinical placement was working with the oldies rather than those that are really mentally ill, psychotic and all that ... they are not really interested in us” (Kirby, 2001).

The mental health components of the undergraduate course deals with many of the psychological aspects of illness and the nurse’s role in responding to these psychological difficulties/distress. Many of these areas appear to have little to do with serious mental disorder, which of course were the traditional concerns of psychiatric nurses. The gender of nursing staff could be significant in this as perhaps females are more attracted to helping relieve psychological distress but not so keen on dealing with lunacy (Rallis, 1990, p.160; Boughn, 1994, pp.410-11; Evans, 1997, p.226).

Other noteworthy findings of the review included the increasingly stressful and difficult nature of mental health nursing practice, especially as a consequence of recent changes in mental health practice across the last twenty five years, changes to the Mental Health Act (1986), the need for mental health services to move away from paternalistic or user lead models of delivery; the need to develop, recognise and support recent movement toward

individual nursing practitioners, and the inadequacy of planning and development of the mental health nursing workforce (*National Review of Nursing Education, Discussion Paper*, 2001). If we view mental ill health as illness, which comes under the authority and increasingly large umbrella of medicine, then we become subscribers to the view that medicine is in control and therefore psychiatric care may be paternalistic and nurses will assume roles that are compliant and subordinate. Within multidisciplinary teams, team leaders are usually male and doctors assuming this role in respect to their position rather than because they are the best person for the job (Warelow, 1996a). Generally, nursing accepts this position although some commentary (Stein, 1967; Stein, Watts and Howell, 1990) argue that nurses often play games to keep the peace and maintain some degree of harmony across the health care system. Nurse Managers appear quite comfortable to take up staff of either gender on a 'who they can get' basis, when looking to employ nurses to psychiatric nursing positions. This is often at the expense of selection on a skill requirement basis. The employment of specific gender is only a factor when 'special' nursing arrangements are required for example in 'high dependency' and for 'specialising arrangements'.

7.9 Rhetoric versus Reality

Happell (1996; 1997; 1998a; 1998b) discusses the promise of tertiary education in relation to psychiatry, and how the comprehensive nature of the tertiary course does not encourage students to work towards psychiatric nursing as a career option. Happell (1997) suggests that psychiatric nursing is in crisis and that the generation of comprehensive training options has not persuaded significant numbers of students of

either gender, to undertake psychiatric nursing as a career choice on completion. Happell (1998a) notes that students' career preferences are still for general areas such as paediatrics, mothers and babies, and acute areas such as accident and emergency, and intensive care. Some commentators such as Wynaden, et al (2000) and Holmes (2002) suggest that the university system has always known that the mental health components of the comprehensive undergraduate degree in nursing are inadequate (Wynaden and Popescu, 1999a; 1999b) and have been/remain reluctant to do anything significant about this problem. Like the universities, many of the nursing registration boards appeared to know that the mental health component of the comprehensive degree is problematical. Holmes (2002) argues that any registration board which did try and promote more mental health components into their comprehensive undergraduate degree, would be strongly resisted by the universities. Holmes (2002) suggests that within the mainstream general hospital system there is an underlying philosophy, which does not want the degree course to contain more mental health content, but rather to be responsive to their particular area(s) of need. To gain the cooperation of local hospitals, it is essential to the university(ies) that they work together for the interest of both providers, the student and the importantly the profession generally. This position means that general nursing and the hospital service requirements always dominate because of this any increase in the mental health content of the comprehensive degree programme is unlikely. Many (Stevens and Dulhunty, 1992; 1994) would agree that university comprehensive courses have been stretched and moulded in an attempt to make them less specialty oriented and the mental health content/issues have been whittled down to fit into the current three year course. On this basis, there is simply no further room for increased mental health content within the

current undergraduate comprehensive nursing degree. Many commentators have noted that increasing the mental health content of the course would come at the expense of moving or taking out more general driven areas and would not be on the curriculum committee's agenda for long as these committees see other specialty areas as more important and of course the precedent is already in place.

Despite strongly expressed and well-founded objections, especially from many psychiatric nurses, and some academics (Arnsward, 1987; Stevens and Dulhunty, 1992; 1994; Wynaden and Popescu, 1999a; 1999b) comprehensive tertiary education became the Holy Grail for nurse education in New South Wales, and eventually other States. Significantly, the Committee that was established to examine the Implications of Introducing Comprehensive Training into New South Wales, Australia (Grimshaw, 1980, p.57) suggested that two thirds of the role of psychiatric nurses was 'psychosocial' and did not believe that competencies in this area required placement in a psychiatric hospital (Holmes, 2001, p.381). This profoundly demeaning attitude toward psychiatric nursing, reflected in the view of some Australian university staff, that it requires no special expertise to teach psychiatric nursing skills, and that it is perfectly acceptable for them to be taught by nurse academics without psychiatric qualifications or experience.

In 1995 the then Minister for Health, The Hon. Marie Tehan, wrote to the heads of schools, Victorian Universities, and the Victorian Nurses Board, expressing concern about the psychiatric nursing content of the undergraduate nursing degree in Victoria. These concerns were underpinned by the cessation of separate undergraduate degrees in

psychiatric nursing which occurred over 1994-95, and which lead to psychiatric service providers experiencing difficulties in employing adequate numbers of qualified registered nurses to deliver good psychiatric care. The minister highlighted the point that, since the introduction of the Nurses Act in 1993, the undergraduate degree was responsible for preparing graduates to work as beginning practitioners in *any* area of nursing practice (Undergraduate Nursing Education in Victoria, 1998, UNEV).

Happell (1999) suggests that despite the primary intent of the comprehensive undergraduate nursing educational programme to prepare graduate nurses to clinically practice at a beginning level in a variety of health care settings, students invariably have very strong opinions as to which specialist areas are most desirable in terms of future employment. Personal reflections of students completing their psychiatric undergraduate units demonstrate some very good skill acquisition or a repertoire of skills but this is not usually translated into working in psychiatry after their graduate year is completed. More positively some students do become interested in psychiatry with the course giving them an introductory outline into mental health and shows students that many of the concerns they had in relation to them being apprehensive or frightened are now shown to be unfounded and the short entrée into some of the complexities of mental ill health prove sufficiently challenging and capture some in the process. This suggests that more psychiatric input into the programme would be a productive exercise in fostering student interest and this would go directly to the recruitment and retentions issues. The introduction of a complete graduate year in psychiatry or an extended rotation of six months through psychiatry in the graduate year offered by some mental health sites have

proven more successful from both a recruitment and retention perspective. One cannot be dismissive of this as it shows that more student time in clinical settings produces a better overall result. Similarly, the Blair Report (2000) centered on conditions and wages across the psychiatric services in Victoria, Australia. Commissioner Blair highlighted some of the tensions which were abundant between and within mental health settings and which came about because of low morale, lack of career structure, retention and recruitment and problems with workloads. These factors caused industrial unrest between the Health Services Union of Australia (HSUA), the Australian Nursing Federation (ANF) and the Service Industry Advisory Group (SIAG) in 1999/2000. Some of this difficulty arose because of issues contained in witness statements, articulating problems which

...go to the issues of recruitment and the measures taken by certain establishments to recruit and retrain psychiatric nurses within the system. It was acknowledged by all parties and recognised by the Commission that there is a crisis within the psychiatric services, as there is within the general hospital system over the recruitment and retention of nurses (Commissioner Blair, Australian Industrial Relations Commission, 2000).

The recommendations from the Blair Report (2000) would in the Commission's view, assist in helping the parties to address some of the current industrial concerns. The Blair Report (2000) chose to conciliate on some matters and moved to introduce Clinical Specialist/Educators (Level 4) and Clinical Consultant/Clinical/Educators (Level 5) into Area Mental Health Authorities at senior management levels, to facilitate recruitment and retention by helping staff in the hospital setting and deal with increased supervision and preceptoring of students. Also, to lift the low morale of staff by enhancing clinical practice standards and developing and promoting research, education and practice

development within any given mental health service. The Department of Human Services hoped that these new strategies would prove successful and that the new positions would provide support to the regular hospital staff and be available to any nursing students on clinical placement. This link between the universities and the mental health agencies may help with recruitment and retention and facilitate theory with practice.

The Undergraduate Nursing Education Report in Victoria (*Psychiatric Knowledge, Attitudes and Skill Requirements for Beginning Level Division 1 Nurses*) (1998) suggested that many nursing schools should consider extending the length of the undergraduate degree from three to four years to incorporate of the recruitment and retention issues, a more defined career structure for graduates to the division and a more complete educational programme and support when the graduate finished their training and moved into clinical practice. This report and recommendation has certainly refocussed the attention of the psychiatric nursing profession into rethinking some aspects of the way psychiatric nursing is taught in universities and reaffirmed how important these skills are across the full spectrum of nursing practice. It is clear that any incumbent government would view funding an extra year as preclusive to their budget bottom line and from a student perspective an extra debt under the Higher Education Contribution Scheme would be considered a disincentive. Overall, the issues of recruitment and retention would not be greatly affected. As pointed out by Clinton and Hazelton (2000c, p.5), one of the recommendations of the *Nursing Education in Australian Universities (NRNE) Report* (1994) was that Australia needs nurses who leave universities with a comprehensive grounding in the theory and practice of nursing.

However unrealistic this maybe, there is a presumption that Bachelor of Nursing graduates will be able to function competently at a beginning level of practice in any clinical area (Clinton and Hazelton, 2000c, p.5). This is the same presumption held by some of the schools of nursing around Australia which continue to trim the mental health areas of the curriculum. More often than not, this trimming is geared by financial considerations driven by the Federal Government, but often Schools of Nursing give up without a fight. This often means that integrated comprehensive approaches in some schools can mean declining hours in undergraduate courses and for clinical placements in mental health nursing in which the nurse works primarily with non-psychiatrically ill persons and where the overall focus is on psychosocial instead of psychiatric issues (O'Brien, 1994, p.96). We have a vicious circle whereby psychiatric mental health nursing complains that it has difficulty in recruiting and retaining staff and a system that almost falls on its sword when changes are made to its programme. Teaching modes and styles might also be problematical, since some are not suitable for the repertoire of skills required by the clinical field to enable students to become suitable beginning practitioners in mental health.

7.10 Teaching and Transition

Clinton and Hazelton (2000c, p.5) suggest that transition to practice can be complicated because of a variety of assumptions and expectations were employers expect that university courses will and probably should prepare nurses for a vocational role as well as providing them with an education. Clinton and Hazelton (2000c, p.5) suggest that it may take about a year to become anywhere near proficient in any chosen area of practice. Evidence suggests that transition is difficult with employers suggesting that some nursing

graduates were unprepared for practice and because of this were reluctant to choose psychiatry as a career option (Arnsward, 1987; Happell 1999, p.483). The transition often took longer if the undergraduate programme had been inadequate and the student felt unsupported across the mental health component of their undergraduate degree that Cross (1998) suggests is currently happening with students often feeling abandoned and unsupported by clinical staff on their placements. This view is shared by Wynaden, et al (2000, p.143), who argue that the current undergraduate curriculum is not comprehensive in nature and that the current programme is inadequate in preparing graduates for beginning practice in psychiatry. Wynaden, et al (2000, p.145) strengthen their argument by suggesting that as at least 20-25% of Australians now experience the burden of a major mental illness, the preparation of a nurse who is competent to work with the mentally ill would appear to be a significant priority. This priority is not being played out in current educational practice arrangements with many of the graduates feeling that they are not ready to practice competently in the mental health clinical environment with their current educational preparation (O' Brien, 1994; O'Brien, 1995; Happell, 1999; Wynaden, et al 2000). The introduction of graduate year programmes in psychiatry which involve graduates undertaking a specialty year in psychiatry on completion, rather than consolidate across three general/clinical areas (one of which maybe psychiatry) would seem at first glance to be a wise recruitment option. These arrangements can impose a significant cost onto the employer that some would not be happy to tolerate, arguing that this is an unfair shifting of costs from the education sector to health. The graduate year option has some linkage to the strategies proposed by Clinton's scoping study (2001) and follow up research completed by Clinton and Hazelton (2000a; 2000b; 2000c; 2000d).

7.11 Knowing over Caring

These views which promote academic competence could be seen as having been developed at the expense of the caring aspects of nursing or a preference for knowing over doing, or by extension the male over the female. As articulated by Porter (Evans, 1997, p.227) who suggests that “nursing will increasingly become an occupation divided between men managers and women ward workers. This point goes to suggesting that academic self-determination is a better predictor of career choice than occupational self-effectiveness. Wells and McElwee (2000, p.15) summarise in saying “nursing is [often] viewed as worthy but not worthwhile”.

7.12 The Australian Mental Health Nursing Workforce in 1999

What we do know is that mental health nurses and mental health nursing, from a recruitment and retention point of view, are in real difficulty. As so accurately portrayed by Happell (1997; 1998a; 1998b), Clinton (2001) and Holmes (2001) the “parlous” state of mental health nursing in Australia has many interwoven strands. Employment trends add an interesting dimension to this area of study.

7.13 Employment Trends, 1987 to 2001

The changing patterns of employment by State and Territory, gender, age and hours worked in nursing occupations over the 1987-01 periods are significant as shown in the Job Growth and Replacement Needs in Nursing Occupations 1987 to 2001 report, by Shah and Burke (2001). They add empirical evidence which considers the changing patterns of employment in this occupation because the boundaries between the roles of nurses and carers, especially in aged care, tend to be blurred. Although there are

similarities in the employment trends across different occupations and across States and Territories, there are also significant differences.

From 1987 employment in nursing occupations grew at an annual rate of 0.8 per cent, which is half the rate for all occupations, to a total of 248 000 in 2001. There were substantial differences among the States and Territories in the rate of growth. In South Australia and Tasmania employment contracted while in Queensland the annual growth was well above the Australian average at 2.7 per cent per year. In contrast employment of Aged or Disabled Person Carers has increased at an annual average rate of 10 per cent to reach 71 000 in 2001. Victoria's share of this occupation was 33 per cent in 2001 compared to 21 per cent for New South Wales.

Employment of nursing workers per 100 000 population, after initially increasing to about 1400 in the second half of 1980s, has been steadily declining. This is despite the ageing of the Australian population over this period and a 75 per cent increase in hospital patient separations between 1986 and 1999. It currently stands at about 1300 which is just below the level in 1987. The analysis at the State and Territory level show that the ratios varied widely across jurisdictions in the mid-1980s but have since been converging to the levels prevailing in New South Wales, Queensland and Western Australia where they have remained relatively stable and close together.

There has been a shift towards shorter working hours among Nursing Workers. In contrast to the labour force in general, where the shift in hours has been from the normal

full-time hours towards very short or very long hours, for Nursing Workers the shift has been from normal full-time hours towards working 16-34 hours per week. For aged or disabled person carers the proportions working either 16-34 hours or normal full-time hours have both increased the proportions working relatively few or very long hours are the ones that have declined. These arrangements tend to suit many female employees as it encompasses and makes provision for having a families and child care.

The shift towards shorter working hours for Nursing Workers, the reduction in the ratio of Nursing Workers per 100 000 population and the increase in the hospital patient separations all point to an increase in labour productivity. However persistent reports of waiting lists for elective surgery and emergency department admissions and the demand in psychiatry suggest there is significant unmet demand for services. Overall, the nursing workforce is older now than they were in 1987. In general, the age profiles across occupations are similar, apart from profiles for Nurse Managers and Directors of Nursing who have a much higher proportion in the 45 and older age group and Registered Midwives who have a much lower proportion in this age group.

The data below looks at Job Growth and Replacement Needs in Nursing Occupations (Shah & Burke, 2001) from 1987 to 2001. Specifically, Registered Mental Health Nurses to give an overview of some of the concerns raised.

7.14 Registered Mental Health Nurses

The employment of Registered Mental Health Nurses has averaged 4600 per year. In the

second half of the 1990s their employment declined significantly (Figure 4). Their numbers in 2001 are well below the level in 1987. The delivery of mental health services has undergone significant restructuring. Many of them because of this restructuring are now either integrated into general hospital services or community care services. This means that some of the work that was originally done by Mental Health Nurses is now probably done by the Registered Nurse. In Victoria they are no longer registered as a separate group, they are now on the Registered Nurses (Division 1) roll (Department of Human Services, 2001). The proportion of males in the occupation has not varied much over time and has averaged 45 per cent, much higher than for any other nursing occupation.

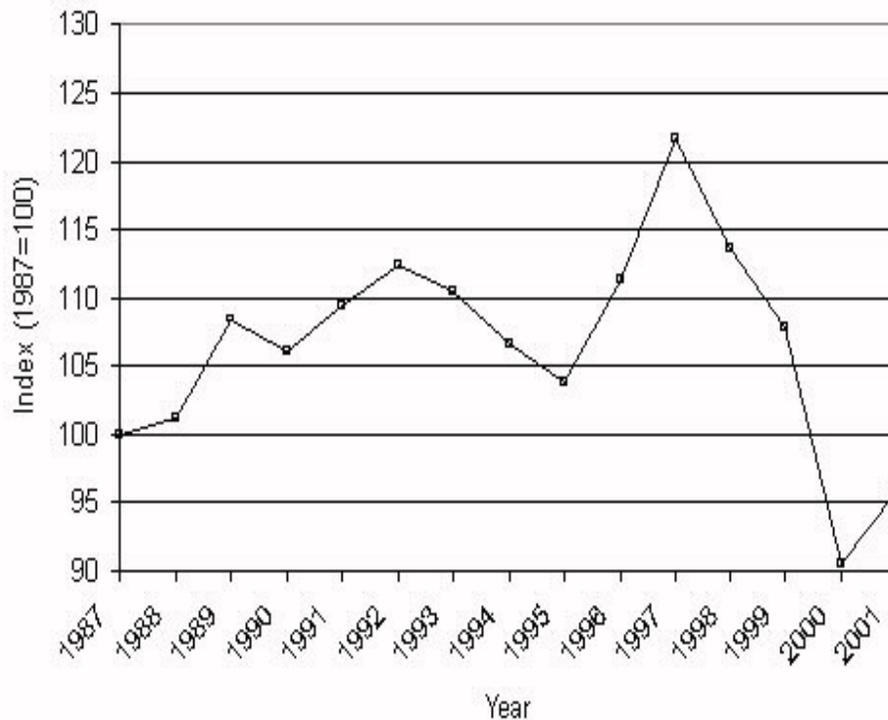


Fig 4. Employment of Registered Mental Health Nurses, Australia, 1987-01

In general, the age profile of Registered Mental Health Nurses has changed in similar ways to that of Registered Nurses (Figure 5). One noticeable difference is the substantially higher increase (37 percentage points) in the proportion aged 35-54 compared to Registered Nurses (18 percentage points).

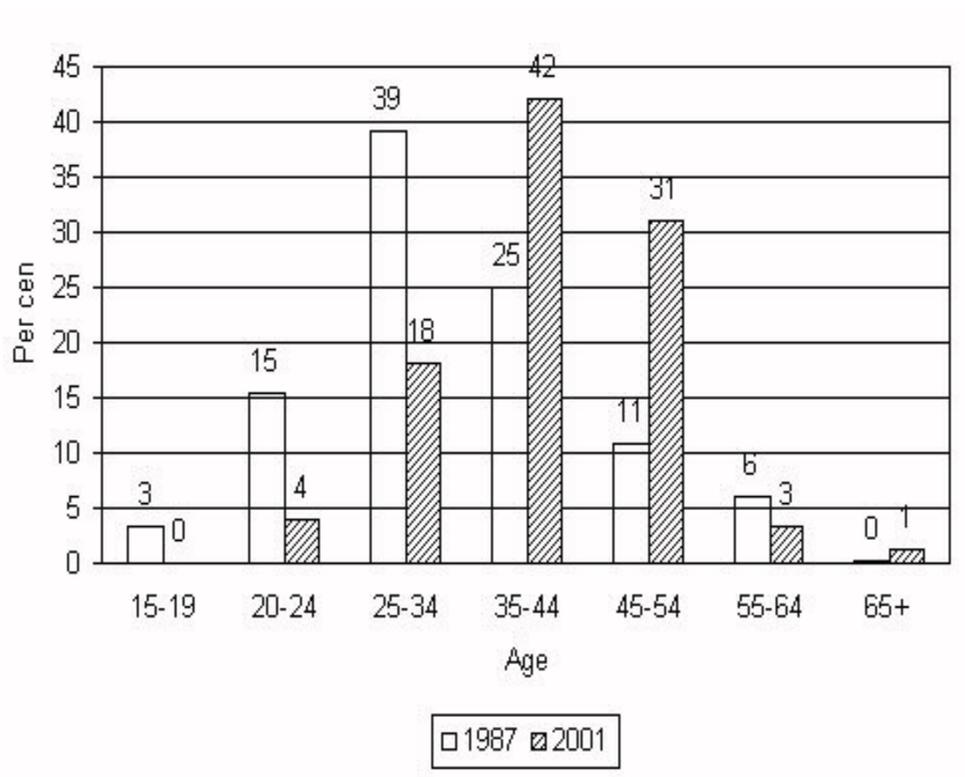


Fig 5. Age profile of Registered Mental Health Nurses, Australia, 1987 and 2001

In contrast to Registered Nurses, Mental Health Nurses are more likely to be working full-time. This is partly explained by the fact that the proportion of males among them is relatively high, and in general males are more likely to work full-time than females. Two out of every three in the group worked full-time in 2001 (Figure 6). The proportion working full-time increased by a small amount between 1987 and 2001, and the proportion working part-time (16-34 hours) fell.

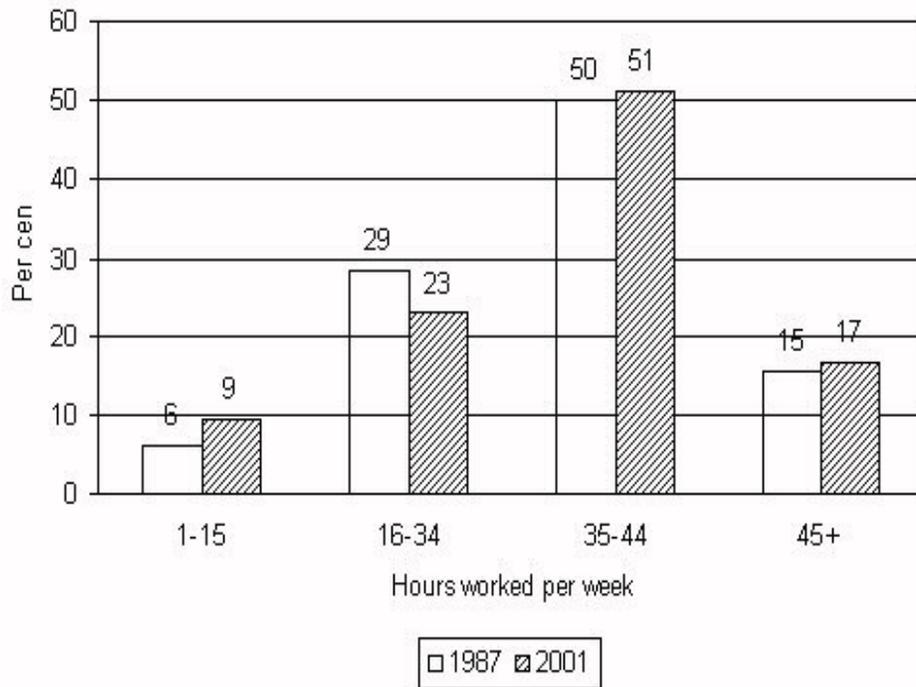


Fig 6. Hours worked by Registered Mental Health Nurses, Australia, 1987 and 2001

There was no data breakdown by gender across this analysis although the reference to males in Fig 4 and Fig 6 is significant in the traditional male role expectations of the Registered Mental Nurse group. Also, the traditional role of male provider in relation to the hours worked. Further to this data there is also clear evidence that due to funding cuts and the rationalisation of educational profiles, Australian universities, despite their achievements in developing nurse education and related research, have not been successful in preparing undergraduate students for their role as beginning practitioners of mental health nursing (Wynaden, et al, 2000 p.145; Clinton 2001, p.3). This in itself has been constrained because of a lack of quality clinical placements and some hostility by some service providers when seeking to arrange placements for nursing students (Clinton 2001 p3). Anecdotal evidence (Bolton, 2001; Smallgood, 2001) from student nurses

doing their psychiatric clinical rotations suggest that it is not that they do not enjoy their mental health course experiences and clinical placements, rather they do not feel confident or prepared and are apprehensive about work as beginning practitioners in the mental health areas.

Wasn't sure what the psychiatric units might entail. The lecturer said they would be different. He said that studying these units might get students to look inwards at themselves as people examine their own value systems and their understandings of what mental illness entails (Bolton, 2001, unpublished data).

I was really apprehensive when I first started my clinical placement in mental health. I was really frightened, not knowing what to expect. Could I talk with patients with a mental illness...what would I say? ...what would I do...? (Smallgood, 2001, unpublished data).

This would appear to suggest that the comprehensive degree in terms of psychiatric nursing is asking too much of its students. A student would require a high skill base and is subject to significant risk factors in the development of that skill base. It was noted on clinical placements for the undergraduate psychiatry (2002) programme at a Victorian university that many of the female nursing students took sick leave across their four-week placement. The hidden agenda could be their concern about the placement and/or the support that perhaps they do not get whilst on their rounds. Evidence from student groups undertaking the comprehensive degree in nursing at a Victorian University clearly showed that male student nurses were less concerned about their clinical psychiatric placements than the female nurses. Many (male and female) had expressed an apprehension to undertake psychiatric nursing, others were openly frightened and recounted stories they had heard about mental illness and impressions they had formed from the media. One female student spoke of

“aggressive patients who struck out” (Robbins, 2001). It is clear that this apprehension or fear is significant across the recruitment and retention of staff. Anecdotal evidence suggests that these issues appear to be more of a factor for female students. Many nursing students ask ‘what should they do’ if they are hit by a patient whilst on their clinical placements. Most of the male nursing students distance themselves from questions about aggressive behaviour from patients not appearing to be bothered by it, thinking that it is just part of the job. Many of the student groups are surprised to hear from experienced nurses that being hit has never happened to them and are a rare occurrence.

Another factor, which played into this equation, was that mature age students also appeared less concerned about their clinical placements than school leavers. Nurse managers spoke of preferring male, mature aged students rather than “young girls who have just left school” (Salmon, 1999).

Postgraduate course offerings and their take up rates have been inadequate to meet the future needs of specialist mental health services. Again, mature aged male students appeared more able to take up this option not being so dependent on finances or having a partner who could help support them (Clinton, 2001, p.3). Clinton (2001) suggests that attempts at delivering mental health nursing courses have been met with a rather limited involvement by both universities and health authorities. Clinton (2001, p.31) offers clear evidence that Australian universities are failing in their attempts to prepare undergraduate students for beginning practice in mental health nursing. He confirms the views of Farrell and Carr (1996) and Happell (1998c) that the introduction of generic undergraduate programmes leading to Bachelor of Nursing degrees has had the effect of diluting the mental health content of nursing curricula. Anecdotal evidence tends to support this.

“...How can you teach these kids how to look after someone with a psychosis in 13 weeks... its impossible... I still haven't mastered it after three years training and twenty odd years experience...”(Kingsley, 2000).

Clinton (2001, p.31) suggests that the structure of undergraduate nursing degree courses sometimes makes it difficult to clearly identify the mental health components. Added to this is the need for universities to ensure that students receive sufficient clinical experience in mental health nursing. With the onset of fiscal imperatives and downsizing, many universities are trying to cost cut across courses, and the mental health segments have not been exempt resulting in yet further dilution of mental health content.

7.15 Inadequate Preparation

At times, Clinton's report (2001, p31) is particularly ascerbic, and he states that not only is the preparation of undergraduates for beginning practice in mental health nursing inadequate, but believes some university based nurses actively discourage students from considering mental health nursing as a career option. Clinton believes that this prejudice is compounded by the attitudes of some of the nurses encountered by students during their clinical placements. A general view of 'horizontal violence' or verbal bullying (as per Roberts, 1983) is often experienced by students in the clinical field where the new comprehensive system is viewed as an easy option by the 'old hands' for the skill base required. Many of the students completing their psychiatric clinical placements provide anecdotal evidence of being closely watched by Registered Nurses and are often excluded from learning activities which would be useful in attracting students to mental health areas when they graduate (Happell 1998a). Many of these Registered Nurses were trained in the late 1960s and 1970s under the old hospital scheme and appear to resent university based programmes, and the students are often on the receiving end of this. The female

students appear to be more often on the receiving end of this horizontal violence or bullying than males, but this of course goes to only an 8 per cent male student cohort. Further to this, there is the perennial dilemma of a lack of suitable, quality clinical placements within acute mental health services, due to the pressures on staff and the range of students competing for placements from a variety of different disciplines. Clinton (2001, p.31), as with other authors with mental health backgrounds, is clearly at one with the thought that a satisfactory clinical placement in a mental health setting encourages and promotes interest in a career in mental health (Lam, 1993). A good clinical placement and an innovative theory programme, which may include Art Laboratory experiences for students, could and may have acted as a catalyst (Granskar, et al 2001, p.250) for students considering both post graduate courses and career selection to include mental health nursing. The reflective quote from an undergraduate student below illustrates this point.

These Art Lab experiences are frightening but interesting ...the school employ actors who are briefed by the lecturers about a specific mental illness ...they play the role of someone who is manic, depressed or someone suffering from a psychosis and the student has a practice at interacting with the patient as if it were real. The student can take a 'time out' and stop the interaction at any time and consult with the lecturer, facilitator or the rest of the group who problem solve and consider different treatment approaches and interactions that might work with particular patients. This style of teaching works particularly well but getting up in front of my peers was difficult at first but it was really useful as I remembered what the lecturer had told me about taking small, slow steps and using 'our repertoire of skills in building a working relationship with my patient. I surprised myself. I'm now interested in a career in psychiatry (Robbins, 2001).

As the Report on the Implications of Introducing Comprehensive Training into the New South Wales System of Nurse Education (Pink Report, 1980, p.16) made clear, it was 'one of the aims of comprehensive preparation to blur the differences between the

psychiatric and general registers, particularly in the domain of psycho-social supportive skills'. It was argued by opponents of the changes, back in the 1980's, that psychosocial elements in comprehensive nurse education 'replace or dilute the psychiatric nursing components' and this would have serious implications for the future quality of care given to the mentally ill (p.47). Today we are saddled by that blurring of roles in the form of an identity crisis and a complete inability to move forward on the issues of recruitment, education and role definition. The areas of biomedicalisation and professional changes, are just two of the many factors contributing to the sense of crisis in psychiatric/mental health nursing in Australia today (Holmes, 2001). It is also notable that specific targets were not identified within the Pink Report relational to specific gender issues. Clearly psychiatric nursing now entails much more in the way of a therapeutic regime and intervention than has been the case in the past. Treatment rather than containment allows the profession to be practiced more readily by both male and female nurses, which has probably always been the case but this point is made to take into consideration the changed training arrangements of prospective mental health employees.

Holmes (2001) ponders about what should be done, saying that nobody has a magic bullet that will cure the ills of the psychiatric system in Australia, or anywhere else. What we do know is that, today, the notion of individuals having 'a life in nursing' is rather outdated, and young people appear to want qualifications that are more 'portable', enabling them to switch the focus of their career in tandem with the changing needs, inclinations and job opportunities. Many young people who would like to work with people who have a mental disorder do not really want to be generic nurses, and do not

want to be specialists like clinical psychologists or psychiatrists. Therefore, in Holmes' view, we need a radically new approach to developing a workforce for the years ahead which encompasses both males and females, and a three year university training course dedicated specifically to mental health and mental disorder but separated from the disciplinary identities that have driven the mental health services in the past would seem the logical choice. In other words, a new cadre of mental health worker, with a new qualification and new role that is 'post disciplinary', based around issues and problems and the skills to deal with them rather than around the restrictive practices of disciplinary protectionism and funding formulas. This would more accurately reflect current trends in research practice, and scholarly notions as to the nature of knowledge and the artificiality of professional boundaries, and would do more justice to the reality of complex, unbounded, dynamic events in the material and subjective worlds of those whom the service should serve (Holmes, 2001, p.381).

In reality, like Holmes (2001), many do not believe this is likely to happen, mostly because of the fear of the new (or change) among psychiatric nursing ranks and the determination on the part of government not to provide anything but the bare minimum in relation to what are still the 'Cinderella services'. Holmes (2001) fears that, just like the asylums themselves, psychiatric services in Australia are beginning to suffer 'demolition by neglect', with the burden of care being shifted to the family, and facilities staffed by a transient and largely untrained workforce. This would be a sad reflection on a nation that boasts the 'good life' and its need to take the high moral ground in its relations with its neighbours, but its most significant impact would be on the lives of people with serious mental disorder, compounding our continuing neglect of their needs and rights. Clearly,

with this point in mind there is no reason to think that increased mental health content in the Registered Nurse programme would not improve recruitment into the mental health sector nor does/would it address the issues surrounding retention. Further, it would not at first glance have any great significance or impact on the quality of patient care.

There has been rigorous argument (Happell, 1997; 1998a; 1998b; 1998c) from some in academia and the clinical field suggesting that change needs to be made (Barling & Brown, 2001; Hazelton, 2000; Clinton & Hazelton, 2000) to the undergraduate psychiatric nursing component with the addition of an extra or fourth year being made available to those nurses wishing to or intending to enter the mental health system (Clinton, 2001). This suggestion has significant weaknesses, notably that any government of the day would not be keen to fund an extra year, thus leading nursing students even further into debt with the current fiscal arrangements under the Higher Education Contribution Scheme (HECS). Obviously, this would make these arrangements unattractive and a significant disincentive for students to consider a career in psychiatric areas of health. Similarly, it would be an injustice for someone who had trained for four years to enter the mental health system at the same level as someone who had only completed three years of those four. With these thoughts in mind, it is unlikely to affect the problem of recruitment because psychiatry would be still drawing the mental health workforce from the nursing cohorts recruited into general courses, which is already a problematical issue in itself (Happell, 1997; 1998a; 1998b; 1998c).

O'Brien (1995) Happell (1996) and Wynaden (1999) consider the implications of mental health nursing as a postgraduate speciality (Clinton & Hazelton, 2000c). On the positive

side, it may draw in older applicants, whom the literature (Hemsley-Brown & Foskett, 1999) suggests are more likely to make nursing a lifelong career choice from both a male and female perspective. Clinton and Hazelton (2000c, p.6) suggest that if the preparation of undergraduate students for beginning practice in mental health nursing is considered inadequate, then more specialist preparation at a postgraduate level is sometimes worse, with evidence suggesting that ‘take up’ rates of university placements is low, reflecting the view that mental health nursing is not an attractive career option (see Figs 7 –17).

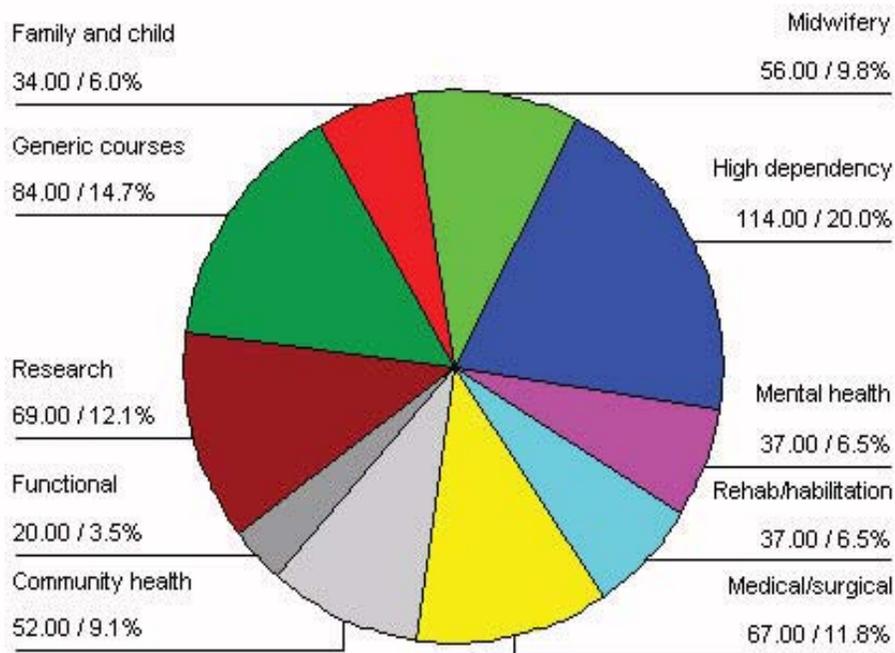


Fig 7: Number of university post-graduate courses offered in 2001 by nursing specialty across Australia

7.16 Post-graduate Student Profiles

Data was collected on the number of 2001 domestic and international students enrolled in

various post-graduate programs, by level of course and nursing specialty, from each university offering post-graduate nursing education across Australia, and one non-university institution in New South Wales.

The advent of and trend towards generic courses (where nursing specialisations were unable to be identified) complicated the process of trying to accurately quantify the number of enrolled and completing domestic post-graduate nursing students in specialty courses. To overcome this problem, an attempt was made to tease out specialties within generic courses and recode the student data into nursing course specialties based on the percentages of domestic students enrolled in the various specialty courses in Australia in 2001. This process also identified that a proportion of generic courses could not be matched to specialties, and as such 10% were left as generic. The remaining 90% of generic courses were apportioned to nursing specialties based on university post-graduate enrolment numbers in the various specialisations across Australia and several large courses where the specialty proportions were provided. The percentages used to apportion the remaining 90% were as follows: Family and Child Health 9%; Functional 4%; Community Health 13%; High Dependency Nursing 33%; Mental Health 16%; Rehabilitation 4%; and Medical/Surgical 11%.

Most post-graduate nursing students were part-time students. Most post-graduate nursing research programs were HECS funded, while coursework post-graduate nursing programs were funded by both HECS and up-front fee-payment, with the fee-structure of individual courses appearing to vary on a year-to-year basis. Up-front fee-paying nursing courses offered at the Graduate Certificate level were approximately \$800 per credit point of

study, while courses offered at the Graduate Diploma can vary between \$800 and \$1600 per credit point of study.

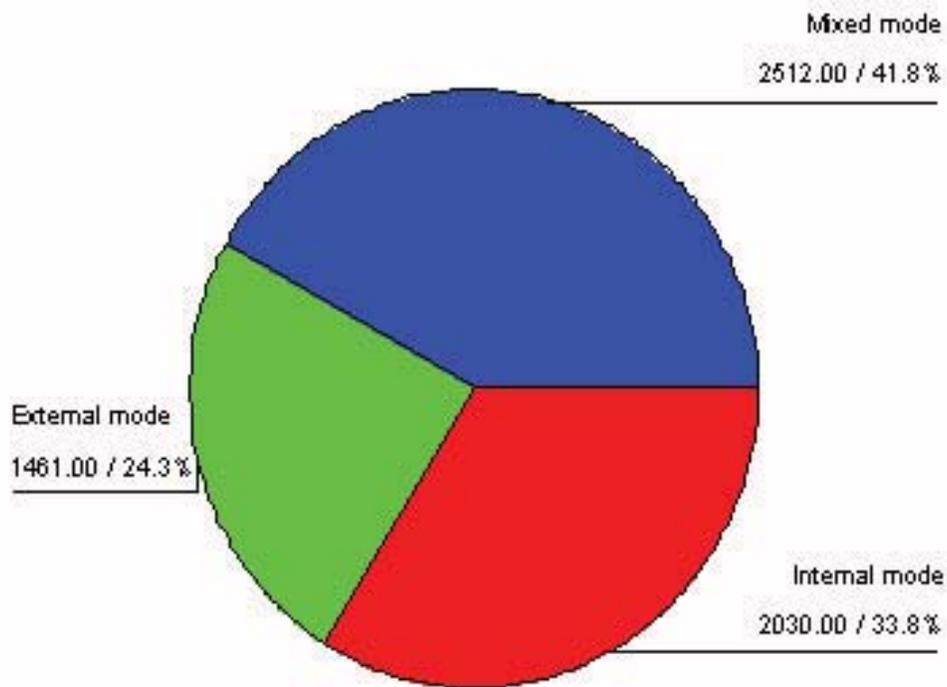


Fig 8: Shows the total number of university domestic post-graduate nursing students across Australia by course mode of delivery. Fig 8, displays two thirds of post-graduate programs are offered as external courses or use a mixed mode of delivery.

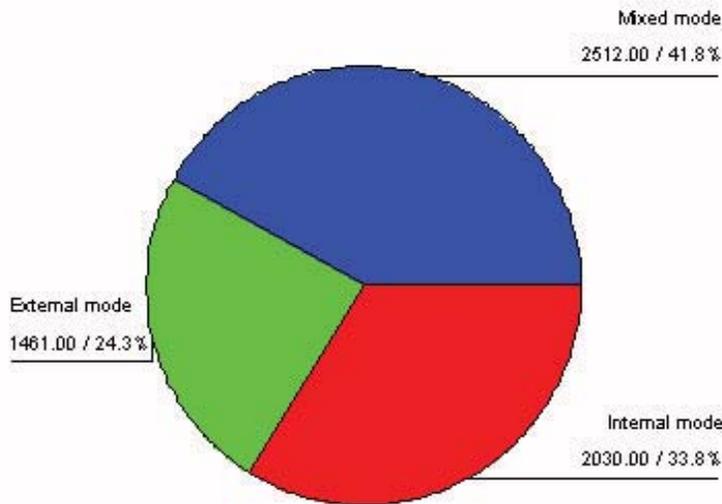


Fig 9: 2001 total number of university domestic post-graduate nursing students by nursing course specialty across Australia

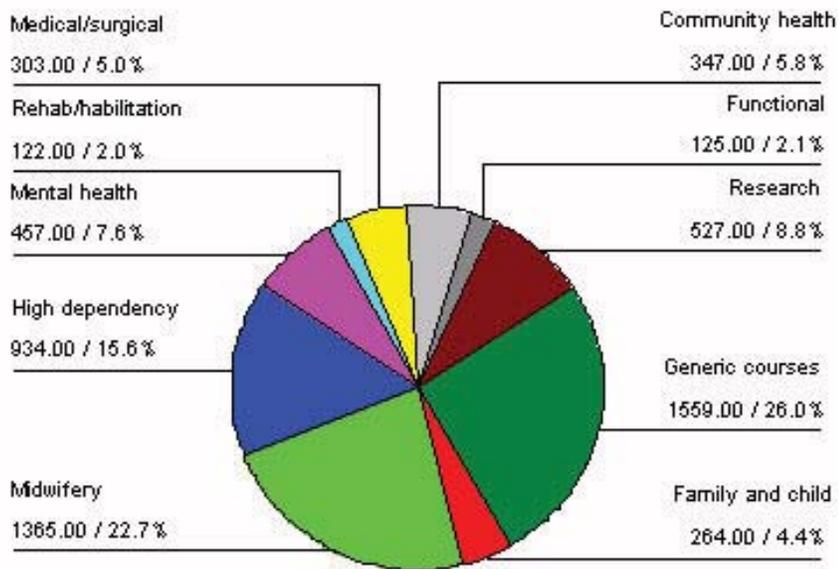


Fig 10: 2001 projected university domestic student post-graduate completions by nursing course specialty across Australia.

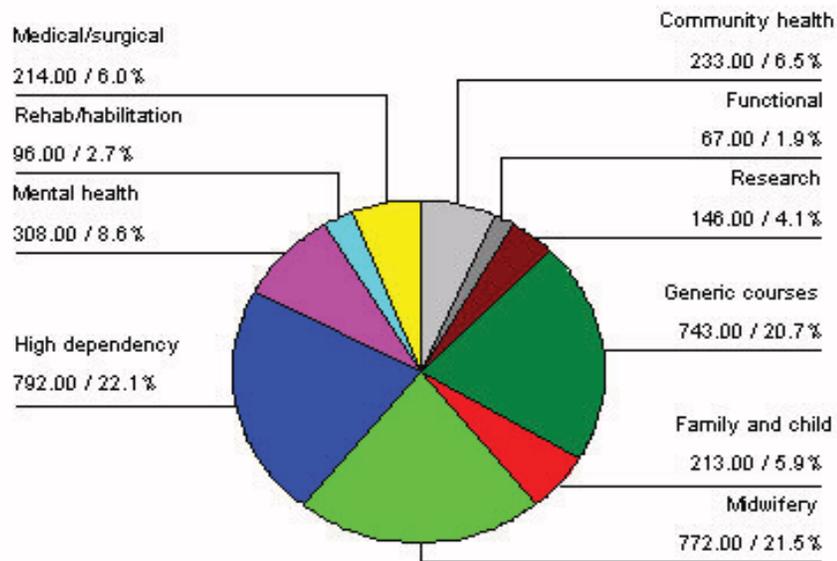


Fig 11: Recoded and apportioned 2001 projections of university domestic student post-graduate completions by nursing course specialty across Australia.

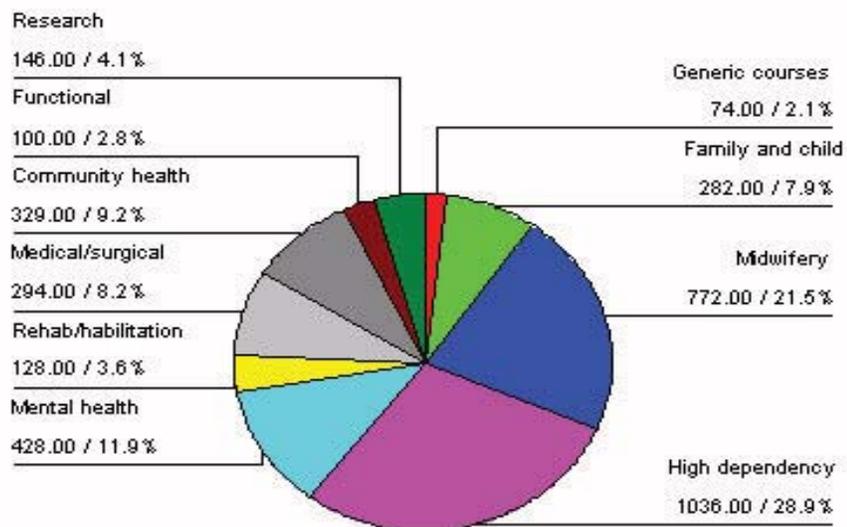


Fig 12: Recoded and apportioned 2001 projections of university domestic student post-graduate completions by nursing course specialty across Australia.

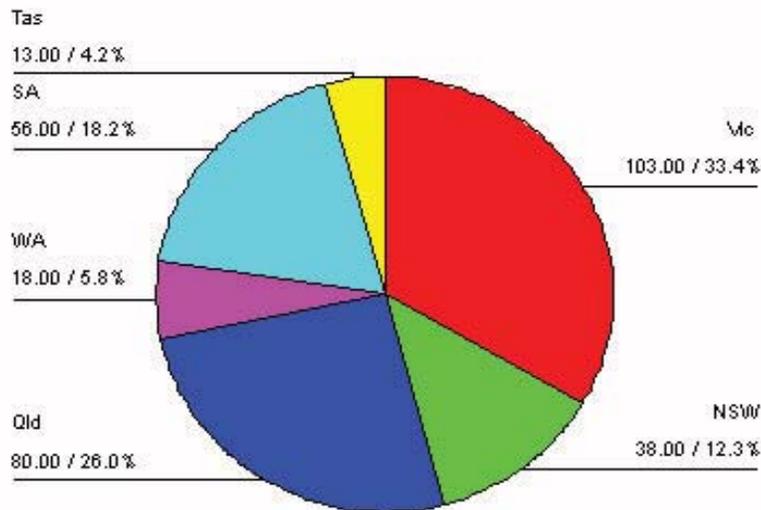


Fig 13: Projected 2001 university domestic student post-graduate completions for mental health courses.

Figs 14 – 18: present some State profiles of the 2001 projected university domestic student post-graduate course completions.

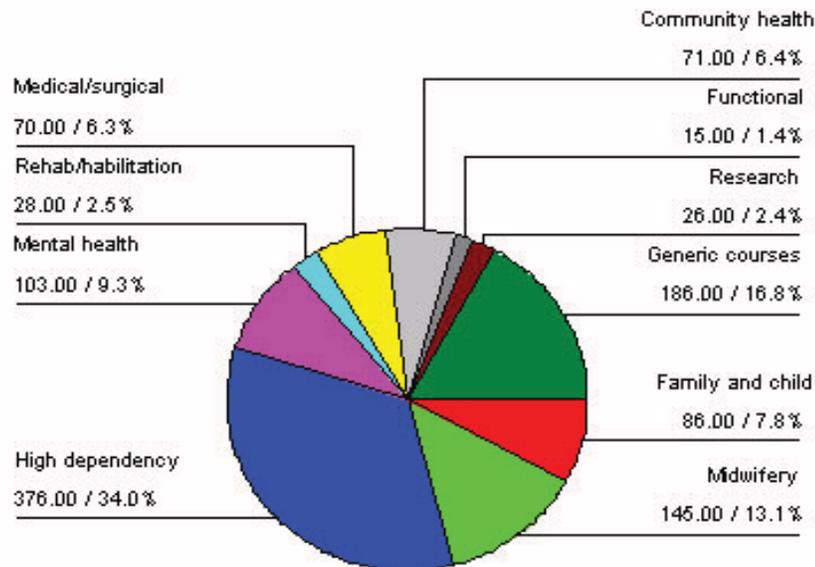


Fig 14: Victorian 2001 projected university domestic student post-graduate course completions by nursing course speciality.

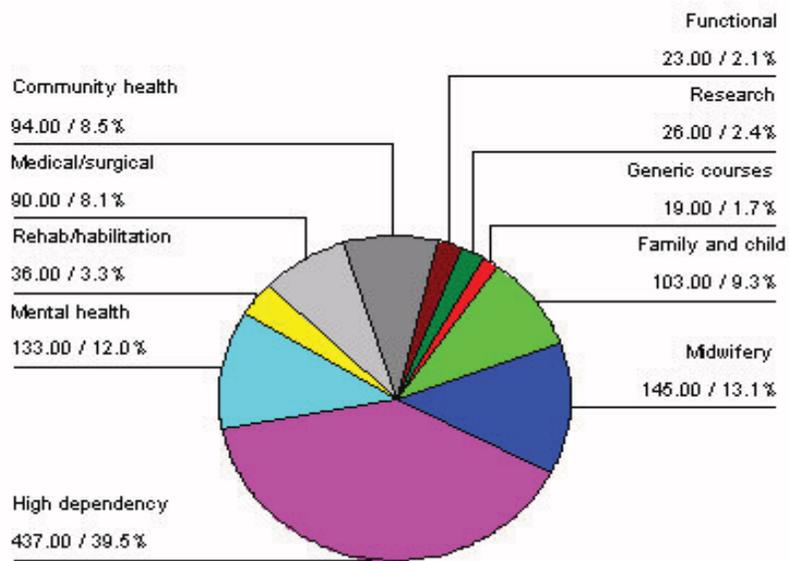


Fig 15: Recoded and apportioned Victorian 2001 projected university domestic student post-graduate course completions by nursing course specialty.

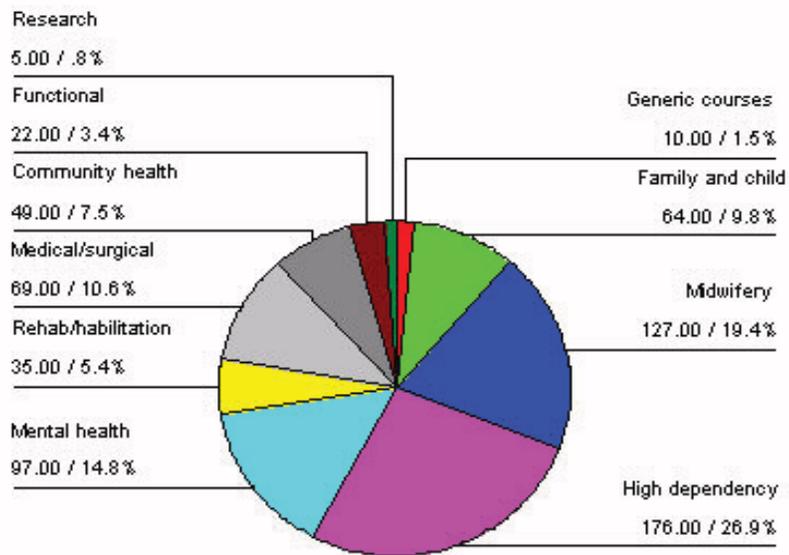


Fig 16: Recoded and apportioned Queensland 2001 projected university domestic student post-graduate course completions by nursing course specialty.

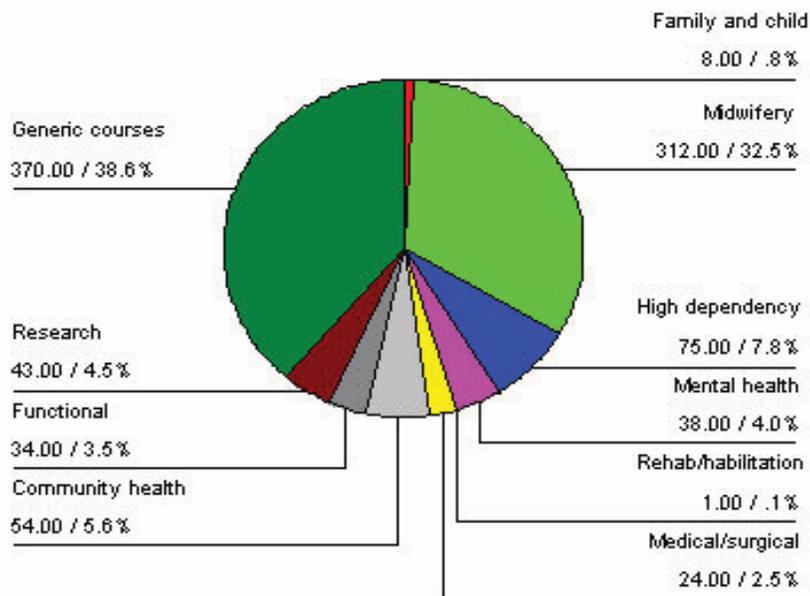


Fig 17: New South Wales 2001 projected university domestic student post-graduate course completions by nursing course specialty.

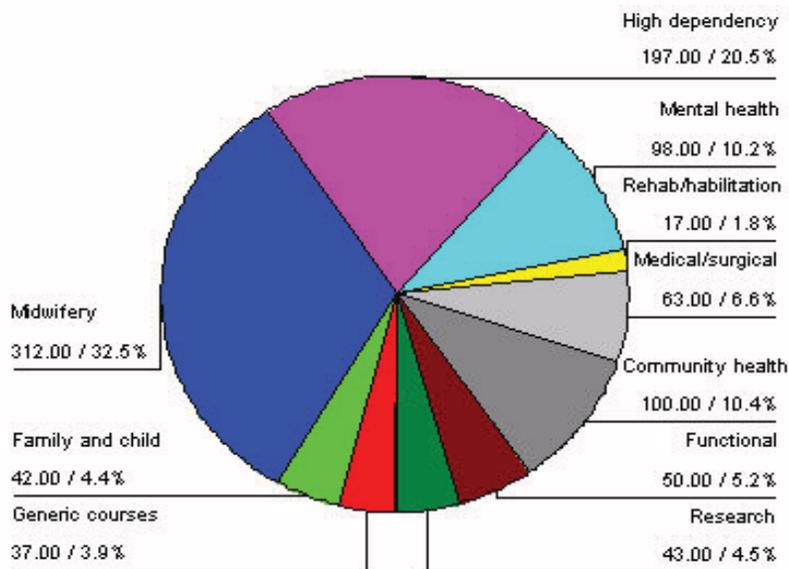


Fig 18: Recoded and apportioned New South Wales 2001 projected university domestic student post-graduate course completions by nursing course specialty.

Figs 7 –18: from Ogle, et al (2001)

Postgraduate education in mental health nursing certainly has its place in Australia but, it appears to encompass the American ‘ideal’, in which Master programmes promote mental health nurses as almost an elite group, since nursing staff with post graduate qualifications work in more consultative and advisory roles and oversee an army of barely trained but cheaper carers. If Australia adopted this idea, all new mental health nurses would be postgraduates and this would only be attractive to nurses if it entailed a correspondingly higher pay scale and range. Postgraduate mental health workers would be in danger of pricing themselves out of the market and it would appear rather clear that health services cannot and will not pay for mental health nurses above basic levels. Some speciality nursing groups in Australia have implemented “a credentialling process as a means of self-regulation for [their] particular specialty area, so that nurses can demonstrate their competence and be publicly accountable for the services they provide”. Clinton (2001, p.35) highlights his concern about these issues when he notes that take up rates for university places in specialist and postgraduate mental health courses is a major problem with “only 366 mental health nurses being produced” (Clinton & Hazelton, 2000 p6) for the years 1996, 1997 and 1998 (inclusive). Dunn (2003 www.theage.com.au/articles) claims that

data released recently by the Australian Institute of Health and Welfare shows that universities have not succeeded in recruiting a larger proportion of male nursing students in recent years. In 2002, 87.7 per cent of nursing undergraduates were female, up from 86.7 per cent the year before and from 86.3 per cent in 2000.

Clinton (2001) suggests further that new graduates in New South Wales and all other jurisdictions do not find the mental health field an attractive career option in which to practice. The Health and Community Services Union in Victoria also allude to the

psychiatric nursing profession being in crisis. They state in a recent submission ([www.hacsu.asn.au/national review of nursing education - 2002](http://www.hacsu.asn.au/national_review_of_nursing_education_-_2002)) that

...there have been less than 400 mental health nurse-graduates in the past 3 years across Australia; that mental health nursing is not regarded as a desirable area of practice for undergraduates; that these trends are alarming in the context of workforce projections, particularly given that the average age of a mental health nurse is 44 years and less than 2% of graduates who enter mental health nursing are male.

It is this latter point that proves interesting to this research for this data suggests that fewer males are now entering mental health nursing, although males undertaking the comprehensive undergraduate course are growing slightly which would appear statistically to have become the province of females, as female numbers undertaking the comprehensive undergraduate course are growing in relation to government funded places.

Statistical data from the NRNE (2001) Discussion Paper gives very little information about gender although does highlight some of the problems linked to supply, demand and retention. The data demonstrates a trend for domestic undergraduate students showing a steady decrease in completions of nursing from a high of 9525 in 1994 to 5844 in 1999. The postgraduate category has had a rising completion rate from 1144 in 1994 to a peak of 1975 in 1998. In 2000 there were 1949 completions. A DETYA study (Urban, et al 1999), which looked at wastage from courses using a 1992 nursing university cohort, showed that a number of factors increased the likelihood of completion, including being a full-time student rather than an external or part-time student. Female students were also more likely to complete than male students and

younger students more likely than older to complete their courses. No further data was offered in support of these claims.

Holmes (2002) argues that these arrangements make psychiatric nursing comparable to aged care services. Few Registered Nurses find the prospect of nursing in this area appealing and Registered Nurses often oversee an army of Division 2 nurses or other care attendant staff, with the overall standard of care suffering in the process. These more expensive options really mean that mental health workers with post-disciplinary qualifications may be overpricing themselves, which could be seen as dangerous within a shrinking health care budget, and as creating an elite in the process.

Post-graduate qualifications in mental health has been adopted by the American Nurses Association (ANA) and by Australian New Zealand College of Mental Health Nurses, and according to Clinton and Hazelton (2000d, p.102), is similar to that taken on board by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), which states that "...the advanced practitioner combines competencies in five areas of clinical practice, research, teaching, consultancy and leadership (United Kingdom Central Council 1994). The issue of advanced practice talks to the point of becoming elitist, as mentioned above, where consultancy, which is more in keeping with the male approach rather than the "hands on" female approach, becomes the 'modus operandi'. Added to this the complex and contentious issue of prescribing rights for nurses. Clinton and Hazelton (2000d, p.102) argue that

...prescribing rights for nurses is contentious but the fact is that nurses in many countries are involved in prescribing in all its aspects except that of signing the prescription. Nurses suggest medications to psychiatrists in person and over the

telephone assess clients and suggest changes of drugs and dosages at clinical team meetings, guide new psychiatric registrars in their prescribing habits, administer *pro re nata* (PRN) medication, and sometimes give medication and obtain the medical order later.

The literature suggests that safeguards are required if nurses in Australia are to obtain prescribing rights. "...The nurse must be educationally prepared for the prescribing role, and client outcomes must be monitored" (Cornwall, 1997, p.2). This once again shifts another of those more masculinist domains into a female-oriented nursing domain. Advanced practice and prescribing rights would of course require legislative change in most jurisdictions (Clinton & Hazelton, 2000d, p.102). Reimbursement from Medicare for consultations by advanced nursing practitioners will also be a contentious issue and it is difficult to see how the hegemonic institution known as medicine will be easily convinced. Advanced practice and prescribing rights, which are being introduced in some areas internationally maybe persuasive in relation to the take up rates for mental health nursing in the future. Similarly, the skills of nursing in becoming more aligned with medicine might prove to be an incentive for both genders across both recruitment and retention issues in the future.

7.17 Summary

This chapter examines gender issues in relation to Australian Nursing Education and looks at the movement of psychiatric nursing education from the apprenticeship model through to the comprehensive programmes now offered in the tertiary sector. Part of this examination looks at the overseas experience of this movement of nursing education and how tertiary education in the face of downsizing in the tertiary sector and government

fiscal policy result in what is being seen as inadequate preparation of nursing generally but psychiatric nursing in particular. These arrangements have resulted in recruitment and retention problems within nursing generally, but more specifically in psychiatric nursing.

CHAPTER EIGHT

DISCUSSION AND SUMMARY

8.1 Introduction

The research has explored how gender and gender differences amongst Australian psychiatric nurses evolved, how they have contributed to the growth of the profession generally, and how their maintenance and otherwise has been significant. A major focus of the research has been a critical examination of the published discourse in the context of Australia's social and cultural development, including changes in professional and health service organisations and education. These have been interpreted within the context of international developments, and have entailed lines of inquiry related to gender, the sexual division of labour, role stereotypes, patriarchy and the history of psychiatry. The overriding aim of the research, using a discourse analysis and historical criticism, is a recovery of the past by adding meaning in light of current knowledge.

This chapter will draw some of the emerging themes together after looking back at the influence of gender across the history of psychiatric nursing and then drawing comparisons between its developing history and more recent developments. The study has shown a number of key areas of change, notably the incorporation of particular gender markers traditionally attached to the other gender as discussed in Chapter three, with males incorporating female gender markers and females adopting male gender markers which this research argues is a useful strategy. Similarly, recruitment and retention across the profession of nursing is problematical especially in relation to mental health and the issue which suggests that recently introduced comprehensive nursing

education programmes do not prepare nurses well for practice in nursing generally but psychiatric nursing areas in particular. All of these issues need immediate attention by the profession.

There is a paucity of available research surrounding the significance of gender for psychiatric nursing. The individual topics of gender and psychiatry have been addressed at some depth but when nursing is added, authors appear to find the combination uninspiring and choose to look into other more 'glamorous' areas of nursing practice. Psychiatry appears to be a troublesome concept to prospective researchers; many holding the view often reflected in the literature that psychiatry is to be avoided. One of the most informative resources on mental health nursing is the work completed by Nolan (1993) who suggests that the historical roots of the present are the springboard for a more enlightened tomorrow, and this proved an invaluable guide and resource to this research. Because of the absence of information about this topic, this study has proven challenging and insightful and should prove foundational to the profession of nursing as a whole and to psychiatric nursing in particular. The current concerns emerging from psychiatric nursing need to take heed from some of the lessons of the past. This is often easier to say than do, and so this study could be viewed as a starting point for further research, filling a silence, and a useful addition to the existing literature.

8.2 Themes and Tensions

This research has demonstrated that there are many emerging themes and tensions, surrounding the relationship between gender and psychiatric nursing. The emerging

themes tended to produce yet more questions, and some of these tensions complicated further some of the ambiguity and paradox highlighted above. It is clear that there is no single 'cause and effect' answer to the question posed at the outset, and that the results are not readily generalisable.

The research argues that men and women construct, live out and participate in very different realities in their everyday lives. The living-out of these realities involves many issues related to their existence and being, and the contextual circumstances in which these realities are played out. Many factors serve as social or cultural markers, which identify at face value the role we are in or playing at any given time. These include personal items such as clothing, families, one's upbringing, employment, ambitions, and personal definitions of happiness or being comfortable in one's biological gender role. The construction of specific social realities means that no universal or singular definition of a specific reality in relation to gender and sex role exists, and more recent discourse supports this view. The traditional position, which describes 'anatomy as destiny', suggests that gender differences were natural and determined by biology with no other factors at play or contributing to this view. This research suggests that this is not so and that by taking a singular view tends to limit the available discourse and uncritically accepts the available gender history, which although important, is not the only relevant factor. This research argues that gender should be seen as a more elastic and inclusive term, which can be stretched by definition and in reality in all sorts of different directions, rather than accepting gender as a single 'cut and dried' identity. This more elastic definition encompasses the complex range of roles played out by particular

genders who work as psychiatric nurses. The literature constructs gender as being built on the idea that boys/males grow up in the knowledge that their strength and physique, and in particular the possession of a penis which is seen as representative of power, gives them more strength which is then played out in provider and leadership roles or in different roles to that of women. Women, because of this construction, then play out their role relational to that of the male and at times behave as emasculated men with feminism being viewed as an adult version or expression of penis envy. One role, according to this theory, constructs the other role and these arguments tend to become rather circular. This research argues that both male and females adopt and adapt gender markers usually associated with the other gender and play them out in the psychiatric nursing role.

The history of psychiatric nursing clearly demonstrates that gender related physical characteristics were prerequisite in the success of people willing or wishing to work in this area. Prior to the introduction of psychotropic medications, the role of psychiatric nurses entailed a measure of strength so as to be able to contain patients, and mobility so as to restrain or recapture those who attempted to escape. Ability to play sport appeared to help, because the hospital's standing in the eyes of the Superintendent was important and was reflected in sporting success, especially against other institutions. The features of strength and mobility are readily associated with males and so they were the more likely applicants. In the late 1950s and early 1960s, literature emerged which was critical of the traditional manner in which mental patients were treated, and played an important role in informing the underlying philosophy of deinstitutionalisation (Healy 1992, in Sands, 2002). This change brought a different ethos to the treatment of the mentally ill

so that, in addition to psychotropic medications, psychological interventions and triage options were available, with an over-riding philosophy, which encouraged patients to engage in self-care under the watchful eye of the nurse. There is widespread belief that nurturing interventions support and self-care were roles more in keeping with that of females, and so females because of these changes became more employable. This belief is not based on empirical evidence although is depicted across nursing and much of the nursing literature. An empirical study is necessary to establish whether in fact females are more suited than males to such roles, and whether the popular view is justified.

8.3 Flexible Boundary Definitions

These issues, which tend to describe sex, script and gender roles interchangeably appear to have some rather flexible boundary definitions, which in some ways describe what the role of a psychiatric attendant/keeper/nurse actually entails. Some of the classic feminist works, such as those by Chodorow (1978) Eisenstein (1982) and MacKinnon (1987; 1989), underpin and support themes relating to sex and gender roles and authors in more recent works (Walsh 1997) are now beginning to suggest that more loosely defined or extended gender roles in which one gender incorporates some of the usual gender markers of the other are more commonplace than we originally thought. The incorporation of gender markers suggests that this may provide distinct advantages to males in the female oriented professions whereby they bring qualities such as forthrightness, militancy and competitiveness amongst others to the nursing profession. They also do not take time off to raise children, which means they have the opportunity to climb the career ladder more quickly. On the other hand, gender markers associated

with masculinity can also advantage women in both female orientated professions such as nursing, and male oriented professions such as the armed forces. Women are now often sought for employment in some mental health facilities because of their apparently superior skills in relation to de-escalating anger and adding more humane approaches to the care of patients and to a whole range of skills and approaches across the helping areas. There is also growing evidence to suggest that women are more emotionally in tune with others, including their patients than males, although empirical evidence also suggests that women are more susceptible to psychological problems and mental illness than men. Evidence suggests that women deal with and manifest symptoms differently to their male counterparts, and seek professional help more readily, and that society tends to over pathologise women's behaviour. These points show that women who embrace more masculine role markers, like males who take on more female role markers, are different and more employable across a whole range of areas. This is significant to those in charge of recruitment and retention, who should look differently at the selection criteria for nurses wanting to work in mental health care. This should encompass a change which encourages more women to consider psychiatric nursing as a career option. By incorporating male gender markers, women remain biologically female, but have some male psychological characteristics, which can be employed to their advantage in the changing job market. Anecdotal evidence suggests that men need to be strong and tough-minded and, in contrast women are expected and therefore allowed to be different.

These arguments would have been abhorrent to the feminist movements of the 1970s but are now being considered differently because over time, and with social change, these

different views have much to offer. The ideals of feminism were quite persuasive in the literature some years ago and certainly facilitated some change in how people thought about gender at the time, but these changes are seen as less convincing with the passage of time, and commentators suggest that any change from what is regarded as a paternalistic society today, toward a more maternalistic society, looks as equally bleak. Notwithstanding this bleakness, any changes would mean seeing the world with a much more balanced view, in which the lives and opportunities of women and men may be considered more equal or symmetrical, rather than exclusively determined by 'female' and 'male' stereotypes located at opposite ends of the spectrum.

This research has identified themes across the changing sexual division of labour within families, the advent of changed roles, with 'house husbands', 'sensitive new age males' and the switching of breadwinner/home duty roles. Feminist groups have been persuasive in changing the specific gender markers from 'man' and 'woman' to the more neutral term of 'person'. Females are becoming more career oriented and with the changing political climate, ideas about child care, maternity leave and job sharing have played their part in this movement. These issues and this movement are significant in the arguments, which show that certain tasks, which have been traditionally constructed as 'male' and 'female' are beginning to change and that these changes are only a start. From a psychiatric nursing point of view these changed arrangements, together with the new comprehensive nursing programmes, have been significant in several ways, Firstly, there are now more females across small numbers available to the workforce wishing to enter psychiatric nursing. In contrast, more males are now prepared to be more actively

involved in child care arrangements, which indicate a switching of roles. Females have become much more career orientated and select nursing as a career rather than a calling. In this, they are much more determined and competitive within the available job market. Deinstitutionalisation, the use of psychotropic medication, mainstreaming and the advent of community based programmes have all had a significant effect on female career opportunity and advancement within the psychiatric nursing workforce, enabling women to bring their caring skills, and repertoire of psychological/emotional skills to psychiatry.

8.4 Masculinities and Femininities

The thesis has described how some of the contemporary literature speaks of different wiring, as though specific genders have their biology wired to act in certain predetermined ways. This suggests that certain behaviours may have genetic links and may help or determine the sorts of employment a person may pursue, how they may act and the sort of person they may be. It will be recalled that Chan (1995, p.11) and Tiger and Fox (1972) argue that human 'biogrammar' is a genetically based phenomenon, which suggests that human behavior can be genetically determined. In support of this view a female business director Mahaux (2003), speaks of "taking testosterone when I have to act like a man" which suggests that gender is a programmable biological entity. She notes that "it's amazing to see how you can be like a man for a few hours and to stay a real woman after". The human genome project is finding some remarkable genetic patterns which, under certain circumstances, connect to specific behaviours and predispose individuals to engage in those behaviours. These issues would form the basis of some interesting future empirical research, perhaps taking this thesis as a starting

point. Other authors, such as Cross and Bagilhole (2002, pp.220-224) speak of feminine and masculine sides to an individual's personality and how people can reconstruct different masculinities and femininities which demonstrate that an individual's gender identity can be "internally contradictory and in tension" (Cross & Bagilhole, 2002, p.221). These opinions fit with many of the themes discussed throughout the thesis which suggest that markers usually associated with one gender can be adopted by the other, and may relate to self and employment, and are context dependent. These changes are often found in psychiatric nursing. In the construction of these different identities, Cross and Bagilhole (2002, p.220) argue that individuals safeguard their original gender identities by distancing themselves from colleagues of the opposite gender or reconstructing different masculinities or femininities.

This thesis has argued that the construction of different masculinities or femininities suggests that a person can be viewed as a collection of masks (or identities), worn and played out according to the given social script or across given contextual circumstances. A person's true self is a social and scripted performance, which is played out differently in different circumstances, and which entails a rather flexible and changeable gender identity component. These arrangements are useful in psychiatric nursing because of the number of different skill areas one needs to engage in across the profession on a day-to-day basis. For example, caring for the baby of a patient who has postnatal depression where one would encourage the mother to become involved in the care of the baby. At the same time, supporting the father about these changed circumstances and extending this care to other family members who may be frightened about what is going on.

Sometimes these identities are played out across different situations in the clinical working environment where individuals adopt or play games to fit in to the accepted structure of the group or situation they are trying to enter. In psychiatric nursing, which now usually adopts a multidisciplinary approach to care, often the nurse is viewed as being at the bottom of the pecking order relational to the team and its functioning. This thesis argues that nurses/females within multidisciplinary teams could recognise the masculine side to their identity and approach the pecking order issue in a different way.

As an aside to this, the literature suggests that human beings play out different roles, in fact we all have numerous roles without sometimes realising this and at times roles blend across given contexts. Becker (1963) suggests that individuals have a master role, which takes over other more auxiliary roles in an individual's life. These auxiliary roles can be and often are interlocking and complementary for example father, husband, doctor, socialite, Christian, and/or many others. Society tends to see a person in terms of this master role that a person takes on and this is often their employment role for example, the role of doctor and takes a lot of a person's time rather than say a biological role like that of a father or husband. The master role of a doctor, for example, is overriding in the eyes of the general public relational to all the other roles, so that an upstanding doctor could not possibly be a bad father or husband. Similarly, if a person has a criminal role, all of the other roles can be and often are assumed to be auxiliary. That a criminal could be a good father, husband, doctor, or Christian, for example, would be problematic.

This writer argues that human beings have an almost endless series of selves, which can

be called upon and utilised in given sets of circumstances almost at will by people in life and employment. These selves have a genetic pattern which is socialised and then learnt or fostered under a whole series of influences associated with cultural norms, 'fitting in', different social circumstances, family and so forth. Core self is lived out around gender, so that a person enacts the learnt self which is arranged by conforming to an accepted contextual and societal definition of being male or female. This would be significant related to the sort of employment available, sought and occupied by particular gender groups, their levels of education, the economic well being of the family and the current school of thought driven by parental and societal expectations. In this, the realities of an individual's set of circumstances would determine how and when they enact different roles.

This thesis has shown that some of the societal expectations are encompassed in discourse, with language acting as a functional instrument imposing structure on an individual's cognition and how people make sense of the/their world. Language which considers gender is interesting because it embodies the question of perspective, which is often bound up with social identity. This social identity encompasses a number of social class, sexual division of labour, gender and ethnicity issues. The place of gender in this debate has two competing interests; firstly, sexist discourse; and, secondly, how language is used by different genders. Sexist discourse embodies a pervasive ideology, which tends to differentiate, marginalise, and often excludes or downgrades women.

Some of the feminist literature suggests that male orientated meanings and hegemonic

ideologies are very powerful, and that to change this would mean men subscribing to an equal relationship with females. At the moment, the dominant/hegemonic position held by males would be difficult to give up and/or change, and some of the literature considers whether the outcomes would be any better. Much of the literature suggests that females are considered secondary to males and that history is constructed from a masculinist point of view. This is found to be the case as we examine psychiatric nursing, where asylum care was initially dominated by men along custody/risk management lines under the watchful eye of medicine. The movement of nursing education into the tertiary sector also has an array of hegemonic underpinnings and it could be argued that this move is representative of a female oriented profession being taken over by the more male dominated university system.

This discourse/position is very powerful, and when contrasted with the distinguishing grammatical and phonological features, which represent the usual characteristics of women's discourse, demonstrates and highlights these differences, and constantly reasserts the status quo. This suggests that women's speech is consistent with their socialised and constructed gender role; that is, it is softer, gentler, more polite, less intrusive, and contains more adjectives of approval. The literature suggests that if one accepts that there are separate discourses for male and female and if there are features in a given language used by both male and female, but some features used more often by women than men, then this must influence gender socialisation. From a psychiatric nursing point of view, this softer more gentle approach used to be at odds with treatment approaches which tended to centre around custody rather than therapy. As these

approaches have changed, a softer, gentler approach to patient care will and should become the treatment style of choice. This particular issue goes directly to female nurses being able to de-escalate anger much more readily than their male counterparts. Similarly, one might puzzle over what effect this would have on the 'fitting in' with the allotted role of a particular profession or occupational group. It would mean that new members would pick up the language and assimilate these features into the role despite the literature often suggesting that these features are generally interpreted as homogeneous. This interpretation suggests that like sexist discourse, the characteristics of female discourse derive from, amongst other things the social disadvantage of women and is in this sense a language of diffidence or powerlessness. These particular arguments also suggest that because females generally adhere to these socialised features they adopt the female orientation to cooperative and more agreeable strategies in the use of language. This would clearly be an advantage to psychiatric nurses employed in any health care setting as more cooperative and agreeable strategies would have a lot to offer in terms of patient care and outcomes.

Clearly, one can extend this argument across the whole nursing profession and by subscribing to the view that contextual circumstances shape 'gender as a performance' gender becomes an important consideration in psychiatric nursing. Males and females in psychiatric nursing fulfil separate yet interchangeable roles, one which encompasses the caring or nurturing side of their nursing or the more feminine role and one which deals with risk management issues, the security of others and general control which are seen more as the male features of their nursing. Both incorporate the other, but are enacted or

played out differently by each gender. These two roles have changed across the development of the profession and especially over the last twenty to thirty years. The notion of these roles being interchangeable demonstrates that more flexible gender arrangements can be employed in practice to the advantage of patients and individual practitioners. The history of nursing has been shaped by a whole series of factors but importantly, when one adds psychiatry to nursing many other complexities come into consideration. This thesis has examined some of the changes over the last two hundred years, and shown that some of these are significant and representative of gender influences to the changing job role and profession. In contrast, the concern by others about people suffering from a mental illness has not changed to any significant extent and mental illness is still depicted in the media in rather stigmatising ways. This stigmatisation has led to some interference by politicians and advocacy groups and to a range of searching inquiries, rhetoric and verbose reports.

Traditionally, risk management, security and control are areas usually dealt with by males and the more caring, nurturing and empathic roles carried out by females. This is not meant to suggest that females cannot take care of security and risk management issues or that males cannot be caring but suggests that these areas are usually ascribed to specific gender as a matter of tradition and are used in the absence of evidence on which to alter such a perception. Clinical practice would have a range of war stories which would bear this out with females deescalating anger and males giving in depth care, both second to none.

This dilemma also impacts on the role status assumed or prescribed within multi-disciplinary health teams, where one's gender is often an unacknowledged factor when health care interventions and specific tasks are decided/allocated. Care of mother and baby in admissions that deal with postnatal depression or puerperal psychosis, for example, would be allocated to female nursing staff, and cases dealing with seclusion or high dependency would invariably be allocated to male nursing staff.

The traditional gendered division of labour was reinforced in the traditional asylum workplace with the spatial division of the asylum into male and female sides, which was based on the constructed ideals of masculinity and femininity held by men who designed and ran these huge institutions. These arrangements, which divided both the staff and patients, suggest that Victorian institutions were highly paternalistic and reflected the accepted cultural norms of the day. We have moved considerably since these constructions but history and tradition get in the way at times.

The other central theme to this research was the notion of gender and caring and how a person acquired the ability to be able to care. Clearly, individuals care in different ways and under the older hospital based training, one's ability in terms of caring was not competency based or measured. Likewise, the current university comprehensive programmes cannot measure how much or how well an individual cares.

Caring for in a nursing procedure and caring about from a more moral perspective are different variations across a similar theme. Much of the nursing literature asserts that

caring is a feminine virtue, and links the ethical ideal and attitude of caring to the carer's earliest memories of being cared for themselves. These arguments imply universalism and that all people who are cared for will be caring themselves with mother-child experiences, bonding issues and an array of individual circumstances adding variables to this particular analysis. These views which link caring as a feminine value seem to suggest that males who are also the recipients of care from their mother as babies would not benefit from the same caring, symbiotic and socialised formula. This thesis examines whether caring is only learnt from one's own mothering experiences and has no innate or inborn quality as depicted in some of the nursing literature which would suggest that mothers who were employed in nursing and gave birth to daughters would also probably become nurses and although this does occur it is not always the case.

In practice, nursing, unlike other occupations, tends to cut across the gendered construction of labour and arguably nursing could be now classified as becoming much more gender neutral. The notion of nursing more becoming gender neutral may prove difficult to the profession as statistically only 7.4% of registered nurses are male (Australian Bureau of Statistics, 1998), with a much higher percentage working in psychiatric nursing. The numbers of males entering undergraduate programmes has risen slightly over the last few years (NBV, Annual Report 2002) and this may be a positive sign and a good starting point. Clearly, the changes to nursing education, and the movement of psychiatric nursing into comprehensive programmes, have been problematic for psychiatric nursing in Australia and overseas, with recruitment being the main casualty. The movement has encouraged a small increase in females considering

entry into the course but retention rate problems have been the result, and it has been counterproductive to the profession generally. It is clear that most graduates select options in general nursing areas, especially those seen as more 'romantic and high tech', and therefore more appealing to graduates. This study suggests that the problem of recruitment and retention of nurses generally, but psychiatric nurses in particular, facing health care administrators, so ubiquitous across the history of psychiatric nursing, might be ameliorated by adopting some of the recommendations highlighted by this research. These recommendations suggest that administrators in nursing need to change some of the long held views about nursing practice. Specifically, that nursing is better suited to females and that this gender orientation is the major prerequisite to employment. Added to this, the view held by those who recruit nurses to the psychiatric areas of practice, which tends to endorse the view that males would be a better employment proposition than females. This research dispels that view and suggests that those who hire staff for hospitals and admit students to nursing education programmes need to select applicants on the basis of their ability to care despite the gender of the applicant. This may direct more males and females to different areas of practice, which the comprehensive programme is supposed to accommodate educationally, and provide more rounded provisions for gender across the stereotypes usually associated with psychiatric and general nursing.

The arguments offered earlier about males being socialised differently to females from day one of life highlights the dilemma that males and females moving into psychiatric nursing may face, because of psychiatric nursing being considered a male domain.

Although only 7.4% of nurses are male, anecdotally, more males are now expressing an interest in nursing with a slight increase in numbers entering the profession across 2001 and 2002. Despite this, it seems that the advertising still tends to target young females in nursing recruitment drives and the stereotypical picture of the nurse is still protected.

8.5 Recommendations

- 1 On the basis of this research, health services and human resources need to be proactive in adopting more gender-neutral recruitment strategies, acknowledging that nursing is work that males can do and embracing a less gendered conception of itself. Secondary school career advice and nursing schools in the tertiary sector should accommodate this gender neutral strategy into their business plans.
- 2 Recruitment drives should emphasise the role function and take a more egalitarian approach. They should start from a recognition that it is not gender that counts or matters and target people who can do the job. Gender is important but to continue to assume that only females can care is rather short-sighted. Some females do not care well, despite evidence which suggests that they should, and often males provide care of a much higher standard than their female counterparts. We need to move the nursing profession toward more gender-neutral territory and revise selection criteria to incorporate and employ those who can care well despite their gender.
- 3 The comprehensive nurse education programmes offered by universities and other educational venues need to increase the psychiatric nursing components of their undergraduate degrees. Part of this extended programme should include

gender and gender issues. We can use the range of skills which each particular gender brings to nursing, and the crossover of gender markers might be a useful starting point for this. On the basis of this research, males calling upon their female qualities/skills and females calling upon their male qualities/skills can only add to the quality of the therapeutic approaches used and the clinical care given. In this career advancement would be more likely across the gender spectrum.

- 4 This research argues that the comprehensive nurse education programmes have not been successful for psychiatric nursing in Australia and that consideration needs to be given to returning to a separate training programme for psychiatric nursing in its own right. It argues that psychiatric nursing is a speciality, which needs to be treated as such. Recruitment and retention have always been significant issues in psychiatric nursing across its history with many inquiries in both England and Australia complaining about staff shortages and the need to recruit better staff. These issues do not usually attract much public attention but now that psychiatry is taught across comprehensive nursing programmes in the tertiary sector it is a topic that is considered more fully within this venue.
- 5 The history of psychiatric nursing could be included within the educational curriculum as a useful resource from which practitioners can learn.

All of the points discussed within this thesis demonstrate that psychiatry, taking a historical perspective, has had and continues to have, a significant gendered nature. This gendered nature has been important to how we practice psychiatric nursing today and

because of this to the care of the mentally ill. Practitioners need to move forward with wisdom, learning from their history, as a catalyst for and to incorporate change.

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