Storytelling in Mental Health Nursing:
Clinical and Educational Purpose

Anna Elizabeth Treloar
RN MA MPHC
Student Number c3098026

A thesis presented in fulfilment of the requirements for the degree of
Doctor of Philosophy
University of Newcastle
September 2014
Statement of Originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University’s Digital Repository, subject to the provisions of the Copyright Act 1968.

Signed: ....................................................

Date: .........................................................
Declaration

I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree to any other University or Institution.

Signed: ....................................................

Date: ........................................................

Anna Elizabeth Treloar
Acknowledgments

My supervisors, Professor Margaret McMillan and Professor Teresa Stone, gave generously of their time and always provided encouragement and prompt assistance in spite of an already heavy workload; and without the storytellers themselves, this project could never have begun.
# Table of Contents

Statement of Originality ........................................................................................................ i
Declaration ................................................................................................................................ ii
Acknowledgments .................................................................................................................. iii
Table of Contents .................................................................................................................... iv
Table of Tables .......................................................................................................................... viii
Table of Figures ........................................................................................................................ viii
Appendices .................................................................................................................................. x
Abstract ......................................................................................................................................... 1
Chapter One ................................................................................................................................. 3

## INTRODUCTION .......................................................................................... 3

1.1. Introduction ......................................................................................................................... 3
1.2. Using reflective stories or narratives ............................................................................... 4
1.3. Background .......................................................................................................................... 5
1.4. Personal stimulus ................................................................................................................ 6
1.5. Learning theories ................................................................................................................ 7
1.6. Research question .............................................................................................................. 9
1.7. Scope of the study .............................................................................................................. 10
1.8. Research design ............................................................................................................... 10
1.9. Methodology ..................................................................................................................... 10
1.10. Significance of the study ................................................................................................. 11
1.11. A note about the language ............................................................................................. 11
1.12. Structure of the thesis .................................................................................................... 12
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.13</td>
<td>Conclusion</td>
<td>13</td>
</tr>
<tr>
<td><strong>Chapter Two</strong></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td><strong>LITERATURE REVIEW</strong></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Introduction</td>
<td>15</td>
</tr>
<tr>
<td>2.2</td>
<td>Search strategy</td>
<td>16</td>
</tr>
<tr>
<td>2.3</td>
<td>The meaning and use of narrative</td>
<td>17</td>
</tr>
<tr>
<td>2.4</td>
<td>Narrative in qualitative research methodology</td>
<td>19</td>
</tr>
<tr>
<td>2.5</td>
<td>The use of narrative in therapies</td>
<td>19</td>
</tr>
<tr>
<td>2.6</td>
<td>The use of narrative in education</td>
<td>21</td>
</tr>
<tr>
<td>2.7</td>
<td>Narrative research in education</td>
<td>23</td>
</tr>
<tr>
<td>2.8</td>
<td>Use of stories in nurse education</td>
<td>24</td>
</tr>
<tr>
<td>2.9</td>
<td>Narrative and clinical reasoning</td>
<td>26</td>
</tr>
<tr>
<td>2.10</td>
<td>Mental health nurse education in Australia</td>
<td>27</td>
</tr>
<tr>
<td>2.11</td>
<td>Mental health nurse education</td>
<td>29</td>
</tr>
<tr>
<td>2.12</td>
<td>Techniques used in mental health nurse education</td>
<td>33</td>
</tr>
<tr>
<td>2.13</td>
<td>Narrative and cultural criticism</td>
<td>39</td>
</tr>
<tr>
<td>2.14</td>
<td>Narrative in medicine</td>
<td>40</td>
</tr>
<tr>
<td>2.15</td>
<td>Narrative pedagogy in nursing</td>
<td>41</td>
</tr>
<tr>
<td>2.16</td>
<td>Problems with using narrative in nurse education</td>
<td>47</td>
</tr>
<tr>
<td>2.17</td>
<td>Narrative and the learning organisation</td>
<td>47</td>
</tr>
<tr>
<td>2.18</td>
<td>Relevance of narrative to workplace engagement and workforce retention</td>
<td>49</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>The future of nurse education</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Summary and conclusion</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Chapter Three</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>3.1. A student’s story</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>3.2. Introduction</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>3.3. Literary analysis</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>3.4. Qualitative methodologies</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>3.5. McCormack’s Lenses and narrative data</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>3.6. Case study research</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>3.7. Summary of methodology</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>3.8. Method</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>3.9. Rigour and trustworthiness</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>3.10 The audit trail</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>3.11 Conclusion</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>Chapter Four</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>DATA COLLECTION AND ANALYSIS</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>4.1. Introduction</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>4.2. Data collection</td>
<td>81</td>
<td></td>
</tr>
<tr>
<td>4.3. First data analysis - Undergraduate nurse workshop</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>4.4. The Data Analysis Template</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>4.5. The data collection and analysis process</td>
<td>94</td>
<td></td>
</tr>
</tbody>
</table>
4.6 Data analysis based on Data Analysis Template ...................... 97
4.7 Data analysis based on tellers’ own interpretations of their stories and on workshop participants’ interpretations ..................... 137
4.8 The six long stories – what do they tell us? ......................... 146
4.9 Conclusion ........................................................................... 153

Chapter Five ................................................................................... 155
DISCUSSION .................................................................................... 155
5.1 Introduction........................................................................... 155
5.2 Researcher reflections.......................................................... 156
5.3 Research question................................................................. 157
5.4 Purpose of study ................................................................. 158
5.5 Discussion ............................................................................ 158
5.6 Complex stories from the collection: Appendices 1 and 2..... 169
5.7 The Six Long Stories suitable for discussion on ‘FITNESS FOR PURPOSE’ ................................................................. 171
5.8 Four examples of stories suitable for educational purpose ... 173

Chapter Six ................................................................................ 179
CONCLUSION ................................................................................ 179
6.1 Significance of this case study for mental health nursing...... 179
6.2 Closer interpretation of the findings ........................................ 180
6.3 Summary of discussion by experienced mental health nurses in two workshops.............................................................. 182
6.4 Thesis statement .................................................................. 184
6.5 The outliers – significance .................................................... 186
6.6 Comparison of findings with previous studies ....................... 188
6.7 Deduction – generalisability.................................................... 189
6.8 Implications ............................................................................. 190
6.9 Conceptual framework............................................................ 192
6.10 Areas useful for future research and applicability to practice 193
6.11 Recommendations and justification of recommendations ..... 194
6.12 Limitations ............................................................................. 197
6.13 Conclusion ........................................................................... 197

References ............................................................................................. 200

APPENDICES ........................................................................................ 221

Table of Tables

Table 1: Numbers & types of nurses in stories......................... 98

Table of Figures

Figure 1: Data Collection & Analysis audit trail ......................... 95

Figure 2: The pond......................................................................... 186

Figure 3: A window on clinical practice and education in mental health nursing................................................. 193
Appendices

Appendix 1: Stories - Numbers 1-40 .................................................. 221
Appendix 2: Stories - Numbers 41-100 ............................................. 263
Appendix 3: Ethics Approval .............................................................. 296
Appendix 4: Ethics Approval (Variation) .......................................... 300
Appendix 5: Poster ........................................................................... 302
Appendix 6: Information Statement for the Research Project 303
Appendix 7: Consent Form ................................................................. 307
Appendix 8: Workshop Plan ............................................................... 309
Appendix 9: Code Blue notes ............................................................... 313
Appendix 10: Code Red Notes ......................................................... 317
Appendix 11: Submitted version of article for Perspectives in Psychiatric Care (accepted 10/7/2014) ......................... 319
Abstract

Mental health nurses and those working in mental health tell stories in formal education sessions such as lectures, tutorials, and in informal teaching and also in the workplace. Many are told to undergraduates and to new recruits. The purposes of the storytelling and the possible interpretations and messages taken away by the listeners have not often been explored.

I collected 100 stories directly from mental health nurses and also from a few previously published sources to uncover the purpose of stories told by experienced mental health nurses to undergraduates and new recruits.

The study determines:

1) The implications of these anecdotes about mental health nursing for the exploration of contemporary mental health practice and education;

2) The educational value of the stories (the essence and rationale of the narratives) for use as stimulus material i.e. as catalysts for learning for both the novice and more experienced mental health nurse; and

3) The relationship between concepts relevant to the enhancement of both practice and education in order to develop a conceptual framework for professional practice and education.

A case study methodology was used to analyse the stories and explore their fitness for educational purpose. This methodology is flexible and often used in educational research. It is particularly suitable where the question is “How?” or “Why?” The components of a case study are people, things, events, contexts and relationships, components which are suitable for analysis of stories about mental health nursing.

Three workshops were held, both to collect stories, and to record insights about the stories. Participants were two groups of experienced mental health nurses, and one group of undergraduates close to registration. Their insights about how the stories could be interpreted and the purpose of telling selected stories were also written down. A Data Analysis Template (based on the work of Tripp (1994) and McCormack (2000a) was used to analyse the stories and this showed that the most significant aspects of the stories were Events, Relationships and Moments.

Anna Elizabeth Treloar
The stories fell into three main groups, the first at the surface level, dealing with the history of mental health nursing and providing examples of mental health nurse humour, the middle level offering a variety of insights into daily work in mental health nursing whether in the hospital, the community, the prison or other setting, and the deepest level stories showed the attitudes and skills developed by experienced mental health nurses.

What was highlighted was the use of silence, the place of tears, the use of apology, the discounting of aggressive behaviour and potentially dangerous situations (although the risk was always understood and recognised), the ability of the mental health nurse to engage with and relate to the most challenging people, the advanced assessment skills held, the strong advocacy by the mental health nurse for the patient or client or consumer, the willingness to be a change agent in new settings for mental health care, and, whether the story contained some reflection or comment or not, the lack of self-aggrandisement and matter-of-fact acceptance of all that is involved in the daily life and work of a mental health nurse. Many of these skills are also required in the facilitation of student learning, particularly when students undertake their first clinical placement in a mental health setting. In this respect there may be similarities between the work of an experienced mental health nurse and the catalysts for effective learner engagement.

These clinical anecdotes capture much which is not contained in textbooks and allow students to enter the real world of mental health nursing, where not everything is predictable and orderly, and where “inspired creativity” is often required to manage difficult situations, and where the essential ambiguity of mental health nursing is demonstrated in a variety of ways. The value of the stories is that educators can use them to provide authentic stimulus material and facilitate discussions using the questions suggested in Chapter 5. These open questions encourage individual responses which may then allow for multi-faceted interpretation by groups of students. This in turn may be a useful preparation for a first clinical placement in mental health nursing, or a way to debrief after a first placement is completed.
Chapter One

INTRODUCTION

“Narratives do not mirror, they refract the past” (Riessman, 2006, p.186).

1.1. Introduction

This introductory chapter begins with the background to and stimulus for the research. There follows a brief overview of the study, including the research questions, aims, design and scope. The significance of the study is discussed and the chapter concludes with an outline of the structure of the thesis.

Most of us grow up hearing stories from our parents and grandparents. Later we may hear stories at school. Mental health nurse educators and clinical mental health nurses have traditionally used stories in their teaching as a way of illustrating to students what they see as the essence of mental health nursing. Other professions use stories in different ways, including doctors, social workers, psychologists, therapists, and educators (see Chapter 2). As Hunter (2008) remarks, “Humans are most certainly a storied people” (p.2).

All stories capture our attention, entertain us and, if they are well constructed, serve other purposes as well. Parables and fables have a strong educational purpose. Epics encourage the development of understanding of moral issues and preserve history. Folk tales, myths and legends create and transmit culture.

Anyone can access stories from websites; students can do so as a discovery exercise. For example these websites would be accessed by nurse academics as a source of stimulus material for students or by the latter, under the direction of nurse academics during a learning event or as part of their general personal pursuit of material freely available to a generation of information fluent students, academics and consumers of mental health.

If stories are to be effectively used in the teaching of undergraduate nurses, they need to have a purpose which is readily apparent to the teacher and readily understandable by the students, although there may be different interpretations and different value or
emphasis placed by students on each component of the story. At the same time the stories must not be so simple as to provide no challenge or focus for discussion, or so esoteric that no meaning is apparent or the meaning only clear to the cognoscenti.

Use of stories will vary depending on the focus of the curriculum. In nursing curricula oriented to the medical model, students are required to learn lists of symptoms and diagnostic criteria, look for a diagnosis and then plan nursing care according to the diagnosis and most prominent symptoms. In contrast, more process-oriented curricula, for example, problem-based, solutions-oriented or practice-based models, rely on learning scenarios as stimulus material. The scenarios are used as stimulus material for learning events which are designed to expand students’ enquiry about the necessary knowledge and skills for appropriate treatment and management of a patient with a particular constellation of symptoms and are designed to expand students’ knowledge of treatment and management of a patient with a particular diagnosis. Carroll (2010) writes about the move towards approaches which may include the use of cases, personal histories or stories which represents

…a shift in academic culture from the traditional, teacher-focused “dissemination of knowledge” model of education to learner-focused models that look at what the learner does and why in the social context of learning (p.235).

1.2. Using reflective stories or narratives

Stories told by mental health nurses come from their perceptions of situations within a real clinical setting and from their own experience. Although they have become crystallised as stories they usually have one unusual or memorable feature, and they are still about real people in a real life situation. In a way they are "simulations" outside the laboratory, but the construct and face validity of the narrative is dependent on the lens of the storyteller.

Students and nurses more generally can practise thinking through a situation embedded in a particular story with the support of other students and the teacher. However they need a framework for this kind of interrogation of clinical situations; they may find there are various interpretations and various ideas on ways to react and
manage the situation. Initial understandings and reactions may change with deeper understanding and following the input of the group.

1.3. Background

By way of example, here are six stories told to me at various stages of my nursing career. All came from practising nurses and clearly they had different purposes in the telling:

i. One night I admitted a man who had had an amputation of the right leg and who had no prosthesis. “Where’s your leg?” I asked him. “Oh,” said the patient, “I left it behind in Queensland. I got tired of it” (from a NUM [Nursing Unit Manager] of an Acute Psychiatric Unit).

ii. One day I got a request to go upriver with the Police as there had been reports that a man had become psychotic on an isolated property. We drove to the house, knocked and found nobody there. All the walls were splashed with blood and the house inside was in disarray (from a community mental health nurse who had been the sole practitioner in mental health for many years in a rural town).

iii. A nurse and a patient worked together in the gardens of one of the former large government psychiatric institutions for 20 years. One day the patient stabbed the nurse with a pair of shears for no reasons that anybody could make out (from a nurse academic).

iv. A patient was brought in by ambulance as an involuntary patient. He was assessed and admitted to the ward by nursing staff. After several hours one nurse noticed an unusual bump on his back. “Either that man has curvature of the spine or there is something else going on there,” he thought. The patient was searched and discovered to have a machete concealed underneath his jacket (from a nurse who had heard the story from another nurse who worked at a large admission hospital in a regional centre).

v. The father of one of our clients with schizophrenia died and was buried. The day after the funeral the son went to the cemetery at night and dug up the grave. He removed his father’s body from the coffin, brought it home and settled
it in an armchair. He then woke his mother and said, “Dad’s home” (from a member of a community mental health team in a rural area).

vi. Now look here, you are young and just starting out and I am old and finishing up. I want to tell you something. Never ever get emotionally involved with a patient. It doesn't work for either of you. We had a doctor here who married a patient. Both committed suicide (from the Charge Nurse of the admission ward when I was still in my first year of psychiatric nursing, an unsolicited story which I will never forget).

Of these, the first is designed to amuse. It may demonstrate one aspect of having a mental illness, though which one would be hard to identify. The next three stories serve primarily to frighten, possibly also to warn of the need to conduct regular risk assessments. The fifth may illustrate extremely bizarre behaviour associated with psychosis.

Only the sixth serves a true educational purpose. The fact that I have remembered it for so many years shows what impact it had. It was offered to me almost as a legacy by a retiring and very experienced psychiatric nurse who saw me perhaps as young and idealistic and likely to confuse “caring” (which was emphasised strongly in nurse education at the time) with other emotions. There was no discussion of boundaries in those days and very little explanation of the therapeutic relationship. This story offers ample opportunity to discuss nurse-patient relationships, caring in nursing, boundaries, professional roles, a team approach, the value of mentoring, the role of clinical supervision and many other issues still important in mental health nursing today.

1.4. Personal stimulus

The impetus for this study came from an undergraduate nursing student who remarked at the end of a mental health nursing lecture, “Lectures are just the same as the lecture notes except that in lectures you get the stories”. This prompted me to wonder whether stories enhanced or detracted from lectures, and particularly what interpretations students made of what they heard, and what messages they took away with them.

At the time of embarking on the study a number of assumptions were at the forefront of my thinking. For example, if a story is chosen to be told to undergraduates it must have
an identified purpose and possible ancillary purpose. It needs to show a situation involving staff and patients from a real clinical setting. It needs to have a structure, with a beginning, middle and end, even if it is only a vignette. Characters must be defined in sufficient detail to make the story credible. What sort of story should be excluded? Perhaps any story told with the sole purpose and effect of shocking, disgusting or frightening, probably any story told with the sole purpose of providing a stage for the teller to exhibit his or her own brilliance, and certainly any story where any character could be identified should be excluded. Stories with a mixed message or conflicting interpretations should be included. Stories which are overly long or complicated should be excluded as, to be effective, they need to be comprehensible and memorable after one telling. These assumptions needed to be tested and helped to shape/develop the research.

1.5. Learning theories

In education there are two schools of thought on how learning happens. The behavioural school sees learning as a type of conditioning which takes place through stimulus, response and reward, whereas the cognitive approach focuses on perception, memory and concept formation leading to the development of understanding and the ability to solve problems. This cognitive approach is where the telling of stories fits (Race, 2007).

Acquisition of knowledge encourages a surface approach to learning as students memorise lists of signs and symptoms, possible treatments and then look for a fixed set of nursing interventions to suit a particular diagnosis. The exam looms and once that hurdle is passed, many of the acquired “facts” will be forgotten (Race, 2007). If, however, students are encouraged towards a deep approach they will go through a process of rearranging the new knowledge in the context of what is already known. Ausubel (1968) said that the most important single factor influencing learning is what the learner already knows. Student nurses bring to mental health nursing knowledge from other courses and from clinical experience, as well as from personal experience. There is a foundation present on which to build new understandings. Clinical anecdotes told by experienced mental health nurses may provide a new perspective, a different way of thinking, a deeper appreciation of what this branch of nursing involves. They
may not have the same educational design features as the more carefully constructed scenario.

By way of example, here is an excerpt from a problem-based learning scenario:

Joe has had major business problems in the past months. He fears that the family home may be repossessed though he has not liked to tell his wife this. He ruminates constantly on his financial losses and comes to blame himself for all of them, even though the recession and the drought have affected many families. He finds he wakes before dawn and cannot get back to sleep although he is constantly tired. His appetite is poor and his clothes seem to hang off him now. He misses his children’s soccer final because he is too tired to go, and cancels a family barbecue for his parents’ wedding anniversary. His mood continues to lower and he begins to see suicide as his best option.

And here is a story taken from real clinical experience, without an overlay of design to guide the student’s discovery learning process:

A woman in her mid-fifties had been looking forward to her husband’s retirement. They had trips planned and she hoped to spend more time with her grandson when her daughter went back to university. However, her daughter moved interstate to attend university taking her son with her and although her husband retired as planned, his activities did not include her as much as she had hoped, and she often found herself at home alone while he was out fishing with his mates or fixing up an old boat he had bought. This continued for several months during which time her energy levels dropped, her mood lowered, her interest in all her former craft activities diminished and she became convinced that she had no role in life anymore and was not needed by her husband, her daughter or her grandson. One day she decided she would be better off dead, so she collected all the pills she could find in the house and went up to her bedroom. Before she took them, she wrote a note which said, “Be careful when you come in as I am dead. Love, Mum”. She pinned it to her bedroom door and took all the tablets. She was found in time, taken to hospital and made a full recovery. By the time I met her she was able to laugh about her note and had a much better understanding of depression.
The problem-based learning scenario should be authentic, but also carefully designed to include clues to direct student learning. The story includes some cues that might direct learning, arising from the woman’s own account of her life until she took the overdose. But the story told in a spontaneous manner, supported by a useful framework for education, can also illustrate many things, in this instance about suicidal ideation. In particular it illustrates ambivalence and the continuing care for and connection with the family. Did she hope to be found? Did she expect to be found? Some students might argue for “attention seeking behaviour”, yet this was a first attempt by a woman with a happy and stable life previously and no history of depression. How else can we explain this? Can we look at the traditional role of the woman as caregiver and what happens if it is perceived to have ended? Can we discuss why nobody including the woman recognised the onset of depression? How well did the woman conceal her thoughts and feelings? Or did nobody notice or ask? How do we seek help? Where do we seek help? What happens if the help is not forthcoming? What are the community’s beliefs about mental illness?

1.6. Research question

In order to begin the processes of discovery in response to the issues inherent in my assumptions, the research was directed towards answering the following superordinate question:

i. What is the purpose of clinical anecdotes told by experienced mental health nurses to undergraduates and new recruits?

Other questions arising from the main question were:

i. What are the implications of these anecdotes about mental health nursing for the exploration of contemporary mental health practice and education?

ii. What is the educational value of the stories (the essence and rationale of the narratives) for use as stimulus material i.e. as catalysts for learning for both the novice and more experienced mental health nurse?
iii. What is the relationship between concepts relevant to the enhancement of both practice and education in order to develop a conceptual framework for professional practice and education?

1.7. Scope of the study

This study aimed to address a gap in the literature to explore the purpose of clinical anecdotes told by experienced mental health nurses to undergraduates and new recruits. During the study 100 stories from the mental health nursing clinical setting were collected and analysed using case study methodology and a Data Analysis Template based on the work of Tripp (1994) and McCormack (2000a). Three workshops were held to collect stories and to discuss interpretations of them and purpose for telling them.

1.8. Research design

After ethics approval was gained, a poster, consent form and participant information statement was emailed to all staff at the School of Nursing and Midwifery at the University of Newcastle and to some staff at Hunter New England Local Health District. An invitation to attend a workshop was included. A pilot workshop was held for a small group of mental health nurses in a private home, and later a larger workshop on campus. In both workshops, stories were told and written down, and a discussion about their possible interpretations and the purpose of telling them was held. A few stories were selected from published sources and appropriately acknowledged, and other stories were emailed by nurses who had heard about the workshop through others, but were unable to attend. Some nurses who did attend a workshop later emailed additional stories. Detailed notes were taken of the content of the discussions. Later a third workshop for undergraduate nursing students close to registration was held, and a small selection of the stories was presented to them for their interpretation and comments. Detailed notes were also taken of this discussion. The 100 stories were analysed using the components on the Data Analysis Template (see Chapter 4).

1.9. Methodology

Case study methodology was selected as the most useful methodology for the project (Treloar, Stone, McMillan & Flakus, 2014). Miley et al. (2012) define it as an “in-depth
examination of a specific circumstance” (p.28) so that it may focus on an individual, a community, an organisation, a practice (such as storytelling) or an event. It is useful where the question is “How?” or “Why?” (Yin, 2009) and the case may be a student, a classroom, a committee, a program but not a problem, a relationship or a theme. It has “a unique life” (Stake, 1995, p.133). Case study has been used frequently in educational research and allows sufficient “organic flexibility” (Snyder, 2012, p.19) for this exploratory question. One of its purposes is to make the familiar seem strange so that attention can be drawn to it (Watts, 2007).

1.10. Significance of the study

The study calls attention to a common practice in the education of undergraduates and new recruits, the telling of stories, whether formally in the classroom or informally in a hospital or community setting. The collection of stories shows the diversity of settings where mental health nurses practice, and also the variety of situations they are called on to manage on a daily basis. The most significant categories for educational purposes from the Data Analysis Template were the components Events, Relationships and Moments, because these demonstrate aspects of mental health nursing practice and situations encountered which are unlikely to be described in undergraduate textbooks or in problem based learning scenarios often used in teaching.

1.11. A note about the language

The majority of the stories use the word “patient” and only a few use the word “client”. No story uses the word “consumer”. The text of the stories has been presented unaltered, though the word “person” is used in preference throughout the thesis itself. Older stories or those describing an episode from many years ago tend to use the term “psychiatric nurse”; the more recent stories use the current term “mental health nurse”. “Nurses working in mental health settings” is used in preference to “mental health nurse” in some parts of this study because not every nurse in contemporary mental health units has had specialised education in the field. Nurses who work in a mental health setting are likely to describe themselves as “mental health nurses”, whether they are Registered or Enrolled, and regardless of what formal study they have completed in the field of mental health nursing. So a new graduate who begins a nursing career in a mental health unit will become a “mental health nurse” by description as will a
Registered Nurse who has 40 years experience but has done no study beyond a first hospital certificate in psychiatric nursing leading to registration.

In contrast the Australian College of Mental Health Nurses requires Registered Nurses to become credentialled before they can assume the title of Mental Health Nurse. The credentialling process requires the applicant to have a current licence to practice in Australia, hold recognised postgraduate qualifications in mental health nursing, have at least one year of experience since completing this (or have experience of over three years working as a Registered Nurse in the context of mental health nursing service), have been practising in the last three years, have completed minimum continuing professional development in the preceding three years, provide two professional referees and sign a professional declaration agreeing to uphold the standards of the profession (Australian College of Mental Health Nurses, 2013).

However, like the profile of the mental health workforce, not all the participants in the first two workshops held were credentialled. All had spent many years in the field of mental health nursing and held qualifications ranging from a hospital certificate in psychiatric nursing to a Master’s degree in Mental Health Nursing to a PhD; at least three were Credentialled Mental Health Nurses. Most held senior positions such as Clinical Nurse Consultant or Nurse Manager or Lecturer. Their years of experience in mental health nursing allowed them to draw on a pool of stories from their own clinical experience to contribute this study. It was the clinical experience which was more important for the purpose of the workshops than being a Credentialled Mental Health Nurse or having a postgraduate degree.

1.12. Structure of the thesis

This first chapter is introductory and provides a background to the study as well as a brief outline of methodology and a statement about the significance of the study. The 100 stories are presented in Appendix 1 (Stories 1-40) and Appendix 2 (Stories 41-100).

Chapter 2 is a literature review and looks at the meaning and use of narrative, narrative in qualitative research methodology, the use of narrative in therapy, the use of narrative in education, narrative research in education, the use of stories in nurse education, narrative and clinical reasoning, mental health nurse education in Australia, mental
health nursing education, techniques used in mental health nurse education, narratives and cultural criticism, narrative in medicine, narrative pedagogy in nursing, problems with using narrative in nurse education, narrative and the learning organisation, relevance of narrative to workplace engagement and workforce retention and the future of nurse education.

Chapter 3 discusses the choice of case study methodology for the project. Chapter 4 provides a summary of the data analysis using the Data Analysis Template which is based on the work of Tripp (1994) and McCormack (2000a) and also reviews the comments made by nurses who attended the workshops. Chapter 5 discusses the findings, and Chapter 6 provides a summary and conceptual framework and makes recommendations for clinical practice and education.

1.13. Conclusion

Undergraduates, like all qualified nurses, bring a wealth of nursing knowledge to mental health nursing from their workplace, from personal experience and from other courses they have taken. They then need to integrate this with the guiding principles of mental health nursing to form a new understanding and appreciation of the role of the mental health nurse. Stories give them an opportunity to review what they know and discover if it will fit the situation described, and then to integrate old and new knowledge in an understanding of what is the best approach. There may be several approaches possible and the best one for each nurse may depend on the nurse’s own personal communication style and on the quality of the therapeutic relationship established. This type of thinking is different from traditional approaches or the “one way/one solution” or answer.

Telling stories is part of being human, whatever our age or professional discipline. If mental health nursing is about communication and relationships and the celebration of the individual, then the stories told by mental health nurses as they teach students need to be collected, analysed and valued, both as a historical record of the development of psychiatric nursing, and as a way of identifying key mental health nursing skills and values, and for the education of future nurses.
In this chapter I have shown how the project came about and provided some examples of stories told to me. In the following chapter I survey literature related to the topic considered from a variety of viewpoints.
Chapter Two

LITERATURE REVIEW

2.1 Introduction

In Chapter 1 I introduced the topic, explained the background to the study including the personal stimulus for the project, outlined the research questions and determined the scope of the study and methodology and structure of the thesis. This chapter gives an overview of literature relevant to the study, presented under a series of subheadings, and covering a variety of perspectives. It moves from a general discussion of narrative, to the more particular, reviewing narrative in therapy, in research, in education, in nurse education particularly, including a look at the education of mental health nurses and summary of techniques used in mental health nursing education. To conclude, it briefly touches on the use of narrative with medical students, reviews narrative pedagogy in nursing, and finally it links narrative to the workplace.

A study of the use of storytelling by mental health nurses as a component of undergraduate mental health nurse education might at first seem a fairly narrow and circumscribed topic. However, the topic reveals connections to and implications for many other fields. Narratives serve an educational purpose in areas related not just to nurse education and may have global implications for nursing practice and research (Grassley & Nelms, 2009). Narratives are used in various types of therapy, and in qualitative research methodology. To be effective, they need to sit within a particular framework. While narrative pedagogy is particularly concerned with the use of narrative in nurse education, narrative also has implications for preparation for practice, the role of the learning organisation and for workforce retention. Although there is a move towards interdisciplinary learning, the use of storytelling can inculcate nursing values and an understanding of what it means to be a professional nurse, in other words, it can help define the nursing role as a separate identity within the healthcare team.

“Yesterday’s stories become tomorrow’s myths” (Bhattacharyya, 1997, p.1). They contain the culture, traditions, values and attitudes of a people and try to answer questions which preoccupy human beings such as where they come from and where they belong. Stories provide a common language to describe human experience (Schwartz & Abbott, 2007). They can provide a framework for social systems and
legitimise power. They may contain historical knowledge, and like fables, parables and folk tales have an educational purpose. Fables are stories with a moral; parables depict real situations. Fairy stories and folk tales both describe life experiences and instil moral values (Bhattacharyya, 1997). In satire follies and vices are ridiculed while legends are non-verifiable stories told as if true (Kirkpatrick & Brown, 2004). “Storytelling is a uniquely human activity that has guided learning since ancient times” (Gazarian, 2010, p.287).

In Australia, storytelling, “yarning”, is a practice among Aboriginal and Torres Strait Islander people which has been part of their learning for thousands of years. It is now being developed as a research approach to shift Western paradigms to fit with Aboriginal perspectives and worldviews. “This Eurocentric comfort zone is undergoing a shaking and a ruffling of its academic feathers” (Geia, Hayes & Usher, 2013, p.14). This yarning is not a static process; it progresses through “loud and raucous engagement, to a sudden move into contemplation and silence” (Geia, Hayes & Usher, 2013, p.15). Storytelling in mental health nursing could share similar features.

Stories are important to people of all cultures, to clients, undergraduates and mental health nurses too.

### 2.2 Search strategy

The initial focus of the search was to discover how narratives have been used in the education of mental health nurses with a view to identifying the purpose of storytelling in the clinical and educational setting. A second aim was to discover what other techniques have been used in the education of mental health nurses. When the first search uncovered narrative pedagogy a search was then made for narrative pedagogy and mental health nursing. This led indirectly to a discovery of the role of narratives in medical students’ education about professionalism which proved relevant to this study. The search strategy was broad in an effort to discover how wide the use of narrative has been in mental health nurse education. Therefore it was difficult to be highly specific as is required for quantitative methodology (Kable, Pich & Maslin-Prothero, 2012). The search for techniques already used in the education of mental health nurses revealed a wide range of different methods.

The initial search terms were “narratives and mental health nurse education”, “narratives and psychiatric nurse education”, and “mental health nurse education”.

Anna Elizabeth Treloar
Thus articles on nurse education in general were excluded. Articles more than 20 years old were excluded unless (like Nehls, 1995) they were seminal. If it was clear from the abstract that an article was not relevant, it was not retrieved. Of all articles retrieved and reviewed, at least 80 were not used: more than 200 articles have been cited, in addition to relevant chapters from books. Articles which had no direct relevance to this such as those about stories told by patients or by carers or by undergraduate students themselves as part of their coursework, were excluded. The initial purpose of the searches was to discover what work has already been done in the area of this study; where results of the study were important Blaxter’s (1996) checklist was used to evaluate, as the articles were largely qualitative. From the material found during the initial search, a purposive hand search was made based on identified articles.

Databases used were CINAHL, Ovid, PsycInfo, PubMed, and Proquest and where an area was difficult or to find an older source, Google Scholar. Rumsey’s guide (2004) was helpful in planning searches.

In 2014 a second brief search was done to look for articles published since the first search was done. CINAHL, Ovid and Proquest were used and search terms were “narrative and mental health nurse education” “narrative and psychiatric nurse education” “mental health nurse education” “clinical stories and mental health nurse education” and “storytelling and mental health nursing”.

2.3 The meaning and use of narrative

Starting in the late 1960s the concept of narrative has spread across many disciplines and professions, and draws on varied epistemologies, theories and methods. Although it once belonged to the study of literature, it has now become cross-disciplinary. It appears in history, anthropology, folklore, psychology, sociolinguistics, communication studies, cultural studies and sociology. Certain professions have also taken it up, including law, medicine, nursing, education and occupational therapy. One of its central areas is human interaction in relationships, which is of great relevance to social work, counselling and psychotherapy. However Riessman and Speedy (2007) found that some researchers in social work and psychotherapy described doing narrative analysis when they were actually involved in discourse analysis or grounded theory research.

The word narrative is used in different ways by different disciplines, often interchangeably with story. A story is a recounted sequence of events while narrative
takes in how this story is actually told (Woodhouse, 2007). Riessman and Speedy (2007) caution that narrative has come to mean “anything and everything” (p.248) but add that all talk and text is not narrative. A narrative requires a plotline, character and the complexities of a setting. The question then is how the facts were put together in a particular way. Which is the intended audience and what is the purpose?

Paley and Eva (2005,p.84) distinguish between narrative and story, saying that narrative is variously assumed to be a naive account of events, a source of subjective truth, intrinsically fictional or a way of explaining. Rather than use the term “narrative” they propose the word narrativity, saying that narrativity is something which a text has degrees of, with story at the high end of the narrativity continuum. A story contains an interweaving of plots and character organised to elicit a certain emotional response; narrative refers to the sequence of events and the (claimed) causal connexions. Narrative vigilance is required in order not to confuse the emotional persuasiveness of the story with the objective accuracy of the narrative. Narrative is a reported sequence of events, “not a portmanteau term for non-medical discourse”.

In anthropology narrative can be an entire life story put together from interviews, observations and documents. In sociolinguistics it can be an answer to a single question. In psychology and sociology accounts of a life may take up a single interview or several interviews or therapeutic conversations. Narrative is distinguished from other forms of discourse by sequence and consequence. The events must be chosen, organised, connected and seen as having meaning for a particular audience (Riessman & Speedy, 2007).

Rolfe (2002) advocates the use of fiction by the helping professions. He argues, based on the work of Weber (1968) that the quantitative paradigm seeks explanation and the qualitative paradigm seeks understanding. But the helping professions sometimes need knowledge which goes beyond the detachment of the first paradigm and the empathy of the second. This third kind of knowledge he describes as identification, an affective rather than cognitive understanding. The professional may engage with the patient on three different levels depending on whether the aim is to explain, or to understand cognitively, or to understand emotionally what the patient is experiencing. Only the third kind of knowledge, identification, allows the practitioner to experience vicariously what the patient is dealing with. This leads him to describe fiction as the lie that helps us see the truth.
Reading fiction allows the practitioners to broaden the scope of reflection to experiences never encountered in person. Paradoxically, Rolfe (2002) argues that the student who invented a case study for her reflective assignment, provided a valuable source of knowledge which allowed this third kind of knowledge, affective understanding or identification, even though both the account and the patient were fictional.

Harrison (2001) continues this argument saying that when works of fiction are used in nursing education as exemplars they confirm what is already known, supplement textbook information and provide patients with inspirational accounts of how others have overcome suffering. They are useful to gain understanding of sensitive subjects or situations that may be considered taboo in certain groups. Literary analysis may discover a political message embedded in the writing, reveal the way minority groups are depicted or increase understanding of human suffering. Fiction uses ambiguity, paradox and metaphor to reveal further what is being described. When Tucker (2010) used fictional short stories in the psychiatric education of medical students and registrars, he saw his charge to them as similar to what a judge says to a jury, i.e. use “only the facts presented, your experience of life, and your common sense” (p.450).

2.4 Narrative in qualitative research methodology

For nurse researchers using the qualitative paradigm, meaning, rather than truth, is what is sought. Reality is regarded as not only subjective but as essentially the construction of individuals interacting in a social environment. The researcher’s interpretation of this is yet another construction. Narrative analysis within the ethnographic paradigm examines the stories of participants from data collected during interviews. The researcher recognises that the tellers of the story select the components to convey the meaning which they want the listener to derive from the telling of the story. The teller conveys meaning not truth and the truth is of the teller’s experience which cannot be objective or externalised (Bailey & Tilley, 2002).

2.5 The use of narrative in therapies

Although therapists claim that what they do has a scientific basis, they are nevertheless fascinated by legends, fables, folk tales, myths, and fairy stories and Bhattacharyya (1997) cites the Oedipus story and its importance in Freudian psychoanalysis and
Jung’s work on dreams, symbols and myths. He notes that a story universalises a common dilemma and reminds the patient that he is not alone; this can bring relief and a sense of hope for a solution. Eventually, the person when a patient has to make meaning out of what he has discovered about himself and the world he lives in. A story can be used to develop insight and to encourage acceptance of what in the patient is “unacknowledged, unseen and possibly rejected parts of oneself” (Bhattacharyya, 1997, p.16). Psychologists have used stories to therapeutic effect; asking people to put their emotional traumas into a story may improve physical and mental health (Pennebaker, 2000). When stories are told they may gain significance from the context in which they are told. The experience and the narrative are inseparable so that psychopathology and psychotherapy can be seen as narrative deviations and as narrative restructurings respectively, i.e. both are a type of narrative phenomena. Psychotherapy taps into the power of stories to restore meaning between the past, the present and the future (Dwivedi & Gardner, 1997).

Narrative therapy or narrative practice in social work is based on the idea that people’s lives are shaped by stories. Stories, whether told by people about their own lives and told by others about their lives influence the meaning that people make of their identities. But one story does not capture all experiences as some will fall outside the dominant narrative. When these experiences are explored they become counter-stories which may ultimately overshadow the dominant stories. In narrative practice the therapist seek to determine how people respond to the difficulties in their lives and then to use them to construct a counter-story. Other considerations in counter-stories are what people value, and what purposes they have. The therapist also considers the politics of experience, viewing people's problems as being outside not within. Problems are externalised; people are not labelled or categorised. The therapist sees people as shaped by the relationships they engage in and also deconstructs community ideas about what constitutes 'normal', 'functional', or 'healthy'. These are also explored in the course of therapy (Sather & Newman, 2010). White (1989) points out that any act of interpretation requires ascribing a meaning to what happened. In therapy people are taken out of a static world and into a world of experience, a world which may be in flux. Their problems are viewed as arising from oppressive stories which have come to dominate their lives (Carr, 1998).

Other disciplines have also used narrative in different ways. Clouston (2003) advocated that occupational therapists use “therapeutic emplotment both to enable the
construction of occupational identity and to explore the occupational values of the
service users” (p.140). Narrative offers a tool for gathering information on occupational
life from the narrator’s perspective. Butler, Ford and Tregaskis (2007) noted that many
women with whom they worked as social workers had been “individually and socially
discouraged from telling their own stories” (p.287). Instead their stories had been told
for them by professionals and researchers, imposing an external meaning upon them
and resulting in labelling and stigmatisation. In response to this one of the authors
developed creative autobiography as a form of emancipatory practice. The role of the
social worker as expert and external validator is questioned, and the women become
the experts.

Speedy (2000) wrote of using narrative ideas and practices in counselling, saying that
people are situated within a “constantly changing web of connections and stories”
(p.365). The moral stance of counselling is moved out of the therapist’s office and into
the global community and is particularly useful in working with disadvantaged groups.

2.6 The use of narrative in education

Educational theorists are divided into the behaviourist school and those who hold the
cognitive view of education (Race, 2007). For the behaviourists, learning is a
conditioning process, requiring stimulus, response and reward. The learned behaviours
are the output and the stimulus is the input. The cognitive approach is concerned with
perception, memory and concept formation. Learning is demonstrated when students
can show what they have learned by solving problems (Race, 2007).

Ausubel combined elements of both schools, emphasising the starting point of learning,
and the need for anchoring concepts and learning objectives, and for learning material
which is clearly defined and set out. Ausubel’s career began in psychiatry and he then
moved to educational psychology. Subsumption or the idea that the big boxes in the
mental pyramid contain smaller boxes or newly found material is the key to his theory
of learning (Ivie, 1998). To Ausubel, the most important single factor which influences
learning is what the learner already knows (Race, 2007) – “Ascertain this and
teach...accordingly” (Ausubel, Novak & Hanesian, 1978, p.v). Students can use
narratives to demonstrate what they already know and use anchoring concepts and
learning objectives to move on to more complex interpretations and solutions.
Students need to be given an opportunity to think out a problem if they are going to learn to think. When there are questions to be answered, they must respond and work actively to find a solution instead of being passive recipients of “knowledge”. They can also try several solutions and interpretations based on what they know; on the material in the narrative; and on what else they need to discover in order to arrive at a solution which fits.

An effective teacher identifies an area for learning and then chooses what strategies will encourage learning. Some see this is a therapeutic alliance similar to what occurs in psychotherapy between therapist and patient. The teacher can provide feedback to the learner, and acts as mentor. The teacher is engaged with the student and can understand the student’s perspective in the learning process. The activity is relevant to the student’s needs, but the teacher allows the student to identify what needs to be learned (Ursano, Kartheiser & Ursano, 2007).

The Gestalt school views problem solving as a process which involves recognising the problem, then gaining familiarity with its elements, reorganising the elements, perhaps digressing into activity which turns out to be irrelevant and eventually experiencing the flash of insight which leads to a solution (Bligh, 2000). This is what is regarded as a deep approach to learning, where new knowledge is rearranged in the context of what students previously knew and where they distinguish principles. To do this, thought is required, rather than the memorising of facts and storing of information characteristic of the ‘surface approach’ to learning (Bligh, 2000). Deep learning involves critically analysing new ideas and linking them to concepts already known and leads to long-term retention of these concepts so that they can later be used in unfamiliar contexts (Houghton, 2004) and requires an intention to understand, an intrinsic interest in the work, the relating of ideas as well as the use of evidence to do this (Baeten, Kyndt, Struyven & Dochy, 2010). It needs not only understanding, but also the development of personal meaning, and the integration of new knowledge into pre-existing knowledge, with a resultant change in how the person views aspects of their world (Turner & Baskerville, 2013). Intrinsic motivation, defined as interest in the subject coupled with an intention to seek meaning, is crucial to deep learning (Balasooriya, Toohey & Hughes, 2005). There is a mother lode of deep learning available but it may not be accessed when the focus is solely on requiring student nurses to provide total patient care while on placement (Tanner, 2010). Where this mother lode of deep learning is
used, learning becomes a process of exploration, discovery and growth, rather than merely a process of knowledge transfer (Platow, Mavor & Grace, 2013).

2.7 Narrative research in education

Casey (1996) used narrative research as an overarching category which includes the collection and analysis of autobiographies and biographies, *bildungsroman*, life writing, personal accounts, personal narratives, narrative interviews, personal documents, documents of life, life histories, oral history, ethno-history, ethnobiographies, auto-ethnographies, ethno-psychology, person-centred ethnography, popular memory, Latin-American *testimonios* and *pamietniki* (Polish memoirs). She sees narrative research as interdisciplinary as it includes literary, historical, anthropological, sociological, psychological and cultural elements. The link is the way in which humans make meaning through language.

However, examining a narrative with the perspective of an academic discipline has given way to examining narrative’s “internal patterns of priorities” (Casey, 1996, p.234). There is a highly constructed text in which cultural framework of meaning is significant, and where there are patterns of inclusion, omission and disparity. What is said and what is not said, the evaluations and the explanation are what are important. Connelly and Clandinin (1990) refer to what they call the re-storying quality of narrative. Broadening occurs when we generalise from the story. Concentrating on the event is termed burrowing. Finally when the meaning is considered and whether a new story which changes the meaning can be created, re-storying is occurring. Narrative thinking uses economy, selectivity and familiarity (Robinson & Hawpe, 1986).

Narrative research in education is concerned with how teachers work and it is their stories which are used by researchers. They generate a new type of theory-practice relationship (Connelly & Clandinin, 1990). The same writers in another paper note that teachers’ stories are essentially secret. What happens in the classroom is kept secret and when teachers leave their classrooms they tell cover stories instead, to show themselves as experts and that they fit into what the school expects of them (Clandinin & Connelly, 1996). Narrative research aims to capture the “richness and indeterminacy...and the complexity of...understandings of what teaching is” ... “Stories consist of events, characters and settings arranged in a temporal sequence implying both causality and significance (Carter, 1993, pp. 5-6). The view of narrative educational researchers is that education is the construction and reconstruction of
personal and social stories, where both teachers and students are the story tellers and
the characters (Connelly & Clandinin, 1990). But as they are constructions which give
meaning to events there are inbuilt problems of veracity and fallibility (Carter, 1993).

2.8 Use of stories in nurse education

In a grounded theory study of what constitutes teaching excellence in nursing,
Johnson-Farmer and Frenn (2009) discovered five major themes which were
engagement, relevance, student-centredness, facilitation of learning and the dynamic
process of becoming an excellent nursing educator.

The core category of engagement required staff to be current and knowledgeable, clear
when communicating objectives, to be student-centred, and to draw students into
active questioning and learning so that discovery becomes enjoyable and using
multiple strategies in teaching content. The use of stories fits with this core category
because it does require the teller to be current and to encourage students to question.

A Swedish project encouraged student teachers, social workers and other
undergraduates who were mentoring children at-risk to use personal experiences
outside the classroom to develop interpersonal skills like empathy, perspective taking
and values clarification. Students described experiences in their workplaces, and were
then asked to rewrite their stories from the perspective of somebody else involved
(Fresko & Reich, 2008). The project acknowledged the students’ non-academic
experiences and helped them relate them to their professional development, especially
with regard to practical knowledge.

However, the use of narratives is different from the use of problem-based learning
scenarios. The latter are often “manufactured” as a basis for working through a
syllabus or course objectives. The better stimulus material is authentic and where
possible derived from actual practice. Narratives are drawn from the clinical setting and
because of this are not “constructed” in an artificial sense. The same focus on their
value for learning is necessary. Woodhouse (2007) regards these anecdotes drawn
from tutors’ own clinical experience as “shop talk”, i.e. the narratives of the professions,
which are told during reports, coffee breaks and wherever healthcare professionals
come together. They lend themselves to a variety of interpretation and may even have
no single satisfactory resolution. Thorne (2008) writes of “nursing’s comfort within the
world of complexity and contradiction” (p.26). Narratives illustrate “nursing in an
imperfect world” whereas problem-based learning scenarios are designed to lead the student to a satisfactory learning outcome and a sense that the problem has been solved. However, “an initial acceptance of unknowing may help accept not finding solutions” (Heath, 1998, p.1057).

A memoir of psychiatric nursing 40 years ago (Gilham, 2011) records a series of anecdotes about nursing in institutions but although these are vivid and show clearly how mental health nursing has changed since then most could not be used as clinical anecdotes for educational purposes because they record only some of the more unusual situations and personalities encountered by the author.

A study of students’ experiences of problem-based learning in mental health nursing found that students felt that PBL suited the more educationally mature students, but that they benefited from the experience by a greater breadth and depth of learning, increased opportunities for self-direction and greater engagement and motivation (Cooper & Carver, 2012). Other benefits were the acquisition of skills seen as essential to mental health nursing such as the positive interpersonal aspects of group work, teamwork, communication and interpersonal skills (Cooper & Carver, 2012). The use of stories could provide similar benefits.

Phillips and Vinten (2010) used Bonk and Kim’s (1998) list of socio-culturally based teaching strategies in a survey which asked clinical educators to rate the innovativeness of ten teaching strategies. Encouraging student exploration and application of their problem-solving skills was the strategy selected most frequently by these educators for current and future use.

The increasing popularity of stories with nurse educators is attributed by Bowles (1995) to the emergence of adult learning theories, the rise of feminism, the growing acceptance of qualitative research methodologies and “the maturation of nursing’s epistemological foundations” (p.368). He contrasts the “simplicity and immediacy of the storytelling tradition” with what he calls “the academically generated and rhetoric laden notion of ‘reflective practice’” (p.365). Storytelling has also been used to teach cultural assessment to nursing students (Evans & Severtsen, 2001).

Lapatin et al (2012) discuss the difficulties of constructing vignettes for use in mental health services disparities research. Their vignettes were to be stories which provided examples of people and their behaviours in particular situations to allow participants in

Anna Elizabeth Treloar
the research to offer opinion on what they or somebody else would do in a given situation. They had to balance clinical accuracy and believability for participants who were parents of children with mental health problems. The stories had to meet DSM-IV [now DSM-5] criteria for the particular disorder but also tally with participants’ experience of how children actually appear. As well the stories could not be so transparent that the diagnosis was instantly apparent. The team who developed the vignettes wanted the participants to be able to think about the vignette but also see themselves as part of it.

2.9 Narrative and clinical reasoning

Clinical reasoning describes the process by which nurses collect cues, process information, come to understand a problem or situation, plan and implement interventions, evaluate the outcome and then reflect and learn from the process. The process is conceptualised as a series or spiral of linked and ongoing clinical encounters (Levett-Jones et al., 2010). This spiral depends upon critical thinking, some of the attributes of which include contextual perspective, creativity, flexibility, inquisitiveness, intuition, open-mindedness and reflectiveness, all relevant to mental health nursing (University of Newcastle, 2009).

There are several types of error in clinical reasoning which are common in assessing patients with a mental health problem. One is fundamental attribution error based on a tendency to be judgmental and blame the patient for the problem; another is known as psych-out error, where the mental health problem is all that is seen and other conditions are ignored or minimised; while a third is ascertainment bias where the assessment is flawed by stigmatising or stereotyping (Levett-Jones & Hoffman, 2013). Narratives can be used to illustrate these errors in a way which becomes immediate and memorable to students.

Bartlett et al. (2008) used Pesut and Herman’s 1999 Outcome-Present State Test Model to teach clinical reasoning in mental health nursing students. The most important difference between this model and previous clinical reasoning models is that the Outcome-Present State model emphasises the framing of the patient’s story. The aim is to move the patient from whatever is the current or present health state to the desired or outcome state. The model’s components include the client-in-context story,
keystone issue, cue logic, reflection, framing, testing, decision-making and judgment. A clinical reasoning web is another part of the process. The cue logic captures all other nursing diagnoses arrived at through reflection on the context of the client’s story (with the exception of the keystone issues). This gathering of all the background information to gain a broad perspective is called framing. It allows for comparison of the present state with outcome state and assists students to see the big picture or frame. In an evaluation of the OPT model, Kautz, Kuiper, Pesut, Knight-Brown and Daneker (2005) found that framing was the most difficult part of the model for students to master. Bartlett et al. (2008) in their evaluation of the OPT model in the education of mental health nursing students found that approximately one third of the students in the study did not master the use of the OPT model, although most mastered it quickly.

2.10 Mental health nurse education in Australia

Fifteen years ago Clinton and Hazelton (2000) wrote a scoping study of mental health nursing education in Australia. At that time service managers all over Australia reported a problem with recruiting and retaining mental health nurses. This was linked to “the perceived failure of the Australian tertiary education system to prepare undergraduate nurses adequately for commencing mental health practice and the inability of the system to prepare sufficient numbers of graduates with specialist postgraduate qualifications in mental health nursing” (p.2). The same authors note that studies are needed which focus on what are the outcomes for consumers from their interactions with graduate nurses.

Five years later Stuhlmiller (2005) advocated a direct entry mental health nursing program, commenting that “rethinking mental health nursing education requires pooling of ideas, exploration of models and alternatives within and outside of Australia, discussion, and trials” (p.159). She believed that the ability to make an even greater contribution to alleviating patient suffering would be a positive influence on recruitment and retention in the mental health nursing workforce. However a recent study by Happell and McAllister (2014a) found that barriers to a direct entry mental health nursing course for undergraduates included academic staffing, staff attitudes, funding and resources, industry support and entry and articulation pathways. The same authors in another study conclude that although the comprehensive model of undergraduate nursing education was intended to provide beginning practice skills across a range of
areas, there are now doubts about the extent to which this goal has been achieved (Happell & McAllister 2014b).

The New Graduate Nurse Transition Report (2009) recorded that for most respondents mental health was the least preferred placement while other new graduates acknowledged that accepting the placement was for them merely a way to gain entry to the workforce.

In 2010 Wynaden recommended that key stakeholder groups should ask the profession of nursing why it has allowed mental health nurse education to be neglected in the undergraduate years. She adds that mental health nursing academics lack the power to influence change or alter curriculum content “at a level that has meaningful outcomes” (p.207) if they are not in senior positions. As there are low numbers of mental health nurses on staff, comprehensive curricula gradually become more generalist and mental health nursing is displaced by psychosocial nursing. An innovative approach at Southern Cross University in Lismore aims to prevent the erosion of mental health content in undergraduate nursing degrees. Mental health content is present throughout most units but contained in “locked boxes” which cannot be altered without going through a school board review. In addition, there is interchange between clinicians and academics in the area (Hurley, Graham, Van Vorst & Cashin, 2014).

The Framework for Mental Health in Pre-Registration Nursing Courses has four elements which are core values, learning outcomes, principles for learning and teaching mental health nursing, and benchmarks (Australian Health Ministers’ Advisory Council, 2008). Universities need to provide an undergraduate curriculum that is “fit for purpose” (Biggs, 2001). However what constitutes mental health nursing course content is not always clear although successive Australian governments have endorsed consumer involvement in all aspects of content development of undergraduate mental health nursing courses (Moxham, McCann, Usher, Farrell & Crookes, 2011). It is the quality and methods of theory and of clinical placements, and the socialisation process encountered by students, which influence their commitment to working with people who have mental health problems. In addition, a national review of nursing education in 2002 recommended that teaching staff maintain current practice and education (McCann, Moxham, Usher, Crookes & Farrell, 2009).
When directors of nursing (mental health) were surveyed regarding their concerns about the skills and attributes of new graduates working in mental health nursing, they focused on six main areas which were foundational knowledge of mental health disorders, recovery-oriented skills, physical assessment skills, therapeutic strategies, resilience and self-development, and finally advanced knowledge and skills – these were emancipatory counselling and teamwork, conflict transformation, practice development and research (McAllister, Happell & Lynch, 2014). Stories such as the ones in this collection can assist in the development of most of these skills.

Morrissette (2010) points out that a significant aspect of nurse education is the monitoring of students' reactions and behaviour during their course as they develop into registered nurses. They have to learn how to establish boundaries and at the same time manage their own reactions through self-care and reflective practice. Crowe (1998a) felt that defining the nursing role helps to validate nursing’s position in relation to other roles and promotes professional accountability. The curriculum at Griffith University at that time allowed the student to deconstruct mental health nursing practice, critically reflect and then reconstruct mental health nursing practice.

McAllister (2000) sees educators as having a dual responsibility “to teach the foundations and to encourage foundations to be tested” (p.39). For her, good teaching is “a risk-taking venture” (p.39) that involves much more than choosing between quantity or quality of knowledge. It needs to be fluid and flexible and this is not easily achieved through the traditional lecture alone. She sees teachers as having a dual responsibility both to inculcate the foundations of the discipline and then to encourage these foundations to be tested and posits that stories can transmit feelings and provide whole images including thoughts and feelings which may be remembered more easily than academic concepts. They convey context, set the scene and organise information. When told well they can strengthen the bond between teller and listener.

2.11 Mental health nurse education

Traditionally before nurse education moved to the tertiary sector, nurses served an apprenticeship in NSW and their learning took place largely on the job in the clinical setting. They undertook “blocks” where they were released from their clinical role for a few weeks in the classroom. At the end of a three-year period (for first registration) they sat for written examinations, having previously completed demonstrations of their competency in practical procedures. General nurses were tested by multiple choice
questions; other branches of nursing were tested by essays or short answer questions. With the transition to universities, the usual university format of lectures and tutorials and written assignments took over. Clinical placements were short and students were supernumerary, i.e. not part of the workforce as they had been in the previous system. The narrow focus on signs, symptoms, diagnosis and treatment was expanded to include broader areas relevant to nursing.

In a study of the mental health content of undergraduate mental health nursing courses in Australia, McCann et al. (2009) found that lectures were the main method of delivery of content in compulsory subjects and noted that although these are cost-effective, “given the interpersonal nature of caring for people with mental health problems and illnesses, they limit the opportunity to engage students and to role play clinical scenarios” (p.527).

If we consider the various ways of teaching offered by a typical online learning platform, we can decide how useful they are to educating mental health nurses. Lectures can be presented in a variety of formats, using slides alone, using slides with voiceover, or using an audio file alone. Students are introduced to basic concepts and provided with basic information. Online tutorials allow for group discussion of set topics or of particular scenarios and also allow students to ask questions. Students can also use email to ask their tutor questions about topics and assignments. Scenarios do not have to be presented in print only; a video clip can be uploaded to add to the presentation. References and supporting information can be posted and links to electronic resources provided. An electronic reading list allows quick access to a basic library relevant to the course. New material or resources can be added as required and are immediately available to all students. Students can participate in social discussion boards which are not related to the course material and start their own blogs to respond to tutorial questions. They can do their work at any time of the day or night to suit themselves and use online material to catch up on work they may have missed in class or to clarify points they did not understand. Some courses are taught entirely online and students and staff never meet face-to-face.

So an online learning platform allows for the provision of a large amount of information and resources, and enables a group of students who may not be able to come together at a particular time and place to share their ideas and discuss topics together. The tutor monitors the discussion and encourages participation and depth in discussion and
consideration of all possible aspects of the topic. But can this online learning platform illustrate the complexities of a therapeutic relationship or the puzzling aspects of an incomplete or poorly done assessment or the decision-making processes involved in aspects of care or the individuality of patients and of the nurses who care for them or the development of a personal style in mental health nursing? Can it be that we rely on stories to show the reality of mental health nursing, to illustrate mental health nursing not in simulation or in the so-called real time, but as it really is? Student nurses yearn for a predictable ward and patients who follow what they have been told to expect or what the textbook outlines, but “nursing in an imperfect world” rarely allows this, and particularly in the field of mental health nursing, where situations evolve depending on context, symptoms, communication, relationships, personal beliefs of both nurses and patients and the all-pervading influence of stigma. This is where stories, told in the spoken word to an audience, as stories have been for thousands of years, can extend what is provided by classroom lectures, classroom tutorials and online learning.

All nurses learn to “think on their feet” and make rapid assessments and decisions based on these rapid assessments but for mental health nurses it is one of their most important skills and one which for students and new graduates is the most difficult to acquire and understand. Student portfolios describing their first placement in a mental health setting frequently report a partial understanding or interpretation of a situation which later reflection and reading allows to develop into a fuller or more complete understanding. But initially the feeling is of perplexity, helplessness, being “out of my depth”. This is the discrepancy and discomfort which signals an incident worthy of reflecting on and likely to be productive of new learning (Levett-Jones, 2007). It is Mezirow’s (1981) “disorienting dilemma”, something which problem-based learning scenarios cannot offer. Scenarios may be used to develop questions designed to aid students to cover relevant themes such as law, patient rights, correct documentation, the mental state examination, nursing management but they do not usually produce this feeling of perplexity. Once the source of information which will enable the question to be answered is found, the “problem” in the problem-based learning scenario is “solved”. Stories, however, can be ongoing, can lead to evolving understanding and awareness of all the issues involved and the possible different ways of dealing with the situation. In addition, the spontaneous input of other students in the class can provide different perspectives, deepen understanding and encourage consideration of a variety of responses to a single situation. Students will come to the class with a basic knowledge of the topic but the discussion of a story without resorting to a textbook for
the “correct” response is more appropriate to tertiary education and likely to be more useful longterm in the making of a mental health nurse, or at least in allowing students who do not choose to enter the field to have a better understanding of what is involved. A shift in perspective or a broader or deeper understanding of a complex situation may be gained from a discussion of a story whereas scenarios designed for problem-based learning usually direct students towards the acquisition of useful facts which provide “answers”. McAllister (2011) advocates the use of transformative learning in nursing as having particular value in considering the health of vulnerable groups, the marginalised and people whom health services do not serve well. Therefore it is particularly useful in mental health nursing education.

Providing nursing students with a sense of professional identity so as to socialise them effectively into the profession is seen as the responsibility of tertiary institutions (Madsen, McAllister, Godden, Greenhill & Reed, 2009). One of the nurse academics who was interviewed for this study (into how the current system of nurse education in Australia is undermining professional identity) commented that students returned from clinical placements having run into problems caused by their “not understanding the unwritten rules that are out there” – in particular this was related to the culture of the place (p.12). Storytelling can also assist with linking theory to practice and in particular to the development of skills in intentional dialogue (Carpenter, 2010).

Clinical wisdom is described by McKie et al. (2012) as recognition of contextual factors, the place of the person and timeliness. Wisdom as practical knowledge is called phronesis. Key concepts are seen as virtues related to self and care for others, knowledge-based decision-making and action and connexions between cognitive and emotional worlds. A balance between knowing and doing is sought, and particularly “the use of skills in contexts characterized by complexity and uncertainty” (p.257). In practice the current focus on competencies may “negate the interplay between knowledge, practice and personal characteristics” (p.262), all highly relevant to the development of mental health nurses.

Cleary and Walter (2006) advocate education models which provide realistic expectations because those that do not eventually lead to job dissatisfaction and high turnover of staff. Inadequate theoretical and practical preparation in mental health nursing have been identified as a primary reason for the unpopularity of mental health nursing as career choice among new graduates (Happell, Robins & Gough, 2008).
A student in the final year of a nursing course who had chosen mental health nursing as a future career said:

In psychiatric [sic] every patient is different, every psychiatric illness you can’t put a label on it, they’re all different. I just get a buzz out of it, the unknown really, ‘cause nobody really knows what causes these things and the best way to treat it, and there’s so many diverse ways of treating it and that’s what excites me (Moir & Abraham, 1996).

However, the very aspects which attracted this student are often those which discourage others, especially if educational preparation for the field has been inadequate. Happell et al. (2008) found that second-year students who had received a higher level of theoretical preparation showed substantially greater interest in a career in mental health nursing than third-year students who had received less theoretical input, even though both groups were fairly similar when their attitudes towards mental illness were measured. The existing literature had focused on clinical experience as the main influence on students’ attitudes towards mental health nursing. Happell and Cutcliffe (2011) write of “the current pre-occupation with clinical guidelines, standardized care plans, care protocols, and slavish adherence to clinical care pathways” (p.332).

### 2.12 Techniques used in mental health nurse education

#### 2.12.1 Lectures and tutorials

Lectures, tutorials and clinical placements form the largest part of undergraduate mental health nurse education. However, within these components, or as an extension to them, a diverse range of different techniques has been employed to enhance the student experience.

#### 2.12.2 Case-based learning

Woodhouse (2007) found that case-based or scenario-based learning in nursing education is often used and that the stories told are usually spontaneous and unplanned anecdotes. In contrast to this, McAllister et al. (2009) planned the stories used and the meaning making was developed specifically. These stories were “human stories instead of simply medical case studies, complex, unfinished stories with multiple characters who may have competing health and human needs” (p.158).
2.12.3 Integrating theory and practice

In an action research project in Finland which aimed at a better integration of theory and practice a nursing school and a university hospital collaborated to develop a new mental health nursing program (Munukka, Pukuri, Linnainmaa & Kilkku, 2002).

Theoretical studies were conducted at the same time as practical training, and the theory was taught by nurse practitioners as well as by nurse academics. Students also had their own personal preceptors on the wards. This project aimed to help students to understand what the patients’ real life situations were like, something which simulation cannot always do. It also allowed the theory teachers to have direct contact with mental health patient care and the students to have a role model of a mental health nurse in the clinical setting. There was thus a triangular relationship between student, preceptor and nurse academic (Munukka, Pukuri, Linnainmaa & Kilkku, 2002).

2.12.4 Clinical Teaching Guide for new instructors

In Canada, a one-page clinical teaching guide for new instructors teaching an introductory mental health nursing course was developed (Melrose, 2002). There were four theoretical components in the guide: understanding mental health nursing is a personal process; feeling unsure about how to help patients provokes anxiety; group involvement and cohesion is highly valued; and non-evaluated discussion time with instructors is essential. Instructors were then provided with four questions matching the four theoretical components to allow them to assess student progress, and behavioural signs from students which demonstrated that the theoretical components were being mastered. Finally very specific and detailed teaching strategies were provided for the instructors. The final strategy was “close the course with unanswered questions”, implying that the expectation was that student learning would be fluid and ongoing, given the complex nature of mental health nursing (Melrose, 2002).

2.12.5 Use of moment maps

In the USA a paradigm shift led to new guidelines recommending content and competency development in therapy and in the neurobiological management of patients. Students who enrolled at postgraduate level were seeking the credentials required by the workplace and by regulatory bodies (Perraud et al., 2006). Previously postgraduate students had been seen by these authors as “primed to read nonverbal
cues, to enjoy the ambiguity of a patient's situation, and to relish the dialogue on the meaning of behaviour (their own as well as their patients)" (pp.216-217). To return to the centrality of the therapeutic relationship in mental health nursing, they investigated the exact content of what the centrality of the therapeutic relationship might mean. They focused on those elements which were supported by empirics, which were linked to patient outcomes, and which could be isolated as cognitive skills which could be taught and evaluated. Because the course was taught online, they used moment maps assignments in which the students selected short pieces of dialogue to display:

\[
\text{the process and content of a patient encounter, their attunement with the patient's narrative, nonverbal aspects of the encounter, as well as their clinical reasoning and sense of the evolving relationship (p.218).}
\]

2.12.6 Development of critical clinical competencies

Gilje (2007) developed eight undergraduate mental health nursing critical clinical competencies. These were therapeutic communication, therapeutic use of self, ability to apply the nursing process, ability to provide physical and emotional safety for patients, self and others, clinical learning, shared and reciprocal communication and thinking, seeking staff guidance and demonstrating professional conduct.

2.12.7 Role plays

Role plays are a frequently used strategy. In one program workshops were organised where patients were role-played by experienced mental health or drug and alcohol clinicians (Curtis, 2007). Students were directed into one of two groups and one from each group volunteered to interview the "patient". The interviewer could call for time out, or ask for assistance from the group, or call on another student to take over the interview. After the interview, students worked together to write up a mental status assessment and/or a drug and alcohol assessment, and also identified gaps in their knowledge, which led to the formulation of learning objectives and the seeking of more information. Student comments immediately after the workshop report increased confidence in understanding the Mental Health Act, assessment, the role of a mental health nurse, and assessment and diagnostic criteria. After a clinical placement they report the benefits of being adequately prepared. In addition they saw academics and clinicians working together in a partnership which valued the contribution of each group, creating a "dynamic bridge between the institutes of learning and of professional
practice, thereby reducing the gap between theory and practice” (Curtis, 2007, p.291). The author also records that a small number of students stated they would have learned more if they had watched professionals do the role plays. Some wanted a handout to take away and found the problem-based experiential approach surprising. This group needed to be encouraged to understand that learning to reflect on their own interactions is important in itself, and that qualified clinicians are not ‘perfect’ “but also need to continue analysing their own interviewing techniques” (Curtis, 2007, p.292).

2.12.8 Weekly critical thought paper

Armstrong and Pieranunzi (2000), believing that priorities in mental health nurse education are that students gain understanding of how the patient experiences illness, and that students begin to become aware of the “interplay of their own assumptions and biases within a therapeutic, dynamic relationship” (p.274), tried to develop teaching strategies that incorporated elements of creative and critical thinking, reflection and an awareness of social realities based in the clinical situation. To achieve this they used a weekly critical-thought paper, which incorporated consideration of the key problem dynamic, underlying assumptions, significant meanings and therapeutic nursing intervention. At the end of the semester students were asked to reflect on these exercises and write a brief description of what the authors call an “ah-ha” moment which “signified psychiatric mental health nursing” (p.275). An important part of this was the students’ growing understanding “that nursing (and mental health care in general) is imperfect” (p.276).

2.12.9 Voice simulation of auditory hallucinations

Dearing and Steadman (2008) describe a voice simulation experience to prepare students for a clinical placement in a mental health facility. The voice simulation experience is a 45-minute audiotaped presentation which simulates the experience of hearing distressing voices and includes whispers, noise and intrusive words or messages. The students used headphones to listen to this while they were given a number of tasks to complete and were also able to hear noise in the surrounding environment. Students who experienced the voice simulation demonstrated a more positive attitude towards patients with auditory hallucinations, than a control group who did not experience the voice simulation. Interestingly, high–fidelity mannequins were considered not suitable for most aspects of mental health nurse education as there is no way to simulate nonverbal communications. Whilst this technique has been widely
adopted it is not without risk: students have been found to have low levels of emotional
health (Whelan, 2011) and high levels of mental health problems compared to their
counterparts (Stallman, 2010) and this technique and other high fidelity simulation
activities may put them at risk.

2.12.10 Standardised patients

Standardised patients (people trained to give an accurate portrayal of patients in
specific clinical scenarios) were used to teach diagnostic reasoning skills for Nurse
Practitioner students (Shawler, 2008). The student interviews with the standardised
patients were videotaped and evaluated later.

2.12.11 Interpretive research group

Shattell (2007) used an interpretive research group to expose students to the real-life
experiences of others. Transcripts from actual patient interviews were discussed and
interpreted on a weekly basis. The focus was on thinking interpretation, understanding
and reflection. Students learn that not all patients, students or teaching staff think alike.

2.12.12 Books, memoirs and films

Sayre (2001) taught by using books written by people who had experienced a
psychotic illness or written from the perspective of the patient. Wall and Rossen (2004)
used literature, film and music which “depicted trends, issues, ethical dilemmas, and
other problems that inform the practice of psychiatric nursing today” (p.36). Masters
(2012) used memoirs and personal accounts from physicians, psychologists and
nurses in undergraduate teaching.

2.12.13 Simulation

Brown (2008) reviewed the use of simulation in mental health nurse education, citing
and stating that the use of simulation allows the student to confront this disorienting
dilemma without any clinical risks. He feels that a variety of mental health nursing
competencies can be assessed using simulation; these include therapeutic
communication, crisis management, de-escalation techniques, interdisciplinary
collaboration and technical skills such as medication administration and use of
symptom assessment tools. Brown (2008) mentions a website with reviews of over 500
films with psychiatric themes, short simulated psychiatric interviews on another website; and CD-ROMS called Virtual Clinical Excursions. Videos clips, role-playing and interactive games are used as part of lectures at his university, Virginia Commonwealth University in Richmond, and evaluation at the end of the course used standardised patients. However McGarry, Cashin and Fowler (2014) caution against high fidelity human patient mannequin simulation, saying it may result merely in a simulation of learning, and may also result in overload and impede student learning if mental health issues are added in the interests of fidelity to other problems presented.

A low-cost narrative-based virtual patient simulation technique was used in the education of acute mental health nurses, and was considered to be “ideally suited to promoting essential mental health nursing skills such as critical thinking, communication and decision making” (Guise, Chambers & Valimaki, 2012). Students are presented with a scenario involving a patient in distress, and must then choose from a variety of different responses. Narrative feedback is given to the students at each step of the decision making process. Computer avatars in nurse education however “fail to meet the requirement of fidelity” and do not allow the subtleties of human communication, particularly the non-verbal. Use of actors, in a multimedia approach to creating a community for an online learning platform, received encouraging early evaluations (Walsh, 2011, p.218).

2.12.14 Clinical clerkship

Student placements at the University of Alabama were expanded from the inpatient psychiatric unit to non-traditional sites such as a senior citizen apartment complex, a shelter for homeless people, a clubhouse for the mentally ill, a group home for children and adolescents, community resource centres, dementia centres, court and support groups for the mentally ill, people with head injuries and Alcoholics Anonymous and Narcotics Anonymous (Pharez, Walls, Roussel & Broome, 2008). A psychiatric clinical clerkship (i.e. a four week placement in a mental health unit) was used to promote attitudinal change towards the seriously mentally ill in mental health nursing students (Romem, Anson, Kanat-Maymon & Moisa, 2008).

2.12.15 Online

In contrast to most of these techniques, a graduate mental health nurse program is offered entirely online, although students also undertake a co-requisite 660 hours
under preceptor supervision which they must record in clinical logs. A virtual ‘grand rounds’ is offered, and written process recordings review student-patient interactions (McGuinness & Noonan, 2004).

2.12.16 Digital stories

A recent initiative is using digital stories created by the use of a combination of computer-based tools to allow students to identify a clinical situation which interested them and then put forward three concepts within this for exploration in detail (Gazarian, 2010).

The diversity of these teaching methods reflect the need to bring students into situations where they can experience what it is like to be a practising mental health nurse, often by demonstrating to them what it is like to be a patient in a mental health setting. However, the variety of methods used also shows the difficulty of achieving this in the average classroom.

2.13 Narrative and cultural criticism

Sanchez and Fried (1997) see the use of student narratives as an important part of helping students become aware of the values and belief systems embedded in their profession. Controlling meaning by deciding on what is the official or culturally acceptable meaning within events, becomes a type of political power. Teachers of the professions can name phenomena, establish the dominant meaning for a particular discipline and reward those who adopt it. If students are allowed to take risks and challenge dominant narratives they begin to develop a critical consciousness. Teachers who examine their own narratives and their relationship to power and status can ask themselves if these stories include special privileges for “people like us”.

Similarly, when narrative therapists make “thin conclusions” about patients so that their life stories are experienced as oppressive and diminishing they may be making these conclusions from their own position of power and authority. If dominant cultural stories about certain groups oppress, clients can create new stories of empowerment and liberation (Prilleltensky, Prilleltensky & Voorhees, 2008).
2.14 Narrative in medicine

The training of medical students in the USA in what academic departments call “professionalism” by using narratives has been advocated by some writers (Coulehan & Williams, 2001). This is the main use of narratives although another movement called the Narrative Medicine recognises the importance of allowing patients to tell their stories in their own time in their own way. For this movement the diagnosis is encoded in the story told and from it come therapeutically important understandings. Narrative competence allows the doctor to understand not only the patient but provides a new way to understand the disease itself (Charon, 2004).

Coulehan (2005) writes that the aim of professionalism in medicine is to produce “humanistic and virtuous physicians” (p.892). However he feels that the focus on rules and behaviours is self-defeating and advocates narrative-based professionalism to combat this, in particular to prevent self-interest from being conflated with altruism. He recognises early attempts to teach professional virtue which included developing the specialty of family medicine, formulating the bio-psychosocial model, adding courses in communication, humanities and biomedical ethics to the curriculum and introducing more creative teaching methods such as problem-based learning. Johnstone (1995), comments on the scandalous neglect of mental health care ethics in mainstream bioethics literature, attributing the latter to the historical association of mental illness with irrationality, to stigma and to the emotion aroused by the idea of psychogenic suffering in others.

The American Board of Medicine states that professionalism “aspires to altruism, accountability, excellence, duty, service, honour, integrity and respect for others” and requires the doctor to put the interests of the patient above his or her own (Coulehan 2005, p.893). To achieve this students need to experience professionalism as a collection of contemporary narratives which they follow either through the role modelling of other doctors or through stories and films. It must be “articulated as a meta-narrative that has developed over 2500 years as a summation of, and reflection upon, many thousands of actual physicians’ stories from different times and cultures” (Coulehan, 2005, p 893). However, the stories which students hear in the hospital setting may come from a different culture entirely, so that clinical education takes place in another moral universe from medical school. The results can be the development of a technical professional identity or a non-reflective professional identity.
To counter this Coulehan (2005) proposes increasing the use of teachers who have a broad humanistic and narrative perspective based on reflection, encouraging and supporting self-awareness in trainees, developing narrative competence and community service. This narrative medicine movement “provides a way of reframing the knowledge, skills, and attitudes of good doctoring under the aegis of language, symbol, story and the cultural construction of illness” (p.896).

Coulehan and Williams (2001) argue that in medical education the emotional or affective and symbolic or imaginative aspects of human experience are distanced. If interactive skills are encouraged at all, they become secondary to the acquisition of technical skills. Tacit learning takes place as the student comes to understand professional values and a sense of professional identity where the hidden or informal curriculum is not made explicit. This informal curriculum is based on doing rather than on saying. Through tacit learning medical students can come to value detachment, entitlement and non-reflective professionalism.

Kleinman (2011) continues this argument writing about “thinned out case reports, and best practice guidelines in a superficial, homogenised, and too-reduced-to-be-real way” (p.804). It is the “divided emotions and hidden values” (p.804) which become problematic when educational resources are made simple and predictable. Whereas history provides a careful factual description of events, narrative offers and stresses the human meaning (Churchill & Churchill, 1982).

The narrative medicine movement belongs to a situated learning theory which requires a balance between formal teaching and participation in authentic activities in the real world. Students learn by interacting among themselves, their environment and others who may be role models. They come to a greater understand by talking about and listening to talk about their roles as doctors (Quaintance, Arnold & Thompson, 2010).

### 2.15 Narrative pedagogy in nursing

One of the first to examine the use of narrative pedagogy in nurse education was Nehls in 1995. She saw it as an alternative to the dominant behavioural paradigm in education, which aims for the efficient transmission of knowledge from teacher to student. Narrative pedagogy focuses on the importance of the lived experience as it is revealed in narratives. In this it is influenced by phenomenology but also by pragmatism which expects that educational experiences must have meaning for the
student. The idea is that people think in narratives in order to make sense of what they experience. This offers several benefits. It shows how signs and symptoms may be interpreted in different ways depending on the context and encourages reflective thinking. It links theory and practice and shows that practice can itself generate theory. It shows students how practical knowledge develops as they gain experience. It promotes partnerships between students and teachers, encouraging co-operation and concern. Finally it encourages students to think, analyse and synthesise the material they have been presented with. However, the use of narratives has been regarded as unscientific and even as the use of falsehood. It is also regarded as a possible threat to the established curriculum (Nehls, 1995).

In a study of 946 nurse educators conducted by Brown, Kirkpatrick, Greer, Matthias and Swanson (2009), although 78% used lectures, only 17% rated them as one of their most helpful strategies. Case-based, narrative/storytelling and simulation were seen as the most innovative strategies. More than half of those who responded regarded critical thinking, knowledge acquisition and independent learning as important outcomes associated with the use of these innovative strategies.

At the University of the Sunshine Coast Narrative Pedagogy is employed to challenge nursing and healthcare paradigms and practices such as the enduring illness model of health care and the emphasis on technique-oriented care (McAllister et al., 2009). The advantages of Narrative Pedagogy include gaining students’ attention quickly, exposing them to moral dilemmas or problem-solving exercises in a controlled setting rather than in a clinical setting, enabling them to use the framework of storytelling to tell stories of success and to develop a sense of community and to explore personal and professional roles to make sense of their lives. Students can also take the perspective of one of the characters which develops a deeper level of knowing (Woodhouse, 2007).

Since the work of Nehls, much has been written about narrative pedagogy in nursing. Kirkpatrick, Ford and Castelloe (1997) looked to storytelling to help “capture the spirit while the facts are learned, mental images formed, and morals internalised” (p.38). These authors define storytelling as “the individual account of an event to create a memorable picture in the mind of the listener” (p.39). They view the purpose as wide-ranging: to entertain, teach morals and values, instruct, relieve tension, pass on traditions, train and manage employees, communicate a message and many other reasons as well. The relevance of storytelling to mental health nurse education is
immediately apparent. Students can learn thinking skills to enable them to solve problems better, and they also learn about the value and quality of life. The hope is that they also learn to understand their patients’ lives better.

Swenson and Sims (2000) used stories as a means of reconstructing and interpreting experience, having found that the dominant behavioural approaches to teaching and learning were inadequate to prepare nurse practitioner students for “the subtleties and nuance of care in the real clinical world” (p.109). They felt that in case-based learning which has been widely used in medical, law, business and nursing education for many years, context is provided for students but only enough to understand the problem, not enough to reflect the meaning of the experience not just for the patient and family but also for the nurse. The purpose of the case is to allow students to narrow their focus, use diagnostic reasoning to define and then solve clinical problems. There is no provision for interpretation. They review the work of Barrows and Pickell (1991) in the development of problem-based learning which emphasises a clinical context for learning and developing skills in working in a group and in self-directed study and of Diekelmann who (in a personal communication (1997) to the authors Swenson and Sims (2000)) defined narrative pedagogy not as “a specific pedagogy or curricular model, but rather an approach that enables the converging conversations of all pedagogies” (p.110). It gathers together conventional, critical, feminist, phenomenological and postmodern pedagogies (Young, 2004). Storytelling is used to reconstruct a complete experience and is not just limited to finding and solving problems. Swenson and Sims (2000) feel that “expert nursing practice is more than simply the application of content to situation; the expert recognises and integrates the unique meaning in every clinical encounter” (p.113). One of their students commented “’Now that I know about how to listen to stories, I’ll never again think of the patient as just a problem to be solved’” (p.114). In a paradigm case, one student was able to unlearn past understandings and instead become a nurse who could think from multiple perspectives and challenge her own current assumptions (Ironside, 2006).

Norrish (2008) found that the use of narratives in a course in behavioural science and psychopathology in Oman resulted in enhanced learning and improved performance which was greatest among the weaker students. He concludes that in Oman there is a cultural preference for oral and narrative learning which resulted in Narrative Pedagogy being especially suitable.
Diekelmann in a 12 year study of the lived experiences of teachers and students in nursing identified the Concernful Practices of Schooling, Learning, Teaching which are the basis of Narrative Pedagogy. These Concernful Practices focus on “the recurring patterns, common meanings and shared experiences of schooling, learning, and teaching nursing” (Andrews et al., 2001, p.252). Narrative pedagogy is “an interpretive phenomenological approach to teaching and learning that develops when students, teachers, and clinicians share publicly and interpret their experiences in the context of nursing” (Andrews et al., 2001, p.253). It aims to overcome the “individualism, isolation, competition, and teacher centredness that prevail in conventional pedagogies in nursing courses” (p.253). It is local and site specific and the solutions produced are not generalisable to other nursing schools, although the processes are transferable.

In conventional teaching, knowledge is considered the foundation for thinking, and thinking precedes action. This action is evidence of a student’s thinking, competence and expertise. Thinking is a process or an outcome similar to problem solving. Learning outcomes are listed to ensure that students develop their thinking ability and know how to demonstrate it. If a particular clinical outcome is achieved, this is taken as evidence of the student’s thinking. The appropriate action in a particular situation is clear; if the student does not determine the appropriate action this is taken as evidence of a thinking problem. Thinking provides a solution to a clinical problem. It applies theoretical knowledge to a situation in clinical practice. But does it explore “the meanings and significances of clinical situations while holding everything open and problematic?” (Andrews et al., 2001, p.255). The teacher helps students learn to read clinical situations. Working nurses do not enter clinical settings with interventions already planned for the patient; they must first read the situation and then respond. In traditional teaching the focus is on content and it is referred to as outcomes-, competency-based or problem-based learning (Ironside, 2001). Desired educational outcomes are specified, as well as the way students can achieve these outcomes, and the methods by which students will be evaluated. Where there are large student-teacher ratios it is efficient, and the evaluation of students is effective (Ironside, 2001). More and more content is added, little is removed, the underlying assumption being that if content is covered, thinking follows (Ironside, 2004). In Narrative Pedagogy the focus is on “meanings, meaning-making, and significances” (Andrews et al., 2001, p.256). However Diekelmann (2001) warns that although interpretive pedagogies such as Narrative Pedagogy can be contrasted with conventional teaching, they exist within and alongside each other, in spite of their very different approaches.
In defining Narrative Pedagogy Diekelmann (2001) states it is “sharing and interpreting contemporary narratives... a call for students, teachers, and clinicians to gather and attend to community practices in ways that hold everything open and problematic”. It is “a gathering of all the pedagogies into converging conversation such that the possibility for anything to show itself is held open” (p.53). Her Concernful Practices of Schooling Learning Teaching (which include both positive and negative practices depending on how the practices are enacted) are:

- Gathering (bringing in and calling forth)
- Creating places (keeping open a future of possibilities)
- Assembling (constructing and cultivating)
- Staying (knowing and connecting)
- Caring (engendering community)
- Interpreting (unlearning and becoming)
- Presencing (attending and being open)
- Preserving (reading, writing, thinking and dialogue)
- Questioning (meaning and making visible)
- Inviting (waiting and letting be) (Diekelmann, 2001; Ironside, 2006)

The Concernful Practices offer a new language of converging conversations as “a way to keep open the possibility for anything to emerge” Diekelmann, 2001, p.64; Ironside, 2001, p.75). Practice is not just a set of behaviours but is also includes “thoughts, feelings perceptions, insights, ways of being and knowing, intuitions, attitudes, longings, dreams, hopes, visions, and values” (Koenig & Zorn, 2002, p.395). In a project to introduce the humanities into nursing education Smith et al. (2004) speculated that learning cannot be separated from feelings.

In Narrative Pedagogy the word narrative does not mean that teachers and students tell and listen to stories as a learning strategy, although it does include public storytelling. It is a “research-based interpretive phenomenological pedagogy that gathers teachers and students into converging conversations wherein new possibilities
for practice and education can be envisioned” (Ironside, 2006, p.479) The emphasis of Narrative Pedagogy is on making the students and the teacher mindful of the “common, everyday experiences...that are often taken for granted, overlooked, assumed, unthought-of, or thought of as unique to one group or another” (Young, 2004, p.125). The focus is on reflection and of seeking the meaning of nursing experiences. Diekelmann (2004) asks how teaching practice would be different if the focus was less on designing, delivering and evaluating content and more on “thinking with students about nursing practice” (p.247). Because Narrative Pedagogy encourages students to reflect on the meanings of stories of clinical experiences, it allows them to synthesise theoretical knowledge acquired in the classroom with what they discover in the clinical setting (Kawashima, 2005). For one teacher who embraced Narrative Pedagogy “‘All the signposts of teaching are gone’” (Diekelmann, 2005, p.252). Most new graduates think in a dualistic, black-and-white fashion; they recognise rules but are only beginning to perceive patterns and are not yet able to establish priorities (Evans & Bendel, 2004). Encouraging interpretive thinking requires cultivating thinking that is analytic, reflective, embodied, pluralistic, contextual and communal (Scheckel & Ironside, 2006).

How nursing is being learned is as important as what is being learned. Ironside (2003) in a study of how students and teachers experienced enacting Narrative Pedagogy found that two themes emerge – thinking as questioning (preserving perspectival openness) and practising thinking (preserving fallibility and uncertainty). Thinking shifted from “being a means to an end to cycles of interpretation in which uncertainty and fallibility are preserved” (Ironside, 2003, p.513). Students are guided to learn to read situations as nurses and then to interpret the many meanings that are present. The shift is not to “simplify or reduce the complexity of nursing practice but to bring that complexity, complete with conundrums and uncertainty, into nursing classrooms and clinical situations, inviting students to think anew about nursing practice” (Ironside, 2003, p.514).

Woods (2012) writes about the “rapt attention” which nursing students give to “a morally focused case study or nursing narrative” (p.5). His students’ interest is captured not just by “the possibility to reflect upon the depth of human relations and interactions that is inherent within multiple realities and dimension but the added possibility of future transformations through praxis” (p.5). Yoder-Wise and Kowalski (2003) caution against use of stories with no point as then the potential for learning is lost, but note that telling
a story which exemplifies the professed values (of nursing) is one of the best ways to share values.

2.16 Problems with using narrative in nurse education

A common criticism is that narrative makes the individual more important than social context (Connelly & Clandinin, 1990). In her discussion about enacting Narrative Pedagogy Ironside (2003) considers what inadvertently accompanies outcomes education and the existing approaches to teaching students thinking, for example, what students are learning which teachers do not mean to teach. She does not, however, consider this in relation to narrative pedagogy.

Jardine (1988) criticised the phenomenological pedagogies as a desire to overcome the scientific-technological-bureaucratic nature of the modern world by a return to the romantic and nostalgic. Others have criticisms related to the authenticity of stories and the perception of them as immature and unscientific, the added weight given to the perspectives of participants who have a voice and the valorisation of dialogue as an educational practice (Ironside, 2001).

2.17 Narrative and the learning organisation

The concept of the learning organisation emerged in the 1980s. Its principles derive from various management perspectives and its practices recognise factors such as culture, problem-solving ability and employee participation. It is linked to the action learning process of Revans and the quality control system of Deming (Wang & Ahmed, 2003).

Argyris and Schon (1978) identified three types of organisational learning. Single-loop learning uses a feedback loop to detect and correct error and leaves the processes and objectives of the organisation as a whole largely unchanged. Double-loop learning occurs where the organisation redefines its goals, polices or even structures. Where the organisation learns about how it learns, meta-learning occurs. Both problem-based learning and the rise of evidence-based medicine provide people with skills not a collection of facts, thus contributing to a reliance on single and double loop learning in health care (Davies & Nutley, 2000).

Wang and Ahmed (2003) identified five focuses of the concept of organisational learning which are focus on collectivity of individual learning; focus on process or
Organisational learning is the collectivity of individual learning within the organisation and is the process by which organisations understand and manage their experiences. An organisation is seen as an information processing system. To stay competitive knowledge cannot be the sole preserve of managers or professionals. Every worker now needs to be a knowledge worker in a company which enables them to make their full contribution. Knowledge management becomes important to the organisation as its knowledge is stored partly in its staff in their experience skills and personal competence, and partly in the organisation itself in the forms of rules, regulations and standards. Adopting total quality management and the pursuit of continuous improvement is a key towards the development of a learning organisation. A focus on creativity and innovation which is the sixth focus recommended by Wang and Ahmed (2003) may require an organisation to unlearn and discard what has been done previously. They see knowledge creation as the core competency if an organisation wants to be competitive and successful. Strategies should be competence-oriented rather than competition-based. The keys are triple-loop learning and unlearning, the creation of knowledge through radical changes, creative thinking, competence-based strategies and organisation sustainability rather than temporary profitability. It is the capacity to create, integrate and apply knowledge which ultimately defines a learning organisation (Thomas & Allen, 2006).

Organisations which make learning a core characteristic are known as learning organisations and this becomes part of their organisational development. Staff arrive and depart but the organisation continues and if it is a true learning organisation it may still expand in terms of competence and capacity. To do this it relies on good internal communication and the assimilation of knowledge acquired by individuals into work structures and routines. To respond effectively to change, a learning organisation needs to develop structures and staff which are “flexible, adaptable, and responsive” (Davies & Nutley, 2000, p.909); they also need to learn so that they can increase their capacity to be innovative and therefore competitive.

Franklin, Hodgkinson and Stewart (1998) in a discussion of universities as learning organisations, focus on learning as a lifelong process, both experiential and programmed. To them it is based in but not bounded by the relationships between individuals and ideas and values. It is reflective and action-based, and uses learning from others, discovery and experimentation. It can be transformative and
emancipatory. They say that organisational learning has many of these characteristics usually attributed to individual learners and advocate for a learning community in universities which is “more open, flexible and ‘metaphysical’ than those normally adopted by universities” (p.229).

The key features of a learning organisation are open systems thinking where staff see the interconnection between what they do and what others do; the improvement of individual capabilities without a focus on individual virtuosity; team learning; changing and updating mental models as a way of finding new ways of doing things; and a cohesive vision and set of values (Davies & Nutley, 2000). The cultural values which underlie this, and which have great relevance to the use of narratives in the education of mental health nursing students, are the celebration of success, the absence of complacency, the tolerance of mistakes which accepts the potential for improvement from these, belief in human potential, recognition of tacit knowledge, openness, trust and a willingness to look outward in an engagement with the world outside as “a rich source of learning opportunities” (Davies & Nutley, 2000, p.1001).

2.18 Relevance of narrative to workplace engagement and workforce retention

Employee engagement consists of cognitive, emotional and behavioural components which are associated with an individual’s role performance. It is not an attitude but “the degree to which an individual is attentive and absorbed” (Saks, 2006, p.602) in the performance of whatever role is required. There are two models of employee engagement. Kahn (1990) found that the three psychological conditions, associated with workplace engagement or disengagement, were meaningfulness, safety and availability. Workers required their work to have psychological meaning and to be psychologically safe; and were more engaged when they made themselves more psychologically available. Maslach, Schaufeli and Leiter (2001) found that burnout involves the erosion of engagement and that engagement is associated with a sustainable workload, feelings of choice and control, appropriate recognition and reward, a supportive work community, fairness and justice and meaningful and valued work.

Both models explain the conditions necessary for engagement but do not explain why there are varying degrees of engagement in response to these conditions. Social Exchange Theory sees obligations as being generated through a series of interactions
between those who are in a state of “reciprocal interdependence” (Saks, 2006, p.603). The relevance for the organisation is that the amount of cognitive, emotional and physical resources which the worker is prepared to give to the work role depends on what economic and socio-emotional resources are provided by the organisation. Saks’ study found that job and organisational engagement were related but distinct and that scores for job engagement were significantly higher than for organisation engagement. Job characteristics predicted job engagement and procedural justice predicted organisation engagement. Both are related to employees’ attitudes, intentions and behaviours but organisation engagement was a much stronger predictor of all outcomes than job engagement. These results suggest that employee engagement can be understood in terms of Social Exchange theory. A more realistic preparation for mental health nursing practice might contribute to employee engagement in terms of better psychological availability of new graduates to the experience of working with mental health patients.

2.19 The future of nurse education

A lengthy report into the education of health professionals, focusing on medicine, nursing, midwifery and public health, found that although health systems are becoming more complex and costly, the education of its health professionals has not kept pace, “largely because of fragmented, outdated, and static curricula that produce ill-equipped graduates” (Frenk et al., 2010, p.1923). The report also notes the scarcity of information and research about the education of health professionals. In the twentieth century, the first reform concentrated on a science-based curriculum. This was succeeded by a move to problem-based learning. The report recommends a move this century to a systems based education, to equip health professionals to engage in critical reasoning and ethical conduct. This is to be achieved through instructional and institutional reforms, guided by a move towards transformative learning and interdependence in education. Informative learning deals with the acquisition of knowledge and skills, its aim being to produce experts, whereas formative learning aims to produce professionals by a focus on socialising students towards values. The transformative level looks to enlightened change, through searching, analysing and synthesising information. The latest generation of students will need to access large amounts of information and then extract and synthesise the knowledge necessary for clinical decision-making (Frenk et al., 2010).
For nursing the challenge is seen as the strengthening of scientific education, and the integration of clinical and classroom teaching. A competency-based approach permits an individualised learning approach not possible with the traditional fixed curriculum. It incorporates communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection (Epstein & Hundert, 2002). The particular relevance of a competency-based approach for mental health nurse education is that it could identify key skills required in a health system where professionals must undertake complex reasoning, deal with uncertainty and anticipate impending change (Frenk et al., 2010).

### 2.20 Summary and conclusion

This chapter has illustrated how including storytelling in undergraduate mental health nursing education may be seen not simply as another way to make the subject relevant to students and to provide realistic preparation for practice. It can add dimensions to their study which rote learning of signs and symptoms and appropriate treatments cannot. At a time when concern is still being expressed about new graduates’ preparation for practice, and about the content of undergraduate nursing degrees, storytelling can take its place with the many other techniques used in mental health nurse education. Authentic clinical anecdotes are different from films about mental illness, from memoirs by psychiatrists and psychologists, and from books about personal experience of mental illness. They also place student learning within a much broader context of human use of story-telling to teach what is important by using material which is open to many interpretations. They have the potential to demonstrate a level of reciprocity and congruence between conceptual frameworks for practice and education and highlight the potential for authentic stories underpinned by a sound rationale to inform appropriate practices for mental health nursing practice. These are the central ideas behind the researcher’s quest for greater appreciation of the reasons behind the use of storytelling by mental health nurses to other nurses and nursing students.

In Chapter 3 I consider various methodologies suitable for this study before discussing case study methodology and justifying its choice.
Chapter Three

METHODOLOGY

In this chapter a story from a student will be used as the basis to explore and justify the chosen methodology. First the story is presented, then follows a discussion of various possible ways to analyse it, then the reasons for selecting case study methodology are given, and finally a brief outline of the method used in the study is provided.

3.1. A student’s story

Mr P was a 41yo male with a diagnosis of Schizophrenia and Depression. It was my second day in the mental health unit, and I was yet to have any interaction with Mr P. I had seen him in quite a distressed state on my first shift, and I had heard that today he had gone for a day trip home with some of the unit staff. I was nervous and uncertain about how to break the ice with the patients. I thought asking how his day was would be a good way to start forming a rapport.

Mr P was sitting in the courtyard, so I joined him, making sure I was close to a door, and checking that I had a duress alarm on. I asked how his day went, and he seemed fairly happy to speak to me about this. He explained the panic attacks and the anxious feelings he experienced during the trip. Throughout our conversation I tried to utilise therapeutic communication techniques to explore his feelings and experiences.

I was also keen to start improving my assessment skills so I could complete a MH-OAT form before the end of my placement, and to increase my ability to form beneficial therapeutic relationships with the patients in the unit. Once I sensed he was comfortable I asked a little more about his illness, as I, having never met anyone with schizophrenia, was interested to hear his experience.

Using some prompting and open ended questions, Mr P began to tell me of his history and experience of schizophrenia, the medications which he was sure were not helping, and the auditory hallucinations he sometimes experienced. I asked what he did for fun, as I hoped to encourage Mr P to find some enjoyable activities to focus on. He stated he had nothing that he could do for enjoyment – not even watch TV, as he found it too hard to concentrate, which he considered was due to his medication.
I also asked him if he had any strategies to manage his panic attacks; then I outlined a mindfulness exercise that he could use to ‘distract’ himself from the anxiety. The EEN who had joined us said nothing.

I had not seen any of the nurses perform any interventions for Mr P, except for administering medications, taking observations, and simply telling him to ‘calm down’ when he was showing signs of distress. I wondered whether asking about Mr P’s condition was helpful or difficult for him, so I went into the nurse’s station to ask this, and discuss my thoughts about the interaction with the RN. Her reply was that that sort of ‘Dr Phil psychology did not work in real life’.

3.2. Introduction

Above is a narrative written by an undergraduate mental health nursing student, Kirstin Flakus, in May 2011, as part of an assignment to write a portfolio beginning with a narrative account of an episode of nursing care during a clinical placement in a mental health inpatient unit. Kirstin gave permission for use of her story in this chapter (see Appendix 11). The expectation is that the narrative is short (400 words only), that it outlines an episode of nursing care requiring mental health nursing skills, that it does not describe a technical procedure only with no inclusion of the therapeutic nurse-patient relationship and particularly that it is detailed and takes note not just of words and behaviour, but also if relevant, of sights, sounds and smells experienced.

This narrative is constructed in a such a way that while the most detail is given about nurse and patient, the dramatic impact and the point of the story come from the silent presence of the Endorsed Enrolled Nurse (even her involvement in the scene is noted only by the pluperfect tense implying a silent arrival) and by the “guidance” offered by the Registered Nurse when the student sought advice and comments on her nursing intervention.

Here the student tells her own story. If it were to be told again by a mental health nurse to a new class of undergraduate mental health nursing students, how could it best be analysed and placed in a broader context? Should it be considered as a personal log or journal? Should it be rescripted so the dramatic elements are more prominent? It is very visual in impact although the description is economical. Does it require only literary analysis? Does it require discourse analysis? Is the sociology of mental health relevant here? How important is the use of metaphor? Is narrative research helpful?
Should it be examined as part of a collection of stories? Is case study methodology useful here?

Consideration of appropriate methodology involves careful consideration of the research question and study purpose. Thorne (2008) remarks that nursing “indelicately straddles the social and biomedical sciences to find its methodological direction” (p.15). In recognition of this, several possible methodologies suitable for use in analysing Kirstin’s story and also the collection of 100 stories are now discussed.

### 3.3. Literary analysis

The elements of the story are the patient’s diagnoses (schizophrenia and depression) and his age (41), with the implication that he may have suffered from two serious mental illnesses for much of his life intermittently. We learn that he was in “a distressed state” but the student attempted to “break the ice” (an interesting metaphor in this context because the therapeutic milieu described sounds somewhat chilly) and to establish rapport. The patient spoke of his panic attacks and anxious feelings while on day leave and the student “was interested to hear his experience” so she could better understand what it is like to have schizophrenia and depression. However her interest was not purely clinical. She asked a very useful question – what did the patient do for fun - and gained useful information about his mental status from his reply as well as providing a distraction to the anxiety. She also offered him immediate assistance in an exercise to help him manage his anxiety. She makes a significant comment when she describes the type of nursing care offered to this man as “administration of medication, taking of observations and simply telling him to 'calm down' when he was showing signs of distress”. This is confirmed by the comment, “The EEN who had joined us said nothing” and by the summary of the interaction given by the Registered Nurse who told the student that that sort of “Dr Phil psychology” did not work in real life. The metaphor of breaking the ice becomes a key to the whole story. The only therapeutic interaction which takes place is between student and patient. There is a distinct chill in this unit as we understand from the focus on medication and vital signs, and the abrupt advice to the patient from staff to calm down, or even the silent and apparently accusatory presence of the Enrolled Nurse. The Registered Nurse is frosty in her assessment of the student’s contribution to the patient’s care. There is little of the therapeutic milieu in this unit. The student’s question about fun is discordant with the way the patient is treated and with the oppressive atmosphere of the unit. The juxtaposition of the two
words is powerful. Here the student’s wish to "break the ice" goes much deeper than the shallow introductory games often called “icebreakers”. We wonder is it ever possible to have fun in a mental health inpatient unit? Is it ever expected? Or do we only focus on the presence or absence of anhedonia as a diagnostic criterion? The student brings her experience of the outside world into this frosty and oppressive environment and assumes that the patient has had or at least should have had the same human experience of fun as she has.

The methodology most suitable is the one which best reveals the underlying purpose of the telling of the story. However for a collection of stories a methodology suitable for a single narrative may not be appropriate. Close literary analysis of the above narrative reveals many themes and can highlight the dramatic purpose of the story. But close literary analysis of a series of stories, while able to provide explication of each single story, cannot identify themes common to the series, which means the purpose of stories told by experienced mental health nurses to undergraduate students will remain concealed.

Collecting stories and viewing them as data to be manipulated, and “cutting them up into little labelled specimens – themes and sub-themes – that can be sorted and counted and weighed” negates the storyteller (Fairbairn & Carson, 2013, pp. 7-8). Van Manen (1990) says that interpretation can be achieved through three different approaches - holistic, selective or detailed. The first looks at the whole text, while the second looks for statements or phrases which reveal its essence. The third requires analysis of every sentence to determine what meaning it points to. Denzin and Lincoln (2005) point out that analysis of text in literary studies often treats the text as a self-contained system.

Given that the researcher is interested in the educative value of storytelling, I will return to my earlier discussion about the need for a framework to underpin student learning. Williams (2001) in a discussion of transformative learning (Mezirow, 1981), notes that people have a frame of reference for interpreting their experience which is based on what has happened to them and what they see, hear or read. This frame of reference comes from the way they were brought up, the culture they live in and on what has been learned previously. Thus experience is filtered through meaning perspectives which for most people are uncritically assimilated. Knowledge and awareness may be decreased but the person finds it safer to remain within a meaning perspective which
does not challenge thinking. These distorted meaning perspectives, including social and cultural norms, as well as language, which determine power and privilege, eventually cause discomfort. Transformative learning can result in changed meaning perspective. Reflection is the key to this and the first stage occurs when a situation results in feelings of puzzlement, surprise or discomfort. This leads to the second stage where current knowledge and assumptions are examined. In the third and final stage the person’s meaning perspectives may be revised or reintegrated (Williams, 2001).

In the student’s story we see this occurring. The student is disconcerted by the Registered Nurse’s comment, but, as the later parts of the portfolio show, she goes away and reads more about what she was attempting with her patient, and we assume reintegrates her meaning perspective based on the way her reading confirms the value and appropriateness of what she was doing. We do not know if the Registered Nurse engages in the same process of revision. Authentic stimuli for learning events are central to learning about contemporary practice. Traditionally critical thinking has attempted to link theory and practice by the use of a scenario from practice to illustrate a practice dilemma. The student is in the midst of a practice dilemma as she shows in her story. What she learned in the classroom is not being supported in the clinical setting. Brookfield (2009) says that reflection becomes critical when it uncovers the dynamics of power in relationships and critically questions implicit social and cultural practices.

Abma (1999) notes that people tell each other stories to discover how they should act in particular situation, as well as how they relate to others, and also “to clarify their identity and role” (p.110). “The most successful stories are those that engage and challenge the students and the teacher” (Miley et al., 2012, p.18). If stories are successfully incorporated into teaching, students will connect the main points of the story to important learning outcomes or concepts. Returning to the story as student knowledge grows may provide new insights and greater depth in discussion (Miley et al., 2012). But there are challenges and risks in the use of stories. Students will learn in the affective domain as well as through doing, seeing and hearing. They may find that what their discipline has taught them is contradicted so that some of their learning unravels. A variety of emotions may arise, some of them contradictory. Stories are valuable for presenting the complexity of a situation but this in itself may lead to dilemmas. Although a story is merely “a snapshot in time” (Miley et al., 2012, p.49),
there may still be misattributions and misinterpretations as context and purpose change.

3.4. Qualitative methodologies

Cutcliffe and Goward (2000) argue that qualitative methodology is most suited for mental health nursing research because of what is common to both. They see this as the purposeful use of self, the creation of an interpersonal relationship, and the ability to accept and embrace ambiguity and uncertainty. They say that in each situation where a mental health nurse forms a therapeutic relationship, making use of the therapeutic self and being empathic, in an attempt to understand the meaning of the patient’s lived experience, this situation could be regarded as an “informal, micro-phenomenological research study” (p.596). They link the knowledge gained by experienced mental health nurses to the accumulation of years of such micro-phenomenological studies. The experienced mental health nurses are those who have the “richest pool of unprocessed qualitative data” (p.596) which they conclude must point the way for future research into mental health nursing practice. Similarly, Warne and McAndrew (2010) wrote of a symbiotic relationship between narrative inquiry, particularly when it involves face-to-face contact, and psychotherapy.

Whichever methodology is used for this study will be qualitative as the qualitative researcher looks to discover knowledge through the capture of the individual’s subjective expiring. The researcher asks, “What is going on here?” (Morse & Richards, 2002). To do this the researcher may use case study, personal experience, interview or observation (Crowe, 1998b). The two fundamental assumptions of the qualitative researcher are that qualified observers can “with objectivity, clarity and precision” report on their own observations of the social world including the experiences of others, and that there is a real subject or real individual who is present in the world and able to report on his or her experiences (Denzin & Lincoln, 2005, p.21). The same authors describe the essence of qualitative research as being a commitment to some version of the naturalistic and interpretive approach, and an ongoing critique of the methods and politics of post-positivism. The socially constructed nature of reality, the close relationship between the researcher and what is being studied and the way the inquiry is shaped by the situation are the essentials. The researchers blend their own observations with material from subjects which may include interviews, life story, personal experiences and particularly relevant for this study, case study documents.
The case study relies on interviews, observations and document analysis (Denzin & Lincoln, 2005).

3.4.1. Discourse Analysis

Discourse analysis is “analysis of how texts work within sociocultural practice” (Crowe, 2005, p.55) with the aim of interpreting how language functions in a given context. It is concerned with how a person’s experience is “socially and historically constructed by language” (Crowe, 2005, p.56). Speakers may not be powerful but can invest power in the words they choose by using particular discourses and by associating themselves with institutions in which society invests power (Smith, 2007). The assumption is that the language we use constructs how we think about and experience ourselves and our relationships with others. Discourses becomes so much part of daily life that they often go unnoticed; discourse analysis aims to expose otherwise unnoticed social issues but through its use nurses can come to understand how “injustices are created and supported” (McCloskey, 2008, p.41). The steps in discourse analysis are choosing the text, and then finding the explicit purpose of the text, how authority is claimed, what are the connections to other discourses, how major concepts are constructed, how naming and categorising occurs, how subject positions are constructed, how reality and social relations are constructed and the implications (Crowe, 2005).

The assumption is that the language we use constructs how we think about and experience ourselves and our relationships with others. If we try to find patterns in a text, we have to consider the cultural context as well. Isolating data from context is not part of discourse analysis because discourse analysis is concerned with how social relations, identities, knowledge and power are constructed through both spoken and written texts. The social and historical context and not the experience of the individual or the hypotheses of the researcher, become central to the inquiry, because both subjectivity and experience are constructed by language. Words and actions derive their meaning from the context in which they occur (Crowe, 2005). The Registered Nurse’s disparaging mention of “Dr Phil” contains a wealth of meaning in the context of an inpatient psychiatric unit where an undergraduate mental health nursing student was attempting to put into practice what she had learned in the course of her studies. So the context in which data is collected constructs the characteristics of the data which is highly important for this study of the purpose of stories told by experienced mental health nurses to undergraduate mental health nursing students. What might be
an entertaining story at a dinner party, or an attempt to debrief after a difficult shift, or a story to illustrate the more arcane aspects of the field of mental health nursing to somebody who does not work in the field, becomes different in an educational context.

“Language as a system is a cultural form that owes its existence to a collectivity of participants who adhere to communal conventions in order to be understood” (Crowe, 2005, p.56). Discourse analysis views text as “cultural representations rather than transparent facts” (Crowe, 2005, p.57). But it is a process rather than a method. In Kirstin’s story it might reveal much of significance about the culture of the particular ward, but may not be the most useful way to investigate the educational purpose of a collection of stories about mental health nursing.

3.4.2. Symbolic interactionism

Symbolic interactionism suggests itself as a methodology because of the “institutional” aspects of the student’s story. Goffman’s 1961 study of the “total institution”, Asylums, is a case study which provides descriptions and theoretical insights which could also be applied to other institutions such as prisons, boarding schools or nursing homes. Goffman’s study of stigma (1963) is also relevant. Goffman’s work resulted in a sub-tradition of symbolic interactionism known as dramaturgical analysis. He focused on the way people interacted in face-to-face contact. He provided a “perspective by incongruity” (Burke, 1984). His main way of doing this was to compare people in everyday situations to actors in the theatre. He distinguishes between doing and being, i.e. between believing in the part played and not doing so. People perform as a member of a team but behaviour changes when the team is not present. Similarly what happens frontstage and backstage also varies (Travers, 2001). The student’s account of her interaction with the patient and the role of the Enrolled Nurse and the comments made by the Registered Nurse, are presented like a small drama. The student believes in her part although the Enrolled Nurse and the Registered Nurse do not. The student is first at the front of the stage, and later, backstage, where she discovers there is a difference between what the ward nurses really think and do and what they might claim to think and do when part of a team. Some light would be shed on the dramatic content of Kirstin’s story but once again, to investigate the educational purpose of a collection of stories told by experienced nurses to undergraduates, this may not be the most useful choice of methodology.
3.4.3. Hermeneutics

Geanellos (1995) considered that mental health nursing research, rather than developing specialised mental health nursing knowledge, relied on the disciplines of psychiatry and the behavioural sciences. She used a hermeneutical approach to interpret a series of mental health nurses’ stories and to develop themes. She felt that this approach allowed “the discovery, illumination and sharing of meanings and understandings” that might otherwise have remained unknown (p.89). Although Geanellos was interested in describing mental health nursing practice with a view to theory development or theory testing, her conclusion is relevant to this study, as she states that story-telling demonstrates its value as “a means of discovering or confirming mental health nursing knowledge” (p.93). For Chang and Horrocks (2008), understanding of people gained through hermeneutics was kaleidoscopic and constantly undergoing change.

In a project to clarify the content and structure of the major subject (nursing care) in the basic nursing program at a Swedish university, a hermeneutic approach was used to interpret and describe this subject (nursing care) (Asp & Fagerberg, 2002). The study comprised understanding, interpretation and application and used descriptions of all the nursing care courses and study guides in the program. Included were teachers’ descriptions of how they viewed the theoretical focus in the courses they taught, and the study lists 64 titles of theses in nursing care defended in Spring 1999. Two integrated aspects of nursing care were considered – the content aspect which covered the nurse’s intentions to enable people to live their daily life to the optimum and the relational aspect which covered the nurse-patient relationship. Data was interpreted and a metaphor of nursing care emerged, which the researchers called “woven fabric”. This showed the different levels of knowledge (philosophical, meta-theoretical, theoretical, technological and empirical) in nursing care. In the authors’ diagram of the woven fabric, the warp has four-twined threads, which symbolise the aesthetical, ethical, personal and scientific knowledge which students develop during the course (Asp & Fagerberg, 2002).

Metaphor is also effectively used in the student’s narrative which begins this chapter. Metaphor is a way of providing two ideas in one context. Metaphors provide no new facts but add depth or a new perspective. As well they can simplify events in terms of a schema which emphasises some parts more than others. Symbolic language is present.
in most cultures (Kangas, Warren & Byrne, 1998). When metaphors are used in a research context, they may become data-reducing devices which generalise from the particular; they may serve as pattern-making devices which place results in a larger context; or they may be centring devices when they force the viewer to understand a mass of observations as a whole (Kangas, Warren & Byrne, 1998). Metaphors can influence thought and action as well as language (Fagin & Diers, 1983). But how to get from a series of stories to metaphors which may or may not achieve this data-reducing or pattern-making or centring?

3.4.4. Narrative Research

At first consideration, narrative research would suggest itself as an appropriate methodology for a study of stories told by experienced mental health nurses to undergraduate nursing students. However, narrative inquiry has a different focus. Lai (2010) in an overview of narrative inquiry, asks whether narrative is a perspective, a method or a special form of speech or writing. Narrative inquiry is the study of the phenomena of development and transition in people’s lives (Lai, 2010). People’s stories are related to everyday life and make the meaning of life as it is lived explicit (Widdershoven, 1993). Sociostructuralists use narratives to study lives in their social contexts and sociolinguists view them as texts which reflect the personality or identity construction. The person’s culture is revealed through the story (Lai, 2010).

Polkinghorne (1995) classified narrative inquiry according to the ways that knowledge is produced. Paradigmatic reasoning in narrative inquiry allows people to construct their experiences by emphasising what is repeated. Individual things are viewed as belonging to a category. In contrast, the narrative approach in narrative inquiry allows analysis of the differences of diversity of people’s behaviour, focusing on the elements which make each particular situation in a story significant. Importantly for this study, narrative inquiry of the narrative type results in a collection of individual cases without generalisation. Whereas narrative inquiry of the paradigmatic type brings knowledge of concepts, narrative inquiry of the narrative type brings only knowledge of particular situations (Lai, 2010).

There are several approaches to narrative analysis. They include the psychological, sociological, anthropological, auto-ethnographic and performance studies of identity. The methodology can drive an agenda for social change through empowerment of those who tell the narrative (Denzin & Lincoln, 2005). Contemporary narrative inquiry is
concerned with an “interest in biographical particulars as narrated by the one who lives them” and uses “an amalgam of interdisciplinary analytic lenses, diverse disciplinary approaches, and both traditional and innovative methods” (Chase, 2005, p.651). There is a broad definition of narrative in this methodology. Narratives can be oral or written, and discovered during fieldwork, an interview or a conversation which occurs naturally. They can be a short topical story about a particular event and specific characters or an extended story about a significant aspect of life such as school. A narrative researcher treats narrative as a distinct form of discourse. It is a way of making meaning retrospectively. It gives the narrator’s point of view which includes why the narrative is worth telling. The narrator is a protagonist either as actor or as an interested observer of the actions of others. This point is very relevant to the use of stories by experienced mental health nurses in teaching undergraduate mental health nursing students. Narrative research also highlights what is unique about each human action and human event, again something which is very relevant to the use of stories by experienced mental health nurses. A narrative researcher sees the narrative as verbal action, as constructing or creating, but also as both enabled and constrained by a range of circumstances. The researcher looks at similarities and differences among narratives and is aware that each narrative is produced for a particular audience and purpose. In investigating all these factors, narrative researchers also see themselves as narrators as they develop their interpretations (Chase, 2005).

Although narrative research is based in the tradition of collecting narratives and analysing themes in these narratives, as is done in literary analysis, researchers rely on one broad question. Interpretive narrative research is guided more deliberately by the researchers who use a pre-planned series of questions and use extra questions for clarification during the interview. The researchers are seeking dominant stories which are narratives put together based on the person’s cultural influences (McQueen & Zimmerman, 2006), although as Kear (2012) found, in a collection of narratives there are numerous threads which connect one to another, and as Hardy, Gregory and Ramjeet (2009) noted, analysing narratives can involve the search for patterns. For Kelly and Howie (2007) the final emplotted whole narrative was a construct which gave “meaning and understanding to the narrative data” (p.141). However, from this collection of anecdotes there will be no final whole narrative as they are too disparate.

Trahar (2009) discusses some criticisms of narrative inquiry: these are that the storyteller’s goal may become therapeutic rather than analytic; that researchers often
re-present personal narratives as if they were authentic; and that due to a desire to focus on the meanings which individuals have ascribed to their lived experience, narrative inquirers oppose any “collective understanding” (p.6) being taken from their work.

Narrative analysis differs from other qualitative methodologies because it focuses on the structure of narratives as a whole, using larger units of analysis such as a whole interview or whole biography. It emphasises that human understanding is story-based and aims to understand the way in which general social processes are interpreted. The richness and complexity of human lives, as well as their historical depth, is what is sought. Narrative analysis works in larger units of discourse rather than framing texts and coding small portions. As well it does not separate the analysis of individuals from the analysis of society as a whole (Rice & Ezzy, 1999). Riessman (2006) describes narrative analysis as a range of approaches to different kinds of text which have a common story; the texts are connected and evaluated for a particular audience.

3.5. McCormack’s Lenses and narrative data

To allow focus on what may become significant components of each story it may be useful to use McCormack’s Lenses which allows consideration of the whole story and of each component of the story from more than one angle. McCormack (2000b) felt that when codes are recombined into themes, we lose the context in which words were spoken or performed or heard, i.e. the contextual, structural and performance aspects of language, as well as the interactional part. She therefore preferred to analyse her data through multiple lenses which include active listening, narrative processes, language, context and moments. Active listening requires immersing oneself into the story; the narrative processes used by the storyteller must be identified; the researcher pays attention to the language of the text and acknowledges the context where the text was produced and finally identifies the moments in the text where something unexpected occurs (McCormack, 2000a). The data is analysed through each lens in turn, and allows interpretation of any type of individual story as well as comparison of themes common to several stories (Dibley, 2011). Eisenhardt (1989) also recommends cross-case searching to force researchers to go beyond their first impressions, especially by using different lenses on the data. Bazeley (2009) warns against merely presenting main themes and supporting them with quotations from participants as the main method of analysis in a qualitative project. She notes that researchers often use
the terms concept, category and theme interchangeably and says that themes are a starting point for a report of findings, but advises that deeper analysis needs improved interpretation and naming of categories, using comparison and pattern analysis to refine and relate categories; and using divergent views and negative cases to challenge generalisations, among others. Thorne (2000) writes that the theoretical lens used by the researcher, the strategies used to collect data, and the researcher’s understandings about relevant and important data are all analytic processes which will influence the data.

3.6. Case study research

3.6.1. Use of case study research

Narrative inquiry may not be the most suitable methodology for the topic. In fact it may only be the case study which is flexible enough to provide the way forward. Thorne (2008) reminds us that methods are not procedures which can be followed in a prescriptive fashion but are “created anew in every research project by researchers who hold their work to a standard” (p.11). “The case study is a research strategy which focuses on understanding the dynamics present within single settings” (Eisenhardt, 1989, p.534) but Miley et al. (2012) define it as an “in-depth examination of a specific circumstance” (p.28) so that it may focus on an individual, a community, an organisation, a practice (such as storytelling) or an event. The Centre for Nursing Research and Practice Development at the University of Newcastle used a case study approach in a 1998 project to develop guidelines on the boundaries of professional practice. Stories described as short case studies were used to show how the guidelines could be applied in practice but the methodology used was case study research (McMillan et al., 2006).

A case study investigates a contemporary phenomenon within its real-life context. This happens especially when the boundaries between phenomenon and context are not clear. It manages a situation where there will be many more variables of interest than data points. It relies on many sources of evidence using triangulation of data. It can benefit from development of theoretical propositions to guide data collection and analysis (Yin, 2009).
3.6.2 Components of a case study

Tripp (1994) explains a case as being constructed by a set of features, which consists of a set of components; each of these components has its own set of properties. These properties are ascribed to the components by the observer i.e. they are not intrinsic to the component. There are five main categories of component which are people, things, events, context and relationships, which derive from “the fact that even at its most minimal, any social situation must at least consist of people participating in events with or without things in a particular place at a particular time” (p.28). In a case study the researcher must ask, Who? and With what? Experiences what? When, where and with whom? This gives the people, the things, the events and the context, in other words each part of the question is a separate component but is also in relation to the others. The categories are fluid allowing people to exist as a component of a context rather than as a separate component of the situation itself.

The unit of analysis in a case study may be a person, agency, event, program, organisation, time, period, critical incident or community. A case study seeks to gather in depth information or consolidate understanding. It does not seek to generalise. Case studies have an integrated system, are bounded and have a purpose (Edwards, 2002). They are useful when the context cannot be controlled but an accurate and detailed view of some particular phenomenon is required. They can be descriptive or explanatory and may even involve testing hypotheses.

3.6.3 Types of case study

Stake (2005) identifies three types of case studies, the intrinsic, the instrumental and the collective. The intrinsic seeks to understand a particular unit of analysis, the instrumental to provide insight or refine a theory and the collective case study looks at a number of cases. He says that a case study is both a process of enquiry about what has been chosen as the case, and a product of the enquiry. The researcher selects a case which is typical but prefers those cases which seem to offer “opportunity to learn” (p.451). The value of the case study is in refining theory and suggesting complexities suitable for further study. The case study also helps to establish the limits of what can be generalised from it (Stake, 2005).

There are different accounts of what makes a case study but Schwandt (2007) reminds us to distinguish between case study where the case itself is the centre, and variable
study where the variables are what is important. The case study is an inductive approach, “perhaps even the ideal inductive approach” (Hamel, Dufour & Fortin, 1983). In some of the accounts of case study its meaning has overlapped with ethnography, participant observation, fieldwork, qualitative research and life history. Its origins can be traced back to medical cases, or to case work in social work. In psychology a case study aims not only to develop knowledge but also to look for a solution to some problem present in the case. Similarly in education a case study may be used to develop and test curriculum and teaching strategies. Today case study implies a type of social research which contrasts with the experiment and the social survey. The case study researcher constructs the case out of naturally occurring social situations whereas the experimental researcher creates the cases studied. Cases studies vary depending on the number of cases studied and the role of comparison, in their detail and the size of the cases, in the extent to which the researcher documents context and to which they confine themselves to describing and explaining, or engage in evaluating and prescribing (Hammersley & Gomm, 2009). Case studies may be used by evaluators because of their inherent strengths and not simply because they are more manageable (Baum, 2008).

3.6.4 Defining case study

Yin (2009) provides a definition of a case study by explaining its scope is investigation of a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly defined. He also provides a planning protocol. The case study copes with a situation where there are more variables than data points and relies on multiple sources of evidence with triangulation of data. It benefits from early development of theoretical propositions which then guide data collection and analysis. Its purpose is to provide in-depth understanding of what is being investigated within its context and later to guide practitioners when they decide if the results are applicable to whomever they are working with (Lee, Mishna & Brennenstuhl, 2010). Typically case study embraces four main concepts which are context, boundaries, time and intensity (Mariano, 1993). The result is “highly contextualised research” (Alorrie, 2004, p.32), where the environment is important. Thomas (2010) stresses the role of the Aristotelian phronesis in case study, explaining that phronesis is about “understanding and behaviour in particular situations” (p.578). In a later article he provides the following succinct definition of case study:
Case studies are analyses of persons, events, decisions, periods, projects, policies, institutions, or other systems that are studied holistically by one or more methods. The case that is the subject of the inquiry will be an instance of a class of phenomena that provides an analytic frame – an object – within which the study is conducted and which the case illuminates and explicates (Thomas, 2011, p.513).

3.6.5 Ways of doing case study

Both Stake (1995) and Yin (2009) wrote about practitioners’ case study methods. Stake was interested in program evaluation and says a new program is usually driven by “issues about which people disagree” (Stake, 1995, p.133). In a later work the same author states that case study is “not a methodological choice but a choice of what is to be studied” (Stake, 2005, p.443). The case needs to be a specific, unique, bounded system. The researcher looks for what is common and what is particular. There needs to be some form of conceptual structure based on a small number of research questions. The case to be studied will be a situation in a milieu embedded in a number of contexts, which may include cultural or social. The researcher observes but also reflects. The case is selected based on opportunity to learn. The activity and function of the case is observed and how it interacts is important.

Triangulation is used to gain multiple perceptions to clarify meaning or to verify the repeatability of an observation of interpretation (Stake, 2005). By teaching didactically the researcher teaches us what has been learned but also allows for discovery learning as the readers use their own knowledge to understand what the researcher has presented. Finally Stake warns that comparison actually competes with learning about and from the particular case as comparison fixes attention upon on or a few attributes thus concealing any case knowledge that fails to fit with comparison (Stake, 2005).

3.6.6 Criticism of case study

A major criticism of case study method is how case studies contribute to empirical generalisation or to general theory. But if the research aims to understand one particular case or to predict outcomes in a clinical setting where the uniqueness of the case is important to the adequacy of its treatment and not a weakness to be edited out, then it can be argued that case study is the only relevant method and the only relevant test of theory is fit to the same case. Even if the aim is only to describe, that does not
stipulate what needs to be described so it can be argued that the theoretical aspect cannot be avoided. If the aim is predictive some explanation is required and causality is more relevant if particular features produce the same result in other cases. A set of cases selected as different examples of the research topic can be analysed as independent cases with constant reference to the initial theoretical ideas (Platt, 2007).

Yin (2009) also raises the point that case studies do not allow much generalisation, but adds that case studies can be generalised to theoretical propositions (analytic generalisation), rather than to populations (statistical generalisation). Other problems discussed by Yin (2009) are the potential lack of rigour, the time required to do a case study and the “massive, unreadable documents” produced (p.15), and the fact that case studies do not establish causal relationships in the same way that true experiments do. A final point is that people may confuse case studies used in teaching with true case study research.

In a defence of the case study Flyberrg (2006) argues strongly that case study produces the type of context-dependent knowledge necessary to allow students to develop from “rule-based beginners to virtuoso experts” (p.220). Experts operate on the basis of “intimate knowledge of several thousand concrete cases in their areas of expertise” (p.221). So, context-dependent knowledge and experience are the foundations of expert practice. Students trained in context-independent knowledge will remain at the beginner level. He says the case study allows the development of a “nuanced view of reality” and is important for the researcher’s own learning because the researcher is close to what is being studied and can receive constant feedback.

Although the case study has been criticised for its inability to generalise, Flyberrg (2006) points out that it is ideal for generalising using the type of test called falsification. If just one observation does not fit with the proposition it is considered not valid generally. The case study can identify black swans which will overthrow the proposition “all swans are white” because of its in-depth approach. The white swan on closer examination often turns out to be black. If generalising is possible, so is hypothesis generating and testing. A case study, by selecting atypical or extreme cases, can reveal more information and provide the deeper causes. Case studies have been criticised for tending to confirm the researcher’s preconceived ideas (bias towards verification) but in-depth case studies often force the researchers to revise their assumptions.
Finally, narratives typically deal with the complexities and contradictions of real life which makes them difficult to analyse into neat formulae. This is another criticism of the case study but to the case study researcher a narrative which is difficult to summarise is a sign of a particularly rich piece of data. Kuhn (1987) remarks that a discipline without a large number of thoroughly written case studies is a discipline without systematic production of exemplars, and that a discipline without these is ineffective.

In further support of the case study in educational research, Crossley and Vulliamy (1984) note that case studies need not be purely descriptive or limited to the micro-level or ignore comparative analysis. Case studies focus on the complexities of educational practice and so can lead to important changes.

3.6.7 Deciding when case study is appropriate

Yin (2009) advises that a case study approach is preferable when the researcher is asking “how?” or “why?” and has little control over events being studied. He also differentiates the case study in research from the case study used for teaching, from ethnographies and participant observation and from “qualitative methods”. An exploratory case study is suitable for a “what?” question such as the topic of this study. Green and Thorogood (2004) say a case study is used where depth and accuracy are required and where naturally occurring rather than artificial phenomena are to be examined. A survey is appropriate where empirical generalisability is required, and an experiment where evidence of causal relationships is required.

The six sources of evidence in case study research are documentation, archival records, interviews, direct observations, participant observation and physical artefacts (Yin, 2009). A major strength of case study research is the ability to use many different sources of evidence and the development of converging lines of inquiry. Patton (1987) recommends triangulation of data sources, of investigators, of theoretical perspectives and of methods. Various analytic techniques may be used such as pattern matching, explanation building, time-series analysis, tabulating frequency of different events, logic models and cross-case synthesis (Yin, 2009).

Stake (1995) says that case study research uses two strategic methods to discover new meanings about cases, which are direct interpretation of the individual instance and through aggregation of instances until they can be described or explained as a class. “Case studies are undertaken to make the case understandable” (Stake, 1995,
They are expected to catch the particularity and complexity of a single case. The case may be a student, a classroom, a committee, a program but not a problem, a relationship or a theme. It has “a unique life” (Stake, 1995, p.133) in that it is something we do not understand sufficiently and which we want to understand. What is important is the commitment to interpretation, organisation around issues, the use of stories, the risks of violation of privacy, the need for validation and the aim of naturalistic generalisation. The case study report may be evaluated according to a checklist provided by Stake (1995, p.131). The researcher's own issues from outside are the etic issues while the issues of the people who belong to the case are inside or emic issues. Most case study reports present both coded data and interpretation although one or the other usually “bears the conceptual load” (Stake, 1995, p.29).

3.6.8 Components of case study research design

The components of case study research design are the research question, its propositions if any, its unit of analysis, the logical linking of the data to the propositions and the criteria for interpreting the findings. Propositions allow the researcher to move in the right direction initially; if the study is exploratory it requires a statement of purpose. An accurate selection of unit of analysis comes from accurate specification of the research question. The quality of the research design is tested in four ways. Construct validity is present if multiple sources of evidence are used, a chain of evidence is established and key informants review the draft case study report. Internal validity (for explanatory or causal studies only) is present if pattern-matching, explanation-building and time-series analysis have been done. External validity requires replication logic in multiple-case studies and reliability requires the use of case study protocol and the development of a case study data base (Yin, 2009).

Runkel (2007) writes of casting nets and testing specimens. The researcher casts a net to find common relationships among cases, but looks at single specimens to discover how an individual case works. The qualitative researcher values the uniqueness of the individual case and context as important to understanding. The research question focuses on cases or phenomena, and looks for patterns of unanticipated relationships as well as those expected (Stake, 1995). Case study has been used frequently in educational research and allows sufficient “organic flexibility” (Snyder, 2012, p.19) for this exploratory question. One of its purposes is to make the familiar seem strange so that attention can be drawn to it (Watts, 2007).
3.7 Summary of methodology

In this study stories are collected from different nurses who have varying work experiences and different specialisations. The stories may be from recent practice, from many years ago or even have been told to the teller by somebody else. The case study is of the phenomenon of storytelling by nurses to others in a mental health setting and each story becomes a case for cross case analysis and conclusions (Yin, 2004). Because not much is known about the purpose of telling these stories and because case study is useful for “what?” questions, it is appropriate for this study. Problem based learning scenarios are constructed with a specific purpose in mind (Wood, 2003); even vignettes used in educating families of children with mental illness are constructed carefully to suit their specific purpose (Lapatin et al., 2012), while sociologists use scenarios in what they call constructive controversy case study to generate discussion and deeper understanding of sociological thinking (Bird & Erickson, 2010). Although case study is bounded it is not bounded by geography. Tripp (1994) defines the components of a case study as people, things, events, context and relationships and these five components are present in any story about mental health nursing practice. Case study is useful where a deeper understanding of a particular practice is required and may describe or explain; it does not seek to generalise though hypotheses may be formed. Stake (2005) stresses the opportunity to learn from the case study as being one of its main aims while Lodge (2001) comments that the “experiment” itself partly determines the direction and content of the researcher’s thoughts. If, as Stake (1995) says, the case can be a classroom, then stories are part of the curriculum in this particular classroom where mental health nursing is being taught, but we do not know what the reason is for their use in the classroom. The experiences of individuals and the contexts of the action are important (Darke, Shanks & Broadbent, 1998). There is going to be some “tension between theoretical integrity and utility” (Thorne, 2008, p.34).

3.8 Method

To explore the purpose of stories told by experienced mental health nurses to undergraduate nursing students I needed a collection of these stories. The stories would be anecdotes or vignettes, therefore usually about 300 words in length when transcribed.
Following ethics approval from the University of Newcastle, experienced mental health nurses were recruited. This was done by using a professional email list, starting with mental health nurses employed by the University of Newcastle, conjoint appointments, clinical instructors and later all academic staff in the School of Nursing and Midwifery. The participant information statement, consent and a poster about the project were sent (see Appendices 5, 6 & 7). Recipients were invited to submit an anecdote by email or to attend a workshop where a facilitator (not the researcher) would provide instruction in how to tell the story and then encourage the writing down of stories which the workshop attenders considered the most useful. The writer’s name did not appear on the story (unless the writer wanted to provide it) and confidentiality was assured.

Sampling was purposive, undertaken by advertising for volunteers at major mental health settings in the Newcastle area. Those who volunteered to participate, enabled snowballing/chain sampling and opportunistic sampling. Nurses who had current or recent experience in any mental health setting were invited to participate. This therefore excluded nurses who have formerly worked in mental health nursing but have not done so for many years. It excluded assistants in nursing (and student nurses) who do not usually work in mental health in the public system but included both Registered and Enrolled Nurses. Thorne (2008) reminds us that representation is an ideal which is not actually technically achievable. All we can aim for is “a certain kind of perspective built from an auditable set of angles of vision whose nature and boundaries we can acknowledge and address” (p.89).

The stories were then analysed as part of a case study, each story thus becoming the unit of analysis. The first step was a close literary analysis but this alone was not sufficient. McCormack’s Lenses (2000a) were used in the next stage of analysis. At each of four stages of analysis detailed Notes were made and kept as one way to ensure reciprocity and trustworthiness (Harrison, MacGibbon & Morton, 2001). Code Black referred to the first analysis made and notes were made in black; stories were analysed in groups of twenty so Code Black is divided into First Notes, Second Notes, Third Notes, Fourth Notes and Fifth Notes. Stories were selected at random from the collection and placed in these five groups of twenty each. In Chapter Four, stories are listed and discussed in the order in which they were first analysed, i.e. they do not appear in numerical order. Code Blue referred to the second look at the stories and notes were made in blue on the Data Analysis Template with the date of the new findings also in blue; at this stage separate “field notes” were typed in blue (see
Appendix 9). Code Red referred to the third look at the stories and notes were made in red on the Data Analysis Template with the date of the revisions also in red; at this stage separate “field notes” were typed in red (see Appendix 10). Finally Code Green referred to the final analysis as presented in Chapter 4. One Data Analysis Template was used for each story; the Notes were typed separately and headed Code Black, Code Blue and Code Red.

3.9 Rigour and trustworthiness

With any qualitative methodology rigour and trustworthiness must be demonstrated and an audit trail showing analytic logic clearly shown; if not, the study will become little more than an interesting journalistic exercise. However it is not simply a matter of ending up with a sow’s ear made out of a silk purse by trying to force standards which apply better to quantitative research to fit qualitative research as well. The same principles govern rigour in both quantitative and qualitative methodologies although they have been redefined and modified to better suit qualitative. Gibbert and Ruigrok (2010) caution that rigour often seems to lie in the eye of the beholder and base assessment of rigour on three strategies: what authors report, the prioritisation of internal and construct validity as being more fundamental and careful reporting of emergent strategies used especially when setbacks occurred. The starting point is whether the observed reality is independent of the observer though as Rice and Ezzy (1999) point out, the more sophisticated approach “addresses the complex interplay of the observer and the reality of what they observe” (p.31), as the researcher is actually “the instrument of the research” (p.41). However Oakley (2000, cited in Meyrick, 2006) reminds us that it is the awareness and acknowledgment of error which is the hallmark of all good research.

Trustworthiness and credibility can be marred or distorted by reactivity because of the researcher’s presence or by researcher bias or by participant bias which is often related to social desirability issues (Rubin, 2000). A researcher develops an interest in the purpose of clinical anecdotes told by nurses working in mental health to undergraduates and new recruits. A group of nurses agrees to narrate and then write down some stories which they personally have used. The researcher then has a collection of data and can begin analysis. At every stage of the process there must be a series of checks and balances to ensure that there is some possibility that the analysis will eventually produce a report which faithfully reflects the content of the
stories, and which identifies meanings which are recognisable and acceptable not just to the participants but to a wider community. As a result of this the wider community, and not just the original participants, may find the results provide insights into other collections or may offer new understandings of the issues discussed and so develop mental health nursing practice. Confidentiality must be maintained at every stage and the right of participants to withdraw at any time upheld. The group who agree to tell their stories must come from a wide enough range of workplaces and sub-specialities to avoid the data being drawn from a very small group who may have specific and particular expertise, beliefs, and priorities. There is a pragmatic obligation to ensure that, even though a practice discipline requires “usable general knowledge” (Thorne, 2008, 227), new ideas which are capable of causing harm if misapplied do not find their way into practice. The collection of stories must be large enough for the possibility of common or similar purposes to emerge but not so large that only a superficial analysis is done. The final report must clearly identify and describe how the process was conducted from first recruitment to completion of the project. If the whole undertaking succeeds it must demonstrate what Thorne (2008, p.222) sees as the “intricate blend” of artistry and science. It should be possible to reveal both the wood and the trees (Blignault & Ritchie, 2009).

There are different types of rigour including theoretical (referring to sound reasoning and appropriate choice of methods); procedural (referring to the clear documentation of decisions made about methodology and analysis); interpretative (referring the difficulties of interpreting data); and evaluative (referring to ethical and political aspects) (Rice & Ezzy, 1999).

The researcher must show that the research is morally defensible, i.e. that the information supplied by participants is necessary and will have a specific purpose (Thorne, 2008). Widdershoven and Smits (1996) assert that stories do more than simply describe events – they give them meaning and show how they fit into practice: “By telling stories, people present their actions as aiming at a common good” (p.276). In fact, the selection of the story about a problem in health care does more than simply describe an experience; it makes a claim that the experience is relevant to the problem and cannot be sufficiently evaluated until the experience is considered and integrated into practice which aims to deal with the situation (Widdershoven & Smits, 1996). In other words, those who agree to tell their stories are providing a preliminary screening for evaluative rigour.
Triangulation of data sources and methods and reflexivity, or an honest account of the researcher’s role, both strengthen rigour in qualitative research (Rice & Ezzy, 1999). In this study the use of notes was one way to ensure this “honest account”. Triangulation is not used to confirm existing data but rather as a “means of enlarging the landscape” (Tobin & Begley, 2004, p 393) in order to provide a wider and more detailed perspective. It may be investigator triangulation, theory triangulation or member checking (Russell & Gregory, 2003). Bias may be introduced both during collection and in analysis of data, and may result from the researcher’s influence on participants, and the researcher’s own unacknowledged beliefs, values and prior assumptions (Darke, Shanks & Broadbent, 1998). The concept of probable truth is important here, probable truth being “the best that we have available until we are confronted with compelling reasons to abandon it” (Thorne, 2008, p.230).

Much has been written about the difficulties of transferring the objective criteria for rigour in quantitative research to qualitative research; the first enquiry was begun in 1981 (Lincoln, 1995) and by 1985 Lincoln and Guba, according to Whittemore, Chase and Mandle (2001) were in an “epistemological quagmire” (p.523) as they developed criteria for rigour in qualitative research. Guba (1981, cited in Shenton, 2004) proposes alternative terms as a test of rigour in qualitative research. So internal validity becomes credibility, external validity or generalisability becomes transferability, reliability becomes dependability and objectivity becomes confirmability.

Credibility ensures that the research measures what it actually intended to measure. Transferability means that the findings can be applied to other settings or situations. Dependability means that a future researcher could repeat the study even if the same results were not gained; this is in contradistinction to the concept of reliability in quantitative research where the expectation is that if the study were repeated with the same methods and same participants in the same context, similar results would be found. Confirmability ensures that the final report contains the experiences and ideas of the participants rather than being slanted to the researcher’s own preferences and outlook (Shenton, 2004). Stige, Malterud and Midtgarden (2009) proposed a different evaluation agenda summarised by the acronym EPICURE (where EPIC refers to producing substantive stories and stands for engagement, processing, interpretation, critique and where CURE refers to the preconditions and consequences of research and stands for critique, usefulness, relevance and ethics). Hannes, Lockwood and
Pearson (2010) wrote a comparative analysis of three online instruments used to assess validity in qualitative research.

Whittemore, Chase and Mandle (2001) write of the need to distinguish between criteria and techniques when making decisions about validity in qualitative research. Criteria are standards which are upheld as ideals but techniques are the methods used to weaken threats to validity. Patton (2002) cautions that it is the human factor in qualitative research which is both the great strength and the fundamental weakness. Angen (2000) writes that more interpretivist qualitative researchers seek to release research from “the stranglehold of validity as truth” (p.379) and to demonstrate trustworthiness “without the necessity of laying claim to uncontested certainty” (p.379).

In a 1995 article, one of a series describing non quantitative methods and showing their value in health research, Mays and Pope point out that all research is selective and “depends on collecting particular sorts of evidence through the prism of particular methods, each of which has its strengths and weaknesses” (p.109). Blaxter (1996) provides a set of criteria for evaluating qualitative research papers. There should be clear descriptions of how participants were selected, and how data were collected and analysed; the methods should match the needs of the research question and limitations of the methods should be discussed; the relationship between researcher and participants should be considered as well as how the project was presented and explained to participants; and data collection and management should be systematic and appropriate. In analysis the researcher must discuss evidence for and against arguments made, being careful to include negative data and anything which might refute conclusions, and also show how the results were fed back to the participants for checking. The COREQ guidelines are useful but were designed for use with qualitative research involving in-depth interviews and focus groups; however the theoretical possibility of the reader being able to duplicate the study methods is stressed (Tong, Sainsbury & Craig, 2007).

Not everything which Shenton (2004) recommends in the pursuit of rigour was possible with this study. Using an established method (i.e. case study) was possible but because of the topic developing an early familiarity with the culture of participating organisations was not. Purposive sampling rather than random sampling was used but Whittemore, Chase and Mandle (2001) ask whether it is the philosophical perspective or the research question which guides decisions about the adequacy of sampling and
Barbour (2001) notes that purposive sampling avoids the selection bias which may be a feature of using pre-existing groups for sampling.

In this study triangulation was a part of data collection and of data analysis (workshop, individual collection, student focus group at end). The researcher should value negative cases or disconfirming evidence to ensure data analysis is trustworthy (Treloar, Champness, Simpson & Higginbotham, 2000; Meyrick, 2006). On the spot “member checking” occurred in the workshops and as Koch and Harrington (1998) observe, there can be ethical and practical problems in returning data to participants later. The right of participants to withdraw at any time and to have their stories deleted was stressed; this assists in establishing honesty and willingness in participants. Frequent discussion with supervisors also took place. Shenton (2004) notes that true transferability is difficult to achieve and warns against disregarding the importance of context; if results of different studies are not “entirely consistent with one another” (p.71) this reflects multiple realities and the reasons for this may be as valuable as true transferability. Dependability is based on a clear description of research design including a reflective evaluation of the project while confirmability is achieved when the research is conducted so that as far as possible the report shows the experiences and ideas of the participants and not “the characteristics and preferences of the researcher” (Shenton, 2004, p.72). The audit trail is crucial to this.

Reflexivity is “the process of reflecting critically on oneself as a researcher” (Bradbury-Jones, 2007). The notes (see Appendices 9 and 10) written at each stage of analysis serve in some part to do this, although not in the detail achieved by Bradbury-Jones in her journalling.

The level of researcher empathy with participants and subject matter may influence the authenticity of the findings (Cutcliffe & McKenna, 1999). This project may have had different findings if the researcher was not also a mental health nurse. One way to guard against this is through the audit trail.

### 3.10 The audit trail

I have had the same two supervisors since being accepted into candidature. I have kept notes of our meetings and emailed both supervisors with a summary of what I understood to be the focus of each interview and the next step to take. Early on I wrote a list of my assumptions about stories told by nurses working in mental health settings
to undergraduates. At the pilot workshop I took notes in summary of everything which was said; this was made easier by the request to all there that only one person spoke at a time. I also have the post-it notes which the facilitator and some participants used to summarise their ideas. I have kept a list of everybody to whom I sent a copy of the advertisement and a separate list of those who replied. I have a list of stories provided and of consents received. The framework for the main workshop was written by the two facilitators based on my responses to a list of questions they gave me. I attended the main workshop but not as facilitator or provider of stories or participant in discussions; I took notes of everything that was said. The workshop participants provided their interpretations of stories collected there and gave their understanding of the purpose of the telling of these stories, thus functioning in the role of Thorne’s “thoughtful clinician” (2008, p.84). This then provided the basis for preliminary data analysis. I also used McCormack’s Lenses (McCormack, 2000a) to assist me to consider the stories from several different viewpoints. Case study method allows the same flexibility. In May 2013 one of my supervisors facilitated a workshop with undergraduates where they were asked for their understandings and interpretations of the meanings of selected stories which I had not yet analysed. Data analysis therefore was not to be conducted by me alone; there was input from the pilot group, the main workshop and finally from a separate group of undergraduate students. The difference between nurses already working in mental health settings and a group of undergraduates who may never have been in a mental health setting will provide some balance to my analysis.

3.11 Conclusion

Of the various qualitative methodologies briefly considered, case study research is the most suitable for this study. It has been used frequently in educational research and is sufficiently flexible to allow for this exploratory question. Although it has been criticised for lack of rigour and inability to generalise, triangulation, use of a facilitator and an undergraduate focus group has strengthened the findings. The writing of case study research is often referred to as telling stories, but Stake (1995) states clearly that case study reporting is not usually storytelling. He says that in a story characters have a problem, attempt to solve it and the situation becomes worse; eventually “by extraordinary and climactic effort” (p.127) the problem is resolved. In contrast cases are not known by their problems although they may include problems and problem solving. The case study researcher examines the problems or issues because through these issues, conditions, complexity and coping contained in the case may be studied.
(Stake, 1995). Not for nothing has case study research been called an “under-explored and under-traversed bridge across traditional knowledge paradigms” (Thorne, 2012, p.281; Luck, Jackson & Usher, 2006).

Stories told by mental health nurses are of their nature interpretive. They interpret a situation which the teller lived through, and offer the narrative to the student for further interpretation. What the meaning of the story is to the teller, and so what the teller’s understanding of the story is, may be very different from what the interpretations made by the students are. It is the purpose of the story told which is central to this study. The following chapter summarises the analysis of data and shows how the components of the stories can contribute to undergraduates’ understanding of mental health nursing.

In this chapter I have discussed the reasons for the selection of case study methodology after briefly reviewing other possible methodologies initially considered. Having justified the methodology and approach to analysis used, I will now move on to the results of data analysis in Chapter 4.
Chapter Four

DATA COLLECTION AND ANALYSIS

4.1 Introduction

In this chapter I will summarise the data analysis of the 100 stories collected, and also present the insights and interpretations from the three workshops held. Finally I will consider the six long stories.

“Words have the power to correct, conceal, and endure” (Wickersham, 2012 p.159): Can the stories told by mental health nurses to undergraduate students and to new recruits do any of these things? Can they change attitudes, values and behaviours? Do they conceal meanings beyond what is immediately obvious? If they are remembered at all, what of their content will endure in the mind and memory of the receiver of the story and how will it be interpreted?

Koch (1998) considered that “nursing work’s wealth is found in the intensely personal, highly emotional, often brutal stories of everyday life” (p.1183) which are experienced by patients and witnessed by nurses. Stories may be the only way to capture and preserve some of this wealth of nursing work, and also the only way to show this “intensely personal, highly emotional and often brutal” (p.1183) world which student nurses enter when they register.

In a consideration of storytelling in healthcare education, Haigh and Hardy (2010) differentiate narrative from stories saying that while narrative is mainly factual, stories are “reflective, creative and value laden, usually revealing something important about the human condition” (p.408). Because of this ability to reveal something important about the human condition, collecting and analysing these stories told by mental health nurses to undergraduates and to new recruits is significant, the more so if the purpose of the telling and the meaning which the students take from the telling is not explored. Robb and Murray (1992) state that while medical humanities in nursing can help to develop compassion, trigger discussion about difficult areas and provide a role model, their real value is in helping both staff and students to discuss patients and health
problems from varying viewpoints. Haines and Livesley (2008) note that a well-chosen story can “help students to consider alternative explanations to their own” (p.231).

“To understand, use and critique nursing knowledge, students reconstruct experience and discern values through what will be a lifelong evolution of their nursing praxis” (Longo & Lindsay, 2011, p.703). These authors explored the construction of praxis with a group of students, and praxis included being/becoming, knowing and doing. An examination of the purpose and meaning of stories told to undergraduates can serve a similar purpose.

Now let us turn to this collection of stories. All stories are numbered and cross-referenced using these numbers to Appendices 1 and 2. Where stories are taken from published sources, references are given for these as well as the number which identifies the story in Appendices 1 and 2.

4.2 Data collection

After ethics approval was gained (see Appendices 3 & 4), the participant information sheet, the consent form and a poster (see Appendices 5, 6 & 7) briefly describing the project and giving the names of the researchers was emailed to a small group of mental health nurses in the Hunter New England Local Health District with an invitation to attend a pilot workshop held in a private home.

This workshop (which was conducted by a researcher/principal investigator who was not the writer of this thesis) had two functions. First it tested the workshop plan and promoted the project; second it encouraged the telling, writing down and collection of a number of stories; and third it provided a preliminary insight gained from this group of experienced mental health nurses into the purpose of the stories collected. The pilot workshop lasted for three hours with participants reluctant to leave what they described as being an enjoyable and illuminating experience.

Subsequently a larger group of mental health nurses in the Hunter New England Local Health District were sent the documents by email with an invitation to attend a workshop held at the School of Nursing and Midwifery. Senior academics were also advised of the workshop and requested to inform anybody who might be interested of the project. In total 37 (plus all staff at the School of Nursing and Midwifery at the
University of Newcastle) were emailed; 26 replied; and 19 actually sent stories or attended a workshop without replying.

From this second invitation a number of mental health nurses expressed their intention to attend either as a result of a direct personal invitation received or because they had heard about the workshop from another person. Once again those who came were experienced mental health nurses. Two had attended the pilot workshop and agreed to mark their stories with “P” to indicate prior knowledge of the workshop process. This workshop was conducted by an external facilitator with extensive experience in education and practice based learning and by one of the researchers who is the principal investigator but not the writer of this. The writer took no part beyond making detailed notes. The workshop lasted for five hours.

Once again stories were told, written down and collected and once again the group of experienced mental health nurses provided their insights into the reason the stories were told to students. Several stated they did not know any stories to tell but quickly discovered that in fact they had a wealth of material. At this stage the researcher did not know what would arise from an analysis of the stories and the tellers did not know either so as far as possible stories were told and collected without bias.

It was not necessary for people to attend a workshop for them to provide a story; some stories were received by email with a scanned signed consent. In one case, a lengthy manuscript containing stories from several different workplaces describing experiences over many years was sent. By January 2013 a total of 55 stories had been collected.

A third group of experienced mental health nurses was then sent an email with the three documents (poster, participant information and consent) and an invitation to provide written stories by email. This resulted in one story (sent on 9/2/2013) with the promise of another to come (sent 31/3/2013).

In May 2013 a workshop for undergraduate Nursing students who had completed a mental health placement was held. Five students expressed interest and of those three attended. From this workshop four more stories were collected with two additional ones sent later by email, and the facilitator (who is a principal investigator of this project but not the writer of this study) asked the students for their interpretation and understanding of a selection of stories already collected. Twelve stories were provided
to the facilitator who then chose four for discussion by the students. The students’ responses were recorded in note form during the workshop by the writer of this study.

By June 2013 87 stories had been collected including a batch from a bundle of old letters written while the correspondent was working in one of the old Schedule V hospitals [the original psychiatric institutions] in Sydney. Some stories already in print (either in a book, a journal or on a website) were included as having direct relevance and interest to this study and to provide as wide a range of different sources as possible. Many were discovered through preparation of the literature review. Others were selected from books because, even if not specifically set in a mental health unit, they focused on the sort of patient problems which mental health nurses manage (e.g. confusion, aggression, grief) or on the sort of goals and attitudes mental health nurses may see as important in their practice (e.g. instilling hope). In any case, participants in workshops and through email also selected which of their own stories they saw as ones which they would tell to undergraduates and new recruits. Therefore while there is an element of personal bias in which stories were told, submitted, sent or included in the collection, each has face and content validity for the purpose of the study.

Preliminary data analysis began after this stage of the project. By July 2013 there were 93 stories in the collection. The hundredth story was received on 3/10/2013 to complete the collection. This number allowed a decision to be taken on ‘saturation’ given that there was a variety of different storytellers, and a range of stories about different practice settings; however it avoided the problem of a large amount of documents, which Yin (2009) notes as one of the difficulties of case study methodology. Russell and Gregory (2003) do warn against pre-specifying a sample for data collection in strict terms, in case important sources are missed. In summary this study uses stories collected in workshops and by email, as well as a few previously published stories, a personal memoir and a collection of old letters. Coincidentally, during the preliminary data collection, a new book “Stories from Mental Health” (Nizette, McAllister & Marks, 2013) was published. This book included stories from patients and carers as well as from mental health nurses and other mental health professionals. Many of the stories were longer than could easily be told quickly to an undergraduate student or to a new recruit, but those which were “anecdotal” in form were included in the collection, and identified as an alternative source within this study.
Another collection of stories written by a mental health nurse covering a period between 1969 and 1974 (Gilham, 2011) tended towards the comical or the sensational but two could be classed as “clinical anecdotes” and were also included in the collection. One “How Many Chairs” described the development of unusual behaviour in a chief male nurse after 57 years of service; the other “Terrifying Italian” recorded effective management by the author of threatening behaviour from a man with paranoid schizophrenia.

An unusual slant was thrown on to the whole project by the discovery of a short story called “Grand Rounds” told in the first person (Adrian, 2012) in which the speaker, a doctor, gives a talk to a group of residents entitled “The Teddy Bears’ Picnic” or “Why Stories Matter” or (sometimes) “The Worst Year of My Life” and (sometimes) “Theory and Practice at the intersection of Art and Medicine” (this is the complete title of the story). The teller begins by saying he will talk about “how and why people I respect and trust insist that a facility in telling and listening to stories makes for a better practice of medicine” (p.9) adding that “if what people talk about when they talk about Narrative Medicine was easy to say they wouldn’t need stories to say it” (p.10). However, as the short story progresses, the speaker in the short story tells his own story interspersed with his official subject matter in flashes which grow more and more detailed. Even when a teller begins to tell a story not intended to be directly related to the self, the ‘self’ intrudes.

4.3 First data analysis - Undergraduate nurse workshop

In some of the stories a single theme was immediately apparent and it was therefore easy to consider them together. Other stories were extraordinarily complex and for these McCormack’s Lenses (McCormack, 2000a) were helpful. I was always mindful that the “surface” message might not be the intended or the final meaning. I was also mindful that the most useful stories for teaching often contain several meanings or else layers of meanings. As the third stage of the project was a workshop for new graduate or undergraduate nurses to explore what they understood as the meaning of selected stories from the database, I decided to start with the shorter and less complex stories so as to have a bank of stories ready for this student/new graduate workshop. However the workshop took place before this group of stories was analysed in depth; thus the students’ comments provided the first detailed analysis of this group of stories, not all of which were used in the workshop.
Story 1 of 12 (number 56 in Appendix 2)

A female new graduate nurse was approached by a more senior male nursing colleague who asked whether she had come over to the dark side yet. When she insisted that this would not happen because she was too positive, the male colleague replied, “You will change” (Hazelton, Rossiter, Sinclair & Morrall, 2011, p.180).

Student A’s comment was that she was “quite positive about the whole situation” as she had found that when she said she was really interested in mental health “they treat you a bit differently”. However she saw the reference to the dark side as being to the difference between the way things should be done versus the ways things were actually done, citing an episode where it took a new graduate, two male nurses and herself just to give a man with dementia a shave. She concluded “and that’s the dark side, treating them a bit worse than required…”.

Student B wondered if the dark side referred to mental health nursing or to “being corrupt”.

Student C interpreted the question as meaning, “Are you jaded?” and added that it would be “pretty sad if a teacher says it”.

Story 4 of 12 (number 41 in Appendix 2)

In the Child and Adolescent Unit working with a psychotic young boy with a significant trauma history: I had a good relationship with him. He was walking up and down the hallway while a group of nurses stood nearby.

In attempting to engage with him I asked him a few questions. At one point I asked him did he want a hug to which he said yes. We then hugged for a brief time. And then continued what we were doing.

Student A saw the issue here as being one of boundaries, saying that she was “not really sure where the boundary is”, and that whereas in aged care she could “spend the day kissing and hugging older people”, in adolescent nursing she was not sure if that was appropriate, adding that as a student it is difficult to gauge appropriateness. She saw the boy as “just going about his day” and said if an educator told her this story she would ask if hugs were offered to everybody or just exclusively to one person,
concluding that she would not copy this behaviour. She said this story would not be appropriate for undergraduate nursing students, as some are only 19 year old girls and "this person could take it as meaning more than it does".

Student B surmised that the young patient may have had the “feeling of being protected which you get from a hug” and said the interaction was “possibly therapeutic”. She said it would depend on the relationship between the staff member and the client whether or not it was suitable for telling to students, but felt there was “history there” so that it was “appropriate to say, ‘Do you want a hug?’”.

Student C commented that she knew that mental health nursing “is different and it depends on how long they’ve known the patient for” adding that she would “baulk if there was a traumatic history”. She felt it was suitable for use with students as it “would create discussion”.

**Story 6 of 12 (number 37 in Appendix 1)**

_He had been a long-term patient in the unit with multiple operations. Lost his legs from stepping in front of a truck while drunk; he always denied suicidality but had been labelled as a mental health patient because he was “depressed” following the accident. He was always pulling practical jokes on staff and other patients._

_I shortsheeted his bed: He thought it was hilarious and jokingly insisted on other staff making his bed that way “to save linen”. _

Student A said that if people have to live (in a particular place) it becomes like their home and playing a practical joke would be acceptable so long as it was taken in the right way and nobody was bullied. However she felt it was not suitable for students as it could be misinterpreted and students might conclude that playing a practical joke on a patient "without having that close relationship" would be acceptable. She stated that “if there is any interpretation needed, it would not be a good idea” (to tell a particular story).

Student B saw a “fantastic relationship between staff and patient – a certain kind of coping mechanism in the guise of humour”. She felt the story would be suitable for students and that it was “touching on the therapeutic relationship a little bit”.

Anna Elizabeth Treloar
Student C said it was “a nice story. I love the story. It’s a way of making someone feel better”. She thought it would be suitable for students as it is “not making fun of the amputee by having a joke”. She had heard different stories about playing practical jokes on patients and said it “goes with mental health even though patients have a physical illness”.

**Story 10 of 12 (number 51 in Appendix 2)**

_In this particular aged care home I was walking down the corridor and I saw an elderly lady sleeping: it was 10.30 in the morning and she was still fast asleep and she looked like she had an enormous tummy, and I sort of took a couple of steps back and I peered into the room again and the director of nursing said to me, “Oh, I wish you hadn't of seen that” and I said, “Why, what was wrong?” and she said “Oh she sleeps with her dog on her tummy” and the dog was under the blanket_ (Quirke, in Nizette, McAllister & Marks, 2013).

Although Student A works in aged care, she found this story puzzling, saying, “What's the dog doing in an aged care facility...?” and explaining that sometimes behaviour doesn’t “appear right” but if the person does that at home, the person will also do that in the aged care facility. For this story she concluded that there may be different ways of looking at it.

Students B and C did not comment on this story as there was insufficient time in the workshop.

Reactions to all stories from the three students were very different and comments reflected the various ways of interpreting “the dark side”, the difficulty of establishing boundaries particularly with an adolescent, the use of the therapeutic relationship in playing a practical joke along with the real possibility of students misinterpreting what was the essence of the story, and the puzzling effect of something unexpected being permitted in a nursing home. Thus all stories opened up discussion of areas of mental health nursing which may be misinterpreted or misunderstood by novices.

### 4.4 The Data Analysis Template

For my analysis I prepared a data analysis template based on the work of Tripp (1994) and McCormack (2000a). There was some correspondence between the key points for case study analysis outlined by both authors because both list Context as one element;
however, whereas Tripp’s final point looks at Relationships, McCormack’s final point stresses Moments where something unexpected happens. Both of these are highly appropriate for stories about mental health nursing. Tripp’s Five Components provide a foundation for analysis while McCormack’s Lenses offer a different perspective and encourage close attention to the text.

In June 2013 the first four stories (the four selected for the May Student Workshop) were analysed. In July stories were selected at random for analysis to avoid any preconceived ideas about their meaning and purpose. The shorter ones were easier to analyse at this stage, because of the limited detail possible in a short word length, though this did not preclude complexity of meaning.

<table>
<thead>
<tr>
<th>Data Analysis Template</th>
</tr>
</thead>
<tbody>
<tr>
<td>Story number...........</td>
</tr>
<tr>
<td>First words............</td>
</tr>
<tr>
<td>Source................</td>
</tr>
</tbody>
</table>

**TRIPP’S FIVE COMPONENTS**
- People
- Things
- Events
- Context
- Relationships

**MCCORMACK’S FIVE LENSES**
- Active listening (immerse self in story)
- Narrative processes (identify)
- Language of text
- Context (where text produced)
- Moments (where something unexpected happened)
- Notes including teller’s own interpretation if supplied

However, after the first four stories were analysed, clarification of some of McCormack’s points were required. McCormack’s Lenses encourage the researcher “to consider the whole and each part of the story from more than one angle” (Dibley, 2011, p.15), whereas Tripp’s (1994) framework for analysis is much simpler and more specific. The Data Analysis Template draws on the work of both so that Tripp’s framework can provide a foundation and McCormack’s Lenses (McCormack, 2000a).
can uncover other aspects of each story as well as taking different perspectives. Tripp’s framework is self-explanatory but McCormack’s headings need some explanation.

Dibley (2011) expands understanding of McCormack’s Lenses as follows (but does not provide any comments on active listening, presumably assuming that none are needed in situations where the storyteller is in a face-to-face interview):

- Narrative processes focuses on the way words are used and on the pattern of words, rather than individual words. A hesitant or chaotic use of words may have a different meaning from fluent or humorous use.
- Language focuses on words used, choice of words, and what is told and how the story is told.
- Context takes into account environment and culture.
- Moments refer to “a sudden intuitive leap of understanding that unexpectedly emerges”, a kind of “personal epiphany” (Dibley, 2011, pp.16-17).

So following McCormack leads us from consideration of single words, to patterns and prosody, to the broader picture of culture and environment (Dibley, 2011), and finally to moments where the story leads to new understanding, which may not occur for the teller, though the expectation is that an audience of undergraduate mental health nursing students would draw many different understandings from this collection of stories if one or more were told to them in a clinical setting.

Writing about plot, Bleakley (2005) notes that plot structures narrative by ordering events into a sequence, but then the tension is usually created “through misfit between the elements of story such as agency, intention, means, goal and setting”. The Data Analysis Template allows a close look at these different elements, through analysis of People for agency, Things for means, and Context for setting, while intention and goal are partly covered in Events, Relationships and Moments.

Rubinstein (1995) points out that narration “often involves two relational aspects” (p.259) with the narrators firstly organising experience for themselves as well as for others, and secondly involving others as active listeners. McCormack’s Lenses also consider this in Relationships and Moments. Sandelowski (1994) adds that in “every
succeeding remembering moment” (p.26) the story will be revised as the present becomes the past and there is anticipation of a future which will give meaning to the whole. During the May 2013 Student Workshop two students remembered and retold with different details and different focuses a story which had originally been told to them by the facilitator two years previously. Neither told (or retold) the story with sufficient organisation for it to be included in this collection but each had taken away different key points and been left with different understandings of the purpose of the telling.

Writing about Narrative Criticism, Pellico and Chinn (2007) note that its aim is not to “reveal the correct view” of a story but to “provide insight and understanding into the work” (p.63). Some of their seven steps match those of Tripp and McCormack. They begin by composing the researcher’s lens, deciding if the stories meet inclusion criteria and then conducting a pilot study. After this the structure of each story is determined. Next stories are analysed for figures of speech, archetypal forms, critical moments (cf. McCormack’s Moments) and themes. Relationships are considered next but they are the relationships among the stories when they are grouped, not Relationships within the stories as Tripp suggests. The final step is writing the full analysis. They cite Burke (1969) whose method involves analysing each story for act (what was done), scene (where was it done), agent (who did it), agency (by what means) and purpose (why did they do it). These steps are very similar to Tripp's. In her study of the dimensions of caring by nurses as described in their stories, Hudacek (2008a) analysed her data in a similar way (based on Giorgi 1985), i.e. the narratives were read for a general sense, then re-read to find the meaning units, following by reflection on what was being investigated and concluding with the synthesis of meaning units.

Gustafsson, Snellma and Gustafsson (2012), in their hermeneutic study of the meaningful encounter, recommend three phases of analysis, of which the second begins with analysis of narrative structure, but then continues to analysis of deep structure, in particular the use of metaphors. Their narrative structure corresponds in part to Tripp's components, whereas the focus on what the meaningful encounter expressed through metaphor is closer to McCormack's Lenses.

The following exemplar from an expert psychiatric nurse is contained in Benner’s “From Novice to Expert”:

Anna Elizabeth Treloar
An unusual day that stands out for me was a day in which a patient had suicided on the unit [during the night], and the psychiatrist did not come in. We notified the family. We gave the night staff an option of staying over for the community meeting of the patients – got the patients up for breakfast, then called this special meeting to inform them of the incident and allow them to talk about how they were feeling. We wanted to deal with and respond to feelings that this loss brought up, e.g., “Why didn’t you protect him? – Can you protect me?” Because a suicide brings up panic and brings down impulse control on the unit, we worked with patients to devise a special three-day emergency plan, whereby we intensified one-to-one availability, stopped off-unit privileges, stopped passes unless plans were detailed with a resource nurse, and stopped admission temporarily (Benner, 1984, p.74).

The teller of the story provides reasons and justifications for actions taken, and at the end of the story Benner herself gives a summary statement, saying that the nurse has a responsibility to build and maintain a therapeutic community, and that this may often involve “interpreting events on the unit to the patients in situations where misinterpretation or misunderstanding might occur” (Benner, 1984, p.74), as well as building relationships with all members of the community so as to promote “an atmosphere of trust and shared communication” (Benner, 1984, p.74). The story is told so as to make its key educational points, and the final summary completes this. No other interpretation is offered and nothing is left equivocal. In contrast, use of Tripp’s Five Components and McCormack’s Five Lenses allow consideration of many aspects of each story, and even when the teller adds reasons for telling, or a brief comment on the story’s significance, there is still much left open.

McCormack (2000a) explains that narrative processes “…alert the researcher to the particular meanings the storyteller wishes to convey” (p.286), and include description, argumentation, augmentation and theorising. Language she sees as both language of text and as a social process which shows how the storyteller speaks about himself or herself in context. Context refers to the immediate social situation and also to the culture the teller belongs to or is situated in. Moments may be personal insights or understandings which the teller gains during the process of storytelling or they may be times “where particular phrases or key words signify something different or unexpected is happening” (p.287).
Once Tripp’s Five Components and McCormack’s Lenses were further defined and clarified for the purposes of data analysis, work proceeded. The first notes were made on the Data Analysis Template in black. Notes from a second reading were made in blue; any additional notes at a third reading were made in red and the final reading had notes in green. Dates of each reading were listed on the template in appropriate colours.

A difficulty was encountered with a collection of stories spanning several countries and a variety of settings because each was long, and written with a large amount of detail and personal comments. These stories therefore required a slight modification of the process used in the Data Analysis Template. For demonstration of how data was analysed in this chapter, a shortened version was sometimes used (omissions indicated by ... in the text of a story), with some of the storyteller’s extra detail and personal responses omitted. As well as streamlining the process of data analysis, this also protected the identity of the storyteller as many details were personal. In the text of each story used in analysis, red brackets were placed round sections not incorporated into this chapter and these omitted passages are shown by a row of three dots in the version in Appendix 1.

It became apparent early on in analysis that some storytellers provided their own interpretation of their story or stated clearly why they tell it to students; there were also frequently very powerful accounts of the emotional impact which the events described in the story had on the teller and of the way it changed practice or confirmed current practice as beneficial.

In contrast to the depth and complexity of most of the stories collected, in a study of registered nurses’ narratives of one caring practice which made a difference in their lives or career, the recorded stories were much less complex and more direct, and the interpretation at the end was often quite simple. The researcher aimed to “describe the dimensions of caring used by nurses as they relate to and clarify the practice of professional nursing” (Hudacek, 2008a, p.125) and says several times in the article that nurses have “chosen to be silent about what they do” (p.126).

To follow are two stories from Hudacek (2008a). Both are short with minimum interpretation by the teller at the end. In the first the interpretation is in the form of a clinical diagnosis; in the second it is in the sadness felt by the registered nurse “for all
the babies I have seen born too early” (p.127) with a reflection on the “privilege of intimately touching and being touched by those in my care” (p.127):

[My patient] was in her mid-30s. Her chief complaint was, “My leg hurts”. She smiled and giggled, inappropriate laughter. She was forgetful. I assessed her cranial nerves, her pupils responded unequally and at different speeds. I kept a close eye on her. I was sure something else was going on with her. Her [computed tomography] was in the view box. She had a large global meningioma (Hudacek, 2008a, p.128).

Roberta was 19 [years old] and Baby Victoria was delivered at only 22 weeks gestation and did not survive. Her family was not able to be with her. She was overwhelmed with the details of the funeral for the baby. She asked me if I would go to the funeral with her the next day, New Year’s Eve. I bought Roberta a book about grieving and loss. I went to the cemetery. A lone car with Roberta and her boyfriend pulled up. No one else was at the funeral. Baby Victoria’s tiny casket was brought out to the gravesite. I cried for all the babies I have seen born too early. Nursing has granted me the privilege of intimately touching and being touched by those in my care (Hudacek, 2008a, p.127).

Hudacek (2008b) also collected stories from student nurses to illustrate the seven dimensions of caring in nursing and these stories were brief, with limited interpretation at the end, often only a statement of what the student understood as having been achieved by the actions described.

To follow are two stories from the student nurses’ stories (Hudacek, 2008b):

On Tuesday, my patient was supposed to go for a cardiac procedure at noon but [sic] turned out to be at 4 pm. Her two daughters were in the hallway crying. I got a box of tissues and talked with them; they were so appreciative. They expressed concern about the procedure and how anxious they were. I just listened (Hudacek, 2008b, p.7).

My patient did not receive breakfast. I found the woman from dietary and got him a good breakfast. He did not receive a lunch tray, so I alerted dietary. I kept hounding them. I feel little things like missing lunch trays take a back seat to many other issues in patient care. I hope I can always maintain a level of caring.
for all of my patients’ needs and know that sometimes a turkey sandwich is just as important to a patient as a medication! (Hudacek, 2008b, p.8)

These stories, both from Registered Nurses and from student nurses, do not have the depth and complexity contained in the majority of the stories collected in Appendices 1 and 2, although all highlight important issues in nursing – accurate assessment in the first, empathy in the second, listening in the third and advocacy in the fourth.

4.5 The data collection and analysis process

After ethics approval was gained from the University of Newcastle, invitations were sent to a small group of mental health nurses known to two of the researchers with an invitation to attend a pilot workshop. The following figure (Figure 4.1) shows how collection and analysis proceeded after this pilot workshop.
Figure 1: Data Collection & Analysis audit trail

Anna Elizabeth Treloar
Some discussion is also provided, as a way to summarise the complexity of the analysis. Thorne advocates for qualitative researchers to employ analytic processes throughout all phases of the research; the data analysis processes are not completely distinguishable from the data (Thorne, 2000). While unusual to provide preliminary discussion in the analysis chapter, the appropriateness may be justified because a case study may be carried out so as to serve as an “interpretive vehicle”, rather than presenting itself as a “truth claim all on its own” (Thorne, 2012, p.281). Case exemplars may illuminate and disrupt assumptions taken from other types of theorising (Thorne, 2012). Preliminary interpretations of the stories and the first insights gained from use of the Data Analysis Template are deepened by consideration of what was discussed in the three workshops, and later in Chapter 5 by a final overview and discussion of the findings of the whole study. Luck, Jackson and Usher (2006) argue that methodologies in nursing research are becoming more flexible.

Quite early on in the process it became clear that the stories fell naturally into three groups. The first group were “surface” i.e. they were amusing or had historical interest or surprise but had little to teach about the clinical work of an experienced mental health nurse. The second group were “middle depth” i.e. they provided insights into the day-to-day work of mental health nurses with some “teachable moments”. The third group were “deep”, i.e. they showed aspects of the essence of mental health nursing, and surprisingly, these stories very often included acknowledgments by the mental health nurses that they felt they had made an error, acted inappropriately, been “out of their depth”, or been pushed beyond what they had expected of the situation. If the metaphor of a pond is used to further explicate this finding, the first group of stories are on the surface of the water, the second group are at the middle level of the pond, while the third group are found in the deep.

It is important to acknowledge that there was the possibility that nurses would select stories which showed them in a good light or adjust them so as to present the teller as hero. However, it was not possible to find evidence of this in any of the stories. Rather, the nurses tended to minimise their role and were often quite laconic in describing dramatic events in which they were involved. Sometimes the nurses were quite self-critical. However, it is possible that the laconic style was in itself due to the knowledge that stories would later be analysed. It is also possible that stories already in print were episodes which the writer had chosen to record for a particular reason, whether to entertain, contrast, or educate; that information provided in interviews again was
disclosed by the teller for a particular purpose and with the obvious knowledge that the interview would eventually be transcribed and published in entirety; that stories which were emailed once again had been edited to the sender’s satisfaction; and that stories told and then written down in the workshops were highlighted so as to show the teller in a favourable light (though in fact most of the workshop stories superficially at least show the teller dealing with difficult situations and not always sure if the nursing interventions had been appropriate).

Some of the stories were discovered through preparation of the literature review. Others were selected from books because, even if they were not specifically set in a mental health unit, they focused on the sort of patient problems which mental health nurses manage (e.g. confusion, aggression, grief) or on the sorts of goals and attitudes mental health nurses may see as important in their practice (e.g. instilling hope). In any case, participants in workshops and through email also selected which of their own stories they saw as one which they would tell to undergraduates and new recruits. Therefore there is certainly an element of personal bias in which stories were told, submitted, sent or included in the collection.

4.6 Data analysis based on Data Analysis Template

The categories from the Data Analysis Template are not discussed in the order in which they appear on the Template. The most significant categories (Events, Relationships, Moments) appear last. The less important categories (People, Things, Events, Narrative Process/Language of Text which however do shed light on the final three), are discussed first. Two categories (Narrative Process and Language of Text) are collapsed into one as they look at similar things. Stories are listed in the order in which they were analysed, i.e. not in numerical order. Stories were analysed in groups of 20 and each group was selected at random in order to provide as much variety within each group of 20 as possible.

4.6.1 People (Tripp)

Nurses

Unsurprisingly, mental health nurses (both registered nurses and student nurses) and patients appeared frequently in the stories. New mental health nurses were mentioned specifically four times. Where there was no distinction regarding length of service or experience teams of mental health nurses were listed as experienced (14 times).
Mental health nurses were described by their shift (morning once, afternoon once, night five times). They were also described by their role frequently – night supervisor once, charge nurse once, chief male nurse once, director of nursing in psychiatric nursing home once. Other descriptions included Child and Adolescent Mental Health Service (CAMHS) community nurse twice, community mental health nurse seven times, nurse practitioner in psychiatry once, prison mental health nurses once, court mental health nurse seven times. The old Schedule V category of Admissions Nurse appeared twice. There were 23 references to student mental health nurses. Sometimes the student nurse was the teller of the tale, either almost contemporaneously, or else in recollection after many years of practice. At other times a student figured in the story told.

Table 1: Numbers & types of nurses in stories

<table>
<thead>
<tr>
<th>TYPE OF NURSE</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>New mental health nurses</td>
<td>4</td>
</tr>
<tr>
<td>Experienced mental health nurses</td>
<td>14</td>
</tr>
<tr>
<td>Morning shift nurses</td>
<td>1</td>
</tr>
<tr>
<td>Afternoon shift nurses</td>
<td>1</td>
</tr>
<tr>
<td>Night shift nurses</td>
<td>5</td>
</tr>
<tr>
<td>Night supervisor</td>
<td>1</td>
</tr>
<tr>
<td>Charge nurse</td>
<td>1</td>
</tr>
<tr>
<td>Chief male nurse</td>
<td>1</td>
</tr>
<tr>
<td>Director of nursing in psychiatric nursing home</td>
<td>1</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Service (CAMHS) community nurse</td>
<td>2</td>
</tr>
<tr>
<td>Community mental health nurse</td>
<td>7</td>
</tr>
<tr>
<td>Nurse practitioner in psychiatry</td>
<td>1</td>
</tr>
<tr>
<td>Prison mental health nurses</td>
<td>1</td>
</tr>
<tr>
<td>Court mental health nurse</td>
<td>7</td>
</tr>
<tr>
<td>Student mental health nurses</td>
<td>23</td>
</tr>
</tbody>
</table>

*Other nurses also appeared depending on the context but their role was not specified.
Doctors

There were five references to psychiatrists and five to doctors (GP, RMO, JRMO) [General Practitioner, Resident Medical Officer, Junior Resident Medical Officer]. There was one reference each to surgeon, physician and ED [Emergency Department] consultant, medical student and ED registrar. Doctors and psychiatrists rarely played a major part in the narrative. Where doctors and psychiatrists were mentioned, they were in the background. It was very unusual for a story to describe any sort of confrontation between doctor and mental health nurse. The nurses themselves were in the forefront. The doctors were always ancillary figures; in no story was a doctor named, though nurses were often named and so were patients (by first name only). In many stories the nurse was working autonomously, e.g. in community mental health, in the community crisis assessment centre, in prisons or with one other nurse on an evening shift in an acute mental health unit.

Allied health professionals

Allied health professionals were mentioned infrequently with one mention each for psychologist, occupational therapist, social worker, Aboriginal health worker, allied health staff and prosthetist. Ambulance officers were mentioned three times and after hours mental health services/mobile treatment teams twice.

Patients (This term is used here as it was used throughout the stories).

A variety of patients was described, mostly patients in mental health settings but sometimes in aged care settings or in cells or gaols. Categorising them was difficult but they were classified under basic subheadings of young, old, gender, diagnosis, unspecified. Categories overlapped e.g. “female patient with BPD [borderline personality disorder]”.

Adolescent patients appeared in six stories and older patients in 12. Diagnosis was not a major feature of stories but rather was given as a way to explain the situation described. The patient as person usually predominated. Diagnoses tended to be broad and usually focused on Axis 1; so bipolar affective disorder appeared five times, schizophrenia 12 times, depression and suicidal ideation six times. Other diagnoses mentioned once only for each were “heroin addict” “alcoholic” “borderline personality disorder” (this also appeared another time as “female patient with borderline personality disorder”), “confused and dementing”, “learning disabilities and challenging
behaviour”, “potentially violent” and “dementia” (this diagnosis also appeared with
patients classified by gender twice). Classification by gender was used where that was
the main descriptor, e.g. “hooded male patient” “young male patient with long hair”
“male patient, deceased” “lost male patient” “naked male patient” “female patient
talking to birds” and “female Yugoslav patient. Unspecified was used for descriptions
such as “2000 patients” “ten patients on holiday” and “gardener patient”.

Relatives

Patient’s relatives included parents (four times), family/relatives (seven times), husband
(once), wife/partner (three times), girlfriend/estranged girlfriend (three times), mother-
in-law (twice), grandmother (once) and children (four times). In the many stories set in
old psychiatric hospitals mention of families was very rare.

Police and others

Police and prison officers figured in several stories. Police figured nine times, prison
officers seven times, and security three times. There were five references to solicitors
or magistrate.

4.6.2 Things (Tripp)

Things proved a surprisingly revealing component for analysis. An enormous variety of
things appeared in the stories. A small number of things were mentioned several times
such as bed, chair, toilet, medication, gardens, cup of tea, food, paperwork. Most other
things were unique, for example, Special Observations list, Polo mints, robotic hands,
pinstripe suit, shotgun, pool table chalk, David Jones [large Sydney department store]
truck, ceramic Buddha, knickers, lamingtons, noose, drainpipe, helicopter, shampoo
advertisement on television, and ski mask. Sometimes the things themselves told a
story, as in "shotgun, car, mobile" or "laundry hallway, showers, fire alarms, fire doors,
pool balls, pool table chalk, pool sticks, lounges, seclusion room, rubber strip, IMI
[intramuscular injection], chair, bushes, notes, incident forms" or “caravan, gas bottle"
or “pink iced cake, candles, pot of tea, grapes, orange juice, plate of iced cakes, cat,
dog”.

Sometimes they set a scene as in “garden with grass, seats” or “valley, woods, bus,
rug, crows, canteen” or “furniture, ski mask, black clothing, reflector sunglasses”. Other
lists of things from an individual story are intriguing e.g. “Animals, tinned food, milk, bills, IMI, restraints, nightie, bed, drip, old clothes, corset, 8542 pounds sterling”.

A few stories contained things which appeared to have no connexion at all when presented solely as “things” e.g. “dog, fibro home, display cabinet, abandoned power station, meat pies, TV, notebooks, steak and onions, bones, bed, videogames, dioramas of death scenes” or “chairs, wedding ring, knickers” or “clothes, perfume, underpants, drainpipe, back garden, gate”.

There are expected juxtapositions such as “alcohol, IV [intravenous] drugs” and the unexpected such as “cow, fire hydrant”. Overall the things which might be expected in a general hospital setting such as “chair, Posey vest, tray table, file, antipsychotic medication” feature infrequently and the unusual list such as “cell, mattress, clothes, noose, paper suit, toilet, jewellery, voicemail” is more common.

4.6.3 Context (Tripp and McCormack)

**Towns and countries**

Analysis of context included both mental health settings and town and or country where the story took place. Four countries were represented – Australia, where 56% of stories occurred, and England, Scotland, New Zealand and the United States, all mentioned once. Towns and cities in England included Bolton, Manchester, London, Whittingham and Scarborough. Australian metropolitan was the setting for 44% of stories while Australian rural was the setting for 9%. Oakdale Park the setting for two stories may be a pseudonym for a large psychiatric hospital somewhere in Australia. Newcastle NSW appeared in 21% of stories (not surprisingly as much of the data was collected in Newcastle), and Gladesville in 5%. Other Sydney suburbs mentioned were North Ryde, Ryde, Matraville, Darlinghurst, Petersham, Bankstown, King’s Cross, Rozelle, and possibly Campbelltown and Paddington. Regional settings included Wollongong and Garrawarra. Rural towns mentioned were Kempsey, Taree and Broken Hill. Not all stories specifically mentioned the place where they were set but this was apparent from details in the story or from the facility where the events occurred or from introductory or explanatory notes provided by the teller through email or in person. In 25% of stories the location was unknown, in one it was clearly rural, in another it was clearly regional.
Treatment settings

The majority of treatment areas were for mental health which is not surprising. They included hospital and community. Where the hospital was clearly one of the old style Schedule V hospitals or its equivalent institution, it was described as “psychiatric hospital” (19 mentions). Where the hospital had mainstreamed mental health services and incorporated a mental health unit in the general hospital, that unit was described as “mental health unit” (21 mentions). There were three mentions of a child and adolescent mental health unit, two of a Psychiatric Emergency Care Centre, one to a ROAM community and one to the Emergency Department. Courts, cells and gaol featured eight times. Community mental health centres featured four times. A private religious psychiatric hospital figured once.

Other locations

Other locations included a funeral, a cafe, a mall, a patient’s home (twice), holiday boarding house, High School, refuge, railway line, rural property and caravan. There were eight references to general hospitals although the stories were not always specific, and seven to geriatric hospitals or aged care facilities.

4.6.4 Narrative Process (McCormack) and Language of Text (McCormack)

In an explication of McCormack’s Lenses, Dibley (2011) felt that narrative processes focuses on the way words are used and on the pattern of words, rather than individual words, whereas language focuses on words used, choice of words, and what is told and how the story is told. However, for the purposes of this study, which used written stories rather than transcribed interviews, the meaning given to each of these two components was adjusted slightly. Narrative processes was used to identify the form and main structure of each story or its source, while language of text was used to look at individual writing style and use of words.

There was great variety in both narrative process and language of text, particularly in language of text where style varied from “basic” to stories showing extreme verbal facility. Sometimes narrative processes encompassed two or more categories, e.g. an email might be in report style.

A quarter of stories were written in nursing report style, that is, they outlined events in a logical and factual manner. Nine stories were transcripts of interviews and taken from a
printed sources (Nizette, McAllister & Marks, 2013). Eleven were sent by email, one came from an academic article (Hazelton, Rossiter, Sinclair & Morrall, 2011). Fourteen were part of a lengthy memoir already written but not published, and ten came from a collection of letters. The shortest consisted of a single sentence. Eleven were classified as “economical narrative” and nine as “complex narrative”. There were some overlaps and some stories did not fit any of these categories, e.g. “opinion piece” “student portfolio style” “begins as report, ends as reflection”. This component of McCormack’s Lenses was most useful in detailing sources of stories, but did provide some insight into type as well.

Categorising the language used was subjective. Most stories fell into categories of “simple, colloquial, conversational” (number =41) or “colourful, descriptive” (number = 13). One was classed as “economical” and two as “very basic”. Seven were seen as “vivid, colourful, dramatic”, three as “witty” and two as “aphoristic”, i.e. these two made use of memorable and quotable expressions to summarise events or meanings. Only 17 of the whole collection provided any sort of explanation or comment or interpretation, and a true interpretation was rare. (Interpreting the stories was done separately from the writing and took place during the three workshops in a spoken discussion, from which extensive notes were taken. However, only a small group of stories could be discussed during the three workshops, as many were collected after these workshops took place, and very few of the stories not written or discussed in the workshops included any interpretation). One story in the collection was described as “wordy”; in contrast, another was described as “simple, unemotional, apart from words ‘angst’ and ‘challenging’”. One of the six long stories (discussed in detail below) was in a category of its own – “Economical, dry humour, minimises risk, immediacy (details ‘rather ceremoniously’ ‘pointed tip broken off’ ‘perplexed’ ‘sat down forlornly’). One had “present tense, immediacy”, another was “emotionally powerful, incomplete” and another was described as “informal”. One used the expression ‘alpha male’ to describe a patient in the story, another used a patient’s own words which contained an obscenity, and a third used a metaphor ‘the dark side’. The long collection of memoirs was exceptionally skilfully written but in most stories, writing style tended towards the simple report style, or the simple descriptive.
4.6.5 Events (Tripp)

The Events component was one of the more complex components and without consideration of Relationships and Moments could be misleading. How best to analyse the stories according to Events was difficult as many stories belong in several categories. Early on it became apparent that there was little difference between what male and female mental health nurses do or what situations they find themselves in. In one story (Number 16) a female nurse was called on to assist in bathing an older female patient; in another (Number 7) an older male patient with disabilities asked a male nurse to “wipe my arse”.

To assist with analysis several subcategories were used of which nurse-patient interactions, used where the interaction was the most significant feature, was the largest. However a summary of Events themselves rarely revealed that it was the nurse-patient interaction which was crucial.

Another large category was “difficult” patient behaviour which gave insights into the types of behaviour which mental health nurses are called on to manage on a routine basis. A smaller category included “difficult” nurse behaviour and there were at least half a dozen instances of problematic or unprofessional behaviour from mental health nurses. A small list of stories primarily showed the unusual quality of mental health nurse humour, sometimes as a way of coping, at other times just as a way of having fun!

A small group of stories dealt with the education of mental health nurses and another small group focused primarily on aspects of nursing care, often basic physical care. The last category described daily life and routine because Events as part of a story were not the key aspect.

Because of the need to consider Events in conjunction with Relationships and Moments, these three categories are discussed after the first four components. The smaller subcategories in Events will be considered first.

**Difficult nurse behaviours** *(The behaviour of a doctor is also included here as it fits best in this section)*

- Male mental health night nurse absented self (Number 11)
• (Senior male doctor suggests tying two young patients together and putting them in one room) (Number 3)

• Chief male nurse “had become extremely peculiar” (Number 57)

• Male EN exploits patients and threatens staff (Number 64)

• Community carer complains to ?manager about dress/behaviour of female community nurse (Number 62)

The Events include a night nurse sleeping on duty, having bribed the night supervisor, and instructing the student nurse not to wake him; a chief male nurse exhibiting behaviour described as “extremely peculiar” (although from the full description there is a possibility that he was suffering from Tourette’s Syndrome and the writer of the story did not recognise this); a male Enrolled Nurse threatening staff and exploiting patients and failing to ensure the safety of one patient in particular; and finally a female community nurse whose dress was provocative and who did nothing to modify the socially and sexually inappropriate behaviour of a male patient when she was making a home visit. The remark of the senior male doctor may have been intended to be humorous but was not accepted as such by the mental health nurse who recorded the story.

Mental health nurse humour

• Female mental health nurse overheard two patients discussing male charge nurse (Number 68)

• Morning mental health nurses added fictitious patient to Special Observations list (Number 77)

• Nurses fed bread soaked in Largactil to seagulls (Number 92)

• Health Commission official visits psychiatric nursing home, sees pets (Number 81)

• Deputy Matron shows relatives a room (Number 82)

• Night nurse feeds barking dog bread soaked in Largactil (Number 93)

• Policeman brings cow to Admission Ward at 3 am (Number 84)
This group of stories shows a “handover” given by an experienced patient to a new patient and the charge nurse’s ability to laugh at himself based on what one patient advised the other; experimental mischief making by two nurses when Largactil was new; an unfortunate denouement to a night nurse’s attempt to sedate a barking dog so she could get some sleep; the black humour of a Deputy Matron telling a story against himself after his attempt to impress the relatives of a potential new patient failed; the morning shift playing a prank on the afternoon shift by creating a fictitious Special Observation (SO) patient and placing him on the SO list; the Matron of a psychiatric nursing home attempting to outwit a Health Commission official and the official responding in kind; and finally the “pseudo-professional” response of an Admissions Nurse confronted with a policemen leading a cow to the main door of the Admissions Ward at 3 am.

**Daily life and ward routine**

- Daily life and routine in a psychiatric hospital (Number 48)
- No events – deals with imagined psychiatric hospital before employment begins (Number 8)
- 10 patients go on holiday to a coastal town with female mental health nurse and male student mental health nurse (Number 15)
- Aboriginal mental health worker and female mental health nurse visit patient at home (Number 47)
- Daily life in voluntary inpatient clinic (Number 19)
- Male mental health nurse takes job as Court Liaison Nurse (Number 24)
- Female arrested, taken to cells, bailed, escorted to Psychiatric Emergency Care Centre (PECC) (Number 25)
- Male Court mental health nurse assesses male prisoner with female medical student (Number 1)
- Off duty male mental health nurse is mistaken for ex-prisoner by former prisoner and as Person of Interest (POI) by police in a car (Number 27)
• Male student mental health nurse starts in new ward (for violent males) (Number 34)

• Male prison mental health nurse sits in courtyard with female patients (Number 54)

• Frequent admission of mother with Bipolar Affective Disorder (BPAD) – depressed (Number 59)

• Prison life (Number 53)

• Psychotic female patient comes to Psychiatric Emergency Care Centre (PECC) via Emergency Department (ED) (Number 100)

In this group of stories there are few dramatic events and little logical progression in the story; instead these stories depict settings where mental health nurses work and the sorts of duties they perform. Two stories contain no events at all and a third is an account of an imagined world. Several describe mental health assessment of patients in the cells or the work of prison mental health nurses, two refer to the Psychiatric Emergency Care Centre, others to different wards, one to a home visit by a community mental health nurse and an Aboriginal mental health worker, and one to a group of patients going on holiday with a mental health nurse and a student nurse. In this group of stories both Relationships and Moments are not the focus, and the Events described do not have a strong narrative component. The story of the off duty mental health nurse being mistaken for an ex-prisoner and in another episode for a Person of Interest by the police is in a category of its own, as both Relationships and Moments are unimportant, and the Events are not significant for the clinical setting.

**Mental health nurse education**

• Conversation between experienced mental health nurse and female new graduate (Number 56)

• Male mental health Tutor wept, fell asleep, became angry, insisted on group hug (Number 9)

• No events – impression gained by student on variety of placements (Number 73)
The stories which focus on the education of mental health nurses span some thirty years. Two written very recently show Registered Nurses advising students not to enter the field of mental health nursing; a third shows the effect of false information given to a group of students before their first mental health placement while a fourth depicts the first impressions made on a new group of students arriving for their first placement in an old psychiatric hospital. Another story shows a tutor with a frontal lobe injury behaving in a volatile manner during a class, while a different story describes cynical advice given to a class in a pharmacology lecture and the result of one student taking that advice. One story describes the consequences visited on a student nurse after she reported a clerk for slapping a patient. However at least two stories recount the happier side of being a student mental health nurse – a male student finds unexpected benefits in his secondment to a general hospital, while a female student nurse enjoys a birthday party for staff and patients in the Assessment Centre.

**Nursing care**

- Visiting RN/aged care assessor noticed dog sleeping on patient’s abdomen in bed under blankets at 10.30 am (Number 51)

- Patient acquired water intoxication by being allowed to drink as much tea as he wanted in a treatment called flooding (Number 14)

- Isolated neglected elderly woman admitted, bathed, medicated (Number 16)
In the nursing care subcategory, physical nursing care was the focus. It was not always well done – one story describes the “production line” style of pressure area care in an old geriatric hospital; another describes the results of a treatment recommended by a psychologist to modify a patient’s incessant brewing and drinking of tea. In two stories comfort is provided to elderly female patients – one is allowed to sleep with her dog in her bed under the blankets in a nursing home and the other is bathed and medicated after a long period of isolation and neglect at home. A touching account of a student taking an amputee for his first shower shows how she put her patient’s needs first in spite of opposition from her facilitator. Two stories are controversial – one shows the resourcefulness of a community mental health team in administering fortnightly depot injections to a patient who refused to leave his home or open the door and the other is a puzzling account of the nursing management of an elderly woman experiencing respiratory distress in an old psychiatric hospital. In both of these last stories the treatment was effective and the patient came to no harm, however some might argue that the actions of the nurses involved were deficient in some respects.

“Difficult” patient behaviours

- Boy smears self with faeces before male mental health nurse could prevent this (Number 42)

- Intoxicated man rings to complain about his neighbour to male mental health nurse on duty in PECC (Number 87)

- Man throws dog over bank counter, Mobile Treatment Team staff visit him at home (Number 65)

- Repeated threats of deliberate self-harm and suicide (Number 6)
• Female patient with hypomania bangs on office door during handover (Number 45)

• Patient menstruates on chair (Number 43)

• Hooded male kicks down front door of mental health unit and enters with knife (Number 94).

• Absconding patient takes taxi to preferred hospital (Number 78)

• Older male patient with dementia punches female Assistant in Nursing (AIN) in the mouth (Number 71)

• Female community mental health nurse visiting patient on rural property meets hostile visitor with gun (Number 39)

• Five teenage girls abscond, three abscond again later, one attempts to strangle self, other patients threaten staff (Number 4)

• Male patient’s forearms amputated by train (Number 13)

• Patient does not throw anything out for 15 years and can barely reach her front door (Number 66)

• Male Aboriginal patient gets into fight with another patient, put into seclusion and attempts to hang self (Number 70)

• Large male patient runs towards cricketer and taps him on shoulder (Number 36)

• Aggressive paranoid male patient challenges male mental health nurse in office (Number 58)

• Male patient leaps through heavy glass door to escape (Number 22)

• Male escapee from gaol gets admitted to voluntary mental health unit and exploits other patients (Number 20)

• Developmentally delayed (DD) man puts turd on counter of cafe (Number 28)
• Recidivist tells male court mental health nurse ‘not to start’ (Number 26)
• Male patient regularly scales fence and runs away (Number 5)
• Confused male patient leaves ward, gets lost in the bush (Number 86)
• Manic male patient spends night in King’s Cross (Number 98)
• Male patient tries to sue Johnny Farnham (Number 97)
• Female patient has referential delusions about her psychiatrist (Number 96)

None of these stories can be fully analysed without a consideration of the patient’s diagnosis (although this was rarely stressed in the stories and sometimes was not known at the time of the incident described). The largest number of stories dealt with aggression, one with a perceived aggressive gesture which was proved otherwise. Absconding features in five of the stories, manic behaviour in two, suicidal behaviour in two, a suicide attempt in two, paranoid behaviour in one and referential delusions in one. One of the six long stories, discussed in detail later, deals with absconding, suicide attempt and aggression, all in the one story. Three stories describe antisocial behaviour and bodily products, two involving faeces, one involving menstruation.

**Nurse-patient interactions**

• Male mental health nurse shortsheets patient’s bed (Number 37)
• Older male patient who has suffered a previous cerebro-vascular accident (CVA) asks male student mental health nurse to “wipe my arse” (Number 7)
• Boy walking up and down hallway offered hug by male mental health nurse (Number 41)
• Female patient could not sleep; male mental health nurse conducts guided imagery/relaxation exercise (Number 91)
• Confused agitated man could not rest (Number 88)
• Patient got up at 4.30 am every day (Number 89)
• Female patient states she had a floating kidney (Number 2)
• Male patient tries to hang self over weekend, afterhours staff did home visit (Number 35)

• Young female patient accosts new recruit, asks, “Are you Cro Magnon man?” (Number 67)

• Multiple admissions and crises (Number 52)

• Male patient mistakes male mental health nurse for an old school friend (Number 44)

• Distressed man reveals suicide attempt (Number 46)

• Male mental health nurse upsets female patient with joke (Number 38)

• Two patients inherit large sums of money and buy a unit but do not know how to furnish it (Number 69)

• Physician believes male patient dying, nurses assess as depressed (Number 90)

• Older woman brings daughter-in-law for crisis care assessment – “things needed to change in her marriage” (Number 21)

• Young male client comes out as gay (Number 49)

• Female community mental health nurse cries at patient’s funeral after he commits suicide (Number 23)

• Female student nurse listens to patient’s stories of her life over two weeks (Number 74)

• Visiting female RN begins conversation with sedated restrained male patient about the Beatles (number 50)

• Dying woman is ignored by nursing team, teller asks her how she feels (Number 76)

• Male nurse touches female patient charged with murder, plays Scrabble and volleyball with female patients and prison officers (Number 54)
• Depressed nun finds purpose in private psychiatric hospital (Number 60)
• Young gay man overhears flatmates talking about him and his sexual preferences (Number 23)
• Female patient talks to female nurse and female prison officer close to release (Number 99)
• Mother finds 14 year old son dead after overdose in family home (Number 32)
• RN visits former patient to give Christmas presents (Number 85)
• Male Court mental health patient attends interview with male court mental health nurse with partner (Number 31)
• Unknown man rings voluntary mental health unit to ask if there is somebody he could talk to (Number 30)
• Hostile male patient sits in silence with male court mental health nurse for 30” (Number 29)

The subcategory of nurse-patient interactions cannot be effectively considered separately from the component of Relationships, and frequently Moments is also a key component. Therefore a brief outline of the main interactions will be summarised here and the stories discussed in more depth later under the headings of Relationships and Moments.

Surprisingly, six stories involved the use of silence by experienced mental health nurses in situations where it was obviously difficult not to talk. Other stories showed the use of active listening and empathy. Three showed the use of humour by mental health nurses in one case with unexpected and therapeutic results, in another with expected and therapeutic results, and in a third case as a way of coping for the mental health nurse.

Several stories touch on boundary issues in a variety of different settings and could provide rich sources of discussion material. In one a new male student mental health nurse finds the request of an older male patient with disabilities to “wipe my arse” confronting but realises this is part of his new job and accedes. In another a male mental health nurse offers a psychotic young boy a hug in a corridor with others...
present. In a third a male mental health nurse sits on the end of a young female patient’s bed when she cannot sleep and takes her through a relaxation and guided imagery exercise. A new male recruit attending a psychiatric hospital is forced to establish boundaries without any knowledge or training when a female patient asks him if he is Cro Magnon man – his response and his recall of the incident twenty years later leads to a therapeutic outcome for the patient. Two community mental health nurses have ample opportunity to exploit two patients with schizophrenia but advocate strongly for them and go well beyond their job description to produce an excellent outcome for the patients. A female community mental health nurse feels she has failed when she cried at a patient’s funeral but is surprised to find his family comforting her and that her actions are validated by her clinical supervisor. A male mental health nurse working in a prison ward for female patients breaks down barriers between nurses, patients and prison officers but never crosses professional boundaries. A female nurse visits a former patient in his ward at Christmas and takes him a bag of gifts (this could be judged as crossing boundaries and probably would be judged thus today). Acceptance and advocacy feature in several stories, as does empathy and active listening.

Often use of “inspired creativity” is apparent. A male mental health nurse, accosted by a large paranoid patient who has mistaken him for an old friend, thinks quickly and, while he does not deny this, ensures that all other aspects and facts in their conversation are reality based. A team of nurses challenge a doctor’s belief that a patient is dying based on their accurate observation of the patient’s behaviour and help him to celebrate his birthday. The use of hymn singing to calm a distressed agitated man was also based on accurate observation as was the nurse’s response to the patient who got up at 4.30 am every day. The provision of meaningful useful work for a depressed retired nun in a religious psychiatric hospital could be regarded as an example of “inspired creativity” as it took into account the patient’s previous occupation and preferences. Many of the stories about the use of silence could also be regarded in this way too.

4.6.6 Relationships (Tripp)

Relationships proved to be one of the most complex components in the Data Analysis Template and provided a true insight into what mental health nurses do in their clinical practice. The majority of the stories dealt with the relationship between nurse and patient. Other relationships mentioned were between family members or between
mental health nurses among themselves or between prison officers and patients. These were not as complex usually as those between mental health nurses and their patients.

Preliminary categorisation was into broad groups of supervisory relationships, custodial relationships, family relationships, professional relationships, unprofessional relationships, therapeutic relationships, and “other” which included all relationships which did not fall into the first categories. Many of these classed as “other”, were between mental health nurse and other mental health nurses; others were between patients and patients or showed an emotional response by a patient to a nurse where there was no therapeutic relationship established.

**Supervisory relationships**

A small number of stories described relationships between nurses which were supervisory, whether as facilitator or as clinical supervisor or as mentor or as manager/educator or as Registered Nurse taking a student on placement in the community.

**Custodial relationships**

Seventeen stories depicted relationships categorised as “custodial” whatever the setting, whether it was old psychiatric hospital, mental health unit, police cells or gaol, and the custodial relationships were not only formed by prison officers, but also by mental health nurses.

**Family relationships**

Family relationships were supportive, concerned or helpful in all cases but two, where a young man coming out as gay did not feel understood or accepted by his family and in another where a young married woman related as a hostile-dependent “prisoner” to her mother-in-law.

**Professional relationships**

As professional and therapeutic relationships were the largest categories they are discussed last here. One third of Relationships described were classed as professional. A differentiation was made between Relationships which were classed as professional, i.e. those where the nurse (or sometimes other person such as prison officer, police officer or solicitor) provided “expertise, special training and a body of knowledge to
which the professional has unique access” (Gerrish, McManus & Ashworth, 2003, p.105) and between those which could be classed as truly therapeutic. The word ‘therapeutic’ comes from the Greek ‘therapeia’ and the basic and most relevant meanings are ‘service, attendance, medical or surgical treatment or cure’ (Liddell & Scott, 1940). Truly therapeutic Relationships were those where the nurse provided more than a professional nursing service and was able to effect a change for the patient or to make a difference in the patient’s life.

**Professional relationships - Use of silence**

The difference between professional and therapeutic relationships was well illustrated by the mental health nurses’ use of silence. In some stories it was use of their professional knowledge; in others they used the silence for therapeutic effect. The following extracts show use of a silence as part of a professional relationship whereas extracts discussed under Therapeutic relationships show how silence was used by the mental health nurse in a therapeutic way.

- Male mental health nurse remains calm with abusive hostile telephone caller (Number 87)
- “I then enquired as to how he would like to proceed. It seemed he wanted to proceed in silence. So we did, for the allotted 30 minutes, and not a lot more” (Number 29)
- “By this time in my working life I was wise enough to avoid the psychological quagmire that these two had just invited me into for a swim. I simply sat as the silence took on a life of its own and one for which antibiotics are usually prescribed” (Number 21)

**Professional relationships - Assessment**

Another aspect of a professional relationship was the account of mental health nurses assessing their patient, often in difficult circumstances or where no other preliminary assessment had been made.

- Assessment interview (Number 65)
- Crisis intervention (afterhours team) (Number 35)
• “This made the Admissions Nurse most suspicious and after a lot of telephoning and cross-checking, she sorted out what was going on” (Number 78)

• “I spoke with him through the bars for long enough to establish that he was not psychotic” (Number 28)

• “With nowhere else to go he presented at the clinic” (Number 23)

• “Puri puri is like bad medicine...had I not had a health worker with me I very easily could have said yep, psychotic depression, probably needs an admission and medication” (McClay, in Nizette, McAllister and Marks, 2012, p.73) (Number 47)

• “Realising that this man was clearly very distressed and a high risk of further attempts of self-harm if appropriate intervention as not forthcoming” (Number 46)

• “I acknowledged his discomfort and asked if I might invite his girlfriend and father to join us and tell us about their concerns” (Number 22)

• “It turned out that she was thyrotoxic but without the usual physical symptoms” (Number 100)

• Female mental health nurse ignored female patient’s statement that she had a “a floating kidney” (Number 2)

**Professional relationships - Reporting**

Reporting of unprofessional behaviour was described in three stories. In two it was mental health nursing students who made the report and in both cases the student was ostracised as a result.

• “Another student and I had recently grassed up a nasty ‘old school’ nurse for cruelty to an elderly patient” (Number 15)

• “Tried to tackle a situation whereby an EN was being cruel to patients and the nightstaff were sleeping all night and being rude to them” (Number 64)

• “In London, as a student, I reported a clerk for slapping a client with dementia” (Number 63)
Professional relationships - Management of aggression

Management of aggressions was more often done in a clearly therapeutic way. However, two stories did not give enough detail to determine the nature of the relationship, so were classed as professional relationships. In the second story the risk assessment proved inaccurate due to the presence on the isolated rural property of an unexpected visitor. This story concludes with the restrained statement, “No one was harmed. This was the only day I’ve ever been at work that I didn’t think I would make it out alive” (Number 39). Both stories minimise the aggression described in the episode.

- “I went into the room and held on to the resident’s free hand and no sooner had I done that [than] the new staff member had let go of his other hand and the resident punched me straight in the mouth” (Number 71)

- “I had taken a new generalist Occupational Therapist (OT) to do a home visit on a well known client who lived on a rural property with her 16 year old son. Both people were low risk.....” (Number 39)

Unprofessional Relationships

Unprofessional relationships were clearly described in five stories, one involving a doctor suggesting to a mental health nurse in the emergency department of two young patients “Can’t we put them in a room and tie them together?”

- Male ED consultant suggest management of two young patients (Number 3)

- “Vince [night nurse] would make up his bed in the day room, smoke a couple of joints and sleep the sleep of the righteous and waken to the sound of his alarm clock exactly half an hour before the morning staff arrived” (Number 11)

- “We caught up and he [an Enrolled Nurse] stepped back, watched the patient assault me and said that he knew where I lived and that I was by myself” (Number 64)

- “For the entire three months I was there this woman [a clerk] would not talk to me and would address me through someone else” (Number 63)

- “This experienced, but non-mental health trained, nurse was visiting weekly and sat talking to her [the patient’s wife] whilst he masturbated. This had been going
on for some time and the nurse neither reported it nor adjusted anything about her behaviour or dress” (Number 62)

*Professional/therapeutic Relationships*

Three stories showed aspects of both professional and therapeutic relationships, where a professional service was provided at the start but towards the end the therapeutic component of the relationship became more apparent, although there was not enough detail to class the relationships as truly therapeutic.

- Assessor begins therapeutic conversation (Number 50)
- “As part of trying to be pragmatic I spent some time outlining the likely options available” (Number 31)
- “Mike sat patiently as the caller said nothing with the phone piece to his ear...After about twenty minutes the caller thanked Mike and hung up” (Number 30)

Professional relationships also included personal care

- Nurse anticipated smearing but left to get gloves (Number 42)
- Male student mental health nurse learns rapidly how to relate to dependent elderly male patient who needs personal care (Number 7)

This group also showed use of touch

- Nurses watched male mental health nurse hug psychotic young boy.(Number 41)

*Collaborative communication*

- Collegial, professional (male mental health nurse and JRMO) (Number 3)

*Other*

Many other relationships were included under Professional Relationships although for various reasons they were not wholly so or even professional at all.
Three showed nurses behaving in ways which they believed were professional or which suited the situation; however in two stories the relationships were clearly “unprofessional” though not intended to be so.

- “The nurse told the policeman he couldn’t possibly admit the cow and shut the door” (Number 84)
- Educator to students (Number 9)
- “Educating” (chief male nurse) (Number 57)

Prison officers provided advice to a mental health nurse using their own style of professional relationship.

- “The officers tell me, ‘You have a right one – he’s Captain Rats’” (Number 1)

Another female prison officer provides a “helping” professional relationship.

- Female prison officer gets counselling for female patient (Number 99)

In two stories the relationships are professional but do not fall into the category of the truly professional.

- Relationships are superficially equal but language shows nurse-patient divide (Number 79)
- Professional but unconventional – Yugoslav patient at Gladesville (Number 80)

One would probably be classed as unprofessional today.

- Christmas gifts for former patient (Number 85)

Two might be classed as negligent depending on how the reader understood the stories and the issues in them.

- “A brief news item later showed her grave and her family mourning her death next to it” (Number 99)
- “One got out, went for a walk in the bush, got lost and was rescued by police helicopter” (Number 86)
Three were professional but ineffective, in the first case because of the multiple care providers involved, in the second because of an assessment by a physician which nurses later proved inaccurate, and in the third because of the patient’s skill at avoiding detection and because of his influence over other patients in the ward.

- Unhelpful (other care providers) but not unprofessional (Number 52)
- Professional but detached (physician to patient) (Number 90)
- Professional but unaware (Number 20)

**Therapeutic relationships**

A third of the stories showed aspects of a truly therapeutic relationship. Dziopa and Ahern (2009b) conceptualised the nine constructs of a therapeutic relationship in mental health nursing as conveying understanding and empathy, accepting individuality, providing support, being there/being available, being genuine, promoting equality, demonstrating respect, maintaining clear boundaries and having self-awareness; these stories supported many of these constructs but provided development of some as well as new aspects. However in a second article Dziopa and Ahern (2009a) point out that although these constructs are important, the personalities of those involved in the therapeutic relationship and the setting also need to be taken into account. Some of these stories demonstrate how the nine constructs are modified or developed depending on the nurse, the patient and the setting. Berg and Hallberg (2000) noted that mental health nurses tended to refer to accounts of doing rather than of relating or being when discussing their therapeutic relationships with patients. This collection of stories includes stories which demonstrate the aspect of being very well.

Aspects of the therapeutic relationship which accord with Dziopa and Ahern’s (2009b) nine constructs include:

**Use of empathy (= conveying understanding and empathy)**

- “The tears flowed more” (Number 40)

**Use of acceptance (= conveying understanding and empathy)**

- “I just let him go with his agenda” (Michaud, Levy & MacMillan, 2013) (Number 89)
Focusing on patient preferences (=accepting individuality)

- Following Eden Alternative though Director of Nursing (DON) had not heard of this (Number 51).

Use of relating (=providing support plus being there/being available)

- “I had a good relationship with him” (psychotic young boy) (Number 41)
- Six year relationship with female community mental health nurse and adolescent patient (Number 6)
- “We worked with this young woman for about six weeks and I managed to build a solid therapeutic relationship with her – along with several other nurses” (Number 43)
- “I nursed Angie for many years and despite the significant impact of Bipolar Disorder on her she consistently provided nurturing mothering and care to Jack [her son]” (Number 59)
- “But it seemed like over a period of a couple of years the things that really helped her to get better was helping her to get some perspective, get her head around her own story, identify her strengths which she’s a very intelligent young person and has been able to go on and enrol in some study...” (Raeburn, in Nizette, McAllister and Marks, 2013, pp. 98-99) (Number 52)
- “Trying to help him build his resilience, trying to help him build his confidence around who he was as a person because this is him and he was proud of who he was. So trying to build on that, trying to make him stronger in that sense” (Page, in Nizette, McAllister & Marks, 2013, pp.88-89) (Number 49)
- Therapeutic but involving “parallel realities” (Number 44)
- “Our role as nurses is to build a relationship...We have continuity, we have the same providers speaking and building and building on the previous contexts and we build that trust...There are opportunities there for good nurses to take it and you have just got to look for every opportunity to talk to your patient or your client” (Bailey, in Nizette, McAllister & Marks, 2013, p.130) (Number 53)
• “Mario never became angry toward me from that moment on. We could have reasonable discussions and he would accept my advice” (Gilham, 2011, p.86) (Number 58)

Use of humour (= being genuine)

• Patient “thought it was hilarious” (Number 37)

• “Inappropriate” response from female mental health nurse to female manic patient (Number 45)

Advocacy/extended role (in some sense=promoting equality)

• “Back at the office I told a co-worker about setting up house for my clients and she said, ‘What about me! I had to marry them off!’ Apparently she had to organise the wedding dress, bridal party, venue – everything to do with a wedding! I got off light!” (Number 69).

Use of trust (=demonstrating respect and demonstrating clear boundaries)

• “You make a difference because they trust you....My role is to get a solution and as long as we professionally keep within our boundaries, as long as we maintain our risk assessment, as long as we are allowing people to go home into a safe environment with the protective situations, then we can do anything” (Bailey, in Nizette, McAllister & Marks, 2013, p.131) (Number 55).

Dziopa and Ahern’s (2009b) ninth construct, that of having self-awareness was demonstrated in the stories where the teller provided some explanation and interpretation and these stories are discussed below at 4.7.

However the stories showed many aspects of Therapeutic Relationships not included in Dziopa and Ahern’s (2009b) nine constructs. These aspects are discussed next.

Use of talking/conversing/engaging

Three stories specifically showed how difficult it can be to initiate any sort of conversation with a patient, but also what determined efforts were made by the nurses in unpromising situations.

• Patients did not engage, student nurse attempted to converse, more experienced nurses ignored patients (Number 14)
• The teller of the story asked a patient how she felt and the patient cried and said that nobody had done that before (Number 76)

• “I tried making conversation with a number of either static or mobile patients. They ignored me or looked at me as if I was part of the cartoon show” (Number 34)

**Use of silence**

Use of silence appears in the section of Professional Relationships but in two stories it clearly achieved a therapeutic result.

In one story the mental health nurse noticed that at the end of the hour he and the patient were breathing synchronously even though nothing had been said.

• “Because I did not know what to say I said nothing. Nor did he for the entire hour” (Number 35)

In the other the nurse tolerated his own extreme personal discomfort at the suicide of his patient’s 14-year-old son.

• “I was not equipped for this situation on so many levels that initially I felt panicked, I almost fled the room. I then thought of who I could pass this over to. I could contact the on call doctor. That’s what nurses do when they are out of their depth. But I couldn’t bring myself to leave the room...So I stayed with the discomfort and said nothing” (Number 32)

Eventually the teller was “overwhelmed with sadness” and when he looked up, the boy’s mother and his sister were also crying.

**Use of apology**

In three stories mental health nurses apologised. In the first story, the teller had come to the psychiatric hospital for his first job interview to commence nurse training and was accosted by a female patient who asked him if he was Cro Magnon man. Natural courtesy allowed him to manage a conversation he was not prepared for and the therapeutic result did not occur until 20 years later. In the second story, the mental health nurse’s self-awareness and personal honesty allowed a difficult relationship to continue and become therapeutic. In the third story, once again the mental health
nurse’s personal honesty and willingness to accept blame resulted in an unexpected but very powerful therapeutic outcome for the patient.

- “I said something inane, excused myself and went on into the office” (Number 67)

- “The flush of anger soon passed and I got up from my seat, briefly left the room, walked straight back in, apologised and started again” (Number 26)

- “This incident formed a foundation of a very good therapeutic relationship as no man had ever apologised to her before” (Number 38)

**Use of objective assessment**

In two stories nurses (in one case a student mental health nurse) make their own assessment of a patient and find that the accepted assessment was incorrect (in the second story the physician had judged the patient to be dying when in fact he was depressed), thus providing a therapeutic outcome in both cases. These two examples therefore are different from the assessments described under Professional Relationships where there is no information about the result of the assessments.

- “I was shocked to find out that her stories were completely true and not delusions as had been thought by the nursing staff” (Number 74)

- “As we leave the room and bid Bill a happy evening, I see the sparkle of life that has returned to those eyes. Bill has hope” (Michaud, Levy & MacMillan, 2013) (Number 90)

**Negotiating systems**

For mental health nurses who work in court cells or prisons skills in negotiating the correctional environment are essential in order to establish therapeutic relationships with their patients, and the mental health nurses first needs to establish a professional working relationship with the prison officers.

- “Being the first person to literally walk the walk between these two systems afforded me a clear and unnerving insight. I would regularly be asked to see a person in the court cells. This individual had usually already been assessed by prison officers and a Legal Aid solicitor as being sad rather than bad. Their
crime usually did not involve seeking money, goods or advantage. It would more likely occur in the context of social dislocation, drug use, chaos and impulsivity” (Number 24)

- “Often what you see is you see this person standing in front of you trembling and they are bewildered that they have just been told they have killed their child and some of them don’t even remember they have done it and all they need is a big hug and, you know, I think many nurses have been chastised...and what we have learnt over a period of time is that it is okay...” (Bailey, in Nizette, McAllister & Marks, 2013, p.131) (Number 54)

**Use of guided imagery or music**

In two stories, nurses use specific techniques with therapeutic effect.

- Female patient could not sleep; male mental health nurse conducted guided imagery/relaxation exercise (Number 91)

- “It was a profound night because all my years of training and education came down to the simple singing of a song and using music to touch his soul” (Perry, 2005, p.45) (Number 88)

**Finding purpose or facing reality**

In another story allowing a retired nun with depression to find a purpose again was therapeutic.

- “Having a purpose filled a void” (Number 60)

In a different story a student nurse stayed with a patient who had a below knee amputation as he looked at himself in the mirror for the first time. Although the student nurse was taken to task by her facilitator she states clearly in her story that she felt confident in her ability to support the man at the time and clearly the result was therapeutic for him.

- “He looked at himself in the mirror and stated, ‘This is the first time I have looked at myself since the accident’” (Number 75)
**Therapeutic/custodial Relationships**

A single story falls between being a Therapeutic Relationship and a Custodial Relationship as the community mental health nurses, faced with a patient who did not want contact but who relapsed regularly when not on a depot, worked out a way to ensure he had his medication without crossing the boundaries he had set up for himself. If the therapeutic intent was to keep the patient in his own home which was what he wanted, then this unusual way of relating could be classed as therapeutic.

- “They knocked on his door once a month, he pulled his trousers down backed up to the screen door and they injected him through that” (Number 95)

A final story shows student nurses attempting to be “therapeutic” by avoiding denying anything to patients because they had been

- “Told never to say no to patients because this could make them violent” (Number 61)

**Other Relationships**

This category includes patient to patient relationships, nurse to nurse relationships and patient to nurse relationships. Patient to patient relationships show an older patient mentoring and advising a new patient, the friendship between a married couple both with a diagnosis of schizophrenia and their friend Phil, a court patient and his partner working as “a team”; but also a controlling male patient, an exploitative male patient, a hostile male patient and a physically aggressive male patient.

Nurse to nurse relationships are usually collegial and friendly. Mental health nurses share a joke in one story, in another an AIN [Assistant in Nursing] tries to mentor a new staff member in a nursing home, in a third the matron of a psychiatric nursing home and a Health Commission official collude in a shared joke. A male mental health nursing student on placement in a general hospital finds unexpected social benefits there and in another story forms an attachment to an older female nurse whom he admires as a role model.

- “She liked me, I fancied her, and got all confused....” (Number 12)
However some stories show less pleasant aspects of nurse to nurse relationships. A male mental health nursing student is puzzled by the behaviour of one of his tutors in training school.

- “During the course of his lecture on mood disorders he variously openly wept, went to sleep briefly, flew into a rage at a fellow student who he perceived had whispered disparaging remarks about him, and insisted we have a group hug at the end to consolidate our learning experience. It was by the second day that I worked out this was a do-it-yourself course” (Number 9)

And in a separate story he finds himself confused in another tutor’s lecture.

- “There was more than a moment or two of disquiet” (Number 10)

In a third story the student finds he must be subservient to a dominant female mental health nurse as they take ten patients on holiday.

In a fourth a student enjoys his placement finding unexpected social benefits.

- Comradely/social (student placement in general hospital) (Number 18).

Not many stories specifically describe how patients related to mental health nurses but in the nine stories which do there is a variety of reactions and responses.

- avoidant (client and son) (Number 39)
- potentially hostile (absconded patient) (Number 39)
- helpful (patient to other residents) (Number 94)
- “controlling”/antisocial (prisoner to all) (Number 28)
- “experimental” “safe” (in therapeutic community) (Number 19)
- dependent (patients to community mental health nurses) (Number 69)
- intimidating (male patient to male mental health nurse) (Number 58)
- superficially “compliant” (patient to mental health nurse) (Number 29)
- “controlled passivity” (Number 13)
In a final group of stories relationships do not fit into any of the above categories.

- experimental, adaptive, educational (prison nurses/prison officers) (Number 54)
- civil (in two cases of mistaken identity) (Number 27)
- not connected (patients and cricketers) (Number 36)
- helpful, non-exploitative (real estate agent) (Number 69)

4.6.7 Moments (McCormack)

Given the study purpose, McCormack’s category Moments may easily be linked to the concept of a “teachable moment” which occurs when a student is “receptive to new understandings (Wagner & Ash, 1998, p.278). They note that when a student’s immediate reaction to an event and when the issues which the student identifies in it are discussed first, the teachable moment is created (Wagner & Ash, 1998). Chally (1992) writes of the importance of incongruities in real situations and says it is these incongruities which allow the student to learn if the teacher is able to assist with this learning. Later the discussion can be developed and directed by the teacher so that all other issues are also investigated. Lawson and Flocke (2009), in a concept analysis of the teachable moment in health behaviour change found that although the term is widely used, exactly how a teachable moment is created needs further investigation. Feigenbaum (2007) provides a dramatic and colourful definition of the teachable moment based on feminist pedagogy:

*The teachable moment is a disruption, a misfiring, a tangent, a digression, followed against the will of critical ordering, occurring in the vulnerable space which opens when the teacher re-envisions student resistance as an attempt to escape. Yearning for more than the text, yearning for the text to be applicable, yearning for knowledge to be produced elsewhere; this attempt to escape is not a resistance, a blockage or a refusal to learn. Rather, it is an attempt at encounter (p.339).*

This collection of stories can provide an opportunity for students to encounter real situations in all their complexity so that students can find that the text is applicable to their clinical practice. Many of the stories do illustrate the disruption, misfiring, tangent
and digression which Feigenbaum (2007) writes about, and which are often key features of episodes in mental health nursing care.

Moments in the collection of stories were subcategorised into Expected, Dramatic Events, Unexpected, Therapeutic Communication and Management, Self-awareness, Breaking the Rules, Joking. Of these the most significant for teachable moments were Unexpected, Therapeutic Communication and Management, and Breaking the Rules. These are discussed first.

**Unexpected Moments**

Thirty one stories showed nurses or patients doing unexpected things, not always with helpful results. Students figure in six stories, and in three of these, are advised not to consider mental health nursing as a career by the registered nurse they are working with or their interest is ridiculed. In another a student nurse reports a clerk for slapping a patient and later, on returning to the ward as a staff nurse, is ignored by the clerk completely. Students are greeted by the site of a naked man running through the grounds of the hospital and a woman talking to the crows when they arrive for placement. Another group of students are advised “never to say no to patients because that could make them violent” and then have great difficulty in interacting with their patients on placement.

Educators also behave in an unexpected way.

- Unexpected emotional outbursts (from a mental health nursing tutor) (Number 9)
- Pharmacology teacher suggested students take 50 mg chlorpromazine (Number 10)

An important group of stories with unexpected moments invite discussion of the need for comprehensive assessment and the need to avoid making assumptions about patients.

- Patient did have a floating kidney (Number 2)
- Patient recovered “I did not recognise her” (Number 43)
• Mental health nurse greets female patient at North Ryde Psychiatric Centre 20 years after first meeting, each recognises the other (Number 67)

• Young female patient recovers “Do you reckon I ever had a mental illness?” (Number 52)

• Patient’s baby grew up “a happy, well-mannered young man...obvious close bond with his mother and father” (Number 59)

• Mental health nurse realises Aboriginal patient is not suffering from psychotic depression (Number 47)

• “Chronic schizophrenic” has unsuspected aptitudes (Number 79)

• Patient’s family confirm her “elaborate fantasies” are true (Number 74)

• Patient confronted by his greatest fear “ego dystonic” (Number 23)

• Psychotic patient turned out to have thyrotoxicosis (Number 100)

• Older female patient has 8542 pounds sterling in her corset (Number 16)

• Patient cannot spell her (stated) name (Number 78)

• Retired nun resists discharge to convent for elderly nuns (Number 60)

• Mental health court patient elects to take a gaol term rather than pay a fine (Number 31)

In one story a patient is described giving a handover on staff to a new patient. In three others the theme is fear of harm but in two, nothing happens.

• Nobody harmed (Number 39)

• Fielder fears patients but patient playing a game! (Number 36)

• Patient attempts to hang self, student “scared” when hears story (Number 70)
In another story a community mental health nurse expects blame from the family of a young man who has committed suicide but is surprised to be thanked and comforted at his funeral (Number 40).

Other Unexpected moments are:

- A doctor makes an unexpected and unprofessional suggestion for the management of two young patients in ED (Number 3)
- Patient became medically ill as a result of a treatment called “flooding” (Number 14)
- Chronically suicidal teenager wants to experience running of the bulls in Spain (Number 6)

Six stories deal with the effects of staff behaviour to provide an Unexpected Moment.

- Staff run with not after patient (Number 5)
- Patient’s delusion is reinforced by staff and patients (unintentionally) (Number 96)
- Patient says “Anyway sixpence” (Number 85)
- Older patient masturbates in front of community RN but she does not alter her dress or behaviour (Number 62)
- “What the fuck was I on about?” asked by patient (Number 29)
- Patient repeated words of a hymn and quietened when nurse sang it (and others) to him (Number 88)

Moments of Therapeutic Communication and Management

Twenty four stories gave descriptions of ‘Unexpected’ encounters which demonstrate therapeutic communication and management. Of these most deal with the results of nurses talking to patients. In five these interactions had positive outcomes; however in one the student mental health nurses had no success in his attempts to begin
therapeutic conversation with a group of patients who had all been assessed as “potentially” violent.

- “We had an amazing and what I consider to be a therapeutic conversation” (Number 75)
- Nurse allows patient to call him “whatever he wanted to” (Number 44)
- Community mental health nurse explores reasons for patient’s anxiety and he discloses he is gay (Number 49)
- Male patient treated as demented has conversation about Beatles and asks, “Tell me what I’ve done wrong that they are locking me up and tying me up in this home?” (Quirke, in Nizette, McAllister & Marks, 2013, p.92) (Number 50)
- Mental health nurse apologises for joke which forms basis of strong therapeutic relationship in context of patient’s distress (Number 38)
- “I never had a single conversation of any quality with a patient in the ward for the three months I was there” (Number 34)

Three stories show the therapeutic outcomes of the effective use of silence.

- Silence from RN provoked silence from caller (Number 87)
- Caller is silent for 20 minutes then thanks nurse and hangs up (Number 30)
- Both community mental health nurse and patient were silent for a whole hour but their breathing became synchronous (Number 35)

Three show the use of empathising.

- “We both knew damn well there weren’t any birds to hear” (Michaud, Levy & MacMillan, 2013) (Number 89)
- “Point was she encouraged both my tendency to be kind and to bat for the underdog” (Number 12)
- Female medical student empathises with prisoner in cells (Number 1)
Another two record the effect of the nurse crying.

- Patient cried – “nobody had done that before” (Number 76)
- Mental health nurse resists urge to leave, cries with patients (Number 32)

One story shows the result of a team of nurses recognising that an elderly patient was depressed but not dying (as the physician believed) – “Bill has hope” (Number 90). Another story shows how a male nurse gained a patient’s respect and friendship by displaying courage when intimidated (Number 58). Two stories show a prison nurse’s work in changing the culture of the female mental health ward where he worked:

- “Referees and officials” (health staff) “breaking that [i.e. not the ‘done thing’] down” (Bailey, in Nizette, McAllister & Marks, 2013, p.130) (Number 53)
- Changes in style of relating to patients and change in attitudes of prison officers (Number 54)

**Moments of Breaking the Rules**

Sometimes the nurses broke the rules with therapeutic result. In only one case was there a clear picture of breaking the rules and being unprofessional.

- Male night nurse slept all night after two joints so as to do day job driving taxis (Number 11)

In five other stories the outcome for the patient was beneficial.

- Dog asleep in bed on elderly patient’s abdomen under blankets (Number 51)
- Patient found a practical joke which highlighted his limb amputation “hilarious” (Number 37)
- Female RN responded to abuse with joking/insulting comment to female patient (Number 45)
- Supervisor advises **against** calling out doctor, advises a cup of tea and a kind word (Number 80)
• Patient accepts unconventional method of receiving IM and stays well (Number 95)

In the last story in this group a male mental health nurse offers and gives a young psychotic boy a hug after receiving permission from the boy and in full view of a group of other nurses who from the details in the story do not react and treat the episode as routine. The conclusion reinforces that this interaction was therapeutic.

• “And then continued what we were doing” (Number 41)

Expected Moments

A small group of stories have a Moment which is actually Expected from what goes before. So in spite of the nurse’s attempts to prevent it, an autistic boy smears himself with faeces; in spite of the nurse’s best efforts with relaxation and guided imagery techniques, the patient wakes up as soon as he leave; in spite of a warning about a man with a history of aggressive behaviour, an AIN still gets assaulted while protecting a new staff member; in spite of a dramatic helicopter rescue, the man with dementia forgets the whole incident; in spite of the eventual diagnosis and treatment of a young man with a first episode of hypomania he still loses his reputation; and in spite of two student nurses’ determination to report unprofessional behaviour they are still ostracised by other nurses.

Dramatic Moments

Another group of stories describes events which as well as being Unexpected are also very dramatic. They illustrate the unpredictable nature of many encounters with mental health patients.

• Patient leaps through unlocked glass door (Number 22)

• ‘Identified patient’ urinates on her wedding ring (Number 21)

• Patient absconds from voluntary mental health unit and murders an English tourist after cleaning out his bank account (Number 20)

• Female patient (?her friend) rings solicitor’s office to say she had “taken her own life” but not true (Number 25)

• Patient later hangs herself in cell in another gaol (Number 99)
• Man has shotgun on rural property when community mental health nurse and occupational therapist (OT) visit (Number 39)

• Hooded male kicks down front door of mental health unit (start) – “It looked as though he had walked through the glass doors” – is tackled by female patient – sits down with other patients and waits for (presumably expected) outcome (Number 94)

• Juxtaposition of “beautiful grounds” and “padded cell” (Number 48).

• “I had to marry them off!” (Number 69)

**Moments of Self Awareness**

Self-awareness was a key feature of several stories. The teller reflects on his or her own actions, preconceptions or attitudes sometimes resulting in a change. In one story the impression gained is that the chief male nurses lacked self-awareness although some of the details provided suggest he may have been suffering from Tourette’s Syndrome.

• Student realises “the moment that I decided I could touch the untouchable” (Number 7)

• “Nothing could have prepared me for the reality of the environment I encountered” (Number 8)

• Mental health nurse says “load of bollocks” but stays for 10 years “and learned some new tricks” (Number 19)

• “Not a good look for our species” (Number 17)

• “I miss the psych nurses – they at least prize individuality in patients and fellow nurses” (Number 83)

• “The T-shirt, haircut and bike are a marker of something important” (Number 27)

• Court mental health nurse leaves legal box, returns and apologises to prisoner (Number 26)

• “I had preconceptions that totally went out the window” (Number 55)
Chief male nurse lacks self-awareness? (Number 57)

Moments - Use of Humour

Eight stories show the sort of humour which mental health nurses enjoy or use to cope with their work.

- Night staff “bewildered” (Number 77)
- Seagulls over-sedated (Number 92)
- Patient’s comment – intended to be amusing? “I think I have let things get on top of me” (Number 66)
- Nurses “had trouble keeping a straight face” (Number 46)
- Health Commission official colludes with Matron (Number 81)
- Deputy Matron did not know prospective patient had made recent attempt to jump off a balcony (Number 82)
- Sedated dog gets run over (Number 93)
- Admissions Nurse declines to admit cow (Number 84)

One story is so complex in its use of Moments (“The Hood”) that it is discussed below under The Six Long Stories. Three stories did not contain a recognisable Moment.

4.7 Data analysis based on tellers’ own interpretations of their stories and on workshop participants’ interpretations

Workshop participants’ interpretations

In 16 stories the tellers provided their own interpretations. However, the most information about purpose and meaning of stories came from the three workshops held in the course of data collection. The third one, for students about to register, has been discussed above. The first pilot workshop and the second one held at the university will be discussed here. Eleven experienced mental health nurses provided their input; two of them came to both workshops and identified the stories they contributed in the second workshop as having been written by participants who had already experienced
the pilot workshop. Most of the stories discussed had also been written down so that they could be included in the collection; however two were not written down formally but an outline of both is included in this section as the comments made on them are significant here.

A new graduate RN1 (MHN 1) undertaking his first year as a mental health nurse attended the pilot workshop and provided insights based on his own experience. This nurse felt that hearing stories gave “time to think about a situation I’ve never been in” understanding that if faced with the situation he would “have to deal with it on the spot”. His question of the stories was, “Why are you telling me this story? Is it going to help me grow?”

Four of the mental health nurses at the pilot workshop provided many insights about both risks and benefits of storytelling. MHN 5 warned that “stories take a life of their own, become reality”, adding that “The Story”, can be potentially really harmful”. He felt that a teller could “take it out, corrupt it, put it back again”, adding that the “emotional state changes it a bit, memory is ‘liquid’, stories are ‘liquid’”. MHN 2 noted that is possible to “accentuate part of a story to make a point, change a story to fit the point” explaining that it is “not fiction, not a documentary, but a director’s cut”. The same nurse commented that “stories are multilayered” and have no particular angle or purpose; “everyone deconstructs...people pick up on bits according to interest” so there is a need to “choose story accurately – what are the other messages not intentional?”

Expanding on this theme MHN 7 wondered what would happen when stories are translated to another setting – could they “backfire horribly?”. This nurse also noted that if the teller does not give an objective there could be “a hidden agenda”. MHN 3 felt that rather than ask students to “reflect”, asking them “how we learn from something” would be more useful.

Both MHN 4 and MHN 6 saw stories as useful to improving practice. “What else had I not been thinking about it before? What could we have done differently?” (MHN 6) and “We could do better” (MHN 4). Stories are also a way to “share expertise, give new staff ideas about how to manage a situation” (MHN 4).

Another use is to “get that experience without having lived it yourself, to extract value, to think about it ethically and morally” (MHN 2). MHN 4 noted that students say “The stories you told made it real”. Stories can promote equality – a story of an error of clinical judgment “levelled things between me and the learners” (MHN 7) and develop
empathy – “Imagine what it’s like in his head” was the comment of MHN 5 to a medical student who found that she could not focus on or make sense of the conversation of a patient with BPAD [Bipolar Affective Disorder] on speed (Number 1).

The story of a patient who put out his own eyes and ate them figured in both the pilot workshop and the university workshop, although it was not written down by the teller. MHN 2 who knew the patient understood that the patient “did it to save the world – he did it for us – a decent man, tortured by illness”. Others in the workshops saw this story as humanising the patient and showing altruistic motives in apparently senseless behaviour.

Silence figured in two stories told at the pilot workshop. One is recorded in the Appendix (Number 21 - Wedding Ring story) but the other was not formally written down. It is about a patient who rang MHN 2 saying “You have 30 seconds to convince me not to kill myself”. After 30 seconds of silence MHN 2 asked, “How did I do?” MHN 2 knew the patient and the patient knew that the mental health nurse knew her – both knew there was nothing the mental health nurse could say. The patient rang back half an hour later. MHN 1 commented that this story would not be good for students as a “certain level of clinical experience” is required. MHN 1 also noted that “underlying factors are not discussed in these stories”. Of the Wedding Ring story MHN 2 commented that it was a “top end intervention...a tiny Allen Key in the toolbox and important for a student”. However to “sit in silence” was recognised by the whole group as an advanced therapeutic skill in mental health nursing.

Other reasons for telling stories discussed briefly at the pilot workshop were to promote discussion - “If you unpack it yourself you don’t get a full picture” (MHN 2); to demonstrate stigma (MHN 6); to give “a message about interacting with a person who is much more powerful” (MHN 6); to scare, put people off “just for the hell of it” although this was not seen as a useful reason for telling stories (MHN 6); and to provide hope (MHN 7).

Although there were some related themes in the university workshop, overall a whole new set of reasons for telling stories and interpretations of them were discovered perhaps because a new set of stories was told and written down. There were warnings about “bitching and moaning” (MHN 2) and about stories which were “apocryphal” or “ghost stories” (MHN 9).
Challenging assumptions and demystifying was a key purpose. Students say they meet people on placement and see them as “just hopeless”, asking “What’s the point? They’re just like this, they won’t change”. MHN 9 tells the Menstruation Story (Number 43) to ask “What difference can you make in their life?” MHN 2 noted that “some student start with those attitudes, really negative attitudes”. MHN 11 saw the need to “demystify and debunk” saying that students have “heard horror stories” and can’t discriminate and stressing that “jargon alienates”. “Storytelling is to acknowledge [that] reality is difficult” (MHN 11) and to counteract “all those stereotypes” (MHN 9) which “reinforce myths” (RN11). Desensitising was another reason for telling stories – “this happens” (MHN 2).

Telling stories to “excite them, interest them” (MHN 8) was mentioned by six mental health nurses. “Students say, ‘You’ve actually rejuvenated my interest, I’m interested again” (MHN 11) Students asked MHN 9 “You make a living from doing that?” and this nurse notes that although “students want pills, ECT, psychosurgery, miracles” stories can demonstrate “incremental changes, the therapeutic relations, small things nurses do that make a difference”. When “facing somebody a student sees as hopeless” a story can show that “it will get better” and demonstrate “how to overcome a challenge” (MHN 3). MHN 2 warned that some stories “might scare the crap out of people” and that although we “assume anybody could be inspired to become a mental health nurse, it might not be so”.

Stories can “raise professional dilemmas – ethical stories where people have maybe not done the right thing caused a bad scene” (MHN 2). Once again the story of the patient who ate his own eyes was told in this context to “raise the patient up, raise admiration of people with a mental illness – he did it to protect all of us” (MHN 2).

A crisis admission may result in “disillusioned” students” because “they haven’t seen a result” (MHN 11) but when “all they see is a snapshot, stories give a longitudinal picture” and help in “uncovering recovery, making it more explicit – some students get it, some just don’t” (MHN 9). MHN 11 noted that mental health nursing is “not like ED where in half an hour a life is saved”.

Particular therapeutic skills in mental health nursing were highlighted by some in the university workshop. MHN 10 said of the New Zealand story (Number 35) that he would tell it “If they ask ‘What are the ways you can be with hostile people?’; because I learned something about being with these people”. Managing risk (“to warn them of
potential issues” - MHN 2) was also important as a reason for telling stories - “be aware, look around, who is in the house, situations you can’t predict” (MHN 8); also “danger of laughing is that you will dismiss risk, because you think attempt is laughable” (MHN 11). Being prepared was the point of “a poo horror story” (Number 42) (MHN 3). Apologising was mentioned as a way to “make something bigger, make something better from that” (MHN 2).

Stories can be used to help students understand what is different about mental health nursing. “Students come in task-oriented as opposed to person-centred” but “telling could be make or break to a student coming in – ‘this is how good it gets’ – no screaming machines, we did it by communicating with another person” (MHN 11).

Mental health nurses acknowledged that there are the “FIGJAM stories” “Hey I did this!” (MHN 2) but also saw stories as able to “validate what we do” (MHN 10) – “I did this and I think I’m proud of it” (MHN 2).

Interestingly, three mental health nurses saw using stories as a way to include students as part of a a group. “Students can look so lost” (MHN 8) but a story shows them “‘You’re with us when you come into our unit, part of the team” (MHN 2). “You wouldn’t say this if not part of the gang – ‘this is a bit wrong, but listen to it”’ (MHN 2). MHN 11 felt that clinical supervision could also help include students as part of a team as they see what is done on the ward and then “a different story is heard in supervision”.

Stories can “reinforce policy and procedure” as they explain why and say “who’s been to Coroner’s Court”, giving the reasons for documenting policy as “a folder of policies has no meaning” (MHN 11).

The need to tell stories in context was stressed – “There’s always a context to the story – for students who say, ‘How the hell do you nurse people like this?’’ the story can “never [be] without explanation” (MHN 9).

“Students are like sponges” so the importance of getting them to reflect was stressed by MHN 3 – “Was there something unusual about that handover?”

MHN 2 felt that using a clinical scenario detracted from teaching as it was not real, and that a story based on clinical practice would be better.
The use of humour as a way to capture students’ attention was noted by MHN 10 – “If you tell to amuse and they’re interested, they’ll take something from it”. However MHN 2 noted that he had “assumed humour, but been stunningly wrong”.

**Storytellers’ own interpretations**

There were 22 stories where the teller provided an interpretation and were more specific in reasons for telling the story. Each had only a single interpretation but, as MHN 2 noted, “If you unpack it yourself, you don’t get a full picture”. Warne and McAndrew (2010), however, felt that stories are often retold and relived by a process of personal reflection. Many of the tellers’ own interpretations demonstrated Dziopa and Ahern’s (2009b) ninth construct of the therapeutic relationship which is self-awareness.

The meaning ascribed to each story by the teller could be extended and expanded if the story were used for discussion with a group of undergraduate mental health nursing students or with a group of new recruits. Misunderstandings or unusual interpretations also provide scope for discussion and may reveal teachable moments as well.

Some of the stories provided explanations, glosses or additional comments which were not formal interpretations of the meaning of the whole story, for example.

- “Remember that we folks in the helping professions like to be made to feel good for what we do, why else would we do it? We like grateful people” (Number 26)

Justifying how a patient was able to hoodwink an entire team of mental health nurses, the teller of the story explains:

- “In our defence when you work with damaged people you have to find a way to be optimistic about their situation. This involves a presumption that we are all motivated by the same needs and wants...so it is probably necessary to presume the best in others” (Number 20)

Another story concluded with a justification.

- “Although I don’t accept presents of course, I made an exception....” (Number 69)

A dramatic account of a visit by a community mental health nurse and a student to a remote property ends with the restrained comment:-
• “This was the only day I’ve ever been at work that I didn’t think I would make it out alive” (Number 39)

A story about a young woman’s eventual and unexpected recovery comments that “the messages that people get sent from the system and the way care’s delivered is interesting and challenging” (Raeburn, in Nizette, McAllister & Marks, 2013, pp. 98-99) (Number 52)

An academic article which used stories told by new graduates about their experiences working in mental health settings found that:

More experienced staff directly challenged them to oppose the development and implementation of new models of care throughout mental health services...what is at stake here is the extent of staff commitment to the development and implementation of more effective services for service user groups considered to be inherently difficult or dangerous to treat (Hazelton, Rossiter, Sinclair & Morrall, 2011, p.180) (Number 56).

However only 16 stories provided a true interpretation of what the teller saw as the purpose of the story.

A story from a student about to register comments that the advice she had been given:

• “Comes from a lack of understanding of mental health nurses’ roles and [lack of] acceptance of mental illness” (Number 73).

A story from a nursing home setting concluded:

• “That’s how the people are and that’s person-centred care” (Quirke, in Nizette, McAllister & Marks, 2013, p.93) (Number 51), (although a cursory reading might lead to the conclusion that care was deficient).

An apparently simple story about the interaction between a male mental health nurse and a psychotic young boy in a child and adolescent mental health unit interprets the whole interaction thus:

• “I had a good relationship with him” (Number 41)
The gleeful explanation provides a humorous interpretation of an episode which contains much more of impact than the comment would suggest and this story is one of many where the teller finds that what would appear to have been a mistake has in fact been beneficial to the patient.

• “Done the wrong thing but got away with it!” (underlining by storyteller) (Number 45)

One of the Six Long Stories concludes with the teller’s saying that the patient was…

• “Having a great deal of trouble adapting to his unwanted independence” (Number 65)

…leaving the mental health nurse “bewildered yet hugely impressed by the peculiarities lurking behind even the most bland of suburban facades”. However there is much more of impact in this story than the teller offers in the final interpretation.

In contrast, the story about the patient with thyrotoxicosis ends with the clear interpretation.

• “When I discussed this later with the ED registrar he said he was beginning to wonder why they had to medically clear patients who seemed to be psychiatrically unwell and this patient had shown him the importance of excluding physical causes for psychiatric symptoms. WIN!” (Number 100)

A story about an unusual method of administering a depot to a patient who did not want to open his front door was interpreted as:

• “Best practice, resourcefulness…” (Number 95)

The teller also invited a discussion of:

• “The ethics of the situation” (Number 95)

A story about the challenges of managing unprofessional behaviour in staff points up that the:

• “Moral of the story is to persist in something however hard if you know that morally it is correct…” (Number 64)
An experienced nurse educator provided many comments and interpretations of one story, saying he would bracket the first paragraph (about previous violence shown by the patient) if telling the story to students. He noted that he “didn’t know how to deal with this” when confronted with the situation (this patient greeted him as an old friend) in his first year as a registered nurse and interpreted the episode as showing the “parallel realities” for the patient and for him. The final interpretation was:

- “How it is sometimes necessary to hang on to whatever hold we can use to maintain a relationship” (Number 44)

and focused on

- “Honesty in the face of potential adversity”. (Number 44)

Another nurse educator clearly spells out the reasons for telling the story about the mother with BPAD [Bipolar Affective Disorder] whose son grew up to be “a happy well-mannered young man” saying she tells it to her students to demonstrate.

- “Positive attitudes…comprehensive non-judgmental person centred care…patient/client advocacy…professional relations. ..and the difference between professional and social relationships” (Number 59).

A student was scared when told a story about how an Aboriginal man placed in seclusion after a fight with another patient then attempted to hang himself and learned from this story about:

- “the vulnerability of the patient and how quickly things can happen” (Number 70)

An experienced mental health nurse reflected on the account of an aggressive patient, interpreting the story of the man who leapt through a heavy glass door as follows:

- “To date I had managed many years around people in altered states without being clobbered. I generally put this down to primarily good luck, followed by being respectful, decent and not least of all, trusting my antenna” (Number 22)

An account of an old psychiatric hospital and the relationships between staff and patients interpreted the interactions thus:--
• “The staff who manned these places were every bit as institutionalised as the patients...” (Number 17)

An unusual story of a therapeutic relationship which took 20 years to bear results concludes:

• “I think her joy that day was because she understood that she was part of someone else’s life story in a positive way” (Number 67)

and the results only occurred after the mental health nurse had

• “the presence of mind to tell her our story” (Number 67)

True interpretations of the whole meaning of a story were rare. The following is a good example of one:

• “If you start out kind, you can always learn more; but if you don’t start out kind, learning more’s impossible” (Number 12)

Other stories provided the teller’s personal reflection on what was described in the story:

• “She must have felt I had not heard or understood...” (Number 2)

However the dearth of true interpretations in most stories reveals what opportunities are contained in them for learning, discussion and the discovery of teachable moments.

4.8 The six long stories – what do they tell us?

The six long stories may serve as paradigms. They contain significant material in terms of People, Things, Events, Context and Narrative Processes and Language of Text but it is the Relationships and the Moments in them which raise the important issues and show mental health nurses managing problems and making decisions in a unique way. All six are too long to be used effectively in a classroom or ward teaching situation though could be most useful for a written assignment where students have time to read and reflect.
For ease of identification all stories have been given titles, although only three were titled by the storytellers themselves. All provide some comment or explanation by the teller although none provides a detailed interpretation of the reason for the telling.

Story 4 was titled “Breakout” by the teller, story 13 was titled “The Good, the Bad and the Harmless” by the teller and story 25 “A Woman Scorned” by the teller.

The other three were allocated titles - story 65 “The Dog and the Dioramas”, story 68 “The Inheritances” and story 94 “The Hood”.

“Breakout” begins with a statement about purpose of telling and gives the context:

This story is a story that I tell other nurses for a variety of reasons. It shows fairly extreme circumstances and how they were managed, through teamwork and luck; and also reminds me of a pivotal moment in my nursing career where I thought if I can survive this then I am able to work successfully in this environment. The situation occurred approximately within the first six months of my nursing career during my new graduate year. The setting was the local and brand new child and adolescent mental health unit (Number 4).

A large number of People appear in this story – five teenage girls, two nurses, security, a male patient, a female patient placed in seclusion – and a complex list of Things (laundry hallway, showers, fire alarms, fire doors, pool balls, pool table chalk, pool sticks, lounges, seclusion room, rubber strip, IMI, chair, bushes, notes, incident forms). The Events are dramatic – five teenage girls engineer a “breakout”, are returned to the unit, staff are threatened with pool cues, a teenage girl is restrained and secluded and then attempts to strangle herself, three teenage girls abscond again. As a result of this behaviour both mental health nurses and security are obliged to adopt custodial and disciplinary styles. Relationships in the context of being therapeutic while the young patients appear to be testing, challenging, “ganging”, confronting and hostile, all of which may be part of their adolescent stage of development. The story is a report in style and the language is simple and descriptive. The Moment is that nobody was harmed in the whole episode.

In “The Hood” instead of patients breaking out, a patient breaks in. “The Hood”, like all these long stories, has a large number of People involved – a female mental health nurse, a male colleague, a hooded male, other patients in the mental health unit...
including one “restrainer” one “soother”, the duress team and the police. The Moment is dramatic as a hooded male kicks down the front glass door of the mental health unit and enters with a knife. The Relationships are varied – the hood is hostile to the nurses, the nurses themselves have a collegial relationship to each other, one female patient is defensive and protective towards the nurses, another acts as a soother to the hood, and eventually the hood shows a dependent relationship to both nurses and patients. In this story there is ample opportunity to discuss the complex relationships which may evolve in a mental health unit as well as to discuss risk assessment, security provisions and situations where equipment fails and the situation could not have been foreseen or prevented. The story is written as a report in a rather laconic style with much understated humour – “Why on earth would anyone break into a mental health unit?” (Number 94).

In ‘The Good, the Bad and the Harmless” the Moment is at the beginning of the story when Brian places both arms on the railway tracks and waits for a steam train to come. Both his arms are amputated half way down the forearm and when the ambulance arrived, “Brian was still conscious and voicing his disappointment at still being alive”. After an account of Brian’s psychiatric history before the injury, most of the story then describes the Relationships formed between Brian and the staff involved in his care and particularly the Relationships formed with the teller of the story:

I hope I was not totally insensitive, I suspect I almost was, though I imagine Brian was getting used to this treatment.

In the ambulance I tried to converse. Talking with Brian was like talking to a full stop. You dropped over the edge and he was still standing there. I caught him watching me often enough to know he was not an empty vessel. He had a certain light in his eyes that made me certain he was still driving his own car and it was a manual.

A young woman called Felicity measured and calculated how best to put some mechanical pieces of plastic and metal to serve as Brian’s limbs. She was astounding. Her patience, technical knowhow, compassion and overall decency were like a slap in the face. I realised I had been surrounded by people playing at being professional for too long. It was like listening to an accomplished jazz musician after you have been strumming along three chord blues with your mates.

Anna Elizabeth Treloar
Brian soaked up her exceptional care in the same way he may have soaked up the train wheels, police brutality or a therapeutic massage, with controlled indifference.... (Number 13).

Later, after the return from the visit to the prosthetist:

I remembered Felicity, I consciously moved sideways. I organised Brian’s clothes and then set about helping him dress. He recoiled slightly from my touch; I carried on, conscious of how intrusive I was and had to be. Touching his emaciated body was both repulsive and oddly enjoyable. For both of us, I suspected. I dispensed with my usual attempted banter. Words got in the way with this man. Slowly over the weeks some sort of tacit choreography and comfort developed. The prototype of his prostheses arrived and surprisingly Brian seemed motivated to move the robotic hand in a purposeful way (Number 13).

At the end there is a reflection on how Brian related to staff and about the staff attitudes towards Brian:

He was a true socialist; psychiatrist, social worker, psychologist, cleaner- he gave them all equal amounts of indifference.

The nursing staff were decidedly divided in their views of whether or not Brian was deserving of care, a common situation in my experience when a patient evokes strong emotions in care givers. To paraphrase:

A. Brian is a sad, isolated and lonely victim of his illness. His illness has resulted in him becoming seriously disabled after trying to end his tormented existence. He deserves and needs the best care to regain some improved quality of life. I feel so sorry for the parents who have suffered just as much in their own way.

B. Brian is a cold calculating PD [personality disorder] who controls everyone around him with his silence. There doesn’t seem to be any clear evidence to support a diagnosis of schizophrenia. His parents feel entitled and think their son is the only patient on the ward.

Over the next forty odd years I would see this dichotomy played out in all manner of clinical situations. Depending on the circumstances and level of sophistication of
the staff involved, the underlying conflict of opinion might be obvious, or well hidden. Medicine and psychiatry aspires to moral neutrality, so it should. But ultimately we are a bunch of people dealing with another bunch of people. It is probably inevitable that the idea of the deserving or undeserving will come into play when dealing with patients.

Brian, being Brian, decided to end the issue. Once the attention dimmed enough he vanished. He left the ward, his prosthetics and people’s opinions behind. How far could a man without hands get? Where could he go? How could he cope? As far as I know these questions were never answered.

It’s likely he finished what he started. Whatever else was driving Brian, I always had the feeling he an intense need to be in control (Number 13).

It was rare for any story to give so much in the way of comment or reflection and these passages are given in full as an illustration of how much material is available in this long story which is eminently suitable for discussion by mental health nursing students. The fact that the story is exceptionally well written increases its value for this purpose.

Like all the six long stories, “A Woman Scorned” has a large number of People in it – a female patient in the cells, a male court mental health nurses, two prison officers, police, magistrate, neighbour, Legal Aid solicitor, private psychiatrist, PECC [Psychiatric Emergency Care Centre] staff, doctor’s secretary and the patient’s eight year old daughter. The list of Things is suggestive –“cell, mattress, clothes, noose, paper suit, toilet, jewellery, voicemail”. The Relationships of staff involved are as expected, i.e. custodial (prison officers to patient) and professional/assessing (court mental health nurse to the patient). The puzzling Relationship is the one between the patient and all staff involved. At all times she is hostile and defensive. Added to this is the reflection from the teller on establishing a new service:

Back then I was finding my way, trying to shape the role and the service. I wasn’t trained to make independent decisions; I had yet to earn respect and credibility and to look comfortable in a suit. I constantly oscillated between the dread of screwing up and the thrill of being a nurse that got to make decisions that had consequences... You are of limited use to a patient if you are not seen as ‘solid’ by the prison officers. I was a guest and didn’t have a key. To gain some benefit for a ‘crim’ as prisoners are known, you have to be able to
negotiate from a position of often begrudging respect as a clinician in a hostile environment. The sensitive new age clinician could take endless umbrage at the gross, politically incorrect ravings of many of the officers. I assumed that most officers were bored and felt powerless, the cynical banter being their one show of strength, albeit an empty one. In my experience, most officers are decent folks but the work culture is toxic.

When officers overtly speak scathingly about prisoners I think it best to pick your fights carefully: when you do make sure you win. By and large ignore obviously shitty comments and negativity, instead focus on the good stuff. It also helps if you are playful and regularly bring good jokes into a mirthless environment. Above all else you have to try and blend being kind and decent to the patient with practicality. You have to try and find a way of being useful to both the patient and the systems involved (Number 25).

There are two Moments in this story – the first when the psychiatrist’s secretary informs the court mental health nurse that “a friend had left a message on the voicemail to say that Scarlet B...... had taken her own life on the weekend” and the second when on the day of Scarlet’s scheduled court appearance the court mental health nurse rings the Legal Aid Solicitor to inform her of this and the Legal Aid Solicitor is “genuinely surprised as she happened to be sitting in a room with a very alive indignant Ms B----.

A lengthy reflection on the whole episode concludes this story:-

Over the next 10 years I had numerous dealings with Scarlet. In time I grew to admire her brassy outer shell and to appreciate her vulnerable core.

People with personality disorder do not have flexibility and adaptability, so at times of high stress they often revert to primitive and unappealing ways of trying to cope. Paradoxically, this inability to cope tends to alienate and infuriate everyone around them, including mental health workers.

No one comes into this life equipped with the ability to self soothe and other mindedness, (the capacity to imagine how others feel and to imagine how they might perceive our behaviour). If we are lucky we get a lot of assistance in developing these skills through adequate attachment and good enough
parenting. Not everyone is lucky. Scarlet had experienced sexual assault at the hands of multiple family members from age 10 years onwards.

It is probably not surprising that she had a remarkable ability to engender strong responses from most people she met. Over the years I noticed that men in authority tended to want to either beat her up, shag her or rescue her, often simultaneously. If you were reasonably self-aware you might notice this process. If not you might project these unwanted feelings on to her. Either way it is perhaps not surprising she made us feel rather uncomfortable (Number 25).

Once again, as with all these stories, there is an invitation for mental health nursing students to discuss the whole account and much to be learned about relationships and reasons for what patients sometimes do.

In contrast to “A Woman Scorned” the story “The Dog and the Dioramas” has much which is puzzling but very little comment, explanation or interpretation. The story begins dramatically when a man throws an Alsatian dog over a bank counter. Like other stories of the Six Long Stories group the Moment occurs at the beginning. The rest of the story provides some clues though much is still unexplained at the end of the story and so much remains open to discussion by student mental health nurses. Even the list of Things is surprising – dog, fibro home, display cabinet, abandoned power station, meat pies, TV, notebooks, steak and onions, bones, bed, videogames, dioramas of death scenes. Little is said about the Relationships between the two mental health team staff who visit the man in his house and the man himself. All that can be noted is that the Relationship was professional as an assessment interview took place. Information provided by the patient merely provided some background to his behaviour as well as revealing some new unusual things about his life, but did not explain them completely. The two mental health staff eventually leave…

- Bewildered yet hugely impressed by the peculiarities lurking behind even the most bland of suburban facades (Number 65).

However, the only intervention required is to contact a Social Worker to help the patient access his money, and ring the RSPCA about the Alsatian dog. There is no mention of a psychiatric diagnosis or the need for further treatment. This story therefore lends itself to a discussion of what our society views as mental illness and what is merely unusual behaviour.
The final story in the group of Six Long Stories, “The Inheritances” shows two community mental health nurses in an extended role. Once again there are a number of different Relationships described – the therapeutic but extended role relationships between the two community mental health nurses and their married patients with schizophrenia, the dependent relationships of these patients to their nurses, the marital relationship between the two patients, the friendship between the couple and their friend Phil (also a patient of the service) and the helpful and non-exploitative relationship between the real estate agent and the couple. The list of Things once again is complex – two legacies, unit, floor rug, TV, video, linen, kitchen ware, furniture, David Jones truck, packaging, boxes, wedding dress, ceramic Buddha. The story is written as a report but with a wealth of detail. The Moment appears to be when the teller is asked to furnish a whole new empty unit for his clients, but the real Moment is the surprising revelation by his colleague at the end of the story that she had to arrange the couple’s wedding. This story lends itself to a discussion about the role a community mental health nurse, advocacy, the vulnerability of mental health patients and particularly about boundaries. The teller discloses at the end that although he does not accept gifts…

- Of course I made an exception on this occasion because it was such an unusual gig (Number 68).

The potential for crossing boundaries and for taking advantage of the two patients existed but the story shows clearly how all concerned only acted in the patients’ best interests and following their requests for assistance.

### 4.9 Conclusion

This chapter has summarised the findings of data analysis which was conducted using a Data Analysis Template based on the work of Tripp (1994) and McCormack (2000a). However accurate and careful the analysis is, in the end the text speaks for itself. These 100 stories from nurses working in mental health have much to tell us about the art and science and professional skill of mental health nursing. Diagnoses were rarely mentioned and never stressed as being important by the tellers of the stories, which focused rather on behaviours of patients and actions of nurses. Where patients exhibited hostility there is rarely a diagnosis supplied to “explain” it away. Often there is no diagnosis, no explanation discovered, no statement from the patient about reasons
for behaviour, and as well an incomplete assessment or psychiatric history taken at the time the story occurred.

In the end it is the reader who will judge their meaning provided the text is supplied. If the reader is a student nurse, guidance in interpreting will be needed. The final chapters suggest some ways this guidance could be offered. This then leads to the purpose of telling the story.

The next chapter is a discussion of the findings, and focuses on which stories are fit for purpose.
Chapter Five

DISCUSSION

“...how do we ever know that narrative matters? Matterness isn’t captured in conventional statistical analysis with probability figures” (Diers, 2004, p.333).

5.1 Introduction

Chapter 4 described the data analysis and discussed some findings and also summarised the three workshops to show how the participants interpreted, understood or commented on the stories they heard. This chapter focuses on the outcomes of the study, retracing the journey from beginning to findings and implications of those findings for education and practice. Consideration is also given to particular elements of the discovery aspects of the case study and implications for any further research.

During a lecture on mental health nursing, a student remarked, “Lectures are just the same as the lecture notes except in lectures you get the stories”. This prompted me to think about why these stories are told to undergraduates and new recruits, both in the academic and in the clinical setting. Were they “fit for purpose” (Biggs, 2001)? Did they mislead? Were they sometimes misunderstood? What possibility was there for varied interpretations? What was the final message remembered by students? Did this message influence their ideas, attitudes or future practice for better or for worse? Could storytelling be detrimental as a way of inducting or orienting new recruits? Might there be occasions when a story told was contrary to the values and principles of mental health nursing? In the collection of 100 stories the tellers showed great pride in their work, and had selected anecdotes themselves; but students are also told “horror stories”, stories which do not demonstrate good practice and stories where the attitudes and values of the teller are not conducive to identifying or developing appropriate skills in mental health nursing. In fact several mental health nurses who attended the pilot workshop and the university workshop cautioned against the risk of choosing “the wrong story”.

I needed to consider the concept of storytelling in the context of student learning. The most useful definition of a story for this study is:
“...relating an interpretation of the events or circumstances of an experience that includes the factors of time and personal meaning; contained within the story and its message are the teachings of the particular culture” (Blecke & Flatte, 1993, p.292).

Before revisiting the study purpose and the related questions, I will return to the assumptions and the hypotheses about the nature and purpose of storytelling in the context of mental health nursing which I held as I began the study. Then I will discuss some of the purposes identified for the telling of the stories and finally the “type” of story.

5.2 Researcher reflections

At the start of the project I was asked to summarise the outcomes of an early meeting with my supervisors and to write down my preconceptions about the project at that stage. My “takeaway word” from that session was “efficacy”. My project needed to show “that stories work and are useful” and not just be a collection of stories. An early research question was, “Are the stories goal-oriented or merely narcissistic?”

I was biased towards seeing the intrinsic value of stories from the clinical setting (as opposed to simulations online, simulations in the laboratory setting, simulations in person, whether using actors or latex masks, or problem-based learning scenarios), because that is how I have learned much of what has been important to me in mental health nursing, from when I finished my first nursing training, a hospital certificate in psychiatric nursing followed by registration with the former Nurses’ Registration Board of NSW throughout further nursing studies at certificate, diploma and Master’s level.

I listed my preconceived ideas (assumptions and propositions) as follows:

5.2.1 Assumptions

- That mental health nurses use stories as part of their teaching
- That the reasons for selection may not always be clearly articulated
- That the message received by students may not be the one intended
- That there may be messages in the stories which are not immediately apparent to sender or receiver
That some stories told may have no educational purpose at all and serve merely to provide “light relief”, to “shock” or to dramatise the teller’s own role

That stories may encapsulate the essence of the nurse–patient/client relationship in mental health nursing in a way in which problem-based learning (PBL) scenarios cannot

That stories may provide insights into the history of mental health nursing which has changed rapidly in the last 20+ years

That a particular story may connect with a particular student and inspire

That stories may be the only way to illustrate the complexity and fluidity of the world of mental health nursing

That stories are ideal for showing alternatives and that there may not be just one “right answer”.

5.2.2 Propositions

That nurses working in mental health orient and induct new recruits by telling stories from their own clinical practice.

That some of these stories may contain little of clinical or educational importance.

That some of these stories may contain insights into mental health nursing which are not freely available in standard undergraduate textbooks.

That some of these stories may offer challenges to new recruits’ currently held ideas and beliefs about mental health nursing.

That some of these stories may provide opportunities for discussion and deep learning about the complexities of mental health nursing.

5.3 Research question

From consideration of my assumptions and the formulation of propositions, the research question emerged: What is the purpose of clinical anecdotes told by nurses working in mental health to undergraduates and new recruits?
A final appraisal of the findings of the case study on storytelling by mental health nurses then determines: the implications of these anecdotes about mental health nursing for the exploration of contemporary mental health practice and education; the educational value of the stories (the essence and rationale of the narratives) for use as stimulus material i.e. as catalysts for learning for both the novice and more experienced mental health nurse; and the relationship between concepts relevant to the enhancement of both practice and education in order to develop a conceptual framework for professional practice and education.

5.4 Purpose of study

The purpose of the Case Study was to answer the question and develop an appropriate conceptual framework. By making a collection of stories told by or suitable to be told by nurses working in mental health settings to undergraduates and new recruits and then analysing them using a Data Analysis Template based on the work of Tripp (1994) and McCormack (2000a) and following case study methodology, I was able to conceptualise the essence of mental health nursing as expressed within the narratives. Comments and interpretations about some stories from some experienced mental health nurses in two workshops were also incorporated, as were the tellers’ own interpretations where they were written down. A workshop for Third Year students close to graduation also provided insights into the educational purpose of a small number of the stories.

Appendices 1 and 2 contain the stories collected. Other stories are recorded and discussed in this chapter to highlight their value for the purpose of the present study. In the following discussion I am reflecting first, on the value of particular types of stories told for different purposes and second, on four of the stories from the collection of 100 most suitable for clinical and educational purpose.

5.5 Discussion

By collecting and analysing these stories I have discovered that a story may be as short and simple as a humorous anecdote about an incident in a ward; it may be constructed to suit educational purpose as is the trigger material used for problem based learning scenarios; or it may be as complex (and so less suitable as a catalyst for learning) as the following.
5.5.1 Reflective stories too personal and too complex for educational purpose

This short story called “Grand Rounds”, told in the first person, offers a different perspective on the telling of stories (Adrian, 2012). The speaker, a doctor, gives a talk to a group of residents entitled “The Teddy Bears' Picnic” or “Why Stories Matter” or (sometimes) “The Worst Year of My Life” and (sometimes) “Theory and Practice at the intersection of Art and Medicine”. The teller begins by saying he will talk about “how and why people I respect and trust insist that a facility in telling and listening to stories makes for a better practice of medicine” (p.9) adding that “if what people talk about when they talk about Narrative Medicine was easy to say they wouldn’t need stories to say it” (p.10). However, as the short story progresses, the speaker in the short story tells his own story interspersed with his official subject matter in flashes which grow more and more detailed. He becomes more and more rambling and emotional, until the final words (p.24) are reached:

   And of course sometimes it’s the mysterious stranger who shows you the answer you’re looking for, cupped like a spider between his two hands. Will you tell me what to say? Open your hands? Not you either? O Stranger! O Patient! O Self! Won’t one of you tell me what to say? Won’t anybody? Please, tell me? (Adrian, 2012, p.24)

After which in the short story there are two minutes of silence from the audience and following that he has to be led from the podium by the chair of the meeting.

In “Grand Rounds” the story of the teller’s distress and disintegration is encapsulated in the formal talk which he is supposed to be delivering. It becomes autobiographical and reflective. This may be the case with other storytellers.

A similar purpose is served by three plays written about various clinical settings. “The Counsellor” (Treloar, 1994) contrasts the emotional instability of the Counsellor with the emotional stability of the Secretary; “Voices, Noises” (Treloar, 2001b) is a radio play where the theme is unrecognised and unanswered calls for help from suicidal patients in the midst of all the other noise of daily life; and “The Interview” (Treloar, 2010) uses a mental state examination conducted by the applicant on herself to identify problems following an unsuccessful job interview. Both the short story and the three plays are too complex and too reflective to be suitable for teaching undergraduates and new recruits.

Anna Elizabeth Treloar
However, the following short story (Treloar, 2001a), written as part of a campaign to recruit school leavers to mental health nursing, is too simple for educational use. It is a descriptive account of a clinical placement only and weighted towards making rural mental health nursing attractive to potential new recruits.

### 5.5.2 Simple story too basic for educational purpose

**Making a difference**

“Give me machines that go beep any day”, said Casey. The group laughed. They were all Third Year Nursing students, about to start on their final clinical placement. Most were going to high dependency areas. But Jackie was going to a rural integrated mental health service. “Because I want to be able to make a difference”, she explained to the group. “Make a difference?” said Casey. “Those sorts of patients won’t even know you’re there”. Everybody laughed again. Casey was considered to be on her way to the top, at least by herself.

Jackie’s clinical began at 8.30 on Monday morning. She had been offered board with one of the hospital nurses whose son had just left home for university. The nurse insisted on cooking her a hot breakfast and then packed sandwiches for her lunch. Jackie’s preceptor met her in the car park, and took her straight to the Intake meeting. “With two staff away sick this week, Jackie, we’re very lucky to have a Third Year – we have plenty for you to do”, he said. The team presented summaries of selected client histories, and Jackie was asked for her opinions about some of them. Next she did a search on the internet for information about Tourette’s Syndrome for which the Child and Adolescent Mental Health Worker was very grateful. She was invited to accompany him when the client was presented on tele-psychiatry. At lunchtime there was a new DVD on Early Psychosis which the team had been asked to review. In the afternoon Jackie went out on home visits and gave all the injections. All the clients assured her they didn’t feel a thing, and one asked hopefully if she would be back next week.

On Monday evening Casey rang. She sounded flat. “How’s it going?” asked Jackie, knowing what high hopes Casey had had of impressing the senior nurses and catching the attention of a resident or two. “I did some obs”, said Casey. “That was about all really – they were too busy to show me much”.

Anna Elizabeth Treloar
On Tuesday Jackie’s preceptor was on Intake, assessing all new presentations to Reception, and dealing with all mental health-related phone calls as well. None of the people who came into the centre objected to Jackie sitting in. She filled in stat sheets and recorded some histories in files. She discussed the new referrals with her preceptor and was pleased to hear some of her observations passed on to the team the next morning at Intake.

On Wednesday Jackie was rostered to work in the hospital, where they had a mental health unit which only opened if it was needed. There were four patients, and one RN, who was delighted to have assistance. One of the patients, a new admission, who was close to Jackie in age, established a rapport with her, and confided that since her admission, she had been thinking constantly of suicide. Jackie recorded this and reported it and she and the patient, with the RN and the patient’s case manager in the community, revised the risk assessment and devised a nursing management plan.

By Thursday Jackie was getting tired, so a day at the Mini Olympics was just the tonic she needed. Teams of mental health clients from all over the region gathered to compete in various sports, which was followed with a barbecue and a swim at the beach. Jackie found that just by just being herself she fitted in well, and everybody enjoyed her being there. The Team Leader thanked her for helping to make the day a success.

On Friday Jackie was back in the centre, taking advantage of a quiet time to finish an assignment. She looked up from her books to find the receptionist in the doorway. “There’s someone here asking for you”, she said. “Just wants to see you for a minute”. The visitor turned out to be the patient from the ward, accompanied by a nurse. “I wanted to say thanks”, she said. “You made a difference to me. I’d been trying to tell someone for weeks, but I couldn’t get it out. Nobody had time to listen. But I felt comfortable with you”.

A month later, the group were all back on campus. Casey was in fine form again. “So tell us, Jackie”, she said, “did you save any lives?” As if on cue, the group laughed loudly.

“Yes, actually”, said Jackie. “I think I did”.

Anna Elizabeth Treloar
If analysed using the Data Analysis Template, in the story provided above we find a variety of People, student nurses, mental health community staff, hospital mental health staff, patients and administrative staff. Things mentioned include hot breakfast, sandwiches, carpark, injections, stat sheets, assignment and books. Events include team meetings, and a Mini Olympics. The Context is rural, and moves between community mental health, hospital mental health and the community itself. The Narrative Process is a simple account of a week on placement, and the Language is simple and conversational in style. All Relationships described are professional (between team members) and (presumably) therapeutic (between team members and patients); the only other Relationship is the helpful one between the nurse who offered board to Jackie and Jackie. The Moment occurs in the final paragraphs where the patient reveals her inability to articulate her suicidal ideation until she spent time with Jackie and when Jackie realises she may have saved a life.

But in this manufactured story there is none of the complexity, surprise or creativity found in many of the stories from clinical practice told by experienced mental health nurses and contained in Appendices 1 and 2.

The following story is another constructed story, aimed at giving a simple mental health message about reducing stigma to a rural community. Once again, this story lacks the depth and complexity of most of the stories contained in Appendices 1 and 2.

5.5.3 Simple story to provide community mental health education and reduce stigmatising attitudes but too superficial for educational purpose

Don't be scared visiting the mentally ill

“Nothing for it, I suppose”, thinks Garry. “Better get it over with...I mean go”. He’s done the washing-up, swept the floor, put out the garbage, tidied the verandah. There’s nothing left to do. So he really can’t put it off any longer.

Garry’s workmate Bill was admitted to the mental health unit of the local general hospital on Monday. Nobody at work was sure why. They knew Bill’s wife had left him, and they’d noticed his work wasn’t as good as it had been. Also he didn’t hang around after work and laugh and joke with them as he used to. And he’d lost weight, wasn’t looking at all well in fact. But nobody thought too much about it.
Then they heard the news. Well, everybody was concerned, but nobody really wanted to visit, as nobody knew what it would be like. So they’d delegated the task to Garry, as he was the secretary of the Social Club. They’d signed a card, and passed the hat around for a gift. And it was up to Garry to choose it. And that was another problem. What to buy? A big bunch of roses? A box of chocolates? Neither of those seemed quite right. Finally Garry settled on a selection of the latest papers and magazines, and a small book on gardening because he knew that was something Bill enjoyed.

So Garry arrives at the front door of the psychiatric unit, clutching his bundle of reading matter, and wishing he was at home. He rings the bell, and a pleasant young man in white shirt and smart blue jeans answers. “Hi, I’m Rick, he says. “I’m the nurse in charge of this shift. Would you like to see somebody?”

“Uh, Bill, please”, says Garry.

“Sure, come on out into the garden. We’re having a barbecue. Have you had lunch yet?”

“Uh, no”, says Garry, wondering vaguely if they put the sedative in the sausages. And would there be straitjackets pegged on the clothesline? Or did they send them out to the drycleaners these days?

In the garden there was a group of people around the barbecue. Nobody in uniform and nobody in pyjamas. “How on earth do you tell who’s who, then? I mean, how do you know who’s staff and who’s a patient?”, thinks Garry desperately.

He spots Bill, and walks over to him. Rather awkwardly, he said, “How are you, Bill? Are you feeling better? I thought you’d be in bed”.

“No mate, I don’t need to be in bed. Thanks for coming. Great, the papers. We’ll all enjoy those. Can you stay for lunch? How do you like your sausages?”

“Uh, cooked, thank you. But where’s the doctor? Shouldn’t he be with the patients?”

“Oh, he’s in the kitchen making the salads. We did send a couple of the girls after him to make sure he cleans up properly. Come and I’ll introduce you to the Social Worker. She cooks a great steak”.

“Isn’t anybody in bed?” asks Garry, more confused than he’s ever been.
“Not now, though Sue slept in a bit as she’s got a cold. Anyway, come and meet the group. They’re a nice lot. You’ll like them”.

At work on Monday, everybody’s keen to know what it was like. “They didn’t keep you there then, Garry?” asks the office wit. “We always thought you were a bit strange”.

“Actually, “says Garry airily, “I am going back next Saturday. There’s an ‘invitation only’ luncheon on for the patients’ families and friends. They’re shopping and cooking for it on Friday. If you want to visit Bill, he’d be really pleased. There’s a video on tonight, and the table tennis competition tomorrow night. You should go. Just be yourself. And relax. You’ll enjoy it. I did” (Treloar, 1989b).

If this story is analysed using the Data Analysis Template, we find that People include Bill, a patient in a mental health unit, his workmate Garry who visits him, other workmates, and various staff in the mental health unit. Things are floor, garbage, verandah, hat, papers, magazines, garden, barbecue, sausages, salads. The Event is a visit to the local mental health unit by a patient’s workmate. The Context is first an office, and then a mental health unit in a rural town. The Relationships are friendly between workmates, professional/therapeutic between unit staff and patients (though not “professional” in the way that the visitor Garry expects) and (presumably) friendly between patients. The Narrative Process is of a simply told story, and the Language is simple and conversational, with occasional touches of gentle humour as Garry’s presuppositions and fears are overturned. If there is a Moment, it is when Garry triumphantly informs his workmates that he has been invited back to an ‘invitation only’ lunch for patients and their friends.

As a story intended to combat stigma towards the mentally ill and inpatient mental health units written 20 years ago, the story probably serves its purpose well enough. But there is little of educational use for mental health nursing students today as is shown by the lack of complexity in People, Things, Events, Context, Relationships, and Moments.

5.5.4 Problem based learning scenario used in examination but too simple for educational purpose

Similarly, the following story (written as a scenario on which a series of questions in an undergraduate mental health nursing examination were based) is constructed with a
view to the questions which must follow and the syllabus content which must be covered.

**ROBBO (Schizophrenia)**

Robbo (46) arrives at ED in the back of a police van. His dog is with him. Robbo is wearing trackpants, a plaid shirt, a beanie and trainers which have a strong odour. In a plastic bag he has a packet of White Ox tobacco and a jar of instant coffee. He is delighted to see the nursing staff and asks immediately for a cup of coffee and a sandwich.

Robbo is well-known to this ED and has had multiple admissions to the voluntary mental health unit which is attached to the hospital, as well as occasional trips north to the closest declared mental health facility. He lives alone in a Department of Housing unit and is on a CTO [Community Treatment Order]. His rent is paid by direct debit. Usually he keeps his appointments with Community Mental Health and goes to his GP for his Risperdal Consta depot every two weeks.

But his long-term case manager has been on leave and Robbo didn’t really engage with the replacement worker who in any case was new to community work and assumed that if Robbo didn’t come to appointments he must be doing well. The case manager ensured that Robbo’s scripts were up-to-date and that there was a supply of Consta available when needed but the relief worker didn’t know this because she had not had time to read Robbo’s file as she was often called to help out in Intake due to a staff shortage. Robbo did ring once but was put on hold and got tired of waiting. His usual GP had to have unexpected major surgery and the locum at the practice was too busy to do anything except see patients who were booked in. Then Robbo’s phone was cut off because he had lost the bill and not paid it. Some old friends came round and borrowed money on pension day but did not give it back. Robbo bought food for his dog but there was not enough money left to buy much for himself.

He had coffee with sugar to keep him going, and took to staying up all night listening to loud music and watching TV. If he was hungry he ate cereal.

Gradually the auditory hallucinations which had been a part of all his adult life returned. He was used to them and knew many ways to manage them most of the time but he forgot to do that and just turned the television up louder to distract himself. The old ideas that he should be careful, keep to himself, lock the doors and windows and not
go out because of aliens returned. He covered the windows with Alfoil to protect himself. Sometimes he slept in the daytime so didn’t get around to going to the bank or shopping or cleaning the unit or washing his clothes. The dog made a bit of a mess too because Robbo wasn’t taking him out for walks. Usually the neighbours overlooked the presence of the dog as he was well cared for, but the combination of Robbo’s increasing isolation, the Alfoil on the windows, loud music all night, a barking dog, and the smell from the overflowing garbage bin in the kitchen prompted them to call the Police.

Robbo is a likeable character and many experienced mental health nurses would say they have met patients very like him, but once again, there is little surprising or challenging about the story. The People are Robbo, a man with chronic schizophrenia, his neighbours, the Police, various community mental health staff, Robbo’s GP, his friends and the Emergency Department nurses. The Things are indicative of the situation – Police van, dog, trackpants, plaid shirt, beanie, trainers, plastic bag, White Ox, jar of instant coffee, coffee, sandwiches, unit, rent, Consta, money, phonebill, dogfood, coffee, sugar, cereal, TV, doors, windows, Alfoil, and garbage bins. The Events include Robbo’s efforts to get help and finally his transport to ED in a Police van. The Context is Robbo’s Department of Housing unit and then the ED. The Narrative Process is of a report and the Language is simple and descriptive. The Relationships show all involved as accepting of Robbo and his difficulties, whether it is the tolerance usually shown by the neighbours, Robbo’s expectation that he will be welcomed on arrival and his request for coffee and sandwiches from the ED nurses, or the role of the Police in transferring Robbo to the hospital. The implication of the Relationships between locum GP and relief mental health worker and Robbo is that they simply had no time to form a Relationship while the Relationship between Robbo and his “friends” appears predatory on their part. The Moment occurs when Police are called and Robbo is taken to hospital. It is expected in the context.

So for the purposes of an examination paper, a diagnosis is made at the start, suggestions about what contributed to Robbo’s relapse are included, an indication that when adequately supported he copes well is given, and some details of his symptoms are provided. Apart from these there is little of interest or significance. The story is believable and similar to the sort of presentation encountered in clinical practice, which are two requirements for the sort of PBL scenarios likely to motivate students as determined by the School of Medicine at Flinders University. However the Robbo story
does not meet the rest of their criteria for PBL scenarios likely to motivate students as it
does not stimulate students to seek further knowledge, is not truly open-ended and
does not encourage application of new knowledge to other contexts; nor is it
particularly exciting (Prideaux & Farmer, 1994).

Even an account of a community mental health nurse’s care of Lil, an elderly woman
with schizophrenia and no family support, while based on a true story, and while
containing many actions and interactions worthy of discussion (Treloar, 1989a), reads
more like a case history than a clinical anecdote which might be told by experienced
mental health nurses to undergraduates and new recruits. There are well-observed and
recorded details which show Lil as a real person who did her best to maintain her
chosen “fiery independence” under very difficult circumstances.

5.5.5 Case history of community mental health client but too long and detailed
for serious educational purpose

Desperately seeking Lil

One week she announced brightly, “I’ve taken up smoking”. (She had never smoked in
her life before, but certainly made up for it at 74). Abruptly she gave up. Another week
the craze was black coffee. Then Milo. Then Panadol and aspirin – as fast as I
unearthed her supply and discarded it, she’d get in a new treasure trove of analgesics,
swearing that the doctor had told her it didn’t matter how many she took as they
wouldn’t do her any harm. Another week a range of laxatives was sampled. Then she
planned to marry again – “The TV gave me a message” – so she rang her daughter-in-
law’s mother to ask if she knew of anybody she could marry. The next craze was
telephoning the emergency medical service in the middle of the night and at weekends
with various complaints. The doctors naturally took a dim view of this. For several
weeks she advertised in the local paper “WANTED Boarder. Gentleman preferred”. There
were no takers for a long time, until a teenager and his girlfriend moved in
without money or food and apparently without any intention of providing for themselves
or paying their way. A few discreet enquiries revealed that the girl was a runaway and
under age and the boy was not well thought of by the youth workers who knew him.
The couple left hurriedly after a refugee staff member visited (Treloar, 1989a, p.29).

This account has historical interest as an early account of a nurse working in a
Richmond-funded position when community mental health nursing was quite new and
when there was little understanding of the role but otherwise does not provide any of the challenges or insights which the majority of the stories in Appendices 1 and 2 do. In many ways it is the only tribute recorded to the life of a person who although “old and lonely and female and powerless…was a valiant schizophrenic” (Treloar, 1989a, p.30).

A story written for a supposed educational purpose only is likely to lack the depth, detail and unexpectedness, the authenticity, of a true story from a mental health clinical setting. If we return to the stories analysed in the previous chapter, the difference between the authentic and the manufactured story becomes apparent.

Although constructing a story to show the positives of mental health nursing to students as a recruitment tool, or to dispel myths about mental health units to a rural community, or to suit a student examination is easy enough, or even writing a study of community mental health nursing in its early days, the final result, when analysed according to the Data Analysis Template, yields little of real significance.

5.5.6 A story which failed to achieve its educational purpose

The methadone shirt

I once had a patient on the methadone program whose American relatives regularly sent boxes full of the most expensive clothes to him, all in large sizes as he was very overweight. One day his methadone prescriber assessed him as depressed and prescribed an antidepressant. His mood improved, he lost weight, and he then insisted on donating his box of brand new XXXL clothes to the three clinic staff (two of whom were overweight themselves). He would not take the clothes home, nor did he want to sell them at a market or swap them. It was his way of saying thank you and also (I suspect) a tactful hint that the staff needed to lose weight too. The clothes were all of top quality; but he had acquired them quite legally. And he was determined to give them away to the staff. So that is how I came to own what I now call “my methadone shirt”.

I told this clinical anecdote as part of an online tutorial in a course about health, social disadvantage and substance abuse. My intention was to show that clients come from a variety of backgrounds so assumptions about how they live and what they own can be misleading. I also enjoyed the way the client turned the tables on the staff with his gift. It was a role reversal story, where the methadone client showed himself as fit, in control of his life, and able to comment gently on the health status of the staff as well.

Anna Elizabeth Treloar
as to thank them by offering a gift. There are the ethical issues involved too, with three staff members accepting these gifts, although the patient was adamant that he would not take his box of clothes home and that he really did want to donate them to the staff.

However one student did not understand the story in this way at all, and responded that it was rather suspicious. The student felt that it was unusual for wealthy families to give expensive clothes to relatives with drug abuse problems, adding that he himself came from an upper-class family and had lived in high society for many years and had found that people in that group did not associate themselves with such relatives. He concluded that he would assume the expensive clothes had been stolen.

5.6 Complex stories from the collection: Appendices 1 and 2

Even in the early stages of analysis the complexity of the stories became apparent. At the workshop for Third Year students about to graduate there were widely different interpretations of the selection of stories brought to the workshop. So in the story about “coming over to the dark side” one student saw this dark side as the difference between the way things should be done versus the ways things were actually done; the second student wondered if the dark side referred to mental health nursing or to being corrupt; and the third interpreted the question as meaning, “Are you jaded?”. Similarly, comments on the story about the male mental health nurse offering a psychotic young boy a hug ranged from considering boundaries to wondering whether the interaction was therapeutic to cautioning against such an interaction if there was “a traumatic history”.

Quite early on in the process it became clear that the stories fell naturally into three groups. The first group were “surface” i.e. they were amusing or had historical interest or surprise but had little to teach about the clinical work of an experienced mental health nurse. The story above called “Don’t be Scared Visiting Mentally Ill” is at this level. The second group were “middle depth” i.e. they provided insights into the day-to-day work of mental health nurses with some “teachable moments”. The story above called “Making a Difference” is at this level. The third group were “deep”, i.e. they showed aspects of the essence of mental health nursing, and surprisingly, these stories very often included acknowledgments by the mental health nurses that they felt they had made an error, acted inappropriately, been “out of their depth”, or been pushed beyond what they had expected of the situation. It would be difficult to construct artificially a story which had the authenticity of this third group. The most
suitable group of stories for the purpose of teaching undergraduates and new recruits to mental health nursing belong to this third group. If the metaphor of a pond is used to further explicate this finding, the first group of stories are on the surface of the water, the second group are at the middle level of the pond, while the third group are found in the depths.

When Tucker (2010) used fictional short stories in the psychiatric education of medical students and residents, discussion was based on four general questions: “What conflicts or behaviours require change? What is the framework in which the change takes place? What are the specific details that promote the change? How could this story be applied to relevant or similar clinical situations?” (p.449).

The collection of stories, which are real stories from the clinical practice of mental health nurses, invites the following questions to be asked of students and new recruits who read or hear them:

- What are the consequences of the actions described?
- What are the intended consequences?
- What results are beneficial?
- What results are not beneficial?
- How could things have been done better?
- What results were unexpected?
- What incidents or outcomes contribute to your understanding of mental health nursing?

So then, what is the purpose of clinical anecdotes told by experienced mental health nurses to undergraduates and new recruits? Often the tellers of the stories selected anecdotes where they showed themselves at a loss, puzzled or even fearing they had acted inappropriately – “done the wrong thing but got away with it” as one gleeful account concludes. The tellers rarely seek to star and show themselves as exemplary clinicians. Rather they recount stories where the situation could not have been predicted, where they felt out of their depth or where they had to call on all their resources to achieve a therapeutic outcome. How they achieved this often uses
aspects of the therapeutic relationship as outlined by Dziopa and Ahern (2009b), but in many cases extends these aspects in ways not discussed by these authors. Many stories show mental health nurses called on to assess patients in difficult situations where little is known about history or events leading up to the assessment. Others show nurses making extraordinary use of silence in their relationships with patients. In other cases mental health nurses apparently break the rules to achieve a desired outcome; sometimes this involves what could be interpreted as boundary violations when taken out of context. The concept of “inspired creativity” is a feature of many stories. Others show the timeframe and the patience and meticulous care in interacting involved in a therapeutic relationship. In some stories the use of apology resulted in a good outcome for the patient or client involved.

The categories of People, Things, Events, Context, Narrative process and Language, while offering extra detail and insights, and ensuring each story is analysed as completely as possible, do not offer the most suitable material for educational purpose.

The most significant categories on the Data Analysis Template for discovering the educational purpose of these clinical anecdotes were Relationships and Moments. The first can be easily linked to an understanding of the therapeutic relationship; the second to the search for a teachable moment. Any discussion with learners would focus on Relationships and Moments.

5.7 The Six Long Stories suitable for discussion on ‘FITNESS FOR PURPOSE’

The Six Long Stories discussed at the end of the last chapter are all good exemplars of the above points.

“Breakout” (Number 4) is unusual in that the teller provides a reason for selecting the story −“It shows fairly extreme circumstances and how they were managed, through teamwork and luck: and also reminds me of a pivotal moment in my nursing career where I thought if I can survive this then I am able to work successfully in this environment”. The Relationships are complex and those between nurses and patients change as the story develops. The surprising Moment is that nobody was harmed in spite of the series of dramatic Events.

“The Hood” (Number 94) begins with a dramatic Moment as a hooded male kicks down the front glass door of a mental health unit and enters with a knife. A complex set of
Relationships is then described. Once again, although the reader might fear the worst outcome at the start of the story, the situation is managed and nobody comes to any harm. In contrast to the story “Breakout” in “The Hood” a man wants to break INTO a mental health unit!

“The Good, the Bad and the Harmless” (Number 13) begins with a dramatic Moment but this is not the most significant aspect of the story. In fact it is the different therapeutic relationships which develop between health staff and Brian which is the key learning point of the story. The teller of the story reflects on his own Relationship and shows how it developed and then provides a final reflection on Brian in an attempt to understand his attitudes and behaviour, though eventually it is inconclusive. There is ample scope for discussion of many aspects of mental health nursing in this story, including what the teller calls “moral neutrality”.

“A Woman Scorned” (Number 25) also has a reflection on the difficulties of establishing the mental health nurse role in a correctional setting as well as insights into the diagnosis of personality disorder and the “strong responses” engendered by the patient. The patient’s behaviour ranged from hostile to offensive to defensive to equivocal and provides ample opportunity to learn about working with people with borderline personality disorder.

“The Dog and the Dioramas” (Number 65) is one of a kind. In spite of a startling Moment at the beginning of the story and more unusual details of the home visit, the mental health assessment team leave without arranging admission. The only explanation provided by the teller for the identified patient’s behaviour is that the patient was “having a great deal of trouble adapting to his unwanted independence”. Did he show symptoms of a mental illness or not?

“The Inheritances” (Number 68) shows the extended advocacy roles sometimes required of community mental health nurses and the need to understand boundaries in these situations. There is ample scope for undergraduates to discuss these extended roles and how boundary violations in this story could have breached the therapeutic relationship.

Each of the Six Long Stories shows the teller struggling to cope with a difficult situation not previously encountered and not expected. Boundaries are maintained and a therapeutic relationship established or developed as far as was possible. Nobody came
to any harm (apart from Brian before he was admitted to the hospital) and in most cases patients benefited from the interactions with the mental health nurses. Aggressive behaviour is minimised by the tellers and often the stories are told with a quiet humour. In the few instances where the teller reflects on the meaning or significance of the story it is clear that the teller does not have a definitive answer.

5.8 Four examples of stories suitable for educational purpose

However, these Six Long Stories, as noted in the preceding chapter, might be considered too long for an effective classroom or facilitator led discussion. Other shorter stories from the collection are better suited for this purpose. Questions which could be used to help undergraduates and new recruits understand the complexity of the story are answered with a brief possible reply, though undoubtedly students would have many different perceptions.

The story about the supposedly inappropriate response to a manic patient is one that is very fit for educational purpose.

NUMBER 45

Working as a beginning mental health nurse in an acute unit: One patient was in the midst of a manic phase and was incessantly intrusive and regularly hurled verbal abuse focusing on staff and their flaws or weaknesses (way of talking, way of dress, body weight, etc.).

On this particular day she began knocking loudly at the office door but was asked to wait until handover had finished. She went away and found a mug and began banging loudly on the office door at which point I opened the door and took the mug from her. She then loudly abused me, calling me a fat so-and-so. I replied, “Have you looked in the mirror recently?” I immediately panicked and thought I had inflamed the situation and expected her to assault me. But she walked away, sat on the floor and laughed and giggled for quite a while. Done the wrong thing but got away with it!

What are the consequences of the actions described? The patient was diverted from her inappropriate behaviour and managed to laugh about the nurse’s response.

What are the intended consequences? The nurse sought time to complete handover.
What results are beneficial? Some kind of rapport was established between the nurse and a patient with challenging behaviour.

What results are not beneficial? There are none described in this story.

How could things have been done better? The nurse could have responded in a more professional but less therapeutic manner.

What results were unexpected? The patient took no offence and her behaviour de-escalated.

What incidents or outcomes contribute to your understanding of mental health nursing? (The student is provided with a framework to appraise the key attributes within the role of the mental health nurse).

Another is a powerful account of the use of silence.

NUMBER 35

It was in a provincial community health centre in New Zealand where I was working as Mental Health Nurse.

For some weeks a young man with a diagnosis of personality disorder had been presenting for weekly centre-based sessions of about an hour.

They had started subsequent to him having self-harmed enough to warrant a short admission to the local psychiatric unit.

On this particular Monday morning the afterhours staff had been called out to his home over the weekend where he had set up a situation of trying to hang himself

Part of the deal of him not being readmitted was that he present for this appointment.

Unlike previous sessions he was hostile, silent and not making eye contact.

Because I did not know what to say I said nothing. Nor did he for the entire hour.

What I did notice is that we fell into a rhythm of breathing at the same time. Our inspirations and expirations were concurrent.
What are the consequences of the actions described? There was no hostile outburst and the nurse provided support in silence.

What are the intended consequences? The nurse wished to assist the patient in his distress.

What results are beneficial? The nurse avoided compounding the patient's distress or escalating his anger. The patient kept his appointment as required and apparently gained some support from the nurse's silent presence with him.

What results are not beneficial? There is none described although the intention was for an hour of talking to take place.

How could things have been done better? The patient had the right to remain silent and possibly this was the only way he had available at the time to show he was in control.

What results were unexpected? The breathing of nurse and patient became synchronous.

What incidents or outcomes contribute to your understanding of mental health nursing? (The student is provided with a framework to appraise the key attributes within the role of the mental health nurse).

The following demonstrates the powerful result of an apology by a male nurse to a female client with a (previously unrecorded) history of abuse by her father.

**NUMBER 38**

I was working in a group therapy based voluntary inpatient unit, dealing mostly with patients with non-psychotic mental health issues.

One patient (who had a borderline personality disorder and dissociative disorder) who I had been working with for several weeks was complaining extensively about a minor issue on the unit (something like the water in the shower not being hot enough). I jokingly said, “Here is the smallest violin in the world playing just for you”. She became extremely distressed and angry. She then told another staff member that her father, who abused her severely as a child, played a record of violin music when he was abusing her.

Anna Elizabeth Treloar
I immediately apologised profusely for upsetting her, and we talked about how she felt, and what I had intended. This incident formed a foundation of a very good therapeutic relationship as no man had ever apologised to her before.

What are the consequences of the actions described? A very good therapeutic relationship was started.

What are the intended consequences? The nurse intended to show the patient that her concern was trivial.

What results are beneficial? The nurse apologised to the patient – “no man had ever apologised to her before”.

What results are not beneficial? Initially the patient was very distressed and angry.

How could things have been done better? The nurse could have avoided joking.

What results were unexpected? In spite of the patient’s initial reaction, the outcome was therapeutic and led to a discussion of the reasons for her distress.

What incidents or outcomes contribute to your understanding of mental health nursing? (The student is provided with a framework to appraise the key attributes within the role of the mental health nurse).

The last story in this group of four examples describes how a nurse used his own overwhelming and painful feelings to empathise with his clients and so assist them in their grief.

NUMBER 32

A woman walked in off the street into the M---- clinic. She was accompanied by her 8-year-old daughter. It was about 9pm on a Wednesday night. Her GP had advised her to come earlier that day.

I invited them into the assessment room. From the onset I felt uneasy. Not because they were odd, or angry, it was just their presence. After my introduction and basic information gathering, we sat in silence for a while. It was a strange while, and one I didn’t like at all.
Her daughter held her mother’s hand. Her mother looked at the floor; her expression was in a language I couldn’t speak.

It was the daughter who spoke. Two days earlier her mother had found her 14-year-old son dead in the family home. It was likely that he had taken a large amount of various prescription medications.

I was not equipped for this situation on so many levels that initially I felt panicked, I almost fled the room. I then thought of who I could pass this over to. I could contact the on call doctor. That’s what nurses do when they are out of their depth. But I couldn’t bring myself to leave the room.

So I stayed with the discomfort and said nothing. I was then overwhelmed with sadness. I felt like it was crushing my chest and in doing so it caused me to sob. Big, hot tears sprung up, rolling over my cheeks like mild acid. I had no control. I started to panic again. I had three young children at home, safe and loved. Since having children I had become horribly aware that a vulnerable passageway had been created that could potentially destroy me if anything fatal was to happen to any of them.

When I looked up we were all crying.

**What are the consequences of the actions described?** Both nurse and patients cried together.

**What are the intended consequences?** The nurse intended to offer a professional assessment and counselling service.

**What results are beneficial?** The nurse empathised through recognising his own distress.

**What results are not beneficial?** None is described in the story although the nurse’s first reaction was to leave the room.

**How could things have been done better?** The nurse could have contacted the on call doctor which was the usual practice for nurses “when they are out of their depth” but this may not have provided a better outcome for the patients.

**What results were unexpected?** The nurse was “overwhelmed with sadness” which allowed the patients to express their own grief.
What incidents or outcomes contribute to your understanding of mental health nursing? (The student is provided with a framework to appraise the key attributes within the role of the mental health nurse).

I have provided an overview of interpretations of stories that have been placed along a continuum from unsuitability-suitability for educational purposes. The final chapter, Chapter 6, centres on case study methodology as used in the present study. In part I am now reflecting on the value of the methodology for achievement of the study purpose. What follows that reflection on the study design is a closer interpretation of the findings, a conceptual framework and recommendations for future research.
Chapter Six

CONCLUSION

6.1 Significance of this case study for mental health nursing

The choice of case study methodology for this research was discussed at length in Chapter 3. Case study research is based on the wish to gain a detailed understanding of a single or small number of cases which are set in their real-world context (Yin, 2012). Some propositions in the form of hypotheses were made at the start and are listed earlier in this chapter; however propositions are not present in every case study (Baxter & Jack, 2008). No conceptual framework was made at the start of analysis, but the results can be simplified and summarised in the diagram of the pond shown later in this chapter.

Although Meyer (2001) felt that there are “virtually no specific requirements guiding case research” (p.329), this study uses the work of Stake (1995; 2005; 2006) and Yin (2004; 2009; 2012) to guide it, and the Data Analysis Template used in analysis of the one hundred stories is based on the work of two more case study researchers Tripp (1994) and McCormack (2000a). Meyer (2001) noted that because the details of design were not clearly specified by early writers on case study research (e.g. Yin, 1989; Eisenhardt, 1989), this becomes “both the strength and weakness of the approach” (p.389). Case study is useful when the question is “What...” or “How...” It is flexible but has sufficient rigour to enable reported findings to be credible. Data can be drawn from several sources as has happened in this study. Common sources are direct observation, interviews, archives, documents, participant observation and physical artefacts, an example of which is computer downloads of employees' work (Yin, 2012). The one hundred stories are the basis, but other material incorporated includes the researcher’s notes entitled Code Blue and Code Red, the summaries of the pilot workshop and the main workshop, the summaries of the student workshop, and my own writing over the years, with explanation of intended purpose of each story and with critical analysis of these stories demonstrating why they are not the best choices for use in the education of undergraduate mental health nursing students.

So this study has used direct observation of nurses telling their stories in workshops, group discussion rather than individual interviews, a personal memoir and extracts from
a collection of old letters as archival material, handwritten stories, emailed stories and published stories as documents, participant observation to some extent in that the researcher was present to take detailed notes at all three workshops and was known as a mental health nurse, although did not speak during the workshop, and in some sense physical artefacts as the stories do describe events which often took place many years ago but which represent the nurses’ work, frequently written in nursing report style. Triangulation involves establishing converging lines of evidence (Yin, 2012) and the workshop discussions of the meaning and purpose of the stories as well as the tellers’ own interpretations in a few stories and the students’ understandings of the purpose of a small group of stories are part of this. Binding the case ensures its scope is reasonable (Baxter & Jack, 2008). In this study the limit was 100 stories, with supplementary data from other sources to allow some triangulation. The detailed analysis of each story allowed a “deeper and richer look at each case” which allows the reader to decide about applicability rather than the researcher making claims about generalisability (Meyer, 2001, p.348). Case studies tend to generalise to other situations on analytic grounds rather than to generalise to populations on statistical grounds (Yin, 2012). The one hundred stories and their analysis allow consideration of their relevance and value if they were to form part of a much larger collection.

Data analysis revealed that the most valuable insights about the clinical and educational purpose of the 100 stories were gained from the categories of Events, Relationships and Moments, and particularly from the latter two. These elements are now elaborated.

6.2 Closer interpretation of the findings

People

A variety of people figures in the stories. Nurses, usually mental health nurses of various types, figure most frequently. Other nurses, doctors and allied health staff are mentioned. Patients (always so named in the stories) appear in most stories. Other groups include family members, and representatives of the law and the prison system.

Things

Lists of things mentioned in the stories occasionally tell a story in themselves; sometimes this story is congruent with the whole text, at other times it is misleading.
when read alone. The variety of things reflects the daily work of mental health nurses both inside and outside the hospital setting.

**Context**

Contexts show the move from the old institutions to modern mental health units based in general hospitals to community mental health work to the role of the mental health nurse in the prison and Court settings.

**Narrative Process and Language of Text**

Narrative process was most often report style and language simple and conversational. The exception was a memoir about the writer’s life as a mental health nurse which is exceptionally well written, colourful, witty, and often highly reflective.

**Events**

Events are one of the three most significant categories on the Data Analysis Template and range from the predictable (e.g. provision of personal care) to the completely unpredictable (e.g. a man throwing an Alsatian over the counter in a bank, a man breaking into a small rural voluntary mental health unit). Events give an idea of the situations a mental health nurse may face even when on a home visit anticipated to be a routine check (when the mental health nurse and the occupational therapy student were confronted by a man absent without leave from an acute inpatient unit and holding a gun).

**Relationships**

Most stories show a therapeutic intent even when the event was conducting an assessment or completing another process. The mental health nurses were not solely focused on finishing a standardized assessment form or doing a risk assessment. Sometimes the therapeutic outcome was not expected, and often the mental health nurses had regrets or concerns about their actions, even though the outcome was beneficial to the patients.

**Moments**

When considered with Relationships it is the Moments which show most clearly the purpose of telling these clinical anecdotes to undergraduates and new recruits. The most significant Moments are classed as unexpected in Chapter 4, but other important Moments are Moments of therapeutic communication and management. The dramatic
Moments are the most memorable, while the few stories which demonstrate Moments of self-awareness might prove the most useful for discussion.

Having provided an overview of the elements of the stories, I now focus on the workshop discussions because these provided the researcher as observer with greater insight into the motives for storytelling in the view of the tellers.

6.3 Summary of discussion by experienced mental health nurses in two workshops

A variety of reasons for telling stories were canvassed in the two workshops, the first a pilot workshop and the second a larger one held at the University of Newcastle.

Pilot workshop

MHN 1 asked, “Is it going to help me grow?”

MHN 2 spoke of the risks of storytelling, explaining that a story is “a director’s cut” and may be changed or be edited or highlighted, while MHN 7 felt that a story could “backfire horribly”.

Both MHN 4 and MHN 6 saw storytelling as a chance to improve practice, while MHN 2, MHN 4, MHN 5, and MHN 7 said storytelling was a chance to “make it real” and to “develop empathy”.

The whole group at the pilot workshop identified the therapeutic use of silence as an advanced skill in mental health nursing.

Main study workshop

MHN 2, MHN 9 and MHN 11 saw stories as a chance to “challenge assumptions”, while MHN 2, MHN 3, MHN 8, MHN 9 and MHN 11 said stories could “excite and interest”.

MHN 2 felt stories could “raise professional dilemmas”.

Highlighting recovery was another purpose identified by MHN 9 and MHN 11.

Demonstrating therapeutic skills such as managing hostility, risk assessment, being prepared and apologising were mentioned by MHN 2, MHN 3, MHN 8, MHN 10 and MHN 11.
MHN 10 and MHN 11 also felt stories can “show what is different” about mental health nursing and “validate” the work of mental health nurses.

Interestingly, three nurses (MHN 2, MHN 8 and MHN 11) said stories could be told to include student nurses in the team; while MHN 11 saw a use as reinforcing policy and procedure by showing what consequences can follow from poor assessments or unhelpful responses.

The findings from the third workshop involving undergraduates are summarised in Chapter 4. The voyage of ‘discovery’ for the researcher at the centre of this case study of the phenomenon of storytelling by mental health nurses has culminated in a heightened awareness of the phenomenon itself, the nature and purpose of storytelling. This has led me to the following statement arising from the research.
Analysis of the 100 stories using the Data Analysis Template, along with the insights from participants in three workshops, and the teller’s own interpretations in some of the stories, demonstrate that clinical anecdotes told by experienced mental health nurses do capture much of significance in mental health nursing. Some of the stories are of the kind which can readily be included in formally published educational events such as workshops underpinned by a particular educational design and by an appropriate framework for education and practice. However, each provides a realistic insight into “nursing in an imperfect world” and the need for mental health nurses to be able to draw on their knowledge and professional experience and their understanding of boundary issues and ethical practice to show “inspired creativity” in apparently improvising words and actions to benefit those who come into their care. This is the true educational purpose of these stories.

The stories depict incidents from the real clinical world of mental health nursing and allow the possibility of multiple interpretations or offer opportunities for focusing on varied aspects in discussion. They highlight what experienced mental health nurses select as key skills and aptitudes, as well as helpful attitudes, and also in some stories demonstrate the “deep level” mental health nursing skills only acquired after many years in clinical practice. Therefore the purpose of telling these clinical stories is both to highlight situations mental health nurses may encounter in the real world of clinical practice, and to demonstrate how experienced mental health nurses respond.

Johnstone (2013) notes that scenarios used in survey research instruments tend to lack “the equivocality and uncertainty” (p.25) of the true clinical setting. The mental health nurses’ responses in the stories are often improvisatory based on professional knowledge, experience, skill and a sophisticated understanding of boundaries and of ethical issues, and are rarely the type of response described in undergraduate
textbooks of mental health nursing. Most stories are open to multiple interpretations, and, depending on the pre-existing knowledge and ideas, the reaction to the story, and its effect on the listener, may serve as exemplars, as inspirations, as accurate depictions, as challenges, as puzzles or as intriguing insights into a world often misunderstood by student nurses.

The stories included in Chapter 5 show the types of stories which have ancillary purpose but which for various reasons are not useful for the education of undergraduates and new recruits, usually because they do not offer enough depth or opportunity for discussion or potential for multiple interpretations of events described. They do not serve as a catalyst for a better understanding of the context and clientele of mental health nursing.

As mentioned earlier, the 100 stories fell naturally into three groups. The first group were “surface” i.e. they were amusing or had historical interest or surprise but had little to teach about the clinical work of an experienced mental health nurse. This group might serve as an intriguing introduction to mental health nursing, giving an insight into the history of the specialty, allowing students to realise how it has developed, and also providing comic relief, which often captures an audience’s attention. The second group were “middle depth” i.e. they provided insights into the day-to-day work of mental health nurses with some “teachable moments”. They covered a range of mental health settings, from the old institutions, to modern acute mental health units in general hospitals, to community mental health, to crisis teams, to court, to prisons. This overall would be the most useful group of stories for providing a catalyst to learning for undergraduates because these stories present the opportunity to look into the many different settings in which mental health nursing care is given, and provide an insight into the challenges faced there. The third group were “deep”, i.e. they showed aspects of the essence of mental health nursing, and surprisingly, these stories very often included acknowledgments by the mental health nurses that they felt they had made an error, acted inappropriately, been “out of their depth”, or been pushed beyond what they had expected of the situation. In spite of the nurses’ misgivings, the outcomes of the interaction were always shown to benefit the person involved in the therapeutic relationship established. These “deep level” stories also showed the therapeutic use of silence, of tears and of apology. This group of stories is more suited to students who choose to specialise in mental health nursing, perhaps those undertaking an elective course as part of their first degree. If the metaphor of a pond is used to further explicate
this finding, the first group of stories are on the surface of the water, the second group are at the middle level of the pond, while the third group are found in the depths. Heath (1998) reminds us that the most challenging problems usually occur “in the swampy lowland of practice” (p.1054).

Figure 2: The pond

Given that the ‘pond analogy’ describes three levels of significance of the stories for educational purposes, I now need to focus discussion on those which remain.

6.5 The outliers – significance

The value of outliers in case study research is that they may reveal something which appeared insignificant initially but which later was recognised as being important to an appreciation of mental health nursing practice given that “Expert nurses link advanced clinical knowledge and judgment with highly evolved caring practices” (Benner, 1993, p.8). The collection of stories demonstrates both but even though Benner goes on to write about “the ethics of heroic care from a perspective of caring practices” (p.8) there are surprising gaps in the stories. Ethics are never formally mentioned though ethical dilemmas are presented. Highly evolved caring is frequently demonstrated in these stories but never defined or described as such. The possibility of rejecting the person in distress is not considered and in all stories the nurse works to establish a therapeutic relationship often in very difficult circumstances.
The Six Long Stories were unusual because of their length which, while allowing complexity, nevertheless described situations involving aggression and challenging behaviours, (Numbers 4, 94 and 25), the development of a therapeutic relationship (Number 13), the conducting of a difficult assessment (Number 65) and the need for advocacy while being mindful of boundaries (Number 68), issues which also appear in other stories.

Of the 100 stories collected and analysed, 12 defied easy categorisation and were unlike any other story in the collection. Number 8 is an account of the “imagined world of mental health nursing” before a student actually begins training; it is not a story, rather a comment on the difference between what was expected and the reality. Number 12 from the same writer is a short comment on a new male nurse’s confusion about his feelings for an older female nurse but concludes with an important statement both about the value of kindness in mental health nursing and the importance of having a good role model or mentor. Number 17 again from the same writer is a comparison between the old institutions and mental health nursing care today, with a realistic conclusion: “These institutions did not bring out the best in people”. Number 19, also from the same writer, describes a therapeutic community, and how society views “the worried well”, and reflects on the fact that women are usually diverted to clinics while men often end up in prison. The fifth story by this writer (Number 24) continues this reflection on the “inherent dilemma” contained in the relationship between the criminal justice system and the mental health system in management of offenders with a mental disorder. These five stories are outliers in that they are reflections rather than a description of a sequence of events. Number 27 (from the same writer) completes these series of reflections with a musing on image and identity and how this may lead to misapprehension: “The T-shirt, haircut and bike are a marker of something important”.

A similar reflection (Number 53) by a different writer looks at the role of the mental health nurse in the prison system and reflects on the difficulties of establishing a true therapeutic relationship in this setting. There is a brief “story” in this long passage but the majority of content is reflection (Bailey, in Nizette, McAllister & Marks, 2013, p.130). Number 54 is by the same writer and contains a very brief story about physical contact with a woman charged with murder but once again, the majority of content is reflection on being a change agent as a mental health nurse working in the prison system (Bailey, in Nizette, McAllister & Marks, 2013, p.131).
Stories Numbers 72 and 73 contain accounts of a student nurse being dissuaded from choosing mental health nursing as a career and were told during and as a result of the third workshop held for Third Year student nurses close to graduating. They are outliers in that they do not describe a clinical incident and no patient is mentioned, only nurses. One begins, “Biggest story I have absorbed is that ALL mental health nurses are lazy, and do nothing” (Number 72).

Another story (Number 83) from a mental health nurse working in a geriatric hospital reflects on the type of “assembly line” type of care delivered to geriatric patients in this old geriatric hospital and concludes sadly, “I miss the psych nurses – they at least prize individuality in patients and fellow nurses” (Number 83).

Number 97 is an outlier because it is the shortest story in the whole collection, only one sentence long. It raises the possibility of clinical anecdotes as tweets, or “short grabs”.

One of my young men with schizophrenia tried to sue Johnny Farnham for stealing his lyrics for “The Age of Reason” (Number 97, complete).

Overall, what the outliers have in common is that they are reflections on mental health nursing practice at various times or descriptions of older styles of care, rather than true stories with a sequence of events resulting in a Moment or a final Event. Two are really advice and opinions given to students on two separate occasions about a career in mental health nursing. A single story is an outlier because of its extreme brevity and may point to an educational technique for the future, where stories are so short that they can be tweeted to students as a way of triggering ideas for discussion later.

6.6 Comparison of findings with previous studies

The literature review showed that a great variety of methods are used in the education of mental health nurses, both undergraduate and postgraduate. These include lectures and tutorials, case-based learning, integrating theory and practice, clinical teaching guide for new clinical instructors, moment maps, use of critical clinical competencies, role plays, weekly critical thought paper, voice simulation of auditory hallucinations, standardised patients, an interpretive research group, books and films, simulation, a clinical clerkship, an entirely online course and digital stories. However it is narrative pedagogy which is most closely related to the use of clinical anecdotes told by experienced nurses to undergraduates and new recruits, because this pedagogy can
explore “the meanings and significances of clinical situations while holding everything open and problematic” (Andrews et al., 2001, p.255). It is “a gathering of all the pedagogies into converging conversation such that the possibility for anything to show itself is held open” (Diekelmann, 2001, p.53). Writing about the professional education of medical students, Coulehan (2005), says that to achieve this students need to experience professionalism as a collection of contemporary narratives which they follow either through the role modelling of other doctors or through stories and films. It must be “articulated as a meta-narrative that has developed over 2500 years as a summation of, and reflection upon, many thousands of actual physicians’ stories from different times and cultures” (Coulehan, 2005, p.893).

Davidhizar and Lonser (2003) noticed that students related success in learning to stories told in their classroom because they could associate facts with a story. ‘You told about what happened when you looked a paranoid patient in the eye too steadily and I never forgot it’ remarked one of the students (p.218). However the authors noted that little information was available to show how students actually perceived the use of storytelling by nurse educators. They list the benefits as enhanced self-esteem as students learn from the not always successful nurse-patient interactions described, the development of critical thinking, greater understanding of ethical issues, increased cultural sensitivity, provision of role modelling to students, and improved communication skills.

This study provides a collection of stories suitable for use in the education of undergraduate mental health nurses and also an analysis of the components of the stories to show what message the students might take from them and a discussion of what the purpose of the telling might have been in the first place, based on three workshops and reflections from some of the tellers of the stories. A suggested framework for discussion is included earlier in this chapter.

6.7 Deduction – generalisability

There are recurring themes in the stories, e.g. the development of a therapeutic relationship, the management of challenging behaviours, assessment of a new presentation conducted in taxing situations, use of silence, mental health nursing in new or difficult settings. A new collection of stories might show similar themes, or completely different ones, depending on the tellers and their areas of expertise. Generalising is not possible but neither is it the intention of qualitative research, though
as Yin (2009) remarks, case studies can be generalised to theoretical propositions (analytic generalisation).

In this study it is not possible to claim that saturation or informational redundancy has occurred. There are an infinite number of stories possible. It is unlikely that another 100 stories would yield redundant, minimal, or no new information so as to further challenge or elaborate the conceptual framework which Russell and Gregory (2013) see as data saturation. However the findings have been strengthened by some use of triangulation. In the three workshops, participants were able to interpret both their own stories and sometimes those of others, and to comment on their potential educational purpose. These interpretations and comments are presented in addition to the analysis based on the Data Analysis template. The stories presented in chapter 5 as not fit for purpose and the reasons given provide another perspective to the study.

6.8 Implications

Ten years ago Diers (2004), writing about the professionalisation of nursing, said that it will only come when nursing practice is professional, which will be achieved through “intelligent caring” (p.159). Raising educational requirements and implementing professional credentialling will not alone be enough even though intuition has been defined as “unconscious intelligence” (Diers, 2004, p.159). “Perceptual recognition of clinical manifestations is a form of skilled know how that is socially embedded and embodied” (Benner, 1993, p.4). The experienced clinical nurse is best suited for “engaged reasoning since clinical knowing requires immediate historical understanding, modus operandi thinking, and an understanding of the particular in relation to the general” (Benner, 1993, p.6).

This study provides a collection of exemplars of these skills with analysis and discussion. Some stories, however, remind us that “an initial acceptance of unknowing may help accept not finding solutions” (Heath, 1998, p.1057).

An effective teacher identifies an area for learning and then chooses what strategies will encourage learning. Perhaps this is a therapeutic alliance similar to that which occurs in psychotherapy between therapist and patient. The teacher can provide feedback to the learner, and acts as mentor. The teacher is engaged with the student and can understand the student’s perspective in the learning process. The activity is
relevant to the student’s needs, but the teacher allows the student to identify what needs to be learned (Ursano, Kartheiser & Ursano, 2007).

The crucial components of the stories (based on the Data Analysis Template) are People, Things, Context, Events, Relationships and Moments. Context is the crucial moderator of a story – the hearer needs to know who was present, the background, and the setting, as well as what happened; from this information comes a better understanding of Events, Relationships and of Moments. As Appleton (2002) remarks, “it is the phenomenon of interest and context that constitute the case” (p.86).

Students bring their own knowledge and experience to their understandings of stories. They are not “empty vessels” as Kirstin’s story in Chapter 3 shows. She had expectations of her first clinical placement in a mental health unit, however, as she shows, they were not met, and her experience with her patient was very different from what she might have looked for based on what she learned in the classroom. Even the RN1 who participated in the pilot workshop (MHN1) asked of a story, “Is it going to help me grow?”

The stories in this collection were selected by experienced mental health nurses to highlight what they felt was important about the profession. Stories can be a powerful catalyst for student learning, and during the workshops the mental health nurses both stated some reasons for their choice of story to tell and also discussed in general what might be the benefits (as well as the risks) of storytelling. The categories from the Data Analysis Template of Events, Relationships and Moments help to provide a framework for stories fit for purpose, as well as demonstrating that some of the skills required in mental health nursing are unique to the profession. Students may gain insights, consider difficulties and enjoy opportunities for discussion about real situations which challenged the nurses involved in them.

The outcomes of the study may lead to a regeneration of values and principles central to the best mental health nursing practice and empowerment of newcomers in the discipline of mental health nursing. The same values and principles and propositions apply to both education and practice. It is suggested that enhancement of behaviours within a therapeutic milieu (helpful or salient) translate to behaviours consistent with facilitating ongoing learning and empowering a new generation of nurses. The same concepts of collaboration, co-construction, and co-learning within the practice environment apply to the learning environment.
“Being in the here and now, side by side, co-constructing care” (Santangelo, 2014) is relevant not only to the mental health nurse’s work with a patient, but also to the mental health nurse’s role in stimulating enquiry and demonstrating professional skills when student nurses are present. Kirstin’s story (at the start of Chapter 3) shows what happens when this does not occur. MHN1 hoped to be able to “grow” from hearing stories from clinical practice, just as patients hope to recover.

So the stories can assist in exploring contemporary mental health nursing practice and when analysed they can provide stimulus material to act as a catalyst for student learning. The categories of Events, Relationships and Moments from the Data Analysis Template provide concepts which are relevant to both the clinical setting and the educational setting. Just as a new patient admitted to a mental health unit needs staff who are able to use a therapeutic Relationship to help the person manage Events and critical Moments in their life on their journey to recovery, so does the new student beginning a first mental health placement also need staff who can manage professional Relationships, and use the daily Events and the occasional critical Moment in the ward to provide a catalyst for learning about optimal mental health nursing practice. In this way, the therapeutic milieu of the unit becomes the crucial moderator for both patients and students.

6.9 Conceptual framework

The constructs within the conceptual framework therefore are Events as catalysts for learning and improving practice, Relationships as mechanisms for developing a deeper understanding of mental health nursing, and Moments as:

> “a disruption, a misfiring, a tangent, a digression, followed against the will of critical ordering, occurring in the vulnerable space which opens when the teacher re-envisions student resistance as an attempt to escape” (Feigenbaum, 2007, p.339).

These three constructs may be seen as common to both clinical practice and student learning and may be framed thus (Figure 3):
6.10 Areas useful for future research and applicability to practice

There are many possible directions in which this research could develop:

i. This study could be expanded and strengthened by making a further collection of stories, perhaps collected through the conduct of workshops in a hospital or community mental health setting rather than at a university, in order to capture a different ‘face to face’ interaction with a participant group.
ii. The stories could be presented to additional workshop participants to discover how a new group of experienced mental health nurses would interpret their meanings and how they could be effectively used in their roles in the education of undergraduate mental health nurses.

iii. A selection of stories could be published with the framework for discussion for use in teaching. This would provide academics and clinicians with richly contextual material for their teaching.

iv. There are also opportunities for collaboration with the Australian College of Mental Health Nurses who are currently collecting stories from their members to record the history and uniqueness of this highly specialised branch of nursing.

6.11 Recommendations and justification of recommendations

i. There is a wealth of stories related to mental health nursing practice but most are never written down. “Untold stories of nursing are lost opportunities to pass down nursing knowledge and skill, to transmit culture and practice, to explore the teachings and learnings of the stories and to preserve their contextual, historical and socio-political meanings” (Geanellos, 1996, p.28). Stories can affect student thinking in a way that traditional lectures cannot (Moon & Fowler, 2008).

ii. In a controversial article about the writing style of nurse researchers, Fairbairn and Carson (2013) recommend that storytelling in nursing research should be regarded as “a way of listening to and learning from each other” ((p.8), rather than as a way of data collection. Masters (2012), comparing memoirs written by physicians and psychologists to those written by nurses notes that while many doctors are good writers, only some nurses can write, and recommended that nursing as a discipline
needs nurses to write well about real life experiences working with mental health patients. The stories in this collection taken from one nurse's memoir belie this criticism. In addition, the workshop provided a framework to assist the nurses to construct their stories in a way that allowed their insight to be thoughtfully conveyed to the reader. They were also caused to provide a rationale for their storytelling. For some nurses, the workshops may have provided an incentive or encouragement to write down more of their clinical anecdotes, and to consider publication.

In a study of critical incidents experienced by second year mental health nursing students on placement, Fisher (2002) found that in most cases when students were able to examine the predominantly negative feelings which arose from the incidents through a structured reflective exercise in a non-threatening environment, they gained in personal growth and self awareness, and were able to resolve the conflicts which arose from their involvement in the critical incident. Rees, Monrouxe and McDonald (2014) recommend that nurse educators “share their own dilemma narratives” (p.10) with their students and do so “with emotion” (p.10).

INFORMAL STORYTELLING SHOULD BE USED BY ALL MENTAL HEALTH NURSES AS A WAY TO ENCOURAGE CRITICAL REFLECTION ON PRACTICE AND PROMOTE LEARNING AND PROFESSIONAL DEVELOPMENT.

iii. Many students cannot understand the concepts read in a textbook until they can relate them to actual clinical experience. There is “lack of engagement – it's not real” as Newton, Billett, Jolly and Ockerby (2009, p.322) found in a study of health professional clinical education.
iv. “Stories are *interpretations*” (Abma, 1999, p.169). Interpretation imposes an order on the events of the story and the events are connected by a plot, and this is the means by which different events are made into a meaningful whole. The events are selected, organised, connected and evaluated to be meaningful for a particular audience. “Storytelling interprets the world and experience in it” (Riessman, 2006, p.186). The sequence of events determines the plot, which is more important than the truth or falsity of the story. People tell their stories to find out how they should act in certain situations, how they relate to others, and what their role is. More significantly, stories “contain an evaluative or moral framework” (Abma, 1999, p.169). According to these insights about storytelling, these clinical anecdotes told by mental health nurses are a valuable resource for the education of undergraduates.
6.12 Limitations

6.1 This study examined 100 stories told by nurses whose first language was English. The stories were mostly set in Australia, though some were set in England, a few in Scotland and one in New Zealand. Stories collected from tellers whose first language is not English and from different cultures would capture different Events, Relationships and Moments, and show different results if analysed using the Data Analysis Template, because of the different Context.

6.2 A decision to use case study methodology was taken and justified in the chapter on Methodology (Chapter 3). However, use of a different methodology might capture different insights into the substance of the stories, for example, the use of Discourse Analysis might bring different perspectives.

6.3 Member checking and testing of stories as fit for educational purpose was done to a limited degree. Further workshops would provide more information about the purpose of the use of clinical anecdotes if told by mental health nurses to undergraduates and new recruits.

6.4 The study did not explore stories from nurses working in a mental health setting who were disaffected. Although it was unlikely that a project of this nature would capture the interest of this group of nurses or that they would volunteer to tell their stories or take part in a workshop, their stories might be very different from those collected and provide new insights, even if the stories were not the most suitable for educational purposes.

6.13 Conclusion

Stake (2006) reminds us that that first objective of a case study is to understand the case. Case studies investigate real life events and in their natural setting. The reader must be left with the understanding that lessons learned from a single case study are especially relevant because the case has covered “the specific steps taken to produce an exemplary experience” (Yin, 2004, p.252).

The case is the real life set of events which provides the data. This study uses the stories as cases or exemplars for cross-case analysis and the case study is of the phenomenon of storytelling by nurses to others in a mental health setting. Other types of material used include the workshops used as an educational tool to guide the
participants’ own reports of their use of storytelling, and other ways stories were collected, my notes as the analysis progressed, my own personal professional profile, the personal material in the final chapter, and the analysis using the Data Analysis Template. As this is description and explanation of a single case it is a particularising analysis. It can use previously known generalisations to help to make particular statements. However, genre is significant too, as genre influences “the expected outcome of a particular narrative construction by constructing a set of expectations for the hero and for the conclusion of the story” (Yin, 2004, p.176). The tellers of the stories were writing or telling for an audience which influenced how the story was told.

Textbooks may sanitise accounts of nurse-patient interactions in mental health nursing and may lack the credibility of true stories from clinical practice. These 100 clinical anecdotes told by experienced mental health nurses give insights into “nursing in an imperfect world” where patient behaviour may be unpredictable, where nurse-patient relationships are constantly evolving, where past history may be crucial to understanding the patient’s current situation but may not yet have been explored and where the setting for assessment, appointment or interaction may be unusual or difficult. The fact that in the majority of stories the nurses achieved a therapeutic outcome with their patients shows that their various ways of managing the often puzzling situations were effective and their obvious pride in the results for their patients and in the skill exercised in their profession may be the most significant message which undergraduates and new recruits take away from the stories. The stories show the priority given to the therapeutic relationship even under very difficult circumstances, and the 16 where the teller reflects on the meaning or purpose of the story demonstrate the nurses’ capacity for critical analysis of their work. They also show advanced skills in mental health assessment and capacity to tolerate taxing manifestations of mental disorders. Interestingly, aggressive behaviour is minimised and the focus is usually on the relational skills which helped to de-escalate. There is no story where the nurse focuses the spotlight on himself or herself solely as self-aggrandisement although Masters (2012) notes that self-aggrandisement may be an inevitable risk for the writer of a memoir. Rather the focus is on the result for the patient. Underlying many stories is a dry humour and the nurse’s ability to laugh at himself or herself. Often there is a passionate advocacy for the vulnerable and disadvantaged and a determination to continue to work with the patient to improve the situation. Equally there are stories where the nurse moves into a completely new setting for delivering mental health care and has to adjust, adapt and work within systems which may not be receptive. In other
stories the nurse challenges existing attitudes and practices among the staff. Storytelling can open up the possibility of seeing “complexity, uncertainty, contradictions and silence” (Chataika, 2005, p.5).

Educators who teach undergraduate mental health nursing students could benefit from this study by an increased awareness of their own reasons for telling clinical anecdotes about mental health nursing. By critically appraising their choice of stories, they may decide which are fit for purpose and which less so. They can use the framework provided in Chapter 5 in discussions with their students about the meaning and implications for practice of whatever story is being examined. They may choose a particular story (their own or one from this collection) to highlight a particular therapeutic attitude or skill. They may also contrast an episode of clinical care which did not demonstrate good practice or which had an outcome not anticipated or expected with a story from this collection which provides a better example. For those students who worry that they do not know what to say to their patients, or who fear “saying the wrong thing and making the patient worse”, there are many stories which show experienced nurses “out of their depth” or temporarily at a loss, but also show a good outcome for the patient as a result of what the nurse said or did. What allowed the nurse to achieve this good outcome could also be a discussion topic and lead to better understanding of the therapeutic relationship.

Making a very broad statement, Grassley and Nelms (2009) claim that storytelling may have global implications for nursing practice and research. If there is a common theme in all the stories, this “global implication” may be the knowledge, skills and attitudes required for “nursing in an imperfect world” in order to make positive changes both to the setting and to the lives of the people encountered by mental health nurses in their daily work, as well as to the students who enter a mental health unit for the first time.


Anna Elizabeth Treloar


Thorne, S. (2000). Data analysis in qualitative research. *Evidence Based Nursing* 3 68-70 doi:10.1136/ebn.3.3.68


Anna Elizabeth Treloar 217


University of Newcastle School of Nursing and Midwifery. (2009). Clinical reasoning instructor resources. Newcastle Australia: University of Newcastle /Australian Learning and Teaching Council/University of Western Sydney.


Young, P. (2004). Trying something new: Reform as embracing the possible, the familiar, and the at-hand. *Nursing Education Perspectives* 25 (3) 124-130.
Appendix 1: Stories - Numbers 1-40

Where stories are taken from published sources, references are given here, throughout the thesis when direct quotations are made, and in the Reference List; where stories were collected from workshop participants and other participants, the source is noted in a coded identification. In some stories parts of the text were omitted, either because they were not directly connected to the story, or because they identified the teller. Where these omissions have been made, ... has been used to show this.

Number 1

 Asked to assess a man in the court cells. Prison officers have three categories for the mentally ill – Captain Rats (psychotic), spinner (decompensating), arsehole (ASPD) [= Antisocial Personality Disorder]. The officers tell me, “You have a ‘right one’ – he’s Captain Rats”

The man has an underlying bipolar illness and had been using psychostimulants. Interviewing him was so hard due to his level of thought disorder. He was trying so hard to be co-operative but he could not stay on track. After about twenty minutes the medical student and I left. I asked her, “What do you make of that? She told me she had a headache. “The poor man, if I have a headache just imagine what it’s like for him?” (SE).

Number 2

 I nursed a woman diagnosed with schizophrenia for many years. She told me that she had a floating kidney. I had been taught never to confirm or deny delusions so never engaged her about this and would change the subject when she raised it.

It transpired that she did indeed have a floating kidney. She must have felt I had not heard or understood one aspect of her health and this shows how important it is to unpack delusions (ES).

Number 3

Anna Elizabeth Treloar
Discussing with nurse and JRMO [junior resident medical officer] the progress of two patients’ care. A man came over and asked what was happening with the two patients. Both young people had been assessed and accepted for admission to the acute mental health unit but there were no beds available at the time. (I thought the man was a bed manager).

The man said, “Can’t we put them in a room and tie them together?”. I said (despite my rising anger), “No, that stuff happened in the 1800s and now we have the Mental Health Act”.

At this stage I turned to the nurse and JRMO and the man walked away and I asked, “Who was that?”. The nurse said, “The ED [Emergency Department] consultant”. I was amazed and realised that [anti] stigma had not come as far as I thought! (RE).

Number 4

Breakout

This story is a story that I tell other nurses for a variety of reasons. It shows fairly extreme circumstances and how they were managed, through teamwork and luck; and also reminds me of a pivotal moment in my nursing career where I thought if I can survive this then I am able to work successfully in this environment. The situation occurred approximately within the first six months of my nursing career during my new graduate year. The setting was the local and brand new child and adolescent mental health unit.

The unit caters for young people from 5-17 and it was the afternoon shift, full and made up mostly of teens (I don’t recall younger children but they were not the problem) and mostly as always made up of girls.

The trouble may have been brewing for some time but the main issue started when about five teenage girls absconded via the laundry hallway. Due to the bugs not being fixed in a new building, if the showers were kept on without ventilation they set off the fire alarms and they open the fire doors. So in an organised plan they set up this to occur and then made a break for it. Myself and another nurse chased after the girls along a long corridor that was the contact corridor with the main hospital. We chased after these girls and negotiated with some to walk back and “frog-marched” two back. The tension upon return to the unit was palpable and security staff had arrived and we proceeded to manage everyone in the common area of the unit and make an attempt
to do a headcount. One male patient who had successfully absconded previously was thought to have escaped but was found in his room asleep.

Other events that occurred that night included managing the threat of having pool balls thrown at us, chalk from the pool table being thrown in our eyes and pool sticks being used as weapons. We removed some of these but had to restrain and remove some from people's pockets or their grips.

Some of the young people were being restrained on the lounges by security staff and this was upsetting other patients who began being verbally abusive to security and nursing staff. One girl punched a security staff member and I had to stop the security staff member from retaliating in a reactive manner.

To manage some of the patients, one of them was placed in the seclusion room. She was observed and during this time she ripped off the rubber strip around the window and attempted to strangle herself with this strip. During this time we were also trying to manage the majority of other young people and they were very emotional, angry, crying and aggressive. One of them told me to go in and help the young girl who was attempting to strangle herself saying “She is going to kill herself”, I had to explain that we needed to get other people outside of the seclusion area settled so that we could manage the girl in the seclusion room. We as soon as we could we entered the seclusion room and removed the rubber strip around the girl's neck and exited the seclusion room. We more than likely gave her IM [intramuscular] medication at this time as well.

The final part of this story was after some period of time three girls were still causing trouble of sorts and went past the fire door in the hallway in the unit and shut it behind them. While still managing the rest of the unit, we made a decision to follow them and bring them back past the fire door so we could observe them. The internal hallway has two other smaller corridors off it with the end of this leading to a short turn and another fire door, this one leads straight to the outside. When we walked around the corner we didn’t find the girls but a wide open door and the three girls were nowhere to be seen. I set up a chair near the door that was busted open and couldn’t be shut and eventually the girls were found hiding in the surrounding bushes.

The night ended late with lots of notes needing to be written, incident forms to be completed and considerable and worthy discussion amongst the nurses of the afternoon and night shifts in an informal debriefing of the night’s events (SR).
Number 5

Run with your client, not after

Chris was always climbing the fence, an eight feet high, chain link structure that surrounded the euphemistic “garden” on three sides. The fourth side faced the three storey, red brick ward that was home of sorts to a dozen people with learning disabilities and challenging behaviour, and half a dozen members of staff. Chris’s most prominent behaviour was “absconding from the ward” – the reason for his admission and an activity he engaged in quite successfully on a daily basis.

The escape itself was never witnessed. Chris would fade imperceptibly from the consciousness of the assembled staff and then suddenly reappear running full tilt away from the fence. The staff would then snap into action, our joint and single purpose to catch him and bring him back to within the confines of the fence. However, our prey stood more than six feet tall and, with daily practice, had developed the athleticism and speed of an ostrich. He could change direction in an instant with no evident loss of speed and could slow down and speed up with no suggestion of inertia.

We would break into smaller units and, running at breakneck speed, try to limit the available directions he might take. We would gather volunteers to the chase as if in a stampede. But catching Chris, despite our greater numbers, invariably took upwards of an hour. Pursuers would retire from the chase exhausted; sometimes entire shifts would change during the hunt. Ultimately, however Chris would be apprehended and, only partially subdued in a ruck of staff, guided back to the ward, where he would be carefully watched for the rest of the day while he returned our gaze as a scowl.

I don’t know how it happened, nobody does. Chris had breached the fence again, and somebody went to fetch him back. But this time the mood was completely different, completely at odds with the usual sense of crisis. Perhaps we no longer cared. Perhaps, somehow, we were inspired. Our solitary staff member didn’t pursue Chris. He didn’t barrel after him like a Pamplona bull. He just ran. Within a few minutes he was shoulder to shoulder with Chris and running alongside. And they kept running. They ran for a further ten minutes or so and then returned to the ward. Nobody laid a finger on Chris. Nobody said a word. There was a ten-minute run and then home.

There were no escapes after that. Just runs (Cromwell, 2004, p.1176).

Number 6

Anna Elizabeth Treloar
I remember my angst whilst working with a 16-year-old girl who had a history of violent assault and who would frequently present to counselling sessions with quite serious self-harm as well as suicidal ideation with plan and intent. It was challenging to try to determine the level of risk and the most appropriate response to ensure safety and maintain a therapeutic rapport.

In sessions, this young woman would often talk about her wish to die. She could not visualise any future for herself. However on one occasion when I asked about future plans and if she had any desire to travel, she spoke about wanting to go to Spain to go running with the bulls. Although a high-risk adventure, to me it was a ray of hope as she was giving some consideration to her future and had a plan for her early adult years. She is now 21 years, still hasn't been to Spain but is attending University and although there continues to be issues with self-harm and suicidality she is still making future plans (SS).

Number 7

It is a miserable grey morning, the type that the north of England has perfected. At 7 am I turn up for my first shift on a medical geriatric ward. The place reeks of cabbage, urine and despair. I try to fake the social orgasm and walk into the ward with a smile sponsored by sincere products. I expect a hive of activity. Instead I find a ward full of elderly people asleep in their own waste products. Then I hear an inarticulate voice from what I discover is the general toilet, shower and ‘sluice’ area. A broken crotchety old man is sitting on a commode chair, his hospital pyjama pants round his ankles, his skinny bottom collapsing through the commode seat. His face is lopsided; I later discover he has had a stroke so half his body was on strike. He was becoming red in the face trying to tell me to do something. I finally and sickeningly realise that he is saying “wipe my arse”... I scrounge up a suitable amount of hospital issue toilet paper (the stuff could take paint off a car, Christ help his piles), I move the commode chair forward and bend down to attend... The man had piles, no doubt he had sat on far too many cold paving stones, but his piles were certainly not the common garden variety prolapsed vein. These were a veritable bunch of grapes... This was a moment of truth, no one had seen me arrive I could just take off my white coat and sneak out and hope nobody sees me. But in hindsight this is the moment that I decided I could touch the untouchable... I suppose I did realise that this is what nursing assistants did, they wiped arse and after all this was a sad broken old man who could not manage it himself. So I wiped his bum and dry retched and when I looked up there was an
attrative woman in a nurse’s uniform, all the other staff had been at handover, hence my isolation. Without any fuss she acknowledged my presence, my name and the fact that I seemed to have already grasped a vital principle in nursing, we wipe arses (SE).

**Number 8**

At the tenderish age of nineteen, having been raised on a diet of the BBC, Coronation Street and more recently having developed an appetite for offbeat art movies, when I thought of psychiatric hospitals I imagined they would be staffed by kind people, who happened to be mostly female, single and interested in me. The staff would be psychologically minded and fascinated by all that ails the human psyche. There would be wise bearded psychiatrists with names like Dr Goldstein who often gave impromptu teaching sessions to captivated psychiatric nursing and medical students. Our working lives would regularly involve lashings of humour and pathos. We would enjoy our time spent exploring the causes of our patients’ madness and importantly soothing their pain. I mean let’s be honest, a large part of me knew this was more than a little unlikely but nothing could have prepared me for the reality of the environment I encountered (SE).

**Number 9**

Harold was a late-middle-aged psychiatric nurse who was apparently a bright and charming man with a measured love of the bottle until he cracked his helmet in a motor accident. This accident involved alcohol and a much younger married female colleague. Since his “accident” (as it was always referred to), Harold had been given to emotional dysregulation and his once fragile hold on sobriety was now past tense. During the course of his lecture on mood disorders he variously openly wept, went to sleep briefly, flew into a rage at a fellow student who he perceived had whispered disparaging remarks about him, and insisted we have a group hug at the end to consolidate our learning experience. It was by the second day that I worked out this was a do-it-yourself course (SE).

**Number 10**

My first and most memorable clinical lecture from Max was on the subject of pharmacology. Now considering that just about all we did for patients at that time was to provide copious amounts of pharmacology, I thought this talk could be most interesting. Max entered the tutorial room with the air of a man who knew much and thought even more. He then proceeded to sit for several minutes with his back to the
class. The silence was so heavily pregnant that it seemed when the birth arrived it
would be a breech. When Max turned to us he announced that ‘psychiatry has as much
to offer humanity as Charles Manson has to offer to the art of child rearing’.

He then produced a bottle of 50 mg Chlorpromazine tablets. He did this with the flair of
an overly dramatic magician. He told us that given we would be “doling out this shit for
the next 30 years the best pharmacological lesson we could have would be to take 50
mgs and go home”. He added that those who did not wish to do so could “stick around
and read a book of their choice”, and if they had trouble choosing he would do it for
them. There was more than a moment or two of disquiet. One of my fellow student
nurses, Lorraine, who was so straight she could only think in parallel lines, developed a
minor but definite facial tic. I went for option A and left feeling Max and I were kindred
spirits and would probably finish up drinking mates. I would be able to learn dream
interpretation at the Royal Duke.

Now, unlike every other substance I had voluntarily taken, Chlorpromazine was not in
any sense fun, and it never pretended to be. It was the first anti-psychotic drug; a major
tranquilliser used in the treatment of illnesses like schizophrenia. It flooded the brain
and jumped all over the neurotransmitters causing things like Parkinsonism. It didn’t so
much creep up on you; rather it plonked itself down on your psychic sofa and just sat
there taking up all the space and offering nothing in return. After the walk back to the
house during which I became increasingly detached from my surroundings that is
precisely what I did, I plonked in my living room chair.

That evening I sat and then sat some more. I complemented this advanced sitting with
dribbled saliva and blurring vision. Luckily the fellow student nurse I was so desperate
to impress did not come round as planned (SE).

Number 11

My first ward of my training was on Vickers 1, a male acute psychiatric ward, as
opposed to Vickers 2 which was euphemistically called a medium stay ward. In reality
no one was ever expected to leave the place and we all soon learned this. In the
seventies acute psychiatric wards were not dissimilar to any total institution. Bugger the
needs, dreams, aspirations of the patients; we had a ward to run. Beds to be made,
atrocious food to be served and pills to be dispensed. The day was structured and
orderly, God forbid that someone should actually require care and attention.
The charge nurse was a man from Northern Ireland called Thomas Mc----. He gave whole new meaning to the ideas of The Troubles. He was rigid, anal and anxious and tried in his own way to comfort his anxiety by trying to turn a ward full of patients with a wide spectrum of psychological sores into a well-run barracks. The psychiatrist responsible for the patient’s care was a Pakistani gentleman whose name I think I have repressed. He regularly misheard patients with broad B----- accents and detained people in hospital because he thought they were planning homicide when in fact they were there planning to murder a meat pie or a curry, a thing that many people of Lancastrian persuasion are given to saying. I later realised that the medical administration believed that Vickers 1 was the Gold Standard within our service because it was orderly, well run and came in on budget...

After a couple of weeks of day shifts to find my feet and jackboots on Vickers 1, I copped my first bout of night shifts. I turned up at ten pm with a bunch of text books and several packets of polo mints. I was mildly excited and anxious probably in equal doses. As a student nurse you were chaperoned by a registered nurse on night shift. God forbid if one of the patients should misplace their superego during the night.

This night I was to work with Vince. After the evening staff left there was still no sign of the enigmatic man and at cross shift no one made mention of the fact he was not present. I busied myself for an hour or so until Vince the man popped his head round the door of the nurse’s station and advised me “he was not to be disturbed”. Now I should point out that Vince turned out to be a considerable physical presence. He was 6’6’, black as the heart of a serial killer and he looked as if he could bench-press a football team with wet duffle coats on. The idea that I could or would disturb him in any way seemed farcical. I later discovered that Vince had seven beautiful children and a beautiful wife and was mercifully devoid of the ravishes of a work ethic. As a consequence he drove a taxi all day and ‘worked’ permanent nights and paid the night supervisor, Mr Brown, some portion of his wages so that he was “not disturbed” by anything such as his nursing duties or green student nurses like myself. Vince would make up his bed in the day room, smoke a couple of joints and sleep the sleep of the righteous and waken to the sound of his alarm clock exactly half an hour before the morning staff arrived ...(SE).

Number 12

I wanted desperately to be a good nurse and in order to be one I had to ‘know things’ about constellations and stuff.
Jennifer G------ was a very well preserved middle-aged psychiatric nurse who was one of the few people I wanted to be like, if I ever became a well preserved middle-aged psychiatric nurse.

She liked me; I fancied her and got all confused about her liking me, mothering me and sex. But that’s a few years of therapy, if I ever get round to it. Point was she encouraged both my tendency to be kind and to bat for the underdog. “If you start out kind, you can always learn more; but if you don’t start out kind, learning more’s impossible” (SE).

**Number 13**

Brian lay face down and placed both his forearms across the railway lines near Green Lane... As the train approached and passed him, Brian could not have flinched. Both his arms were severed at the same point, half way down the forearm.

The train did a surgical amputation. Well, that’s what the surgeons noted, they should know. Rather than bleeding to death, as Brian had intended, the heat and the force of the wheels dissected the bones and cauterised the major blood vessels. By the time the services arrived Brian was still conscious and voicing his disappointment at still being alive.

After the surgery, which amounted to little more than cleaning up the wounds, Brian was detained in a psychiatric unit in M------. Later when he was considered less of a risk to himself, transferred to Vickers 1.

The first time I met Brian was the morning I had to escort him to M------ Royal Infirmary. He was to see the prosthetic team who planned to rebuild Brian, or parts of him.

Brian was 32 years old. He was of average height but well under the bar for his weight. He was so emaciated that his pelvis held up his oversized pants. He had long greasy straw-coloured hair. From the look of it, what hair he had was leaving home soon. He had standard issue nicotine-stained fingers and teeth. In essence he looked like a caricature of a chronic schizophrenic, not that we are allowed to use terms such as this nowadays.

When Brian was 19 years old he apparently smoked his first joint. This was sufficient to unlock the hounds in his mind and his world would never be the same again. He had
older parents who were both academics. They were liberals and educated so it was perhaps not surprising that they adopted an anti-psychiatry stance. “Myth of Mental Illness” and “Asylum” were very influential books at that time. They did all they could to keep their son from involuntary treatment. Brian was meanwhile busy evolving a complex and dastardly paranoid delusional scheme which he did not want to share with anyone, why would he? His parents tried their best to manage Brian’s increasingly bizarre and often scary behaviour. He nearly burned down their very nice house when he did some radical rewiring of the houses electrics, to ‘improve security’.

One of the consequences of this protection was that Brian was quietly ‘bonkers’ for about two years before he talked to his first psychiatrist. He then spent ten years trying to make sure this was the last time he did. He drifted in and out town and mostly out of contact with the rest of humanity.

On the morning we met, Brian was still in bed with the ambulance waiting. You need hands to do so many things, as Max Bygraves so accurately pointed out. The first time I ‘helped’ Brian to dress said so much about his controlled passivity and my need to do for others and get to appointments on time. I hope I was not totally insensitive, I suspect I almost was, though I imagine Brian was getting used to this treatment.

In the ambulance I tried to converse. Talking with Brian was like talking to a full stop. You dropped over the edge and he was still standing there. I caught him watching me often enough to know he was not an empty vessel. He had a certain light in his eyes that made me certain he was still driving his own car and it was a manual.

A young woman called Felicity measured and calculated how best to put some mechanical pieces of plastic and metal to serve as Brian’s limbs. She was astounding. Her patience, technical knowhow, compassion and overall decency were like a slap in the face. I realised I had been surrounded by people playing at being professional for too long. It was like listening to an accomplished jazz musician after you have been strumming along three chord blues with your mates.

Brian soaked up her exceptional care in the same way he may have soaked up the train wheels, police brutality or a therapeutic massage, with controlled indifference. By the time we left I was inclined to amputate his lower limbs.

Because of shifts I didn’t see Brian for about a week. I next encountered him lying on his bed wide awake. I thought I was probably mistaken but there seemed to be the semblance of a smile on his poker face.

Anna Elizabeth Treloar
I remembered Felicity, I consciously moved sideways. I organised Brian’s clothes and then set about helping him dress. He recoiled slightly from my touch; I carried on, conscious of how intrusive I was and had to be. Touching his emaciated body was both repulsive and oddly enjoyable. For both of us, I suspected. I dispensed with my usual attempted banter. Words got in the way with this man. Slowly over the weeks some sort of tacit choreography and comfort developed. The prototype of his prostheses arrived and surprisingly Brian seemed motivated to move the robotic hand in a purposeful way.

After about a month Brian’s parents became aware of where and how he was. He had flatly refused permission for anyone to be contacted on his behalf. I knew for sure that one of the nursing staff had sought them out and informed them of the situation. I suspected because of his parents’ level of education and income an unusual amount of energy was generated. Numerous ‘case conferences’ were organised. Allied staff, who would normally not be seen outside the weekly ward round were now present in force on the ward. They formed an orderly queue to talk with Brian.

He was a true socialist; psychiatrist, social worker, psychologist, cleaner- he gave them all equal amounts of indifference.

The nursing staff were decidedly divided in their views of whether or not Brian was deserving of care, a common situation in my experience when a patient evokes strong emotions in care givers. To paraphrase:

C. Brian is a sad, isolated and lonely victim of his illness. His illness has resulted in him becoming seriously disabled after trying to end his tormented existence. He deserves and needs the best care to regain some improved quality of life. I feel so sorry for the parents who have suffered just as much in their own way.

D. Brian is a cold calculating PD (personality disorder) who controls everyone around him with his silence. There doesn’t seem to be any clear evidence to support a diagnosis of schizophrenia. His parents feel entitled and think their son is the only patient on the ward.

Over the next forty odd years I would see this dichotomy played out in all manner of clinical situations. Depending on the circumstances and level of sophistication of the staff involved, the underlying conflict of opinion might be obvious, or well hidden. Medicine and psychiatry aspire to moral neutrality, so it should. But ultimately we are a
bunch of people dealing with another bunch of people. It is probably inevitable that the idea of the deserving or undeserving will come into play when dealing with patients.

Brian, being Brian, decided to end the issue. Once the attention dimmed enough he vanished. He left the ward, his prosthetics and people’s opinions behind. How far could a man without hands get? Where could he go? How could he cope? As far as I know these questions were never answered.

It’s likely he finished what he started. Whatever else was driving Brian, I always had the feeling he an intense need to be in control (SE).

Number 14

James, or ‘Jimmy’ as he was universally known, was a man who had been in hospital as long as anyone could remember. As a result his case notes had the volume of “War and Peace”, if not the complex plot and literary quality. Jimmy received no visitors and he didn’t seem to mind or notice. He was tall, thin and wherever you encountered him you could be sure he would have the same pinstripe, threadbare suit on, plus a cigarette and a cup of tea on the go. By the time I arrived as a student nurse on Vickers 2 (the medium stay ward) there had apparently been numerous attempts to remove Jimmy’s suit, usually when he was asleep. All had failed and it seemed that we had decided to wait until the suit disintegrated and removed itself from Jimmy. I for one was not going to hold my breath as I suspected Jimmy did running repairs on his favoured garment in the quiet of the night. I had found out that he was a tailor before he became mentally unwell.

Jimmy had what we would these days call treatment resistant schizophrenia. That is, he had the kind of schizophrenia that no anti-psychotic medication had ever put a dint in. Essentially, Jimmy was either asleep or actively psychotic. Like many of the patients on Vickers 2 he kept up a relentless dialogue within his own head. He had two- and sometimes three- or four-way conversations with the voices in his head and the people around him seemed far less engaging to him.

In those days staff were told to ignore a patient’s delusions and auditory hallucinations and in theory staff were to reward behaviour that related to the real here and now. It was widely believed that to acknowledge a patient’s delusions and voices would somehow reward and encourage them. In the case of Jimmy, for most staff, this translated into an excuse for staff to completely ignore Jimmy, all of the time.

Anna Elizabeth Treloar 232
As a keen student nurse I found sitting in the nurses' station talking about Wanderers' loss on the weekend had limited appeal and much to the disapproval of older, more experienced staff, I tended to spend my shifts sitting and attempting to engage with the patients. The older staff would counsel me and tell me that “I would soon learn”. Interestingly in 2008 I took part in some research with University-trained nurses who had decided to work in mental health. The research took the form of regularly meeting with the new graduates to mentor and record their first clinical experiences as mental health nurses. Surprise, surprise, these nurses reported identical experiences and were still being told by those wise and experienced nurses that “you will learn”.

Anyway, another idiosyncrasy of Jimmy’s was his compulsive drinking of tea. I often found him pouring boiling water on to packets of tea into the sink to make a super pot. He then added monstrous amounts of sugar and scooped it out by the cup full. Fearing he would be interrupted, his arms would operate like pistons as he drank more than his fill. The fact that this behaviour was potentially very harmful to Jimmy’s health was not given much consideration. Of more concern to the staff was the fact that each ward was issued an allowance of precious commodities such as tea; Jimmy could use up a month’s worth of provisions in a day and cause the unthinkable. A psychiatric ward with NO TEA! Staff approached this problem in their usual sophisticated and psychological way. Locks, keys and threats to Jimmy.

When Marsha was made aware of the situation she took a psychological behavioural approach. Paradoxically called flooding. She argued that if Jimmy had unlimited access to his stimuli it would lose its hold on him. So for a trial period Jimmy was given the key to the land of unlimited tannin. Jimmy was admitted to a medical ward within 24 hours. He drank so much that he flushed out all the salts from his body and he became very ill and was transferred to a medical ward. Oops, back to the drawing board and I must say the credibility of psychology was put back for many years (SE).

**Number 15**

In April in my second year of training, I was doing a stint on Vickers 2 when that dreaded time of year came, holiday time... The hospital had sent one student and one registered nurse along with ten lucky patients there for the past five years...

Given that you were effectively at work for a week solid, without overtime or time in lieu, being selected for the -------- gig was usually a disciplinary move in the case of the registered nurse, and, in the case of the student, a serious vote of no confidence in
your future at T-------. Another student and I had recently grassed up a nasty ‘old school’ nurse for cruelty to an elderly patient. He eventually got fired but we got instant Coventry. I was told in no uncertain terms that “You won’t amount to anything ------- ‘cause you don’t understand loyalty”. 

Being enlisted, I got to spend the week with Brenda C-----. For her part, she had always been found wanting in the area of humanity and tact but more recently in the area of being able to count Schedule 8 drugs. Now Brenda was a type of psychiatric nurse that I am sad to say is probably a global phenomenon. When you first met her she was kind of sexy in a peroxide way. She had a good body, a face that threatened to be pretty on occasion and a snarl that said “I know you all want to shag me, well you can’t”. This said, if you spent more than half a shift with her you soon stopped noticing her physical attributes and started to pity the ground she spat on. On a good day Brenda had the psychological mindedness of a bottle top, the kindness of a coat hanger and the warmth of a toilet seat in winter. She liked nothing better than to quietly and passively enrage a patient to the point of violence only to stand back and watch someone else cop her handy work...

Brenda made it clear to me from the onset that she had no intention of walking around the town with this bunch of bedraggled losers (that’s my interpretation of what she said, I will not repeat her words); “You look the part, you can do it”, she ordered me. She would give out the pills and ration the cigarettes based on her whims and menstrual cycle. She then commandeered the only decent bedroom and bed. I was left with a camp bed in a room so tiny that my thoughts had to sit on top of each other. The camp bed I was given was left over from a medieval torture chamber, usually next to the iron maiden which I suspect was often preferred. I walked around like an arthritic banana for weeks afterwards. My closet was right next door to the male patients’ dormitory. I don’t think Pink Floyd at the height of their imagination and acid-taking could have produced the sound track that came from that room... (SE)

Number 16

About 8pm an ambulance arrived with an elderly woman to be admitted involuntarily. I do not use this term lightly. Elsie C------ was the lady in question. The attending ambulance men had the look of people who had just witnessed their entire families being executed before their eyes. It is the height of political incorrectness to say someone is barking mad, but I can safely say that Elsie was. She entered the admission area restrained in a wheel chair and she was barking! Not the dry yap of the
excited Jack Russell, it was the dark bass tenor of the Irish wolfhound, under threat and possibly on its last legs.

To this day I don’t think I have seen anyone in such a state of displeasure, distress and general neglect. We were told she had no known living family; no teeth and her dentures were AWOL. She was covered in lice, scabs and multiple layers of decaying smelly material that may have been at one time clothing. Given her garb and the wizened appearance of her face she did not look entirely human.

The ambos [ambulance officers] said there was a multitude of other animals in her house, some of which she may have known about and some which may not have been catalogued to date. The RSPCA and the B------ Museum would be busy for a while. It seemed that no other human had entered her abode for many years until those unfortunate ambos did. Elsie had a stockpile of tinned food. Her milk was delivered and paid for without human contact, along with other essential bills. The neighbours, none of whose houses were physically close, knew she was in the house but they had given up on trying to make contact. She never left the house and she would never answer the door.

Being definitely nil by mouth, Elsie was given a double scoop of intra muscular antipsychotic medication, into what she had left that could be called muscle. Considering her body weight and her poor health, it took an incredible amount of time for her barking to become more like snoring. The restraints were cautiously removed. She then had to be undressed, deloused and bathed. ... I remembered that Janice was working on Vickers 1 next door. “It would be much kinder to have a female present ....”

Janice was a joy to work with. I believe we did a good job, after we had a mostly clean, though cadaver-like Elsie dressed in a standard hospital nightie propped up in bed with a drip in her arm. Why did I keep thinking about the Bates motel? We had a large plastic bag full of clothes for the incinerator. Even though it was well past my knocking off time, I hung around with Janice. I had always wanted to but had previously lacked a valid and noble reason to do so before. We went to burn the contents of Elsie’s unique wardrobe. When I came to toss Elsie’s corset into the flames, I paused. It seemed much too heavy. Not only was there something odd about her having a corset in the first place. Then it was the weight and shape.

The whale bones inserts had been removed, the empty spaces filled tightly with large denomination bank notes twisted in tight tubes. With difficulty I removed the contents of
a single tube. A preliminary count would estimate Elsie’s corset could solve both Janice’s and my national debt for the next few years. Come to think of it, that of some small African nations. We looked at each other...

Elsie died two days later. No one claimed her money which amounted to 8542 Pounds (SE).

Number 17

If like myself you have been working in mental health since the early seventies up to the present, you have witnessed changes that would have given a mediaeval human a seizure, or at least a panic attack to last his entire life. I caught the tail end of the large psychiatric hospitals, the ‘Bins’ as they were fondly known. We had a generation of psychiatric patients, many of whom remained in hospital not because of symptoms of their mental illness, but because they had lost the necessary skills required to live out in the world.

I trained at a time when it was widely believed that mothers caused Schizophrenia with their pathological mothering (well they are responsible for everything else, so why not?). The seventies were a time when we gave ECT like we had too much electricity and insufficient light bulbs. The pills we gave people had the subtlety of a jackhammer and we dished them out in crude amounts.

The combination of better pills and the realisation by health economists that we had far too many people living in hospital brought about a strong push to close the bins and reintegrate psychiatric patients into the community. This closure of the ‘Bins’ meant that these psychiatric patients had to go somewhere. From a Minister of Health perspective, it had to be somewhere that cost a lot less than a financially cumbersome psychiatric hospital. In reality this meant supervised accommodation in the community. The loonies came to a suburb near you.

Today I regularly hear the people talk of the ‘good old days’ of large psychiatric hospitals. All I can say is that if you voice these sentiments, just like if you can remember Woodstock, you probably were not there, or if you were you have the compassion of a rusty bicycle chain. It is all well and good to idealise these ‘asylums’, but at the end of the day they were total institutions, in the way that Goffman so accurately described them. These institutions did not bring out the best in people. Few patients thrived and unlike in the movies few produced interesting art work or put on operas. They ate, slept and often paced within the walls of the institution. The staff who
manned these places were every bit as institutionalised as the patient, just a different flavour. Not a good look for our species (SE).

Number 18

Across the Great Divide

In the UK in order to become a RMN (Registered Mental Nurse) in the 1970’s you were required to successfully undertake two placements in a general hospital, in a general surgical and medical ward. I suppose they wanted us to be, at least, a bit like a proper nurse. Although T-------- was in the same grounds as B------ General Hospital we managed to maintain a barrier between psychiatry and general medicine that would have impressed any infection control. There was a longstanding and firm belief that psychiatry was the poor cousin, along with developmental delay. They hated their corresponding placements at T--------, because ‘there's nothing to do’. In the eyes of the efficient task-orientated Florence Nightingales, most psych nurses were:

- Male
- Useless
- Lazy
- Impractical

All smoked, just like the patients they supposedly looked after. I heard one nurse describe us as ‘as much use as an ashtray on a motorbike’. Most of my fellow students looked forward to their general placements with the relish of cuddling a rabid dog who is holding a toilet brush between its teeth.

For my part, I could not believe my luck. Here I was, an essentially shy, anxious, unconfident lad who could no more chat a girl up in the pub than I could dance the lead role in “Swan Lake”. Now almost every working day I got to spend with attractive, mostly single women. You didn’t have to shout to have a conversation either, there was no disco music blasting. However, there were lots of secretions and excretions to be extracted, poured, measured and disposed of (SE).

Number 19

Anna Elizabeth Treloar
I had no way of knowing at the time but M----- Clinic was considered by many people in

town to be an anachronistic throwback to the 70’s ‘encounter days’ run by people who
could smell a ‘group’ at a thousand paces and wouldn’t know a ‘real’ lunatic if they did
a Latin American dance on their laps. Although the ‘clinic’ was part of the public mental
health system it did not have gazetted beds, hence you could only be a voluntary
patient. In the eyes of the rest of the staff in the local public mental health system this
meant the clinic had the credibility of a current Irish Minister of Finance. For God’s sake
psychiatry without coercion, that’s like ballet without tutus. The clinic’s patients were
unkindly referred to as the ‘worried well’. Given the types of lives most patients had
experienced I always found this a bit rich.

Most of the clinic’s inpatients were female and had usually experienced various
degrees of abuse, neglect and trauma as children. This had left their neurobiological,
emotional and social health compromised. I often wondered why the clinic had evolved
into a mostly female unit. I suspected that most men did not to take to the endless
‘groups’ and the emphasis on personal responsibility for change. In my experience
damaged and damaging men generally see the loci of control as being ‘out there’. “If
only my mum, my girlfriend would stop behaving like that then I could stop feeling bad
and get on with my life”. Interestingly when I started to work between the criminal
justice and the mental health systems the ratio of boys to girls was a mirror image of
the clinic. The men I began to meet in the cells had identical developmental histories to
the girls in the clinic. It seems that if you expose little boys and girls to the same sort of
malarky you get two different broad outcomes.

The clinic ran as a therapeutic community (for a detailed explanation of this you will
have to find an old psychiatric text in the ‘outmoded ideas’ section of the library).
People lived together and attended daily groups run by skilled facilitators who used the
daily rough and tumble of the clinic’s life to help the patients identify their general
pitfalls in relating to others. The theory at least was simple; some people have not
learned how to effectively relate to themselves or others. So patients inevitably bring
their bags of dysfunction to the clinic with them and the staff assist them in learning
some new, more effective tricks. I heard this process likened to flight simulation.
People could experiment in their relationships with other patients; it was safe because
the relationships stayed there.

After my first shift I said, “What a load of bollocks”. I stayed for the next ten years and
learned some new tricks (SE).

Anna Elizabeth Treloar
Heidi walked into the staff room, sat down without being invited to and told me, “Andrew has been taking me back to his flat, giving me cocaine, fucking me, handcuffing me and taking pictures”. She was a fifteen-year-old patient in the M----- Clinic, it was 2.30 am and I was on a night shift. I had been sitting there with a bunch of stale neurotransmitters doing a Mexican standoff in my brain. I was at that point that anyone who has worked the night shift knows only too well; only being capable of looking at the pictures in “New Idea”, the stories being too academic to tackle. I did not want to hear this, especially if were to be true.

Two weeks earlier I had been on a morning shift when Andrew M----- had been brought by the by the police for assessment. Being a morning shift, my brain chemistry was viable, I was up to the job. Andrew M----- had been brought for assessment because, although he had almost certainly breached an order protecting his estranged girlfriend from him having contact with her, the attending police were worried about his mental health. Was he more in need of help than punishment? Perhaps? Well as the ‘triage’ person, I would help decide.

I spent the next thirty minutes interviewing this unremarkable man. He was 32 years old, a nurse and had recently come to Newcastle from Brisbane “for a fresh start”. Things had started to go wrong with his new relationship some weeks ago and he was “simply not coping with work and life”. He described symptoms indicative of a depressive illness that had either already set up shop in his head or one that was applying for planning permission from the council. I thought he was a bit of a needy wimp to be truthful but he was a nurse, and he did seem to have had his heart broken (I am a sucker for the broken heart syndrome). My overall impression was that he was a rather bland man. After some consultation with the psychiatrist whose name was on the beds we decided to admit Andrew to hospital for a better evaluation. Andrew was thankful and accepted the offer. Because he had only recently started work he did negotiate to try and go to work three days per week. One of the ‘strengths’ of the clinic was its flexible approach to patient care.

The attending police left without following through with charges. No doubt with some relief that they could avoid the paper work and perhaps some reassurance that Mr M----- would get some help.
Heidi explained that Andrew “knew things about everyone” and he had been “getting people to do all sorts of things”. As Heidi was telling me this it turned out that’s exactly what Andrew was doing. He had used his connections within the patient group to find out in advance that Heidi was going to “talk”. By the time I went to check on him he was long gone.

Over the next couple of days the fog that Andrew M----- had conjured up began to clear. He had had sex with at least three patients, on one occasion up against the wall in the room next to the staff room whilst staff were at cross shift. He had borrowed money and exchanged confidences with almost all the female patients. He had done so without raising so much as an eyebrow from any of the professionals at the clinic. Professionals who would pride themselves on being kind, smart, observant and savvy judges of human kind.

Given that Heidi was a minor, a complaint was made to the police. When they attended his rental flat, he was a ghost. After much gnashing of teeth and self-flagellation by both staff and patients alike, things started to return to something akin to normality at the clinic. Though for weeks I did keep stepping on skins that Andrew had shed and left behind. I imagined that would be the last we would hear of the enigmatic Mr M-----.

A month later the body of a young English tourist was dragged out of Lake M-------- by some fishermen. The man had apparently been murdered by a man and woman who had hired a yacht with the dead man days earlier. The dead man’s bank account had been cleaned out. A picture was posted in the N--------- Herald – it was Mr M-----.

The article went on to explain that Mr M----- was an escaped prisoner from Queensland’s Boggo Road prison. He had managed to hightail it from the clinic after he faked a medical emergency. He then fled to NSW and morphed into another identity. There was no mention of his brief stay in the M----- clinic.

Mr M----- then found his way into the clinic. This was unfortunate for the vulnerable woman he encountered.

Should the staff have smelled a fox and sensed his motives? In our defence when you work with damaged people you have to find a way to be optimistic about their situation. This involves a presumption that we are all motivated by the same needs and wants. There are few Mr M-----s, as far as we know. So it is probably necessary to presume the best in others.

Anna Elizabeth Treloar
The more I thought about the situation and my small part in it, the more relieved I was to be a neurotic, needy person who craved the affection and love of others. I don't want to be a fox (SE).

Number 21

To complement the inpatient Unit the M----- Clinic offered a 24 hour walk-in and talk service. Crisis Contact Assessments or CCA’s were one of the most interesting aspects of the work there. I suspect that because the clinic was not part of mainstream mental health services, [people] felt much more at ease about walking off the street and exposing their mucky psychological underbellies. Families often came on masse to thrash out conflicts that had sometimes been festering for decades and being people they wanted it sorted then and there by someone they had only just met.

One Saturday morning two women walked in off the street. They were well preserved and obviously well to do middle-aged women. The cost of their clothing alone would have kept a small Afghani village in small arms for a year.

In counselling work there is the important concept of the Prisoner. Many people go along to get help not because they are genuinely motivated to change the way they relate to themselves or others, rather they are there because some significant other in their life has said, “You go and get help or I am out of here”. Counsellors ignore this phenomenon at their own peril. I suspect there is a mountain of psychologically wasted energy somewhere the size of Western Australia which formed as a direct result of clinicians missing the actual agenda of the person sitting before them.

Mrs J------- and her mother-in-law had come along because ‘things needed to change in her marriage’. Well that was as much as either party was willing to say. I became anxious when it became apparent that Mrs J------- had adopted the persona of a hostile dependant, a petulant eight-year-old in the company of her critical mummy.

I invited her in to talk in private; she took the opportunity to sulk in private. I then invited her mother-in-law into the equation who took the opportunity to talk about Mrs J------- as if she was presently holidaying abroad. She was one of those women who use words like a camouflage jacket.

By this time in my working life I was wise enough to avoid the psychological quagmire that these two had just invited me into for a swim. I simply sat as the silence took on a life of its own and one for which antibiotics are usually prescribed. Then without any
foreplay Mrs J------stood walked into the centre of the room. She violently removed her wedding ring and placed it on the floor. Having done so she squatted over the ring like some shaman and parted the gusset of her knickers. She dribbled trickles of urine on the ring. Having performed this highly original and unexpected routine, she returned to her chair as if nothing had happened and continued to sulk. Many quips jumped into my head at this point, and as any of these if vocalised could have resulted in my deregistration, I chose to leave them there. Mrs J------’s mother-in-law shot me a glance that said, “This has not happened, we have never been here”. She then hoisted her daughter in law to her feet and they left. Now how do you write that one in the notes? (SE).

Number 22

Late one Saturday evening three people rang the afterhours bell to the clinic. You entered the upper floor of the clinic from the street by way of a large glass door that was locked from the outside. Being a voluntary establishment the door was never locked from the inside. At the door was a Gary, a handsome young man, his stunning girlfriend and her father. They all entered gingerly, but it was Gary who seemed the most anxious and he was the focus of the others’ concern. After some social foreplay I took him to a private room and tried to both put him at some ease and to get some idea as to why they had come along tonight.

He was fidgety, taciturn and he seemed suspicious of what I considered open-ended and non-threatening questions. My psychological antenna began to do a gymnastics routine. He seemed decidedly paranoid and distressed and importantly most unhappy about being in the room with me. I acknowledged his discomfort and asked if I might invite his girlfriend and father to join us and tell us about their concerns. To date I had managed many years around people in altered states without being clobbered. I generally put this down to primarily good luck, followed by being respectful, decent and not least of all, trusting my antenna. I stood to leave the room, expecting him to stay and wait. Perhaps not surprisingly he followed me out into the waiting area where both parties were sitting just by the door. I vocalised my concerns openly and the plan for a joint consultation. The young man stood facing the door; you could have bounced a penny off his aura. His face was blanched; his muscles rigid and his pupils decided they wanted full occupancy of his eyes. His girlfriend glanced at her father and then stood up. I think she was planning to physically comfort Gary. At this point he sped to the door, gaining more speed and momentum than I would have ever thought humanly
possible given there was only a few meters available to him. The door which of course could have been opened with a press of the handle, had a 10-centimetre steel bar running horizontal at the level of the handle, about halfway up the door. The door was heavy and this bar was to assist its opening. This meant if you ever planned to leap through this formidable door, not only did you have two and a half centimetres of glass to contend with, you had to either go under or over the bar, not great options.

Now if in some parallel universe I had been asked to coach someone to leap through this particular door, I would have trained the person to do exactly what Gary did.

1. Not for one millisecond did he hesitate.

2. He leapt over the bar shoulder first, head tucked.

3. He gained enough momentum to be ahead of the glass as it shattered.

4. On landing he executed a perfect tumble.

5. In one graceful movement he was on his feet clear of the debris.

After performing this amazing feat he ran like the hordes from hell were chasing him for his soul. I turned to the others, a small part of me expecting to see them holding up cards with a perfect 10 on show. In fact they were sitting mouths ajar looking astounded and distressed. Given that no one other than Carl Lewis equipped with a Taser stood any chance of successfully pursuing and then negotiating with Gary, we retired to a room to discuss what had been going on.

What had been going on was that Gary had been consuming enough amphetamines to give a park bench psychosis. He had not slept for several days and in the process had used up all the neurotransmitters he would be requiring over the next week. To add to it all, he had formed some odd ideas about his girlfriend and her father which would have had Freud ignoring Anna for a week. I rang the police because whilst there was no obvious blood we didn’t yet know if Gary was injured or if he meant harm.

Within the half hour before his girlfriend and father had left I received a phone call from Gary’s grandmother who lived in a suburb far away enough to mean Gary had either got a taxi or he had continued to move at the pace we last saw him going at.
It emerged that apart from a slight cut on his foot he was unscathed. His gran managed to settle him (SE).

Number 23

Michael was a 22-year-old lad who turned up to the M------ Clinic without an appointment in a right old pickle one Tuesday afternoon. He was tearful, trembling and oozing despair in a quiet, noble sort of way. He was physically beautiful and wearing tasteful, casual clothing; his hair had recently seen a haircut that would have put a hole in a hundred dollars. Whatever scent he wore was sophisticated and of obvious quality. It subtly spread around the room making it a more pleasant place to be. I normally feel perfumes and aftershaves in my eyes.

Michael was unable to speak for a long time. I would begin to ask him a question, he would try to answer but due to the level of his distress he would finish up gagging on his words. His tears and snot blended like only snot and tears do.

Michael was a lad who had always known he was exclusively homosexual. In psychological parlance his sexuality was ego-dystonic. So much so that when the objects of his desires started to get a clear focus, he was repulsed. He rewound the movie over and over again hoping for a different role for himself and a different cast for his life’s movie. Around this time his anxiety, which had always been jockeying for supremacy, moved into the driver’s seat and adjusted the seat and control panel. It was not the kind of chauffeur to have.

He was the only child of parents who gave him everything and nothing in equal amounts. This left him with a neutral emotional bank account and a lack of confidence. Once he knew he was ‘queer’ he felt cursed and guilty about feeling cursed about feeling guilty.

He was a bright, diligent and careful student who got enough marks on the board to do almost any University course. All the courses he considered failed to interest him. He opted for the least competitive one which was least likely to cause him to become employed. By the age of twenty he had made an art form of avoidance. The fact he had never had a physical fight or consummated a relationship was proof of his unwillingness to get anything dirty.

About a year before he met a girl on his course who made a move on him. She should have known he was too good to be true. He neither rejected her come-on nor
encouraged it. After a long sexual Mexican standoff she became ‘his friend’. Though from what he said she seemed to harbour the scorned woman’s syndrome covered in paisley. When a room became available in the share house she lived in she invited Michael to fill the gap. He bravely did so, tolerating a benchmark of anxiety that would have probably destroyed a ‘lesser man’. He did however lose weight and many hours of sleep.

In the following six months he worked hard to tolerate the other lads in the house who threw their Y chromosomes and dirty underpants around. From the way he described them they were boys whose parents had told them from day one they were special because they were special. Michael felt outside the group for the most part but for the first time in his life he had some sense of inclusion.

On the morning of the day he presented to the clinic he had come home early from Uni because a lecture was cancelled. He was in his bedroom at the back of the house reading quietly, as was his tendency. His flat mates returned. He heard the boisterous shenanigans of the boys and girl even before they entered the house. Then he heard his name mentioned. His flatmates had no idea he was home and so they were giving free reign to their thoughts about him. He sat still not wanting to listen but feeling he could not now walk out of his room, they would all know he had heard.

His flatmates articulated his greatest fears about himself. He said it was as if their voices and thoughts were inside his own head. He felt like the new sense of himself as being a bit all right ‘was being deconstructed’. He gagged and nearly puked. He had to escape the room. He quietly opened his window and manoeuvred himself to the drainpipe. He lowered himself down to the back garden, quietly opened the gate and fled.

With nowhere else to go he presented at the clinic (SE).

**Number 24**

In 1997 I took on the role of the Court Liaison Nurse for ***** Mental Health Services. This was the first of its kind in New South Wales and the money to fund this position came about from the Burdekin report into deaths in custody. However, it should be pointed out that for many years in other Australian states and in similar countries to Australia these types of roles were already well established and seemed to be doing a grand job.

Anna Elizabeth Treloar
It has long been noticed that prison systems throughout the developed world seem to have a disproportionately high number of people with mental health problems. Research was later to confirm people’s anecdotal observations. It was therefore logical to put in place a system whereby people with mental health problems who have committed relatively minor crimes be ‘diverted’ to the mental health system. This is of course fine if there is a welcoming system to divert these individuals to.

Being the first person to literally walk the walk between these two systems afforded me a clear and unnerving insight. I would regularly be asked to see a person in the court cells. This individual had usually already been assessed by prison officers and a Legal Aid solicitor as being sad rather than bad. Their crime usually did not involve seeking money, goods or advantage. It would more likely occur in the context of social dislocation, drug use, chaos and impulsivity. Staff persons sensibly enquire of me “Why is this poor bastard not in hospital, blind Freddy can see he needs help?” I often shared their clinically naïve though humane assessment. However, when the person was transported just a few hundred meters to the Psychiatric Emergency Centre at the local Psychiatric hospital I was just as likely to be confronted by the question “What’s this man doing here? - he should be treated in the prison system”. Therein seems to lie an inherent dilemma. When people with mental illness do criminal things both systems look to each other for accountability and ownership of the problem. These persons, whom I shall refer to as mentally disordered offenders (a World Health Organisation term which essentially means someone who is thought to have a mental health problem who has committed a criminal offence) fail at being either a worthy psychiatric patient or a stand-up prisoner...

Each system has its own particular language, its separate computer and record system. After all, both systems evolved to serve very different purposes, one to treat and one to punish. However, in reality a high ratio of people are processed either at different times or the same time by both systems (SE).

Number 25

Scarlet was one of my first assessments in the custody setting. She left the tide mark high. Back then I was finding my way, trying to shape the role and the service. I wasn’t trained to make independent decisions; I had yet to earn respect and credibility and to look comfortable in a suit. I constantly oscillated between the dread of screwing up and the thrill of being a nurse that got to make decisions that had consequences.
That morning I arrived at work to find multiple voicemail messages regarding a woman taken into custody the night before. These messages all emitted low frequency frustration, anxiety and tension. As I trundled down to the police station in my new suit, matching shirt and tasteful tie, I felt like an impostor. Long before I was admitted into the cell complex I heard Scarlet’s hoarse attempts at a scream. At that time there was no prison nurse at the cells. I was greeted by two prison officers of a particularly jaded persuasion. They gave me a cynical lowdown on the situation. They mentioned several times that Scarlet was a sex worker, implying that this somehow changed the situation. I wondered if the local sex industry had introduced a course for workers to better cope with acute stress of incarceration, though I didn’t articulate this thought.

You are of limited use to a patient if you are not seen as ‘solid’ by the prison officers. I was a guest and didn’t have a key. To gain some benefit for a ‘crim’ as prisoners are known, you have to be able to negotiate from a position of often begrudging respect as a clinician in a hostile environment. The sensitive new age clinician could take endless umbrage at the gross, politically incorrect ravings of many of the officers. I assumed that most officers were bored and felt powerless, the cynical banter being their one show of strength, albeit an empty one. In my experience, most officers are decent folks but the work culture is toxic.

When officers overtly speak scathingly about prisoners I think it best to pick your fights carefully: when you do make sure you win. By and large ignore obviously shitty comments and negativity, instead focus on the good stuff. It also helps if you are playful and regularly bring good jokes into a mirthless environment. Above all else you have to try and blend being kind and decent to the patient with practicality. You have to try and find a way of being useful to both the patient and the systems involved.

After this necessary interaction with the jaded ones, I got to meet Scarlet. I encountered a naked woman standing in the cell with her mattress in front of her. I felt guilty noticing that from what limited view I had she seemed to have a dancer’s body; I wasn’t thinking the waltz. I filed this thought away in the unacceptable tray and focused on her eyes. This alarmed me even more. Her conjunctiva was blood red and weeping, capsicum spray will do that. It is said this is why Mike Tyson cries after sex.

Scarlet seemed to have expended most of her capacity to shout, so she was shouting hoarsely. Her clothing had been removed from her after she tried to fashion a noose with her jumper. She was given a standard issue white paper suit, which she duly ripped to shreds and used to block the toilet.
Her list of injustices would make the complete works of Shakespeare look like a shopping list. This was the part of the show where you are probably best to soak up the rage, a vital part of this type of work, indeed an important aspect of all types of work. A real pro can soak up hostility without feeling it is personal. I reminded myself that despite the fact that I am the only person within the physical or emotional orbit of this woman, it is not personal, I just happened to be on duty that morning. You keep it human without getting psychological septicaemia.

It seemed that the police had attended her home in relation to a restraining order being sought by a neighbour. From Scarlet’s perspective, the police were rude, intrusive and refused to take reasonable directions from her.

The police facts spoke of two calm reasonable officers attending the premise of Ms Scarlet B------. They were consequently exposed to a level of violence seldom seen outside of R-rated video gamesmanship. Who would ever know? I take the view that police facts are what an often weary officer types up at the end of a long shift and as such they reflect a multitude of variables.

The bottom line is that when a Magistrate is faced with a set of police facts from two sober police, regarding an out of control citizen, having a Law degree won’t increase your chances of predicting the outcome.

At the end of her rant Scarlet performed a deft manoeuvre and produced jewellery from what I presumed was her vagina - “The fuckers weren’t going to steal this”. She ever so deftly replaced it. I believed her.

The first task is to decide if this person needs diverting as soon as possible to the mental health system. Now we get to the pointy bit...

It turned out that Scarlet was currently an outpatient of a private psychiatrist. After speaking with him and gaining a sort of reassurance that there was a ‘management’ plan in place, I prepared a letter for the Magistrate and with some good work from the duty Legal Aid solicitor, Scarlet was bailed to walk with me to the Psychiatric Emergency Centre of the ----- ------- hospital.

I had imagined that upon her release from custody that she would be grateful for and relieved with this arrangement. On the brief walk up the hill to the hospital she dismantled this notion with brutal efficiency. Her sense of righteous indignation had not abated; in fact it had gained momentum. It was now a force of nature. Given that she
was not ‘out of touch with reality’, just very displeased with its current format, I knew it was unlikely that the assessing doctor would be motivated or able to negotiate anything resembling negotiation. Scarlet was already in outpatient treatment so she would almost certainly not be admitted to hospital, rather be ‘discharged into her own care’ with the understanding that she would be seeing her psychiatrist next week.

Fact was, Scarlet was not a ‘good outpatient’. Although her sex work meant she could pay the cost of therapy, she was impulsive, entitled and tended to make care givers feel unwarm and unfuzzy. If in doubt, which she often was: attack.

It was late on Friday afternoon. Despite my anxiety I didn’t wait around to see what happened at the Psychiatric Emergency Centre. Scarlet was more than capable of alienating the staff without my assistance.

On Monday I rang the office of Scarlet’s psychiatrist to see if the plan we had negotiated was solid. There was an awkward silence before the secretary told me that a friend had left a message on the voicemail to say that Scarlet B------ had taken her own life on the weekend.

I would like to say that my first response was sadness and concern for the welfare of her 8-year-old daughter.

My first thought was for my embryonic credibility and for my job. Secondly I thought “What a selfish cow, we had all bent over backwards to help”. Then I did some mental arithmetic to assess my medicolegal responsibility. I reread my clinical notes. Coming in a lame fourth was sadness and concern.

I spent the next few days before Scarlet’s next due court appearance in a distracted fog. On the day of court I thought to ring her Legal Aid solicitor to give her the heads up. She was genuinely surprised as she happened to be sitting in a room with a very alive, indignant Ms B------. I could never be sure but the only person I thought likely to ring with the ‘news’ was Scarlet.

On discovering that Scarlet’s heart was still beating her psychiatrist sacked her, presumably for failing to be a reasonable patient who had not died and who rang with bad news that turned out to be so good for us all. I felt a selfish relief and embarrassment at feeling off the hook. I got to assess another day.
Over the next 10 years I had numerous dealings with Scarlet. In time I grew to admire her brassy outer shell and to appreciate her vulnerable core.

People with personality disorder do not have flexibility and adaptability, so at times of high stress they often revert to primitive and unappealing ways of trying to cope. Paradoxically, this inability to cope tends to alienate and infuriate everyone around them, including mental health workers.

No one comes into this life equipped with the ability to self soothe and other mindedness, (the capacity to imagine how others feel and to imagine how they might perceive our behaviour). If we are lucky we get a lot of assistance in developing these skills through adequate attachment and good enough parenting. Not everyone is lucky. Scarlet had experienced sexual assault at the hands of multiple family members from age 10 years onwards.

It is probably not surprising that she had a remarkable ability to engender strong responses from most people she met. Over the years I noticed that men in authority tended to want to either beat her up, shag her or rescue her, often simultaneously. If you were reasonably self-aware you might notice this process. If not you might project these unwanted feelings on to her. Either way it is perhaps not surprising she made us feel rather uncomfortable (SE).

Number 26

At 3pm I was called back down to the cells for the fifth time that day. As I sat in my office I recall thinking, “Why do I have to be functional? Maybe it’s not too late to have a traumatic unhappy childhood and get a pension”.

The prospect of seeing yet another prisoner was bad enough but the situation was compounded when the duty solicitor told me who it was I was to see. Darren was a 22-year-old man who I had seen in similar circumstances four times in as many months. His crimes were always variations on a familiar theme. Breach of AVO (restraining order), common assault, resisting arrest, assaulting officer in execution of his duty, and malicious damage. Darren was the kind of lad for whom Charles Dickens would have been hard pressed to come up with a more tragic story. Throughout his childhood and adolescence he had attracted enough psychiatric labels to use every scrabble tile twice over. Yet despite his apparent low IQ, plethora of psychiatric labels and high potential for violence he had managed to find a partner and to split his DNA with her three times so far. For the most part they were a devoted though volatile couple who seemed to put
in the hours with their children, albeit in a state of stress. Every care agency in the town had, at various times, flown the flag for this family. Inevitably they let us down by being who they were.

Despite knowing this it is very easy to become cynical and superior when dealing with lads like Darren. It is likely that his life style and criminal shenanigans work to mark the boundary for nice middle-class, middle income folks like us. We can feel secure and removed from the likes of Darren. The problem is of course that he lives not five minutes from me and even if he spends a couple of months in prison he will be coming to a cinema near me very soon. So it makes good sense for professionals like myself to try and remain practical and optimistic. However, on this particular day I was, without really being aware of it, fed up with Darren and the way he lived his life without thinking of ‘consequences’; I was ready to give him some straight talking to help him see how destructive his behaviour was. Even if I was aware of my motives I might well have done it anyway. Sometimes you just get sick of being reasonable. I had of course forgotten one fundamental fact; my comfortable, respectable lifestyle comes to me by virtue of Darren’s shenanigans.

So I enter the solicitor’s interview box where I do most of my assessment and start. I didn’t get very far for Darren looked me square in the eye and told me “not to start”. On our previous meetings in the cells he has been tearful, anxious and seemingly desperate and grateful for any help. Remember that we folks in the helping professions like to be made to feel good for what we do, why else would we do it? We like grateful people. However, this time Darren is certainly not being ‘grateful’, he is telling me that I can’t lecture him. At this point I feel a flush of anger; after all it is me that the guards will let out. Who the hell does he think he is? The flush of anger soon passed and I got up from my seat, briefly left the room, walked straight back in, apologised and started again (SE).

Number 27

**A case of mistaken identity**

Not long ago I was sitting in the … mall on my day off. I was passing time before a movie started. I had lots of money in the bank which was legitimately earned. However, I had cycled into town wearing a black Bonds T-shirt and some baggy shorts, no tattoos but short-cropped hair and an air of something. Without a suit I quickly revert to
my innate working-class persona. Memories are hard-wired into the way you hold your body and despite a good deal of effort to lose that edge I think the shadow stays.

Given that I have been in the town so long and have met so many younger men who have either been prisoners, psychiatric patients or combinations of the two, not surprisingly I see combinations of these lads all the time. The point is that they remember my face to varying degrees but understandably do not necessarily remember the context. So garb can throw things off. This day a rum lad, who obviously recognised my face, approached me as I sat happily alone. He asked, "‘ave you got any White Ox’? For those of you who have not been incarcerated in New South Wales, White Ox is prison issue tobacco. He thought he recognised me from prison. I had assessed him in the cells about two months ago, dressed like a solicitor and behind the dividing line of the Perspex glass of the interview rooms.

A week later early one Sunday morning I was cycling to a friend’s house to take her two young daughters out for a couple of hours to give her a bit of respite and to allow me to play at being a granddad until my sons give me full legitimacy to this role. I had on more or less the same clothing as in the mall. As is my tendency, I cycle like I am on the run from something I just met in a nightmare. Because of my opinion of the driving skills of the average [person], I usually cycle on the pavement. A police car passed me going in the other direction, on its way back to the station for change of shift. Despite this they turn around and pull me over - dodgy guy, cycling like he just shot up speed, has been up all night. I give them my name which is fed into the computer to see if there are any outstanding warrants. Their demeanour is generally shitty. If I had not developed a skin of servility on top of a natural tendency to be polite, I might well have questioned their right to stop and question me as I went about my righteous business. This in my experience from reading thousands of police fact sheets can set in motion a cascade of mutual antagonism.

One of the officers recognises my name, the whole interaction changes shape. I am on the inner. Inside the circle of the law. We exchange banter and I cycle off very quickly.

The T-shirt, haircut and bike are a marker of something important (SE).

**Number 28**

Norman is a large developmentally delayed man who enjoys many simple pleasures: shoplifting, lighting small fires, and showing his tiny penis to strangers. In reality his belly is so large and his penis so tiny that few little old ladies have actually seen it but it
is the thought that counts, and as little old ladies have big imaginations, many prosecutions have followed.

His simple pleasures have given him a criminal record that produces a 35-page printout from the court computer. In twelve years I have only seen two other rap sheets that dwarf his. When he is not in prison he tends to live an itinerant, feral and interesting life which involves a lot more than his ‘simple pleasures’. He travels the length and breadth of New South Wales on trains free of charge. A prison officer I know who was on holidays with his family in Byron Bay told me he saw Norman roller skating down the main drag with nothing on other than his large, stained underpants. He was listening to a Discman and singing along to what seemed to be Bon Jovi, to the delight of numerous beautiful overseas travellers. The office also pointed out that Norman appears to have Van Gogh’s ear for music (the one he cut off!). However the one talent that singles Norman out from the crowd is his ability to poo at will. This may not seem particularly noteworthy until you consider his genius for timing and location.

There used to be David Jones store in the city centre. It had a restaurant, which was in fact, a café with a blue rinse. It was frequented almost exclusively by those older [women] who sport high opinions of their incomes, designer labels, bad hairdos and spare tyres. On his visit to town Norman called in for a cuppa and he did his usual trick of eating anything that stood still enough whilst he was in the queue to pay. Some women took exception and security was called. A ‘scene’ ensued with Norman standing his ground and becoming redder than red in the face, whilst continuing to graze. At this point the security man decides enough and starts to physically remove him. Norman reached down the back of his trackie bottoms and brings out a turd which he places lovingly on the counter, right next to the lamingtons I later heard.

The police facts tactfully made reference to distressed patrons hurrying to leave the premises, several of them sustaining bruising in the ensuing rush. I think had Norman removed a Kalashnikov rifle from his pants there would have been less of a stampede to leave. I have no doubt the local psychologist noticed a peak in the referrals of middle-aged women with PTSD around this time.

I was asked to see Norman in the afternoon but I was warned beforehand by the Corrections officer “He’s bronzed up”. “What?” I asked. “You will soon smell what I mean”. Norman had done what he often did in custody, the ‘ultimate’ control. Not the hardest inmate or the keenest Corrections officer would dream of going near him. I spoke with him through the bars for long enough to establish that he was not psychotic.
His matter was dealt with later in the day, in his absence. He was fined, hosed down and released on to an unsuspecting public (SE).

Number 29

I suspect every public mental health system in the developed world has its “Ten Most Unwanted Patients” list. Chris S--------was at least the ace of clubs on the local hottest ten, by the time I got to meet him, about twelve years ago.

He was directed to see the Court Liaison Service as a condition of bail. He had allegedly (my time working in the court system has taught me the importance of “allegedly”), terrorized the Department of Housing staff, causing untold psychological damage to staff, and some told damage to several articles of furniture in the process.

He arrived for his 2pm appointment on time, most unusual for a court liaison client, his garb was a bit unusual as well.

He was wearing a ski mask, black clothing and a pair of reflector sunnies. I wondered how Mr Egan, “the skilled helper”, would arrange the seats on this occasion. I invited him cordially into the office and tried my best to ignore that he looked like he had just come from a bank job. One he was keen to get back to, and to continue telling the tellers, “Get on the fucking floor and don’t move”. You know the script, I won't elaborate.

He sat and probably stared at me, but I couldn’t be sure as his sunnies just gave me a nice hologram reflection of the office. I continued with my cordial enquiries as to his general situation. I then enquired as to how he would like to proceed. It seemed he wanted to proceed in silence. So we did, for the allotted 30 minutes, and not a lot more. I did at one stage ask if he would mind taking of his hat and glasses as they made me “a bit uncomfortable”. He didn’t respond and his sunnies didn’t say anything either.

After some 30 minutes of less than golden silence, I explained that our time was up. I got up to show him out. At this point he took off his glasses and asked “What the fuck was I on about?”. I was about to see my next patient. “I am about to leave the office, I suggest you do too, Mr S--------”. He huffed and puffed, but he didn’t blow the house down.

I imagine it took Mr S-------- considerable effort to sit silent for 30 minutes. Especially in an office with no air conditioning in January. I know it did for me...
Of course, I have no real idea just what he was thinking. But his get up, body language, silence and staged menace spoke volumes. It was impressive. I have always admired effort.

The Legal Aid solicitor representing him asked the next day if I would be willing to see him again at short notice; Mr S------ was due to appear in court soon. “Of course I would” (SE).

Number 30

Some years earlier when I was working a night shift at the M----- clinic with a stunningly smart Kiwi nurse, Mike J-----, I observed the power of allowing silence. The clinic not only ran a 24-hour drop in assessment service, it provided 24-hour phone contact. Ex inpatients often rang to head off an escalation of a brewing crisis. There was also large numbers of new contacts.

The phone rang in the wee small hours; Mike answered. The person enquired if there was someone there that they could talk to. Mike assured him he was. No more was said. Mike sat patiently as the caller said nothing with the phone piece to his ear. There was no raising of his eyebrows, no attempt to tacitly take the piss out of the situation with me. After about twenty minutes the caller thanked Mike and hung up.

Pregnant silences will either abort or go full term and give birth of some sorts. If the birth is rather premature, then perhaps a skilled person may be able to help incubate it (SE).

Number 31

Kevin O------- was a pretty typical Legal Aid referral to Court Liaison. A bit of a rum lad that had seen more trauma and domestic violence as a lad, than you would likely see in 20 episodes of the ‘The Bill’. He had a lengthy, but not exciting, criminal record that began in his early teens and had not shown any signs of petering out until he met his current partner with whom he had had a couple of kids. Debbie sat in on the assessment. They were clearly a team.

I instantly liked them both. They had stoicism and a forthright manner that I always admire. His solicitor had picked up on the fact that as an adolescent he had attracted more psychiatric labels than formal education.
Fact was he had never been interested in the kind of treatment options he had been offered to date. As a young person he was offered dexamphetamine for his AD/HD [Attention Deficit Hyperactivity Disorder] and various other drugs for his various other acronyms.

As an adult his only contacts with mental health services seem to have been unrewarding for all involved. He had been taken a number of times to the Psychiatric Emergency Centre in a state of heightened arousal, and personal drama, by the police. After reading the clinical notes, the assessing doctors clearly thought he should not have been. He was a naughty and needed to face the music, so the band had played on.

As part of trying to be pragmatic I spent some time outlining the likely options available. They listened without complaint. I suspect, like most people who have done the rounds, they knew instinctively that I was a realist and would do my best. The Kevins and Debbies have well developed instincts about people. They are also exquisitely sensitive to being talked down to or disrespected. Given that he was facing a moderately serious assault charge, given his criminal record and the likelihood he would never join a men’s group and get in touch with his inner child, he was looking at a lagging. Unless of course we could come up with some alternative plan.

I was keen to avoid this outcome, given how generally things had been improving. It would be such a waste of the tax payer’s dollar and would be stressful for their family.

This would likely involve seeing a psychiatrist, keeping appointments and reducing or ceasing his regular use of cannabis. If he did so my hope was that he may well get a Good Behaviour Bond and likely a fine. He and Debbie didn’t have to consider for very long. “Thanks all the same, we can’t afford a fine. I’ll do a couple months and come out sweet” (SE).

Number 32

A woman walked in off the street into the M---- clinic. She was accompanied by her eight-year-old daughter. It was about 9pm on a Wednesday night. Her GP had advised her to come earlier that day.

I invited then into the assessment room. From the onset I felt uneasy. Not because they were odd, or angry, it was just their presence. After my introduction and basic
information gathering, we sat in silence for a while. It was a strange while, and one I didn’t like at all.

Her daughter held her mother’s hand. Her mother looked at the floor; her expression was in a language I couldn’t speak.

It was the daughter who spoke. Two days earlier her mother had found her 14-year-old son dead in the family home. It was likely that he had taken a large amount of various prescription medications.

I was not equipped for this situation on so many levels that initially I felt panicked, I almost fled the room. I then thought of who I could pass this over to. I could contact the on call doctor. That’s what nurses do when they are out of their depth. But I couldn’t bring myself to leave the room.

So I stayed with the discomfort and said nothing. I was then overwhelmed with sadness. I felt like it was crushing my chest and in doing so it caused me to sob. Big, hot tears sprung up, rolling over my cheeks like mild acid. I had no control. I started to panic again. I had three young children at home, safe and loved. Since having children I had become horribly aware that a vulnerable passageway had been created that could potentially destroy me if anything fatal was to happen to any of them.

When I looked up we were all crying (SE).

**Number 33**

Whittingham has long since closed its doors for business, but in the earlier part of the last century it was the London of psychiatry. It was supposedly the largest psychiatric hospital in Europe.

Nestled in a valley and surrounded by woods you would not have known it was there. I believe this was the intention. It was almost self sufficient in food. It boasted its own internal postal and transport systems. Pizza Hut never once delivered.

Back to the opening scene. We alighted from the bus and were being disorientated by a nurse educator, Colin ... Colin lacked anything vaguely resembling a functional personality. ..

As we strolled down the tree-lined avenue I was almost knocked over by a naked man. It was December so I didn’t imagine this was part of a spring ritual. He moved with a
grace and elegance that belied his stature. To accompany his balletic movements he was singing quietly, and from what I could hear, in perfect pitch. I don't think it was something current on Top of the Pops.

Colin neither acknowledged the presence, or the artistry of this huge naked man. I thought what would he notice? I didn't have to wonder for long.

A little further down the lane we encountered a woman. She looked like a bag lady version of Anne Bancroft. She was wearing a rug of some sorts but she managed to look dignified all the same. As we passed she appeared to be mid conversation with a large mob of crows. And I mean conversation, in the real sense of the word. She would talk crow, not turkey, and the birds would reply after seemingly considering what she had just said. Neither party were just waiting to put their bit in. I was spellbound. When I looked around I realised that Colin and my peers were not spellbound, they were bound for the canteen, with some purpose.

I later discovered that Irene had been in hospital since just after the war. She was Polish, couldn't speak English. She no longer spoke Polish (SE).

Number 34

As I entered St John’s day room the telly was on. The volume was at the level preferred in a Prague disco at 2 am. “Looney Tunes” was mid caper. The air was thick with cigarette smoke; a number of patients were sitting in a stupor, the majority were either pacing around the room or the courtyard.

There was no staff to be seen. When I located the team they were in a room with a telly that was not tuned into the cartoons, rather the horse racing. So began my stint on St John’s.

I tried making conversation with a number of either static or mobile patients. They ignored me or looked at me as if I was part of the cartoon show. So I decided to have a look at the patients’ case notes, which were well organised and orderly. I was astounded to find that each patient not only had what resembled something that then passed for case notes, they also had a set of notes from their original admission to hospital. On average the men had been a continuous inpatient at Whittingham for 30 years. To my delight, and horror, there was a police style photograph, front and side with a name printed.
In the early years there was a once or twice yearly doctor’s entry. I probably laughed out loud when I read “no longer masturbating, no parasites”.

St John’s was not a forensic ward, as such. These men were not detained because of being mentally ill and having committed a criminal offence, it was their potential for unpredictable violence that separated them from most patients.

I soon learned that this potential for violence did not include anyone wearing a white coat, the home strip of the male nurses.

I concluded that thirty years of effective conditioning, that you do not strike a man in white, was the reason that I was automatically immune from their wrath.

I must be honest, I felt relieved and more secure. Problem was it was also the reason, along with untreatable psychosis, that I never had a single conversation of any quality with a patient on the ward for the three months I was there. It was a lonely placement as I didn’t like horse racing either (SE).

**Number 35**

It was in a provincial community health centre in New Zealand where I was working as Mental Health Nurse.

For some weeks a young man with a diagnosis of personality disorder had been presenting for weekly centre-based sessions of about an hour.

They had started subsequent to him having self-harmed enough to warrant a short admission to the local psychiatric unit.

On this particular Monday morning the after-hours staff had been called out to his home over the weekend where he had set up a situation of trying to hang himself

Part of the deal of him not being readmitted was that he present for this appointment.

Unlike previous sessions he was hostile, silent and not making eye contact.

Because I did not know what to say I said nothing. Nor did he for the entire hour.

What I did notice is that we fell into a rhythm of breathing at the same time. Our inspirations and expirations were concurrent (NE).
Number 36

It was in the grounds of a large city psychiatric hospital where members of the public on Sunday afternoons would enjoy informal games of cricket.

Longstaying and trusted inpatients at the facility would often be out and about on the extensive and attractive grounds.

They were familiar sights to the regular cricket players.

One of these inpatients was a tall large and fit individual whose task it was to tend the gardens and he was around every Sunday, always keeping a large distance from the players.

One Sunday afternoon, however, from a distance he fixed his eyes on one particular player who was having a boring time fielding during a particularly long innings.

It made the player feel uneasy.

Then all of a sudden this inmate ran at the player from a long distance with great velocity with a ferocious look on his face.

The player was petrified and could not move.

When he got to the player, he tapped him on the shoulder and said, “Tipped you last”!

(NE)

Number 37

He had been a long term patient in the unit with multiple operations. Lost his legs from stepping in front of a truck while drunk; he always denied suicidality but had been labelled as a mental health patient because he was “depressed” following the accident. He was always pulling practical jokes on staff and other patients.

I shortsheeted his bed. He thought it was hilarious and jokingly insisted on other staff making his bed that way “to save linen” (SI).

Number 38

I was working in a group therapy based voluntary inpatient unit, dealing mostly with patients with non-psychotic mental health issues.
One patient (who had a borderline personality disorder and dissociative disorder) who I had been working with for several weeks was complaining extensively about a minor issue on the unit (something like the water in the shower not being hot enough). I jokingly said, “Here is the smallest violin in the world playing just for you”. She became extremely distressed and angry. She then told another staff member that her father, who abused her severely as a child, played a record of violin music when he was abusing her.

I immediately apologised profusely for upsetting her, and we talked about how she felt, and what I had intended. This incident formed a foundation of a very good therapeutic relationship as no man had ever apologised to her before (SI).

Number 39

I had taken a new generalist OT [occupational therapist] to do a HV [home visit] on a well known client who lived on a rural property with her 16–year-old son. Both people were low risk (except for Mum’s occasional pyromania possibly secondary to hypomania), however when we arrived, there was an unknown man in the house that they had met on the train. This wouldn’t have been a huge problem except he had a shotgun and as we found out, was AWOL [absent without leave] from M...... [Mental Health Unit] with a diagnosis of schizophrenia. He was not a fan of mental health staff. There was no mobile phone reception and the car was parked 150 metres away from the house. Two hours of negotiation and de-escalation reasonably to no avail, when we had to lie to this unhappy visitor, in order to get back to the car. Client and her son stayed out of the house and refused to come with Mental Health. We were able to leave the property and drive 50 kilometres to get mobile phone reception to inform the police. No one was harmed. This was the only day I’ve ever been at work that I didn’t think I would make it out alive (NO1).

Number 40

In response to a colleague’s distress whilst telling his story, I’m reminded of my own tears re a client.

He died by suicide.

He was recovering from a drug-induced psychosis. Beautiful young man, gorgeous family. Employed. Had everything going for him.
His family invited me to his funeral. I went hoping to sneak off before anyone saw me. This did not happen. I was trapped and overcome by sadness and distressed at this loss.

His family hugged me and thanked me! The tears flowed more.

I had conflicted emotions about crying in front of patients/families and sought supervision. She told me about her own experiences with emotion and the only two other people that she knows have admitted to crying in front of clients’ family – both were well-respected psychiatrists. I was validated and normalised (NO1).
Appendix 2: Stories - Numbers 41-100

Where stories are taken from published sources, references are given here, throughout the thesis when direct quotations are made, and in the Reference List; where stories were collected from workshop participants and other participants, the source is noted in a coded identification. In some stories parts of the text were omitted, either because they were not directly connected to the story, or because they identified the teller. Where these omissions have been made, ... has been used to show this.

Number 41

In the Child and Adolescent Unit working with a psychotic young boy with a significant trauma history. I had a good relationship with him. He was walking up and down the hallway while a group of nurses stood nearby.

In attempting to engage with him I asked him a few questions. At one point I asked him did he want a hug to which he said yes. We then hugged for a brief time. And then continued what we were doing (SR).

Number 42

At a child and adolescent inpatient unit I was looking after a young boy who had autism and was not toileting properly. I had found him in the past having smeared faeces over his body and this time I observed him just sitting on the toilet and ran to grab some gloves. Upon my return I was too late. I put gloves in my pocket from then on (SR).

Number 43

I met a young woman who had been admitted to a mental health admission unit where I was working in a clinical capacity.

She was very frightened and depressed and had psychomotor retardation to the point where she was oblivious to the fact that she had her period and had bled on the chair that she was sitting on.

I asked her (dumb question) how she was feeling – and it took her several minutes to explain – “ratshit-just hopeless-etc”.

Anna Elizabeth Treloar
We worked with the young woman for about six weeks and I managed to build a solid therapeutic relationship with her, along with several other nurses.

Several weeks after her discharge from hospital the young woman visited us to say thank you. She introduced me to her parents who accompanied her - but I did not recognise her at first. Her facial expression and body language had changed so much.

She had been so “hopeless and helpless” but now she was well. This left a powerful effect – I was convinced that mental health treatment and nursing management could be effective (NO2).

**Number 44**

[*I nursed a man who had recently punched a co-worker and threw him on to a low verandah roof. The patient was huge and very paranoid]*.

When I met the man as I came on to my 12 hour night duty shift, he looked at me with affection and, smiling, said, “You’re not Charles-you are Paul-yes-Paul-long time no see-I haven’t seen you since school”. He then put his arm around me and patted me repeatedly.

I didn’t know how to deal with this. Should I tell him that I wasn’t Paul and that I was 20 years under the man’s age?

In the end I just allowed him to call me whatever he wanted to, but addressed myself as Charles, and all that is associated with my life was discussed as appropriate.

The story is about parallel realities and how it is sometimes necessary to hang on to whatever hold we can use to maintain a relationship.

It is also about honesty and the person and that honesty in the face of potential adversity (NO2).

*Need to bracket this for a story intended for students!* [comment from storyteller about first sentence].

**Number 45**

Working as a beginning mental health nurse in an acute unit. One patient was in the midst of a manic phase and was incessantly intrusive and regularly hurled verbal abuse
focusing on staff and their flaws or weaknesses (way of talking, way of dress, body weight, etc.).

On this particular day she began knocking loudly at the office door but was asked to wait until handover had finished. She went away and found a mug and began banging loudly on the office door at which point I opened the door and took the mug from her. She then loudly abused me, calling me a fat so-and-so. I replied, “Have you looked in the mirror recently?” I immediately panicked and thought I had inflamed the situation and expected her to assault me. But she walked away, sat on the floor and laughed and giggled for quite a while. Done the wrong thing but got away with it! (TT)

Number 46

Acute assessment of suicidal man. Took student nurse as observer. The man was very distressed and tearful in the context of acute opioid withdrawal, financial stress and social isolation.

The man was asked about any idea of self-harm to which he replied, “Yes”. Further questioning revealed that his plan was to gas himself in his caravan. When pressed to reveal any attempts using this plan, he again replied, “Yes”, so I enquired as to why it had not worked, and he tearfully replied with head bowed, “I ran out of gas!”

Both the student nurse and myself avoided eye contact as both had trouble keeping a straight face, realising that this man was clearly very distressed and a high risk of further attempts of self-harm if appropriate intervention was not forthcoming.

The student and I talked about the uncomfortable, guilty feelings, but also acknowledged mental health nurses’ black humour (TT).

Number 47

There was one lady that we had, she was referred to us, the story was she was crying all the time, she wasn’t sleeping, she was really sad, she was depressed, so we went around. I went around with the health worker and she was very sad and she was crying and she was depressed but the health worker that I was with at the time said, well could there be any other reason that this might be happening and she couldn’t really identify and he got permission to ask the family and so she said yes and so we contacted a family member. Now this was over a couple of days so we didn’t rush. She was hearing...when she was awake at night she described that she was hearing all
these children calling out in the middle of the night and it was keeping her awake and she was tearful etc and when the health worker checked with her family, she had taken a child away without permission from the community and the family member said she has probably had puri puri put on her and that she needed to fix that.

Puri puri is like bad medicine, like most Australian culture would know pointing the bone but there’s all different versions of how that can be done and that is it can make somebody sick or make bad things happen to them or those sort of things....had I not had a health worker with me I very easily could have said, yep, psychotic depression probably needs an admission and medication – and that lady didn’t need any medication (McClay, in Nizette, McAllister & Marks, 2013, p.73.)

Number 48

There was about 2000 patients, there was a male side and a female side, and mostly we worked...the female nurses worked in the female side of course and male nurses worked on the male side. There were two houses away from the main hospital, Orchard House and Forest House, and they were mixed, a very advanced idea in the early sixties.

We’d make sure they all got up, made their beds, took them down to breakfast and then the nurses served the meals. It would come in a big bain-marie and you served each patient. You knew what they could eat, what they were allowed to eat, what they liked to eat, and you just served the meal for them. And you tidied up and the bain-marie would be taken out and then you’d clean the ward. We have a big buffer so all the nurses – to polish the floors, all the nurses had quite slim waists. It was good exercise. And the patients would get in and help and then you might take them for a walk, them to play cricket or tennis or something. We had an occupational therapy department and they could actually go there and work. They used to make Christmas crackers and sell them to the public. Some patients had other jobs. There was one lady called Martha and she would scrub the corridors. We had 20 miles of corridor altogether and they were wide enough for a car to drive through and still have room either side. And Martha would scrub about eight square feet a day but she knew everything that went on in that hospital and she got paid for it. Several of the other patients would go to work. Sometimes they could walk by themselves; sometimes you took them. They might work in the sewing room, in the kitchen, in the laundry and in the garden, depending on what they did. Some of them just sat in the ward and we’d try
and encourage them to do some activity. A lot of craft work, we did a lot of craft work then.

I think the good thing is that people were safe there. They didn’t have many restrictions then. They were beautiful grounds. They could go and lay under a tree, they could go and do work and get money if they wanted to. And also we checked that they had food, their regular meals. They had to come into bed at a certain time, depending on summer or winter, it was earlier – summer time it was usually nine o’clock. But they came in and I think they felt safe with us. The worst things, we actually had padded cells there and as a first-year student you had to polish those padded cells. They were leather and you had to make sure the leather was all soft. The walls were a bit like a chesterfield sofa but the floor was like a dome, it was all very, very soft, horrible to be in though. There was only a little square for a window. I only ever saw that used once (Lees, in Nizette, McAllister and Marks, 2013, p.81).

Number 49

There was a young boy who was 17 who had been referred to our service not that long ago. The GP had referred him for anxiety and it was only after really spending a lot of time talking to him about what are some of the situations that make him anxious and what makes him feel like he has concerns around anxiety that he was able to identify that he was gay and had really struggled with that his whole life, had just decided to come out and talk to his family about that, which wasn’t well accepted. Some of his friends were quite supportive and quite responsive to it but he felt like he really needed some additional support in that area and building on some skills that he could help take with him in his life. Trying to help him build his resilience, trying to help him build his confidence around who he was as a person because this is him and he was proud of who he was. So trying to build on that, trying to make him stronger in that sense. We also referred him on to another service which further enhanced that and made him realise that he wasn’t alone in this journey (Page, in Nizette, McAllister & Marks, 2013, pp. 88-89).

Number 50

I was in a home once that I came across a youngish man, he was 62 years old. He was in a secure dementia area. He was in a chair; he was tied into the chair in a posey vest, which is almost like the old vests that we used to see in archives in mental health. He had a tray table in front of him, which was a further restraining device. He was actually
facing a corner which, when I first saw him, it looked like he was the old dunce in the classroom that was put in the corner because they were misbehaving, and he was trying desperately to gain attention from anyone who walked past by throwing his head around and calling out. When I approached the staff they explained to me that he was always calling out and no matter what you did, he was always calling out.

I looked at this man’s clinical file, discovered he was on massive doses of antipsychotic medication as well and he was really very drowsy. I looked further at his chart and I always look at the bio, so I always try to get the story behind the person when I am assessing because I like to see the person. I like to understand the person behind what is going on so I get a handle on what treatment they really should be getting. This man was 62 years old and I realised that being from the UK he probably liked the Beatles and I’m a great Beatles fan, so I sat down next to him and I touched his arm and I started to talk and I said “You lived in England and that was the time when the Beatles were all the rage” and he lifted his very drowsy head and he looked at me and we started to converse about the Beatles.

After a few minutes I then started to question him about what it was like here, living in this particular home and he looked at me, once again very drowsy, and he said, “This place is terrible”. As I stood up to go he reached out and he touched my arm and he said, “You’re a nice lady. Can you please tell me what I’ve done wrong that they are locking me up and tying me up in this home?”

Now I went home and cried. This is not an uncommon experience (Quirke, in Nizette, McAllister & Marks, 2013, p.92).

Number 51

In this particular aged care home I was walking down the corridor and I saw an elderly lady sleeping: it was 10.30 in the morning and she was still fast asleep and she looked like she had an enormous tummy, and I sort of took a couple of steps back and I peered into the room again and the director of nursing said to me, “Oh, I wish you hadn’t of seen that” and I said, “Why, what was wrong?” and she said “Oh she sleeps with her dog on her tummy” and the dog was under the blankets. And then I asked her if she had heard about the Eden alternative and she hadn’t and I said well, you practise it (Quirke in Nizette, McAllister & Marks, 2013, p 93).

Number 52
I've even had, recently I had a young girl who...who I worked with for a couple of years and she...originally I met her in a homelessness refuge, she then moved on through a series of relationships, ended up living with her mother, and I mean this is a girl who had a history of addiction to heroin, in and out of hospital for various crises, self-harm, suicidal, suicide attempts on several occasions over a period of many years, and she had several doctors look at her and say you’ve got bipolar disorder, you’ve got personality disorder, you’ve got depression, you’ve got schizophrenia and these sort of labels that we put on people and we try to...we’re trying to help them in a kind of a way.

But the delivery of her care had been so fragmented for various reasons that no one really got their head around the whole picture; and it’s not to say that I...I had the whole picture, because I’m not sure that anyone can actually ever get that. But it seemed like over a period of a couple of years the things that really helped her to get better was helping her to get some perspective, get her head around her own story, identify her strengths which she’s a very intelligent young person and has been able to go on and enrol in some study and, so forth, and, to cut a long story short, now she’s completely off all the mood-stabilising medication, off all medication altogether, hasn’t used drugs for sort of you know a year and a half and the other day was in my office saying, do you reckon I ever had a mental illness, do you reckon I ever had you, and so it’s...the messages that people get sent from the system and the way care’s delivered is interesting and challenging I think (Raeburn, in Nizette, McAllister & Marks, 2013, pp. 98-99).

Number 53

The complexity of working in forensic mental health services within a prison system as opposed to a hospital system is the contrast of our role within the service. When we work in a hospital we are the predominant providers of care: the nurses and the doctors determine the way that the day goes for the client. In the prison system, (where) they [i.e. prison officers] are responsible for our patients (who are their inmates) and so we are invited into the prison to provide services to their customers, and from that perspective our role changes because we are invited in. We provide service at their whim, so to speak, so often access to patients is very difficult. The patients are part of the prison establishment and they have to relate to all of the prison roles, activities and the security systems that we have got in the prison, so access is hard. Some of them are in their cells in prison wings and some of them are in prison hospitals, but those prison hospitals, for the lay person, they are just another bunch of cells that happen to
be in one building called a hospital. We have to deal with the philosophies of care that relate to both our prison service and our health service and that is an area of conflict for me and it is an area of conflict for a lot of nurses. Our role as nurses is to build a relationship. My training in both forensic and in mental healthcare was that the relationship is the key thing; the relationship is the key to all nursing, and so we build a relationship of trust. We have continuity, we have the same providers speaking and building and building on the previous contexts and we build that trust. Whereas, in the prison service the philosophy is that you don't create a relationship with your client because a relationship is something that can be breached and a relationship becomes a chink in security, so while we are trying to build relationships, they are trying to stop us having relationships, not actively so, but the philosophy is different.

The prison service often doesn't have enough staff, or staff is doing other duties and you can't get them out, and we have periods of time where we would expect to spend an hour with a client and we only may get five minutes. We can't walk through the prison and identify patients who may be at risk. During our normal nursing observation, we will watch someone in a ward situation who is withdrawing, who is slowly deteriorating, whose behaviour is just subtly changing, and as nurses we would pick that up. Those clients don't get picked up early because the prison officers don't have that training, so often they get brought in an advanced state of psychosis to us or they get an advanced state of depression. Whereas, if they are in a ward situation we would pick that up by sitting having coffee with them, walking with them, sitting maybe in a quiet room, in a lounge with another group of people picking them up and watching the corrections; we don't get that ability in the prison.

It is also our role in the prison to educate officers, prison officers who have their own training. It is to build relationships with the prison officers to give the information to sort of identify when the patient is deteriorating or not deteriorating. That also has a conflict of confidentiality. The role of prison officers is to collect data, to collect information and they keep their own files. They have their files for different reasons and so keeping our own information confidential is difficult, but there are ways around it where you can talk and you can identify things to look for and it is about using every opportunity.

Every prison is different and I think mental healthcare in prisons is improving all of the time, but the opportunity to sit with your patient often doesn't happen without having a security person in the same room or outside the door, so we use those opportunities. We use meal times, when you are walking from A to B, we use exercise yard time to
get amongst the clients, and the good nurses are the nurses that talk to the patients and not to each other. You often see excellent nurses who position themselves in amongst the exercise yard where clients can come up to them and talk in confidence. We used to watch one nurse who always used to take two chairs into the exercise yard, put them against the sale boards, sit down in one and he would just sit there and the second chair was never empty and I learnt a lot from that, where you just make yourself available – you use opportunities. Clients are desperate to talk. There is a prison culture that often having to talk to you when you sit down in an exercise yard or a common area, where being seen talking to staff is seen as a weakness, in the culture of the other prisoners and their status...

I always think there are two teams in the prison. There is the green team and the blue team and everybody has a role in a team; and the prison officers have their role and the inmates have their role and the people in civilian clothes like the health professionals and the various health people coming in are like the referees and the officials. You have a role to play in a team and it is not the done thing to be seen talking to prison officers and it is often not the done thing to be spending time talking to nurses. We have a great role in breaking that down and moving amongst the patients or the inmates and making ourselves available. There are opportunities there for good nurses to take it and you have just got to look for every opportunity to talk to your patient or your client (Bailey, in Nizette, McAllister & Marks, 2013, p.130).

Number 54

One of the things that I often find distressing working in the acute admitting area in the prison is that you will get someone who has come into the prison who has been charged with some offence that is pretty awful, for want of a better description – an offence where a child may be killed or a family member may be killed or something like that – and what you are looking at is the person as your client who is in tremendous distress. They are bewildered; they have got only a little bit of comprehension of what they have done. They may have killed their daughter and at times I am thinking back when I have seen young mothers who have come in who have killed their own children while they have been psychotic and while they have been unwell. Everybody treats them like a leper, no one touches them; no one is allowed to talk to them. The only people that have physically touched them were the people who have clipped their handcuffs on them and often behind their backs when they are being transported from A to B and these people actually need physical contact.
Often what you see is you see this person standing in front of you trembling and they are bewildered that they have just been told they have killed their child and some of them don’t even remember they have done it and all they need is a big hug and, you know, I think many nurses have been chastised. “You can’t touch the patients, you can’t” and what we have learnt over a period of time is that it is okay and the way I go about it is…in the prison there are cameras everywhere and what I tend to do is go and stand underneath the camera. You would give someone a hug and you would sort of put your arms around them where your hands are up, where they are always exposed to the camera, or you touch them on the arm, constantly holding their hand between their hand and their elbow where everybody can see openly what you are doing. You know you do this in the prison and very quickly prison officers come running and “You are not allowed to touch the client, you know. Are you passing contraband or anything like that?” and we constantly do those things to a point where people start accepting that as normal behaviour. When we set up that unit, which was a women’s high-dependency unit, we started going and having morning tea with our patients and sit at the table in the common area and have a cup of tea with the patients. But once we started doing it and after about three or four months the prison officers started joining us and often you would have a big round table where there would be two or three patients, a couple of nurses and a couple of prison officers. Then we started playing cards with them and then we started playing volleyball with them and so, by example, and by being inclusive, you can actually create the change and you can create an environment. Then, you know, we sit down and it is such a joy to sit down and look out into the prison wing at these horrible concrete walls and metal tables bolted to the floor then you would see a nurse and two patients and a prison officer playing scrabble together and you would think, “Yes, we are getting it right”. I remember Christmas Day and the first time in that unit we went and made up lolly bags and we put them in all of the inmates’ cells while they were out exercising and got caught doing it and we got admonished and dragged before the governor; and the following year it was allowed. So progress does happen, but it is up to us to make it happen (Bailey, in Nizette, McAllister & Marks, 2013, p.131).

Number 55

Prison is an awful place; it is cold, it is hot, it is never just right. It is noisy, the gates are made to clang, the halls always echo, there is no privacy and I often sit in the courtyard with the patients and they have got these high walls that are about 15 and 16 feet tall. The only thing they can see are these planes going away or going somewhere without
them, so by going to work you actually make a difference. You make a difference because they trust you. You are someone fresh to talk to, you have got an attitude of wanting to listen to them and it is not as though you have to listen to them, and it is incredibly rewarding just by going to work. You make a difference by going to work and I think that is what you get out of it, for me anyway.

One of the things that impressed me is that often it is one of the safest areas to work in. People are very fearful of people who have committed crimes and fearful of forensic and often it is a fear of the unknown, but our clients because of the nature of what happens, there are really good practices for safety and you have got to maintain the practices for safety. There are a lot of protections in place so it is not a place to be fearful of; it is a great place to learn.

I had preconceptions that totally went out the window. I thought prison would be full of a lot of bad people and what I found was it was full of a lot of good people who have done some bad things but they are not bad people. They are people I would have in my home. They are people that I would trust to drive my car to do this, to do that. You know, that was the things that surprised me the most, they were people that you can trust.

I have seen lots of people who have been caught stealing food, caught breaking into buildings for somewhere to sleep. They are not bad people. We make such a difference and I think that one of our roles is because we can, particularly in my role at the moment. My role is to get a solution and as long as we professionally keep without our boundaries, as long as we maintain our risk assessment, as long as we are allowing people to go home into a safe environment with the protective situations, then we can do anything (Bailey, in Nizette, McAllister & Marks, 2013, p.131).

Number 56

A female new graduate nurse was approached by a more senior male nursing colleague who asked whether she had come over to the dark side yet. When she insisted that this would not happen because she was too positive, the male colleague replied, “You will change” (Hazelton, Rossiter, Sinclair & Morrall, 2011, p.180).

Number 57

He [the chief male nurse] started working at Oakdale as a kitchen hand when he was 13 years old. He rose through the ranks purely because of his length of service. This
was how promotion occurred at Oakdale. It had nothing to do with ability or qualifications. He retired two years after I met him. He had been working there too long and had become extremely peculiar, to say the least...

One day, at lunchtime, I was walking along a path, and I saw him walking toward me. As he drew closer, he said, “Come here, boy...bop-bop! How many chairs in the recreation hall...bop-bop?”

I had no idea how many chairs were in the hall. In fact, I couldn’t see the importance of the question. I made up a number, “One hundred and seventy-six, sir”.

“Correct! Very good..bop-bop! Woo-woo! Good boy!” And, he went on his way...

It seemed the hospital couldn’t attract young people to become psychiatric nurses. The chief male nurse thought it would be a good idea if he personally involved himself in a recruitment drive. He decided that he should visit twelfth-year school students in order to give talks on the benefits of becoming a psychiatric nurse....

One young man stood up and asked, “Do you find that, after a few years of working in a place like that, it can affect people?”

The chief male nurse replied without hesitation, waving his arms in the air, “Affect you, boy...bop-bop? Look at me..woo-woo...look at me! No problems!”...

The recruitment idea was a complete disaster. Not one single recruit was found (Gilham, 2011, pp.45-46).

**Number 58**

Mario was Italian, probably around 35 years old. He was a huge man who came from a very large, influential Italian family. His parents owned a chain of stores throughout the city and the suburbs.

Mario had intermittent attacks of paranoid schizophrenia. Most of the time, when he was reasonably well, he lived with his family. When he became uncontrollable, they would bring him into Oakdale Park for a few weeks to be medicated. He would recover and then return to his family. He would usually be admitted to a short-term, semi security ward.
I was working in that ward for a period of several weeks when Mario was brought in by two officers in a police wagon. We could hear him thumping, banging, and shouting in the back of the wagon when it stopped outside the ward.

One of the officers said, “We don’t know how we’re going to get him out”.

We had a guy on the staff who considered himself to be a martial arts expert. It was with some amusement that he was referred to as Mr. Kung Fu.

He said, “Just leave him to me. Open the back door of the wagon, and I’ll get him out”.

The back door was opened. In went our self-proclaimed expert, and within 30 seconds, out he flew, landing on his back on the ground. Then, six staff entered the wagon and dragged Mario out, struggling and shouting abuse.

Over the next few days, Mario became a little more controllable. He was an odd kind of guy. Although he was paranoid, his character was very conventional and conservative. His hair was always cut short, he was always neat and tidy, and he despised anyone who appeared unkempt. On one occasion in the shower room, he grabbed another young patient who had long hair. Somehow, Mario had gained access to a pair of scissors. He held that young guy down on the floor and cut off most of his hair.

His size and his unpredictable bouts of anger made Mario very intimidating. The day after his admission, Mario’s parents brought his car to the hospital car park and left it there, ready for Mario to drive around in the future when he started getting better and would be allowed to go out for the day. Our immediate duty was to check the car. We opened the trunk and found knives, homemade wooden weapons like clubs, and various other offensive items.

One day, I was in the ward by myself. It was lunchtime. I was sitting at the desk in the office, and behind me was the locked door to the outside of the ward. Mario walked through the internal office door while I was sitting in my chair, the desk between us. He stared at me with a very intimidating look and with a sly smile, he said, “What’s to stop me dragging you across that desk, knocking you down, taking the key from you, and walking out that door?”

He was leaning across the desk, and his face was three inches from mine. At that moment, Armageddon was happening inside me, but I didn’t show it on the outside. I tried to look as calm as possible.
To his question, I replied, ‘What’s to stop you, Mario? Me!”

He looked at me for a moment, and a big, meaningful smile came across his face. He just turned around and walked out of the office. I could not believe my luck. I thought my number was up.

From then on, Mario was polite, friendly, and respectful toward me. I couldn’t believe it! I think, even in his madness and paranoia, he knew that he could overpower me without any problem at all. I think he admired somebody who seemed to display some courage. He even tended to befriend me. If there was a problem with Mario, the nurse in charge would ask me to talk to him. Mario never became angry toward me from that moment on. We could have reasonable discussions, and he would accept my advice.

When the time came for Mario to leave the hospital, he shook my hand, gave me a large bear hug, kissed me on the cheek in the Italian fashion, and said good-bye and that he hoped he would meet me again in better circumstances (Gilham, 2011, pp. 84-86).

**Number 59**

In my role as a student supervisor for undergraduate Nursing Students during their Mental Health practicums I endeavour to instil positive attitudes as well as facilitating positive experiences for my students.

We discuss the importance of registered nurses providing comprehensive, non-judgemental, person-centred care to all patients regardless of their diagnosis. During these discussions the number of people who require assistance for mental health issues at some time and therefore the likelihood of nursing someone in any health care setting with a history of mental health issues or illness is raised.

I believe students developing skills in patient/client advocacy is essential to being an effective registered nurse. The importance of professional relations and difference between professional and social relationships is discussed in depth.

To facilitate this learning, I reflect on patients I have cared for, discussing the whole person. For example a patient with a diagnosis of Bipolar Disorder who was admitted to my ward on a regular basis. Often deeply depressed, somewhat dishevelled, poverty of speech and withdrawn. Despite this, Angie was a devoted, loving and caring mother. Her son Jack (who was a boarder baby in Children’s Ward when he was an infant),
was thriving well, beautifully dressed in immaculately clean clothes, had no rashes and was a contented baby. I nursed Angie for many years and despite the significant impact of Bipolar Disorder on her she consistently provided nurturing, mothering and care to Jack. Jack displayed behaviour consistent with a happy, well-mannered young man, who had an obvious close bond with his mother and father (NW1).

Number 60

I also discuss the importance for all people to feel they have a role. An example I use is a patient I nursed many years ago while working in a private religious mental health hospital. She was a religious nun who had been the bursar for her order until it was decided she should retire from this position and move to a convent where elderly nuns resided. This relieved Sr. Joan of any role or responsibilities which she confided distressed her and she felt redundant. She had a history of depression. Improvement in Sr. Joan’s mood and affect were evident following admission and medication adjustment. She also took on the role of praying and reading to a couple of very frail nuns on the ward. Having a purpose filled a void. Sr. Joan was always very resistive to discharge and stated she wasn’t permitted to do anything when she went home (NW1).

Number 61

Group of students arrived at Bankstown Hospital (where I was a NUM but had a fairly hands on role with the students because I was concerned about some of the other staff’s attitudes “rubbing off”). Saw students mixing with patients and congratulated them and we debriefed afterward. Transpires that they had been told never to say no to patients because this could make them violent so they were turning themselves inside out to avoid the word (ES).

Number 62

People wear the most peculiar things at work. Two students came straight from a building site wearing stubbies [very brief shorts for men], another had a T-shirt “Suicide is a beautiful thing”, and a staff member was wearing a top so low that I could see her belly button when she leaned forward, let alone most of her breasts. I had called her in to talk about the fact that a community carer of the older client’s wife rang to complain that this experienced but non-mental health trained nurse was visiting weekly, and sat talking to her husband whilst he masturbated. This had been going on for some time and the nurse neither reported it nor adjusted anything about her behaviour or dress.
Unfortunately I gave an involuntary gasp when I saw her cleavage and it was hard for me to remain impassive when talking to her about boundaries (ES).

**Number 63**

People in mental health facilities are vulnerable and we have a duty of care to them even if it costs us. In London, as a student, I reported a clerk for slapping a client with dementia. Unfortunately I was sent back to the same ward as a staff nurse. For the entire three months I was there this woman would not talk to me and would address me through someone else.

In fact this did not bother me very much because her behaviour said more about her than me (ES).

**Number 64**

More serious was a situation I found myself in as a new NUM in Sydney. The NUM before me had been compromised by something she had done which was against the rules. I avoided this and tried to tackle a situation whereby an EN was being cruel to patients and the night staff were sleeping all night and being rude to them. The EN used to watch patients undress, and had just been found not guilty of carnal knowledge of a developmentally disabled patient (impossible to prove given his vulnerability). First there was an anonymous note saying that I was “unprofessional” (it was misspelt). Instead of trying to hide it which was my instinct I published the note in the communication book and many staff commented on it and gave me their support and expressed outrage at the cowardice of the anonymous writer.

More worryingly was the occasion that the EN and I chased a patient who was running towards a road to throw himself under a car. We caught up and he stepped back, watched the patient assault me, and said that he knew where I lived and I was by myself. He also used to sidle up to me and say that he knew I desired him. All of this was hard to prove or report but I persisted and one day he threatened a patient with a chair in full view of several nurses and I was able to discipline him. It was hard to put up with the bullying but I could live with myself afterwards and am glad I persisted. In fact I had a postcard from a nurse who resigned after I had spoken to her about her treatment of patients. She thanked me and said that she had got caught up with the ward culture and lost her way and I had allowed her to rethink and regain her professionalism and caring.

Anna Elizabeth Treloar
Moral of the story is to persist in something however hard, if you know that morally it is correct – you can live with yourself afterwards and change will happen (ES).

Number 65

Some years ago, when I was working for the Mobile Treatment Team, a colleague and I attended the home of a 40 year old gentleman who had been referred via a local bank branch manager as he had apparently thrown a German Shepherd dog over the counter – in the days before the security glass – in protest in not being able to access any money from his father’s account after he had passed away some weeks earlier.

On attending the nondescript fibro home it was apparent, that this was no ordinary mental health assessment. We sat with the man in his kitchen/dining room, my colleague across from me, my back to a long display cabinet along one wall, and began to interview the man who was friendly if rather anxious. I became aware through the course of the interview that my colleague was distracted by something behind me, and in fact could not keep their eyes off whatever fascination they had discovered.

The man regaled us with tales of the close relationship he had had with his father – how they used to every day walk around the abandoned power station before eating two meat pies at the local yacht club (always two, not one), before returning home to watch the various television programs that they had recorded on duelling TVs and notarised in thick note books, until the close of their day when they would eat steak and onions…every night. The evidence for such habitual gustatory delights was very much in evidence in the vapours of the home. When his 76 year old mother had moved back briefly to the family home to help care for her ailing husband – after some years of estrangement – they used to tease her by filling her bed each night with the bones from their eaten steaks. She would apparently ignore them and stay in her room, playing video games.

By the conclusion of the interview it was clear that this man had relied on his father for everything and he was having a great deal of trouble adapting to his unwanted independence. On turning around to look behind me at last, I saw what must have been dozens of what can only be described as tiny beach shell people dioramas acting out gruesome death scenes that the man wished to have visited upon his sister over the years, many of which he was happy to elaborate upon, including death by decapitation should she fall from a circus trapeze (admittedly an unlikely scenario for a
married 47 year old check out lady at Coles), complete with hand painted splatters of blood. It was the most animated we had seen him throughout the interview.

We left him to his cornucopia of odours and promised to have a social worker contact him to help him with access to his bank accounts, contacted the RSPCA about the dog and drove off, bewildered yet hugely impressed by the peculiarities lurking behind the even the most bland of suburban facade (NW2).

Number 66

Asked to do a home visit in Broken Hill by a woman’s relatives, a friend knocked on the door of someone who had been off the mental health team’s books for some ten years. She answered the door with some difficulty and peered down at him from on top of a pile of newspapers. She had not thrown anything out for fifteen years and the level of the floor had risen alarmingly and she was stooped over on top of a pile which reached half way to the ceiling. Terry asked how she was. “Well, I think I have let things get on top of me” (ES).

Number 67

I started nursing at the North Ryde Psychiatric Centre now known as the Macquarie Hospital. The N.R.P.C. was built in 1965 by way of apology to the people of N.S.W. after the Royal Commission into the management of mental health in 1958. The N.R.P.C. was built on acres of beautiful park land with a distant view of the Sydney skyline and incorporated all that was bleeding edge in psychiatry at the time.

The N.R.P.C.’s glory days were already behind it when I arrived with my father for my employment interview just out of school in March 1977. Walking across the lawn to the head office, a young woman came bounding, literally bounding up to me, stopped right in front of me and with her head to one side resting on both hands in sleeping pose, said, “Are you Cro Magnon man?” The young lady was about my age, very well spoken dressed a little bizarrely and obviously mischievous.

I remember looking back at my father’s car behind me then to the office in front of me, thinking that this is a fork in the road. I said something inane, excused myself and went on into the office.
The young lady was indeed a patient of the hospital, having been admitted soon after leaving an exclusive Sydney ladies’ college. She was very disorganised, disinhibited and vulnerable.

Twenty years later I returned to Macquarie Hospital for a one-off agency shift and again met the young lady, who, like me, wasn’t so young anymore. She remembered me and I told her about our first encounter on my first day of nursing. Well, she laughed the laugh of one who was part of an intimate joke of many years standing, and she laughed on and off all that day. She kept looking at me and smiling and I think her joy that day was because she understood that she was a part of someone else’s life story in a positive way, a special place, really. I was so glad that I got to see her again and that I had the presence of mind to tell her our story (YR1).

Number 68

This is a story from the old Caritas ward in Darlinghurst where I worked for years as mostly an in-charge nurse. The story itself was reported by a colleague who overheard two patients having a conversation in the garden.

According to this nurse she was sitting in the garden not far from two patients who were having a conversation about Caritas. One of the patients was an older, more experienced one and the other a new arrival. Apparently the older patient was giving an introductory talk to the new arrival describing Caritas, including a rundown on staff.

At this point I appeared in the garden attending to some business. As I walked across the grassy area my colleague overheard the older patient telling the new arrival while pointing in my direction: “Don’t fuck with that bald cunt!”.

Naturally, my colleagues made sure that this stuck with me forever by regularly giving the same jolly warning to any new nurse joining the team (ID).

Number 69

I worked as a community mental health nurse for the first time in 1987 in Sydney when workers did a bit of everything - intake, acute care and case management. I had on my case load a recently married couple both of whom had chronic schizophrenia, both of whom had very recently come into very substantial amounts of money by way of inheritance; I think he got three hundred and sixty thousand dollars and she got two
hundred and fifty thousand dollars within a couple of months of each other. Neither had family of any kind and now they were both rich.

Before I was able to catch up with them I got word that they’d just bought a property. I was furious! I imagined some real estate agent unloading a dump for top dollar on to my vulnerable clients. I went storming around to their new address to discover that they’d acquired a light and airy ground floor one-bedroom unit with a large sunroom all newly renovated in Paddington pink and grey. The unit was about a hundred metres from the police station, even closer to a bus stop and within walking distance to the town centre. They paid eighty thousand dollars. The same unit today is worth about six hundred thousand dollars. I made a point of finding the real estate agent to apologise for the abuse I didn’t give her. She beamed at me saying that my clients obviously needed a lot of help so she looked after them.

Next came the fit out and I mean everything because my clients had been living in a hostel and had nothing between them except money. I went with, let’s call her, “Jo”, to David Jones [big department store in Sydney], where I pointed out a very nice little floor rug and said, “Do you like this rug, Jo?” She turned to me in a state of panic and said, “Oh dear! I don’t know! What do you think?” Jo was already overwhelmed and I didn’t have a lot of time to devote to this project. I said to her, “Do you trust me? Would you like me to buy the things you need?” She said, “Oh would you please?”

I called over the sales assistant and told him that I intended to furnish a complete unit here today and that I required two things from him: best quality everything and a fat discount at the end. He agreed and off we went - TV, video, linen, kitchen ware, furniture – everything. We spent ten thousand 1987 dollars that afternoon. I went around to the unit a couple of days after as the David Jones truck disgorged boxes upon boxes of merchandise, realising that now the real work begins – warranties, instructions, cubic metres of packaging, assembling and moving stuff. My clients sat amongst it all not sure if they were allowed to touch anything or not. I was about to quit nursing when along came Phil! Phil was also a client of our service and a good friend of my clients. He took one look at the treasure trove and said, “Wow!” He then proceeded unbidden to open the nearest box, pull out an instruction pamphlet and read it. Apparently, Phil loves “things” and was happy to help my clients sift and sort everything which he did day after day until everything was done.

Back at the office I told a co-worker about setting up house for my clients and she said, “What about me! I had to marry them off!” Apparently she had to organise the wedding,
dress, bridal party, venue – everything to do with a wedding! I got off light! My clients gave me a little ceramic Buddha by way of thank you for helping them and although I don’t accept presents of course, I made an exception on this occasion because it was such an unusual gig and besides, I had just discovered Buddhism for myself and I saw their little gift as quite serendipitous (YR1).

Number 70

A Registered Nurse at an adult inpatient facility tried to explain why students were not allowed in the “fully secluded” observation area of the facility. The RN told a story about an Aboriginal man that had been very violent and difficult to manage while at the facility. The staff decided to put him in the isolation room following an aggressive violent fight with another patient. There were three staff members, from memory, needed to sedate and physically move the patient into the isolation room. According to the RN, no sooner had they closed the door of the isolation room than the man had taken his T-shirt off, ripped it into a long strip of fabric, tied it around his neck and was attempting to hang himself.

This story scared me, particularly about the vulnerability of the patient and how quickly things can happen (NO3).

Number 71

While working as an undergraduate AIN [Assistant in Nursing] I was mentoring a new staff member that had some experience in aged care but never in an acute dementia care setting. I was describing one of the residents as ‘the alpha male’ and told her that he becomes quite physically aggressive and that he should always be cared for by two staff members. At dinner time, I could hear the new staff member calling out from down the hallway for help. So I rushed down to find her with the resident, who was covered in faeces and becoming very resistive to the staff member trying to direct him to the toilet. I went into the room and held on to the resident’s free hand and no sooner had I done that, the new staff member had let go of his other hand and the resident punched me straight in the mouth. The new staff member became very upset and said that she never wanted to work in this work again and that she was terrified of this particular resident (NO3).

Number 72
When on my recent clinical placement a RN asked me what I wanted to do after I graduate, I said that I want to do mental health nursing. The RN said to me that I will find it very difficult to get out of mental health nursing if I do my new graduate position in mental health and that I would be better off doing a general nursing new graduate position (NO3).

Number 73

Biggest story I have absorbed is that ALL mental nurses are lazy, and do nothing.

This was not my experience at my placement. I think this opinion comes from a lack of understanding of mental health nurses’ role and [lack of] acceptance of mental illness (NO3).

Number 74

On my medical [mental] health placement during my second year of study, I had the privilege to meet an outstanding woman that was actually a patient of the facility. I felt that I had a lot of free time on my placement and spent quite a considerable amount of time talking to this particular patient. She was experiencing auditory hallucinations and would often answer to these voices which occasionally made it difficult to hold a very meaningful conversation. Over the course of the two weeks she had told me the most remarkable stories about her time during the war and serving as a spy in New Guinea watching and listening to the Japanese on the radio. She spoke of the horrible weather conditions and the cruel nature of what she heard during these radio transmissions. She also told me about her first husband that she had met during the war, that he was an American airman and that she had returned to America with him and that he had not been the same person on returning home. She spoke about her second love, a gardener, that she never married but still spoke of as being “the love of her life”. The staff in this ward would remark at the end of each shift that her stories are elaborate fantasies and [say] “Wouldn’t it be nice to be able to see inside her head?”. On the last day of my placement my RN mentor asked if I would like to sit in on a family conference about this lady and her niece that lived interstate would be on teleconference. I jumped at the opportunity because I was interested to see how the conferences worked and secretly I wanted to hear from the niece a little bit about this lady. I was shocked to find out that her stories were completely true and not delusions as had been thought by the nursing staff. This woman is a war hero and responsible for the safe passage of some soldiers through her intelligence work. I decided that day that
I would never assume that what a patient tells me is not the truth and that I would always listen with compassion, understanding and [be] non-judgmental. (NO3).

Number 75

Looking after an orthopaedic patient who had a below knee amputation. Had been in the hospital for two months prior. I was able to give him his first shower since the accident. I allowed him to take his time. At the end of the shower, I wheeled him to the basin so he could clean his teeth. He looked at himself in the mirror and stated, “This is the first time I have looked at myself since the accident”. We had an amazing and what I consider to be a therapeutic conversation. I felt well within my scope.

Later that afternoon I told my facilitator about this and she was livid. She thought that dealing with this patient’s mental health was a problem I had to deal with – that I shouldn’t have been exposed to that sort of thing (YR2).

Number 76

At an aged care facility a resident had isolated herself in her room. She had been diagnosed with terminal bowel [cancer]. She was ignored by other staff. No one had addressed her mental health and it seemed she was deemed as a “pain” and not worth the staff’s time.

[When this story was told in a workshop, the teller added that she asked the woman how she felt and the patient cried, and said nobody had done that before] (YR2).

Number 77

I worked an afternoon shift in Ward 7 (Admissions) on Australia Day and when I collected the list of Special Observation patients, I saw one named Cranston Snord. So I said, “Who’s this Cranston Snord?” and the others said, “Oh, don’t worry about him; we think he ran away”. It turned out some enterprising nurse on the morning shift had invented him and the nurses spent the rest of the day gleefully writing up fictitious nursing progress notes about him. He was a Buddhist and was very distressed on admission when his request for a bed of nails was refused; however he cheered up when suspended from a light fitting by his toenails. Later in the day he forgot himself and bit off the charge nurse’s nose and they had to recommend fasting, in preparation for a course of ECT and psychodrama, which they were confident would effect a cure on the following day. When the night staff came on, I said, “Watch out for Cranston
Snord” and they looked bewildered – probably they spent the rest of the night doing headcounts trying to find him (RA).

Number 78

I was relieving in the Admission Office on Australia Day and a very foolish patient from Rydalmere Hospital arrived by taxi, without the fare (a favourite psychiatric patient trick is cruising around in taxis, returning to the ward and leaving the staff to soothe the driver and arrange payment). This girl had decided she’d rather be a patient at Gladesville so she’d walked out of Rydalmere to try to effect a transfer. She’s famous for this sort of behaviour. She didn’t want to give her real name so she invented one, modelling it on the Yugoslav names she half knew. She produced something like Gavratilova Navritikolov, very ingenious, but when asked to write it, she couldn’t! This made the Admission Nurse most suspicious, and after a lot of telephone and cross-checking, she sorted out what was going on. The medical officer on duty saw the girl for 15 minutes and sent her back to Rydalmere. Next time she will probably call herself Mary Smith! (RA).

Number 79

Today I assessed a chronic schizophrenic who’s done labouring jobs all his life and left school after repeating Second Year, and yet scored well on work knowledge tests and turned out to have an interest in and aptitude for art. We had a birthday party for the other nurse, with a pink iced cake and candles and a big pot of tea (also grapes, orange juice and a plate of iced cakes). Guests included two clinical psychologists, two assessment nurses [students], one registered nurse, one secretary, one heroin addict, one alcoholic and one schizophrenic. Patches the cat stalked in but I insulted him so he left crossly. Dog Toby made a beeline for Alf the Alcoholic and had a long friendly talk with him. It was fun but we forgot to ask the Social Worker who had locked herself in her room and was silently writing reports. She forgave us and we gave her a creamcake (RA).

Number 80

Busy two shifts – lots of old ladies wetting their beds (as the male nurse remarked gravely the next morning, “Yes, we had a very wet night”), and an old Yugoslav lady wheezing and groaning in such an alarming manner that I rang up the night supervisor for advice. She (with enormous common sense) pointed out that if I called out the duty doctor and clanked to the bedside with oxygen cylinders the old lady would certainly
die of fright, and suggested a cup of tea and a kind word! As it was, the old lady woke up to find me taking her blood pressure, and two male nurses looking important at the end of the bed, and rolled her eyes and said, “I’m finished!” “No, you’re not”, I said firmly, “You’re going back to sleep in a minute”. Which she did (RA).

Number 81

The nursing home matron told us a funny story about the official cat, Abigail, who was tactlessly very much in evidence when a Health Commission official visited. The official began to complain, but the matron said, “Cat?? What cat? This is a psychiatric nursing home and you’re hallucinating like the rest of them!”. The official went downstairs, saw a bird in a cage in one of the bedrooms, and said firmly, “I don’t see it!” (RA).

Number 82

And now for a piece of black humour. Psychiatric nurses keep themselves going by laughing horribly over jokes like this. The Deputy Matron had the task of showing some relatives of a prospective new patient over the nursing home. “And this”, he said proudly, “is a very nice little three-bed room with its own balcony”. “Oh, I don’t think that would be quite suitable”, said the daughter, “You see, Mum’s just tried to jump off a balcony” (RA).

Number 83

I am working in the two worst wards at the moment. The nurses that do best are big cheerful strong girls without too many thoughts in their heads – for them it’s an efficient industry for feeding, washing, toileting and bedding down old ladies. They make a lot of loud hearty noise and don’t notice what they’re doing. Speed and efficiency are valued more than anything else here. I miss the psych nurses – they at least prize individuality in patients and fellow nurses (RA).

Number 84

A reminiscence from my Gladesville days, a story from another Gladesville trained nurse who is also working here. While he was Admissions and Night Sister in the Admissions Ward, one night a policeman appeared at the door at 3 a.m., leading a cow which he’d found on Victoria Road (it belonged to a Gladesville doctor). The nurse told the policeman he couldn’t possibly admit the cow and shut the door. The policeman crossly tied it to a fire hydrant and went away (RA).
Number 85

I went to visit my favourite patient (Joseph) – the man who’s lost both his legs, the use of his right arm and his speech. A mean old bat of a sister was in charge of the ward but I marched in firmly and she glared at the bag of presents I was carrying. I couldn’t wrap them because with one hand he wouldn’t have been able to open them. He was very pleased to see me and we had a muddled aphasic-type conversation with more goodwill than clarity. He managed to wish me a merry Christmas and I gave him two kisses and said I had to leave to go on duty. With great feeling, he said to me, “Anyway, sixpence!” So I replied, “Yes”, because it was impossible to mistake the warmth in his tone. Stroke patients often start off in their head meaning to say something and find quite a different word comes out of their mouths. Which is what happened to poor Joseph. If I write a book about nursing, I will call it, “Anyway, sixpence”. It’s one of the nicest things anyone’s said to me (RA).

Number 86

I have been a naughty nurse and had a spot of bother (like Frank Spencer). While I was in charge of two wards containing 56 confused and demented patients, one got out and went for a walk in the bush, got lost and was rescued by police helicopter. Sunburnt, but otherwise unscathed. Unfortunately, he doesn’t remember anything about his pleasant bushwalk or his thrilling ride to Wollongong Hospital for observation in a police helicopter. Meanwhile, back at the ward, poor Sister had to ring the patient’s wife (she was out), notify the supervisors’ office, ring all the police stations, be interviewed by a constable from Helensburgh, write the ward report, write the contingency report, visit the duty supervisor, explain myself, and write a statement which will be perused with interest by the matron tomorrow. The nurses who were actually working in the men’s ward at the time were unperturbed by the whole thing as they knew it was my responsibility to get my ear chewed for the incident. I am not in really big trouble – all the senior nurses said it could happen to anybody, and the duty supervisor told me he’d once taken ten patients into the bush and one had been lost for a whole month. It is a hazard of psychiatric and geriatric nursing, especially in a hospital situated in the bush. The irony of the situation is that after dealing with all the consequences, I had to come back to my room and write an assignment on this topic – “Compare and contrast the advantages and disadvantages of home care versus hospital care for the early demented patient”. I had planned to say that hospital offers a safe environment. I have now modified my views (RA).
Number 87

A man rang the PECC unit the other night, quite obviously intoxicated and proceeded to yell down the phone about his neighbour who was using ice and selling drugs. I asked where he was calling from and he said Sydney, so I asked why he had called Newcastle. He then launched into a tirade of abuse, saying “no f...er wants to f...ing help and they all hang up!”. I (very calmly) pointed out that there was little I would be able to do from Newcastle and suggested he call the police, at which stage he again launched into another tirade calling me an “incompetent c...”. I was silent and he eventually spluttered into silence. Continued silence and a sheepish voice from him, “Hello? Have you hung up on me yet?”. “No”. “Why not?”. “I wanted to see if you would calm down”. “F... off”, and he hung up (SI).

Number 88

A year or so ago I was working as a shift manager on nights. A man of about 85 years of age became increasingly restless and agitated. He had a progressive dementia and he was more disturbed than any patient I had cared for in my 25 years or more of nursing. That night, two nurses were required to care for him.

Around 0300 hours Peggy (the other nurse I was working with) observed that, in spite of his verbal lashing-out, he had never once cursed. She remarked that he must not have “bad” words in his normal vocabulary because usually what is in a mind comes out in confusion.

The night wore on with our patient experiencing agitation, yelling, and extreme restlessness. He would bite his own hands and arms and grab on to anything near him. We began to wonder if we could ever help him rest. I remember feeling helpless and hopeless.

Then I heard him repeat a series of words in a garbled fashion and recognised the words of an old hymn. I began to sing the hymn and immediately he became quiet. The change was instantaneous and profound. Peggy was able to leave for a break while I sat beside him singing every hymn I could remember. As long as the hymns were sung, the patient rested.

We later found out that the man had been a lay pastor. He was loved by many, many people.
I loved being his nurse because none of the usual textbook interventions worked. He required flexible, creative nurses who were not afraid to try the unconventional and who were willing to stay... (Perry, 2005, p.45).

**Number 89**

One elderly fellow I will always remember. He was a hermit; he lived in the mountains. Every day he would get up at 4:30 a.m. I would find him up in the lounge just sitting and smiling. The first time I saw him there I said, "You're up...why can't you sleep? Do you have pain? Would you like some warm milk? Shall I have the doctor order you a sleeping pill?" He just said politely, "No, no, no, no, I always get up early at home. You know the birds sing their best songs in the morning."

I just let him go with his agenda. What was I going to do, put him back to bed? He was 88 years old, and he had seen many early mornings.

I remember him because he wasn't a man of many words. I just sat with him. We both knew darn well there weren't any birds to hear, but we just sat there listening.

I just sat with him.... We didn't talk much. I thought if I had been living alone all those years I wouldn't have much to say either. I just knew it was a great morning start for him. What I think he meant was; you do your best in the morning (Michaud, Levy & MacMillan at Beth Perry Athabasca University Moments site).

**Number 90**

A physician approached the nurse I was watching and asked her to come to take a look at Mr. Bill S-----. Entering the room, we find a man lying in bed, silent, and staring at the wall, his eyes fixed. The doctor concludes that the patient is close to death, and that the diagnostic test scheduled for Mr. S----- that day should be cancelled.

After the physician leaves, the nurse does her own assessment of the patient. She goes close to him and studies him very intensely. Placing her hand on his forehead she says, "Bill are you sad? Are you sad because today is your birthday?" She stays in this pose for a few minutes, waiting for a response, a signal, a clue from the patient. I see nothing. She sees what she needs to see.
Leaving the room, the nurse walks up to the doctor and says, "I think you are wrong about Mr. S-----...his eyes are reacting. He is not dying, he is just down and depressed."

During the day as we visit Bill's room he becomes more and more responsive. The nurse talks to him about his life, asking him questions about his children and his birthday wishes. At first he doesn't say much, but eventually he begins to talk.

Just before change of shift, the nurse gathers her colleagues together to help her surprise Bill with a cake. Together they sing the most rousing and sincere happy birthday song I have ever heard. The man who was supposedly taking his last breath cuts the cake, and eats a piece with his tea which the nurse had carefully steeped to his liking and served to him in a china cup.

In a final demonstration of caring, she places a birthday kiss on Bill's forehead, setting an example for the other nurses who follow her lead. As we leave the room and bid Bill a happy evening, I see the sparkle of life that has returned to those eyes. Bill has hope (Michaud, Levy and MacMillan at Beth Perry Athabasca University Moments site).

Number 91

Eddie told me this story. He was on night duty in the ten bed Acute Psychiatric Unit at Wollongong. One young woman could not get to sleep so he sat on the end of her bed and told her to imagine she was in a boat gently rocking on the water. Over several minutes he built up the imagery for her and she began to settle and relax and seemed close to sleep. But when he got up to leave, she wailed, "Oh but Eddie...I want you in the boat with me!" (RO).

Number 92

Eddie told me another story too. When Largactil was a new drug, he was working in Scotland. He and a friend soaked some bread in Largactil and then threw it on to the roof where seagulls gathered. The seagulls ate the bread and Eddie said it was the funniest thing to see them staggering around, losing their balance and trying to fly (RO).

Number 93
Eddie told me another story about Largactil as well. A night nurse complained to him that she could not sleep during the day because the neighbour’s dog barked a lot. Eddie suggested she give the dog some bread soaked in Largactil to make it sleep. She did this, but when Eddie asked how the plan had worked, she told him that the dog fell asleep in the middle of the road and was run over accidentally (R0).

Number 94

It was a Friday evening shift in winter. I was working with a male colleague on a voluntary ward which was at maximum, 10 inpatients ranging in age from 24 years to 75 years. At 1850 the front doorbell rang and I responded per intercom to a hooded male.

“Good evening can I help you?”.

He replied, “Let me in, I want to see someone”. To which I replied, “Who would you like to see? Are you wanting to see a doctor or are you visiting someone?”.

The hood replied impatiently, “Just let me in, open the door”.

At first I was wary but now this concerned RN replied firmly, “I am unable to let you in unless you can tell me what is it you want”.

The hood grumbled something incoherent into the intercom and, surprising me, suddenly turned from the door and walked away. My internal alerts were glowing – warning, warning. Immediately I forewarned my colleague who fortunately had heard part of the conversation and agreed this person may present a problem. We attempted to page for a HASA [Health and Security Assistant] to attend from the general hospital, but before the page was answered, in fact it was never answered, we observed the hood return to the front door.

He rang and asked to be let in. Again I replied, “I am unable to let you in unless you can tell me what you require”. He replied loudly, “Then I will let myself in”. To my astonishment (why on earth would anyone break into a mental health unit?), he threw two almighty kicks with his large foot into the locked automatic front doors, and walked into the front foyer. From our vantage point, the nurses’ station, it looked as though he had walked through the glass doors. My colleague had hit the duress and we were confronted with him at the station door.
He opened the door and walked into the office and pulled, rather ceremoniously, from his jacket, a large dirty kitchen knife. I think the pointed tip had been broken off. We had thought the nurses’ station door was locked but the lock was broken and even though we checked the snip, the door was never going to lock. The hood looked us over as I made soothing noises and slowly gesticulated ‘please put the knife down’. (I was unable to speak at this point). But the hood’s interest had narrowed to my male colleague and he was jabbing the knife toward him as he attempted to talk him down. I could see the patients from the office and knew several of them were in their room, however those I could see looked oblivious to what was happening. So in my hurried and almost panicking thoughts I knew I had to warn the duress team that the incident they were responding to included a weapon. I slowly edged my way from the office, as the intruder looked perplexed and under the influence of a substance. He was still menacing my colleague but had not escalated his behaviour. I successfully left the nurses’ station and made my way to the door where the team would arrive, very disappointed they were not already there and guilty that I had left my team member to continue fending for himself. However, we needed the Police ASAP.

In the meantime one of the patients noticed that there was an intruder in the office and [that] he was threatening the male nurse. She entered the office and grabbed him from behind around the neck. The hood was so surprised that he dropped the knife and left the office and went to the TV room and sat down forlornly with one of our patients, who, realising what had occurred, spoke calmly and quietly to him. My colleague fortunately was safe by the time and the duress team and Police arrived.

My life span was shortened by 10 years that evening but everyone was safe even though it could have turned out very badly. Our workplace has been renovated to make it more secure against intruders with violent intent (YE).

**Number 95**

I tell this to students about best practice, resourcefulness and to look at the ethics of the situation.

Here is something that would be very hard to document in someone’s case file. The crisis team looked after a person diagnosed with schizophrenia, he was chronically paranoid, hospitalisation did nothing to improve his condition but made him very miserable because he valued his own company above all else. Various medications had been tried to little effect but a monthly Modecate injection kept him out of hospital.

Anna Elizabeth Treloar
However, he did not let the crisis team into the house. After several years of abortive attempts to gain access and hospitalisations as a result of his non-compliance with medication, the team and him came to an agreement. They knocked on his door once a month, he pulled his trousers down, backed up to the screen door and they injected him through that (ES).

**Number 96**

One of my patients at Bankstown had long term relapsing schizophrenia and a crush on her psychiatrist. At the time there was a shampoo ad for Decore [http://www.youtube.com/watch?v=1b3p8cJeNgc](http://www.youtube.com/watch?v=1b3p8cJeNgc) (please watch this for the lyrics) of a man shampooing himself in the shower. Whenever she saw this ad (which was probably every fifteen minutes) it said to her that Dr Andrews was in love with her. The other problem was that it was such a catchy tune that many of the nurses and patients found themselves humming it as they went about their business (ES).

**Number 97**

One of my young men with schizophrenia tried to sue Johnny Farnham for stealing his lyrics for “The Age of Reason” (ES).

**Number 98**

A 19 year old man presented to our ward with his first episode of mania after having spent the night in King’s Cross. He was dux of his class, shy and likeable, expected to finish his university degree with great distinction. It was totally out of character for him to go down to the Cross, he got drunk, tried IV drugs for the first time and slept with a sex worker. The consequences of this one night was that he contracted HIV, ruined his reputation and finished his relationship with his long-term girlfriend (ES).

**Number 99**

I was working in Primary Health at a large rural gaol. The prison officers knew that I was a Mental Health Nurse and one day a female officer asked me to come and talk to a female indigenous prisoner who was “a bit upset”. At the time that gaol had no mental health nursing service.

We three women sat together on a bench in the very large grassy yard with gum trees in the background and high walls all around.
The young prisoner told me about her life. She had been imprisoned several times before and had a young child she hoped to see again soon. She was about to be released and told me proudly that she would be ok this time and said, “I’ve got my furniture”. It was stored in her mother-in-law’s garage. She was more settled after using her time with us to tell her story and make some plans for when she got out.

Many months later I heard that she had been imprisoned again (while intoxicated) in a rural gaol in the south of the state, a long way from where I had met her. She had hanged herself in her cell overnight.

A brief television news item later showed her grave and her family mourning her death next to it.

I will always remember her name and her pride in her furniture and feel sad that it was not enough to undo all the negative experiences of her short life (RA).

Number 100

The other night I was called by the ED registrar to see if PECC would accept a 28 year old patient from ED who was grossly psychotic. Paranoid, abusive, aggressive. She was echolalic and incoherent at times. The registrar said she was the most obviously psychotic patient he had seen. We reviewed past mental health contacts and the last was 10 years ago with a history of substance abuse and no psychosis. She had a history of thyroid problems but was asymptomatic for thyrotoxicosis and her drug screen was clear. I advocated with the registrar that a more thorough medical clearance was probably warranted, given the rapid onset of psychotic symptoms (as it is unlikely that a person with no previous psychotic symptoms would develop such severe symptoms suddenly). It turned out that she was thyrotoxic, but without the usual physical symptoms. She was admitted to a medical ward and discharged the following day, avoiding involuntary mental health detention, probable delayed medical treatment and stigma. When I discussed this later with the ED registrar he said he was beginning to wonder why they had to medically clear patients who seemed to be psychiatrically unwell and this patient had shown him the importance of excluding physical causes for psychiatric symptoms. WIN! (SI).
Appendix 3: Ethics Approval

HUMAN RESEARCH ETHICS COMMITTEE

Notification of Expedited Approval

To Chief Investigator or Project Supervisor: Conjoint Professor Margaret McMillan
Cc Co-investigators / Research Students: Conjoint Professor Teri Stone
Ms Anna Treloar

Re Protocol: What is the purpose of clinical anecdotes told by mental health nurses to undergraduate mental health nursing students?

Date: 03-Sep-2012
Reference No: H-2012-0123
Date of Initial Approval: 03-Sep-2012

Thank you for your Response to Conditional Approval (minor amendments) submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under Expedited review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is Approved effective 03-Sep-2012.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual

Anna Elizabeth Treloar
progress reports. If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal Certificate of Approval will be available upon request. Your approval number is H-2012-0123.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for Monitoring of Progress, Reporting of Adverse Events, and Variations to the Approved Protocol as detailed below.

PLEASE NOTE: In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- Monitoring of Progress

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

- Reporting of Adverse Events

1. It is the responsibility of the person first named on this Approval Advice to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
   - Causing death, life threatening or serious disability.
   - Causing or prolonging hospitalisation.
Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure. Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma. Any other event which might affect the continued ethical acceptability of the project.

5. Reports of adverse events must include:
   o Participant's study identification number;
   o date of birth;
   o date of entry into the study;
   o treatment arm (if applicable);
   o date of event;
   o details of event;
   o the investigator's opinion as to whether the event is related to the research procedures; and
   o action taken in response to the event.

6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

Variations to approved protocol

If you wish to change, or deviate from, the approved protocol, you will need to submit an Application for Variation to Approved Human Research. Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation.

Variations must be approved by the (HREC) before they are implemented except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

Linkage of ethics approval to a new Grant

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Professor Allyson Holbrook

Chair, Human Research Ethics Committee

For communications and enquiries:
Human Research Ethics Administration

Research Services
Research Integrity Unit
HA148, Hunter Building
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 18999
F +61 2 492 17164
Human-Ethics@newcastle.edu.au

Linked University of Newcastle administered funding:

<table>
<thead>
<tr>
<th>Funding body</th>
<th>Funding project title</th>
<th>First named investigator</th>
<th>Grant Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Anna Elizabeth Treloar</td>
<td>299</td>
</tr>
</tbody>
</table>
Appendix 4: Ethics Approval (Variation)

Notification of Expedited Approval

To Chief Investigator or Project Supervisor: Conjoint Professor Margaret McMillan
Cc Co-investigators / Research Students: Conjoint Professor Teri Stone Ms Anna Treloar
Re Protocol: What is the purpose of clinical anecdotes told by mental health nurses to undergraduate mental health nursing students?

Date: 09-May-2013
Reference No: H-2012-0123

Thank you for your Variation submission to the Human Research Ethics Committee (HREC) seeking approval in relation to a variation to the above protocol.

Variation to:

1. Expand the participant group to include undergraduate nurses who have completed a clinical health placement.

2. Conduct a workshop for undergraduates and new graduates.
   - Participant Information Statement, version submitted 15.4.2013
   - Consent Form, version submitted 15.4.2013.

Your submission was considered under Expedited review by

Anna Elizabeth Treloar
the Chair/Deputy Chair.

I am pleased to advise that the decision on your submission is Approved effective 08-May-2013.

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal Certificate of Approval will be available upon request.

Professor Allyson Holbrook

Chair, Human Research Ethics Committee

For communications and enquiries:

Human Research Ethics Administration

Research Services
Research Integrity Unit
The Chancellery
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 18999
F +61 2 492 17164
Human-Ethics@newcastle.edu.au


Linked University of Newcastle administered funding:

<table>
<thead>
<tr>
<th>Funding body</th>
<th>Funding project title</th>
<th>First named investigator</th>
<th>Grant Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna Elizabeth Treloar</td>
<td>301</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5: Poster

ARE YOU A NURSE CURRENTLY WORKING IN THE MENTAL HEALTH FIELD?

WOULD YOU BE WILLING TO TAKE PART IN A RESEARCH PROJECT ABOUT THE EDUCATION IN MENTAL HEALTH OF UNDERGRADUATE NURSING STUDENTS?

I am interested in the clinical anecdotes which nurses working in mental health tell to undergraduate nursing students and to new recruits about their own clinical experience.

These stories are not formal case studies but short (500 words or less) stories about incidents which the teller sees as significant, exemplary, puzzling, provocative, challenging or problematic.

There is a wealth of these stories in mental health nursing; however their purpose has rarely been examined or analysed.

This study aims to record some of these stories and investigate their purpose.

If you agree to provide a story, your name will not appear in the final report and your personal details will remain confidential.

Informed consent is required before you proceed and you are free to change your mind and withdraw your consent at any time without giving a reason.

This project forms part of my Master of Philosophy candidature in the School of Nursing and Midwifery at the University of Newcastle, Callaghan NSW 2308. It is supervised by Professor Margaret McMillan and Professor Teresa Stone.

If you would like more information please email

Anna.treloar@newcastle.edu.au

Anna Elizabeth Treloar
Appendix 6: Information Statement for the Research Project

Professor Margaret McMillan
& Ms Anna Treloar
School of Nursing and Midwifery
University of Newcastle
Callaghan NSW 2308.
Mob: 0408 431 269
Margaret.McMillan@newcastle.edu.au
Anna.treloar@newcastle.edu.au

Information Statement for the Research Project:

An exploratory study of clinical anecdotes used by nurses working in specialist mental health areas with undergraduate nursing students.

Document Version H-2012-01233 dated [29/08/12]

You are invited to participate in the research project identified above which is being conducted by Ms Anna Treloar and Professor Margaret McMillan from the School of Nursing and Midwifery at the University of Newcastle and Professor Teresa Stone from the Faculty of Health Sciences at Yamaguchi University Ube Japan.

The research is part of Anna Treloar’s studies at the University of Newcastle, supervised by Professors McMillan and Stone.

Why is the research being done?

The purpose of the research is to collect clinical anecdotes about mental health nursing practice which nurses who work in specialist mental health areas use with undergraduate nursing students to assist with their orientation to practice and ongoing education. These anecdotes will be analysed to discover significant aspects of their content and to determine the purpose of telling the story.

Who can participate in the research?

We are seeking nurses who work in specialist mental health areas.

Anna Elizabeth Treloar
**What choice do you have?**

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you.

If you do decide to participate, you can withdraw from the project at any time without giving a reason and have the option of withdrawing any data which identifies you.

**What would you be asked to do?**

If you agree to participate, you will be asked to attend a one day workshop and provide one or more clinical anecdotes about mental health nursing practice for discussion at the workshop and later analysis by the researcher.

These anecdotes will be stored securely at the School of Nursing and Midwifery for at least 7 years and the names of the author removed if as a result of the project further work is undertaken in the form of journal articles or texts.

**How much time will it take?**

The workshop will last for no longer than one 8 hour day.

**What are the risks and benefits of participating?**

We cannot promise any benefit to you from participating but we believe that the stories will provide beneficial learning stimuli for future mental health nurses and will serve an educative purpose for you personally.

**How will your privacy be protected?**

Any information collected by the researchers which might identify you will be stored securely and only accessed by the researchers unless you consent otherwise.

Data will be retained for at least 7 years and held at the School of Nursing and Midwifery at the University of Newcastle. If authors provide their names, these will be removed before storage.

**How will the information collected be used?**

The aim of the study is to explore and explain the rationale underpinning the clinical anecdotes used by nurses working in specialist mental health areas to undergraduate nursing students.

The objectives are to:
1. Collect narratives from experienced nurses in order to interrogate the purpose of their use in practice and education

2. Analyse the stories collected to more fully appreciate the educative value and therapeutic intent for neophyte nurses

3. To compile a resource of exemplars depicting actual practice for use as educational stimulus material.

The information collected will be used as part of Anna Treloar’s Master of Philosophy thesis.

Individual participants will not be identified in any reports resulting from the research.

A summary of results will be provided to participants on request.

**What do you need to do to participate?**

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher.

If you would like to participate, please:

- Email your intention to attend the workshop to anna.treloar@newcastle.edu.au
- Attend the workshop and complete the attached consent form on arrival.
- Participate by writing down one or more clinical anecdotes about mental health nursing practice.
- Ensure you do not identify any patient in your clinical anecdotes.

**Further information**

If you would like further information please contact Professor Margaret McMillan Margaret.McMillan@newcastle.edu.au

Thank you for considering this invitation.
Professor Margaret McMillan
Conjoint Professor
School of Nursing and Midwifery

Ms Anna Treloar
MPhil Candidate
School of Nursing and Midwifery

*Complaints about this research*

This project has been approved by the University’s Human Research Ethics Committee, Approval No. H- .

Should you have concerns about your rights as a participant in this research, or have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 4921 6333, email [Human-Ethics@newcastle.edu.au](mailto:Human-Ethics@newcastle.edu.au).
Appendix 7: Consent Form

Consent Form

Professor Margaret McMillan (chief investigator)
School of Nursing and Midwifery
University of Newcastle
Callaghan NSW 2308
mob: 0408 431 269
Margaret.Mcmillan@newcastle.edu.au

Anna Treloar (student researcher)
School of Nursing and Midwifery
University of Newcastle
Callaghan NSW 2308
Anna.treloar@newcastle.edu.au

Professor Teresa Stone (co-investigator)
School of Health Sciences
Yamaguchi University
1-1-1 Minami-Kogushi
UBE, Yamaguchi
755-8505 JAPAN
teriston@yamaguchi-u.ac.jp

An exploratory study of clinical anecdotes used by nurses working in specialist mental health areas with undergraduate nursing students

Anna Elizabeth Treloar
Consent

- I acknowledge that I have read and understand the information statement provided.
- I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
- I understand that the aggregated results will be utilised for research purposes and may be reported in scientific and academic journals.
- I agree to participate in the above research project and give my consent freely.
- I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing and have the option of withdrawing any data which identifies me.
- I understand that a summary of results will be provided to participants on request.

I consent

- to attending and participating in a workshop to collect clinical anecdotes used by nurses working in specialist mental health areas with undergraduate nursing students.
- to providing one or more clinical anecdotes in written form for discussion and later analysis.

I understand that my personal information will remain confidential to the researchers.

I have had the opportunity to have questions answered to my satisfaction.

Print Name: Anna Elizabeth Treloar

Signature: Date:
Appendix 8: Workshop Plan

Workshop Objectives

- Demonstrate strategies which maximise clinical reasoning skills learning in a range of patient situations in a simulated learning environment
- Cause students to view themselves as action-oriented learners

Appropriate size of audience: 50

Abstract

This workshop centres on a simulated learning event, common to a Problem-based curriculum, in which participants are caused to question and justify practice, to think about care situations and to perform actions (clinical interventions) to best manage those situations. It models an integrated approach to learning which values thoughtful, highly skilled and efficient action and the ability to examine clinical situations, deconstruct them from a number of perspectives, and reconstruct them around core concepts essential to practice.

Description of the workshop and rationale for importance

Health professions have not fully appreciated the integration of thinking and doing to create informed action, and have historically tended to ‘compartmentalise thinking from doing’ (Pearson 1992, p.219). This does little to promote integration of theoretical and clinical learning activity.

This modelling of simulation provides a modality for experiential learning and evaluation and demonstrates a risk-free environment where learners can integrate theory and practice without the fear of harming patients. This is especially important when real-life experiences are discouraged given such risk. When integrated appropriately into learning and competence testing, simulation plays an important role in acquiring the critical - and reflective-thinking skills needed for competent, safe patient care (Gaba, 2004; Seropian, 2003). Simulation, as defined by the NCSBN (2005), is an educational process. This simulated learning experience imitates the working environment and requires the learner to demonstrate procedural techniques, decision making and critical thinking. It exemplifies an educational technique (not pure technology) in which elements of
the real world are appropriately integrated to achieve specific goals related to learning or evaluation.

While there is increasing emphasis on development of cognitive abilities in students and recognition of the complex nature of contemporary practice, this should not lead to a dichotomy between clinical skills and theoretical knowledge. Some suggest that emphasis on theoretical knowledge results in a devaluing of clinical skills and, consequently, devaluation of clinical practice practical and theoretical knowledge are inevitably and infinitely intertwined.

Recent decades have provided evidence of a paradigm shift in education, which now views learning as the construction of meaning in context rather than *what to learn* and *how to do things* (McMillan and Conway, 2006). Contemporary education challenges health professionals to question and justify practice, and emphasises the ability to think about care situations and to perform actions (clinical interventions) to best manage situations. The challenge centres on learning which values thoughtful, highly skilled and efficient action, the ability to examine clinical situations, deconstruct them from multiple perspectives, and reconstruct them around core concepts essential to practice.

Problem based Learning (PBL) is a recognised teaching and learning strategy and curriculum design which uses simulation to provide an integrated approach to acquiring knowledge, skills and behaviours required for effective clinical practice. However some models of PBL do not achieve this outcome, focussing on acquisition of knowledge only and not including structured, integrated learning opportunities to acquire skills, behaviours and relevant conceptual knowledge. Little’s (2000) model of PBL integrates learning principles of PBL and includes simulations as the stimulus and context for learning.

**How this workshop will engage the participant in active learning**

A Simulation-PBL (S-PBL) Model developed by the Department of Nursing in Cheju Halla College, Korea in 2004 in collaboration with the University of Newcastle Australia will be the basis for modelling best practice and resources used by both countries’ nursing programs. The workshop will model the different PBL events (participant analysis of scenarios, participant engagement in self-directed learning, participant feedback as resource sessions, short resource demonstration by facilitators to guide appraisal of strategies employed,
suggestions for improvement provided by participants, and participants accessing video clips of clinical laboratory sessions and the various types of simulation used in an integrated learning module).

**Session plan (Session activities, Activities sequence, time allotments for each activity)**

<table>
<thead>
<tr>
<th>Content</th>
<th>Participant Activity</th>
<th>Facilitator activity</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| Introduction – 20 mins  
Objectives, what we know | **Activity 1**  
Participants respond by raising hands to identify categories of participants.  
**Activity 2**  
On post–it notes, participants complete:  
The most important thing I want to get from the workshop is….  
**Activity 3**  
In groups of 3, identify what simulations are currently used by participants. | Introduction of facilitators  
Objectives of workshop  
Audience identification | Means of canvassing audience membership.  
Ensures audience objectives can be addressed by facilitators.  
Acknowledges experience of participants and provides opportunities for networking. |
| Setting the context  
Presentation of S-PBL approach | **Activity 4**  
Whole group discussion of model presented. | PP presentation of S-PBL module overview | Core principles highlighted as guidelines for analysis of learning event components. |
| the PBL scenario as a context for learning | **Activity 5**  
In groups of 5, participants review scenario parts and identify relevant clinical skills.  
Participants provide feedback to whole group. | Facilitators list clinical skills identified.  
Present plan of learning events for module. | Activity centres on Participants’ views & critique arises from peer evaluation. |
| Integrated Simulation lab | **Activity 6**  
Whole group discussion | Demonstrate using video/ PP | Exemplars provided for critique. |
| Integrated Simulation Assessment | **Activity 7**  
Whole group discussion | Demonstrate using video /PP | Identification of acquisition of skill development and associated conceptualizatio |

Anna Elizabeth Treloar 311
### Four content areas to be associated with the workshop

- Simulation highlighted integrated curriculum approaches
- Practice based learning events
- Models of curricula based on experiential learning
- Criteria for testing authenticity of learning events
Appendix 9: Code Blue notes

CODE BLUE NOTES

Saturday October 5th 2013

Write up analysis chapter using subheadings from Tripp’s Five Components and McCormack’s Five Lenses. But both have “Context” so combine notes for that.

1. People – any need to count number of nurses, doctors, police, patients etc? Or just record how often the type is mentioned e.g. police mentioned in so many stories. But there are many different types of nurses mentioned and that might be significant especially when the nurses are student nurses. Similarly, under patients there are patients who are named, patients with a specific diagnosis or behaviour, and then sometimes just an amorphous group “patients”. Usually it is clear whether the nurses are male or female and in some stories this is significant in the nurse-patient relationship so should be recorded.

2. Things – before Code Black completed this did not seem particularly important. But it turned out to provide an unusual slant on many stories. In some cases, the things alone told a story in 5 or 10 words. E.g. “cafe, cup of tea, tracksuit pants, turd, lamingtons, police fact sheet, bars of cell” and “shotgun, car, mobile” and “caravan, gas bottle”. In other cases, the juxtaposition of things was intriguing but meaningless without the full story. In others what could have been assumed was not actually the point of the story e.g. “cat, bird in a cage”. Dogs appeared in several stories. So did chairs, and gardens and parklands. There was enormous variety in things mentioned.

3. Events – used to summarise main happening in each story on Data Analysis Template.

4. Context – varies from hospital wards to old psychiatric institutions to acute mental health units to ED [Emergency Department] to PECC [Psychiatric Emergency Care Centre] to community mental health settings to patient’s home to cells to gaol to court to nursing homes to aged care facilities.

5. Relationships – this will probably be one of the key sections of the analysis chapter. Even in a brief story it is possible to discern a wide range of different
relationships. Often they could be characterised as truly therapeutic even though superficially they appear to “break the rules” or rely on inspired creativity. At other times there is not enough detail to describe them as therapeutic but it is clear that a professional service was given. Some stories describe relationships which are custodial only. Where stories are set in gaols there is an interesting tension between the relationships of prison officers and the relationships of nurses, both with each other and with prisoners/patients. Often families feature in the stories and where there is no detail about how they relate to the patient the relationship can only be described as “family”. Sometimes the relationship between nurse and patient or between patient’s family and nurses is not what would be expected but there are only one or two stories where this relationship is unprofessional. Some relationships could be called “pseudo-professional” e.g. those of some prison officers to patients, those of some nurses to patients (also described on first analysis as “task-oriented” “indifferent” “disregarding/indifferent”). In one story the relationship is equivocal and could be interpreted as “therapeutic” or as “custodial”. Most nurse to nurse relationships are clearly collegial but some were “dominant-subservient” or “collusive”. Justifying these terms will need a lot of careful work! Some of the relationships shown by patients towards nurses were very difficult to characterise e.g. “controlling/antisocial” “assertive”, or puzzling “defensive/protective” “hostile/dependent”.

6. Active listening – this category was not used on the data analysis template as McCormack based her articles on interviews which she then transcribed.

7. Narrative processes – in the first 20 or so stories analysed this category was not sufficiently refined. Later on I decided to use it only as a way of saying what form the stories took – i.e. collected in workshop and written down, sent by email, transcript of interview published in other sources, memoirs, reminiscences, old letters.

8. Language of text – refining narrative processes then allowed this category to describe literary style however briefly, i.e. simple narrative, report style, conversational, basic, colourful and highly descriptive, explanatory, opinion piece. “Aphoristic” was used where the writer or teller condensed meaning and interpretation into a single sentence though this is not the best word for this and I need to find a better one.

10. Moments – nearly every story provided a “moment where something unexpected happened” thus justifying the use of McCormack’s Lenses for analysis. Often the teller kept the moment for the final sentences but sometimes it appeared in the middle of the story. At other times it was the teller’s interpretation or explanation which was the true moment. Along with relationships moments will probably be the most important sections of the chapter.

- Does use of humour detract from a story’s value?

- Do stories which describe a way of mental health nursing which is now gone have value?

- Therapeutic use of silence features.

- So does “Done the wrong thing but got away with it” – there are several stories where the teller feared initially having made a mistake or acted unhelpfully but discovered that the reverse was true based on outcome for the patient.

- Aggression from patients is usually minimised, not the main feature of the story.

- Two or three stories describe an episode where the nurse’s actions could have been classed as negligent. One story describes a nurse whose behaviour was unquestionably unprofessional.

- Need list of settings or countries? Stories from different countries, different hospitals, different towns and cities.

- Do section on male nurses and female patients, female nurses and male patients, male nurses and male patients, female nurses and female patients and differences in ways of relating?

- Do section on student nurses and their views of their stories? Most stories told many years after events occurred.
• Discuss the few very long complex stories separately as paradigms? They may turn out to have the main elements of all stories.

17th October 2013

• Do section on lessons nurses wanted to spell out (as opposed to “hidden” messages)?

• Look at uncertainty.

• Look at silence.

• Look at minimisation of aggression.

• Look at true sympathy, i.e. crying/feeling with....
Appendix 10: Code Red Notes

CODE RED NOTES

SUNDAY NOVEMBER 17TH 2013

Start by headings from the DAT i.e. people, things, events, context/place, narrative processes/language of text, relationships and moments. Of these things, context/place, and narrative processes/language of text will be relatively easy, events will be a major category and will take time, and people will be complex. The key headings are relationships and moments, and will be done last.

Both Tripp and McCormack use context so one heading will cover both there, and active listening is not a useful heading for stories which were all written down so will not be used. Analysing narrative processes and language of text together will make things clearer than discussing those headings separately. Thus the original ten headings become seven.

Accurate numerical figures for people is not possible, as sometimes police are mentioned twice in one story (two different situations so two different mentions) but only counted once, and sometimes it is not possible to determine if the nurse was male or female, or even if the nurse was a mental health nurse. There is a distinction between student mental health nurses, and other students in different placements.

For things there are half a dozen categories which appear frequently, e.g. chairs, cup of tea. For most other things, there is only one mention.

Events are key. Code Black summarised the main event in each story but this was subjective and need to be refined.

Context/place was expanded to include town or country as well as setting.

Narrative processes and language of text was refined at Code Blue so that narrative processes noted the form (email, transcript of interview, journal article, published material etc.) and language of text notes the style of each story. Style varied from “basic” to those showing “extreme verbal facility”.

This will be the basic analysis. Summaries already prepared for people, things, place and narrative processes/language of text will make it easier.
Summaries will probably not help for events, relationships and moments and I will have to devise a different way to analyse these headings.

Later I will analyse the six long stories in depth as paradigms, using the DAT once again to demonstrate the analytical process.

After that I will look at the tellers’ own interpretations where provided. And at some stage I will look at the notes I made in the three workshops and incorporate them.

I will have to link the stories to the research question and this will be difficult as not all were specifically told to students or intended for students. But the fact that they were told or written at all does suggest the tellers saw them as significant even where the stories did not come from a workshop or as follow-up.

In conclusion I can use the pond metaphor as a lead in to the final chapter (Conclusion/Recommendations) to partly answer the research question and show the purpose of stories.
Appendix 11: Submitted version of article for Perspectives in Psychiatric Care (accepted 10/7/2014)
A Narrative in Search of a Methodology

Anna Treloar, RN, MA, MPHc, Teresa Elizabeth Stone, RN, BA, MHM, FACMHN, PhD, Margaret McMillan, RN, PhD, and Kirstin Flukus, RN

Anna Treloar, RN, MA, MPHc is a lecturer, School of Nursing and Midwifery, University of Newcastle, Callaghan, New South Wales, Australia, and a Mental Health Nurse, Integral Health, Armidale, New South Wales, Australia; Teresa Elizabeth Stone, RN, BA, MHM, FACMHN, PhD, is Professor of International Nursing, Faculty of Health Sciences, Yamaguchi University Graduate School of Medicine, Yamaguchi, Japan; Margaret McMillan, RN, PhD, is a member of the Central Coast Local Health District and a Conjoint Professor, School of Nursing and Midwifery, University of Newcastle, Callaghan, New South Wales, Australia; and Kirstin Flukus, RN, is a Second Year RN and works in ICU, Port Macquarie Base Hospital, Port Macquarie, New South Wales, Australia

Search terms:
Case study, mental health nursing, research design, research qualitative, story, teaching/learning strategy

Author contact:
anna.treloar@newcastle.edu.au, with a copy to the Editor, pgrson@nc.edu.au

Conflict of interest statement:
The authors report no actual or potential conflicts of interest.

First received March 13, 2014; final revision received June 8, 2014; Accepted for publication July 10, 2014.
doi: 10.1111/jpc.12081

PURPOSE: Research papers present us with the summaries of scholars' works; what we readers do not see are the struggles behind the decision to choose one methodology over another.

DESIGN AND METHODS: A student's mental health portfolio contained a narrative that led to an exploration of the most appropriate methodology for a projected study of clinical anecdotes told by nurses who work in mental health settings to undergraduates and new recruits about mental health nursing. This paper describes the process of struggle, beginning with the student's account, before posing a number of questions needing answers before the choice of the most appropriate methodology.

FINDINGS: We argue, after discussing the case for the use of literary analysis, discourse analysis, symbolic interactionism, hermeneutics, and narrative research, that case study research is the methodology of choice.

PRACTICE IMPLICATIONS: Case study is frequently used in educational research and is sufficiently flexible to allow for an exploration of the phenomenon.

The starting point for this paper was a narrative written by an undergraduate nursing student, Kirstin Flukus, in May 2011, as part of an assignment to write a portfolio beginning with a narrative account of an episode of nursing care during a clinical placement in a mental health inpatient unit. The expectation is that the narrative is short (400 words only), that it outlines an episode of nursing care requiring mental health nursing skills, that it does not describe a technical procedure only with inclusion of the therapeutic nurse-patient relationship, and particularly that it is detailed and takes note not just of words and behavior, but also, if relevant, of sights, sounds, and smells experienced.

The Student's Story From Clinical Placement

Mr P was a 41 year old male with a diagnosis of Schizophrenia and Depression. It was my second day in the mental health unit, and I was yet to have any interaction with Mr P. I had seen him in quite a distressed state on my first shift, and I had heard that today he had gone for a day trip home with some of the unit staff. I was nervous and uncertain about how to break the ice with the patients. I thought asking how his day was would be a good way to start forming a rapport.

Mr P was sitting in the courtyard, so I joined him, making sure I was close to a door, and checking that I had a nurse alarm on. I asked how his day went, and he seemed fairly happy to speak to me about this. He explained the panic attacks and the anxious feelings he experienced during the trip. Throughout our conversation I tried to utilize therapeutic communication techniques to explore his feelings and experiences.

I was also keen to start improving my assessment skills so I could complete a [standardized assessment] form before the end of my placement, and to increase my ability to form beneficial therapeutic relationships with the patients in the unit. Once I seemed he was comfortable I asked a little more about his illness, as I, having never met anyone with schizophrenia, was interested to hear his experience. Using some prompting and open-ended questions, Mr P began to tell me of his history and experience of
Schizophrenia, the medications which he was sure were not helping, and the auditory hallucinations he sometimes experienced. I asked what he did for fun, as I hoped to encourage Mr P to find some enjoyable activities to focus on. He stated he had nothing that he could do for enjoyment— not even watch TV, as he found it too hard to concentrate, which he considered was due to his medication.

I also asked him if he had any strategies to manage his panic attacks; then I outlined a mindfulness exercise that he could use to "distract" himself from the anxiety. The Enrolled Enrolled Nurse (EEN) who had joined us said nothing.

I had not seen any of the nurses perform any interventions for Mr P except for administering medications, taking observations, and simply telling him to "calm down" when he was showing signs of distress. I wondered whether asking about Mr P's condition was helpful or difficult for him, so I went into the nurses' station to ask this, and discuss my thoughts about the interaction with the Registered Nurse (RN). Her reply was that that sort of "Dr Phil psychology did not work in real life".

This narrative is constructed in such a way that while the most detail is given about nurse and patient, the dramatic impact and the point of the story come from the silent presence of the enrolled enrolled nurse (EEN)—even her involvement in the scene is only noted by the pluperfect tense implying a silent arrival—and by the "guidance" offered by the registered nurse (RN) when the student sought advice and comments on her nursing intervention. (An enrolled nurse is not registered but after further study and training is then enrolled to give medications.)

The immediacy, the drama, and the very humor in this story captured my attention and we sought permission from Kirstin to use her story as a starting point for a project involving the collection of clinical anecdotes told by nurses to undergraduate students and to new recruits in mental health settings. So as Kirstin told her story about her first experiences in mental health nursing, I began to look for the most suitable methodology to analyze this collection of stories. We were both students, though at different levels. Kirstin's story is completed above; this paper is the account of my search. The purpose of the search was to choose a methodology that was capable of capturing as much significance in the collection of stories as possible while also providing insights into their educational purpose.

What is the most appropriate methodology to explore the purpose of stories told to undergraduate students and new recruits to mental health nursing? Students are encouraged to tell their own stories in their clinical portfolios as Kirstin does here, but they are also the recipients of a variety of stories told to them by staff already working in mental health settings. Kirstin's story was used as a pilot story in an examination and eventual justification of what methodology would be most suitable for investigation of the educational purpose of a collection of stories told to undergraduates and new recruits in mental health nursing.

This paper briefly considers several possible qualitative methodologies suitable for determining the educational purpose of a collection of stories told by nurses to undergraduates and new recruits. To begin, there were a number of questions that warranted careful consideration in the choice of methodology for such a study. Should Kirstin's story be considered as a personal log or journal? Should it be rescripted so the dramatic elements are more prominent? It is very visual in impact although the description is economical. Does it require only literary analysis in which case it could be considered as a personal journal or a drama? Should it be examined as part of a collection of stories? Once it becomes part of a collection, literary analysis becomes less useful as it focuses on single words and phrases and the meaning of a single story, rather than taking an overview of a collection and its possible common purposes.

In case study methodology helpful here? The phenomenon at the center of study is storytelling by experienced clinicians to others who are new to that environment and to the experience of caring for people expressing symptoms of mental illness (both acute and chronic). There was also a need to embrace the potential to consider the narrative as a learning resource for both clinicians and their peers in novel situations. This required a level of analysis of the elements of the narrative that were meaningful to both education and clinical practice.

Literary Analysis

The elements of the story are the patient's diagnoses (schizophrenia and depression) and his age (41), with the implication that he may have suffered from two serious mental illnesses for much of his life intermitently. We learn that he was in "a distressed state" but the student attempted to "break the ice" (an interesting metaphor in this context given the frosty atmosphere of the ward) and to establish rapport. The patient spoke of his panic attacks and anxious feelings while on day leave and the student "was interested to hear his experience" so she could better understand what it is like to have schizophrenia and depression. However, her interest was not purely clinical. She asked a very useful question—"What did the patient do for fun?"—and gained useful information about his mental status from his reply as well as providing a distraction to the anxiety. She also offered him immediate assistance in an exercise to help him manage his anxiety and asks a significant question when she describes the type of nursing care offered to this patient as "administration of
medication, taking of observations and simply telling him to 'calm down' when he was showing signs of distress.' This is confirmed by the comment, "The EEN who had joined us said nothing" and by the summary of the interaction with the RN who told the student that that sort of "Dr Phil psychology" did not work in real life. Dr Phil hosts a popular U.S. psychology television program, which is shown in Australia too. The RN's comment possibly referred to the apparent speed and ease of changes achieved in participants' lives during the program.)

The metaphor of "breaking the ice" becomes a key to the whole story. The only therapeutic interaction that takes place is between student and patient. There is a distinct chill in this unit as we understand from the focus on medication and vital signs, and the abrupt advice to the patient from staff to calm down, or even the silent and apparently accessory presence of the EEN. The RN is frosty in her assessment of the student's contribution to the patient's care. There is little of the therapeutic milieu in this unit. The student's question about fun is discordant with the way the patient is treated and with the oppressive atmosphere of the unit. Ice and fun seem to be a mismatch. The juxtaposition of the two words is powerful. Here the student's wish to "break the ice" goes much deeper than the shallow introductory games often called "icebreakers." We wonder is it ever possible to have fun in a mental health inpatient unit? Is it ever expected? Or do we only focus on the presence or absence of anhedonia as a diagnostic criterion? The student brings her experience of the outside world into this chilly and oppressive environment and assumes that the patient has had or at least should have had the same human experience of fun as she has.

Linking Study Purpose to Choice of Methodology

Having undertaken a preliminary appraisal of the essence of the narrative, it would seem that the methodology most suitable is the one that best reveals the underlying purpose of the telling of the story. However, for a collection of stories a methodology suitable for a single narrative may not be appropriate. Close literary analysis of the above narrative reveals many themes and can highlight the dramatic purpose of the story. But close literary analysis of a series of stories, while able to provide explanation of each single story, cannot identify themes common to the series, which means the purpose of stories told by experienced mental health nurses will remain concealed.

Although writing distances us from the lifeworld, it can also draw us more closely into that lifeworld, and interpretation can be achieved through three different approaches—holistic, selective, or detailed. The first looks at the whole text, while the second looks for statements or phrases that reveal its essence. The third requires analysis of every sentence to determine what meaning it points to (Van Manen, 1990). Denzin and Lincoln (2005) point out that analysis of text in literary studies often treats the text as a self-contained system. The decision might be to go with all three—some stories will stand out as having greater value as a "whole" and to dismember them will not "add value" because the intent is made clear. Others might contain several "critical incidents" that describe situations, actions, and outcomes (either positive or negative for either both the narrator and the recipient; others might contain a sequence of behaviors that make up a "learning event" or constitute a "teachable moment.

Williams (2001), in a discussion of transformative learning (Mezirow, 1981), notes that people have a frame of reference for interpreting their experiences which is based on what has happened to them and what they see, hear, or read. This frame of reference comes from the way the person was brought up, the culture the person lives in, and on what has been learned previously. Thus experience is filtered through meaning perspectives which for most people are uncritically assimilated. Knowledge and awareness may be decreased but the person finds it safer to remain within a meaning perspective that does not challenge thinking. These distorted meaning perspectives, including social and cultural norms, as well as language, which determine power and privilege, eventually cause discomfort. Transformative learning can result in changed meaning perspective. Reflection is the key to this and the first stage occurs when a situation results in feelings of puzzlement, surprise, or discomfort. This tends to the second stage where current knowledge and assumptions are examined. In the third and final stage, the person's meaning perspectives may be revised or re-integrated (Williams, 2001). In the student's story we see this occurring. The student is disconnected from the RN's comment, but, as the later parts of the portfolio show, she goes away and reads more about what she was attempting with her patient, and we assume re-integrates her meaning perspective based on the way her reading confirms the value and Appropriateness of what she was doing. We do not know if the RN engages in the same process of revision.

Traditionally, critical thinking has attempted to link theory and practice by the use of a scenario from practice to illustrate a practice dilemma. Brookfield (2009) says that reflection becomes critical when it uncovers the dynamics of power in relationships and critically questions implicit social and cultural practices. Hence, it seems that we will be using different types of narratives with different intents attributed to the storytelling for the purpose of transforming behavior, the outcome of learning. The stories are to become the catalysts to learning about (a) people experiencing problems with their mental health, (b) optimal nursing practice in these situations, and (c) learning about oneself and others in particular situations especially those that demonstrate "cognitive dissonance." Now to the choice of a suitable methodology.
A Narrative in Search of a Methodology

Qualitative Methodologies

Qualitative methodology is most suited for mental health nursing research because of what is common to both which is the purposeful use of self, the creation of an interpersonal relationship, and the ability to accept and embrace ambiguity and uncertainty (Cattellie & Goward, 2000). In each situation where a mental health nurse forms a therapeutic relationship, making use of the therapeutic self and being empathic, in an attempt to understand the meaning of the patient’s lived experience, this situation could be regarded as an “informal, micro-phenomenological research study” (Cattellie & Goward, 2000, p. 596). These authors link the knowledge gained by experienced mental health nurses to the accumulation of years of such micro-phenomenological studies. The experienced mental health nurses are those who have the “richest pool of unprocessed qualitative data” (p. 596) which they conclude must point the way for future research into mental health nursing practice.

Whichever methodology is used will be qualitative as the qualitative researcher looks to discover knowledge through the capture of the individual’s subjective experience. The researcher asks, “What is going on here?” (Morse & Richards, 2002). To do this, the researcher may use case study, personal experience, interview, or observation (Crowe, 1998). The two fundamental assumptions of the qualitative researcher are that qualified observers can “with objectivity, clarity and precision” report on their own observations of the social world including the experiences of others, and that there is a real subject, or real individual who is present in the world and able to report on his or her experiences (Denzin & Lincoln, 2005, p. 21). The same authors describe the essence of qualitative research as being a commitment to some version of the naturalistic and interpretive approach, and an ongoing critique of the methods and politics of positivism. The socially constructed nature of reality, the close relationship between the researcher and what is being studied, and the way the inquiry is shaped by the situation are the essentials. The researchers blend their own observations with material from subjects which may include interviews, life story, personal experiences, and particularly relevant for this study, case study documents. The case study relies on interviews, observations, and document analysis (Denzin & Lincoln, 2005).

Discourse Analysis

Discourse analysis is “analysis of how texts work within socio-cultural practice” (Crowe, 2005, p. 59) with the aim of interpreting how language functions in a given context. It is concerned with how a person’s experience is “socially and historically constructed by language” (Crowe, 2005, p. 56). Speakers may not be powerful but can invest power in the words they choose by using particular discourses and by associating themselves with institutions in which society invests power (Smith, 2007). The assumption is that the language we use constructs how we think about and experience ourselves and our relationships with others. Discourse becomes so much part of daily life that we often go unnoticed; discourse analysis aims to expose otherwise unnoticed social issues but through its use nurses can come to understand how “inequities are created and supported” (McClokey, 2008, p. 41). If we try to find patterns in a text, we have to consider the cultural context as well. Isolating data from context is not part of discourse analysis because discourse analysis is concerned with how social relations, identities, knowledge, and power are constructed through both spoken and written texts. The social and historical context, not the experience of the individual or the hypotheses of the researcher, becomes central to the inquiry because both subjectivity and experience are constructed by language. Words and actions derive their meaning from the context in which they occur (Crowe, 2005). The RN’s disparaging mention of “Dr. Phil” contains a wealth of meaning in the context of an inpatient psychiatric unit where an undergraduate nursing student was attempting to put into practice what she had learned in the course of her studies. So the context in which data are collected constructs the characteristics of the data, which are highly important for a study of the purpose of stories told by experienced mental health nurses.

What might be an entertaining story at a dinner party, or an attempt to debrief after a difficult shift, or a story to illustrate the more arcane aspects of the field of mental health nursing to somebody who does not work in the field, becomes different in an educational context. “Language as a system is a cultural form that owes its existence to a collectivity of participants who adhere to communal conventions in order to be understood” (Crowe, 2005, p. 56). Discourse analysis views text as “cultural representations rather than transparent facts” (Crowe, 2005, p. 57). But it is a process rather than a method. In Kirstein’s story, it might reveal much of significance about the culture of the particular ward, but may not be the most useful way to investigate the educational purpose of a collection of stories about mental health nursing.

Symbolic Interactionism

Symbolic interactionism suggests itself as a methodology because of the “institutional” aspects of the student’s story. Goffman’s (1961) study of the “total institution,” Asylums, is a case study that provides descriptions and theoretical insights which could also be applied to other institutions such as prisons, boarding schools, or nursing homes. His study of stigma is also relevant. His work resulted in a sub tradition of symbolic interactionism known as dramaturgical analysis. He focused on the way people interacted in face-to-face contact. He provided a “perspective by incongruity” (Burke, 1984).
His main way of doing this was to compare people in everyday situations to actors in the theater. He distinguishes between doing and being, that is, between believing in the part played and not doing so. People perform as a member of a team but behavior changes when the team is not present. Similarly, what happens in front of the stage and backstage also varies (Travers, 2001). The student's account of her interaction with the patient, and the role of the EEN and the comments made by the RN are presented like a small drama. The student believes in her part although the EEN and the RN do not. The student is first at the front of the stage, and later, backstage, where she discovers there is a difference between what the word nurses really think and do, and what they might claim to think and do when part of a team. Some light would be shed on the dramatic content of Kirstin's story but once again, to investigate the educational purpose of a collection of stories told by experienced nurses to undergraduates, this may not be the most useful choice of methodology.

Hermeneutics

A belief that mental health nursing research, rather than developing specialized mental health nursing knowledge, relied on the disciplines of psychiatry and the behavioral sciences resulted in a hermeneutical approach being used by Geenellos (1995) to interpret a series of mental health nurses' stories and to develop themes. She felt that this approach allowed "the discovery, illumination and sharing of meanings and understandings" that might otherwise have remained unknown (p. 89). Although Geenellos was interested in describing mental health nursing practice with a view to theory development or theory testing, her conclusion is relevant to this study, as she states that storytelling demonstrates its value as "a means of discovering or confirming mental health nursing knowledge" (p. 93). For Chang and Harrocks (2006), understanding of people gained through hermeneutics was holistic and constantly undergoing change.

In a project to clarify the content and structure of the major subject (nursing care) in the basic nursing program at a Swedish university, a hermeneutical approach was used to interpret and describe this subject (nursing care) (Asp & Fagerberg, 2002). Data were interpreted and a metaphor of nursing care emerged, which the researchers called "woven fabric."

Although metaphor is only one aspect of hermeneutics, it is also effectively used in the student's narrative which begins this chapter. Metaphor is a way of providing two ideas in one context. Metaphors provide no new facts but add depth or a new perspective. As well, they can simplify events in terms of a schema, which emphasizes some parts more than others. Symbolic language is present in most cultures. When metaphors are used in a research context, they may become data-reducing devices that generalize from the particular, they may serve as pattern-making devices that place results in a larger context or they may be centering devices when they force the viewer to understand a mass of observations as a whole (Kanga, Warren, & Byrne, 1998). But how do we get from a series of stories to metaphors which may or may not achieve this data reducing or pattern making or centering?

Narrative Research

At first consideration, narrative research would suggest itself as an appropriate methodology for a study of stories told by experienced mental health nurses. However, narrative inquiry has a different focus. In an overview of narrative inquiry (Lai, 2010), we ask whether narrative is a perspective, a method, or a special form of speech or writing. Narrative inquiry is the study of the phenomena of development and transition in people's lives. People's stories are related to everyday life and make the meaning of life as it is lived explicit (Widdershoven, 1993). Socio-structuralists use narratives to study lives in their social contexts and sociologists view them as texts that reflect the personality or identity construction. The person's culture is revealed through the story (Lai, 2010). Narrative analysis differs from other qualitative methodologies because it focuses on the structure of narratives as a whole using larger units of analysis such as a whole interview or a whole biography (Rice & Eddy, 1999).

Importantly for this paper, narrative inquiry of the narrative type results in a collection of individual cases without generalization. Whereas narrative inquiry of the paradigmatic type brings knowledge of concepts, narrative inquiry of the narrative type brings only knowledge of particular situations (Lai, 2010).

There are several approaches to narrative analysis. Narratives can be oral or written, discovered during fieldwork, an interview, or a conversation that occurs naturally. They can be a short topical story about a particular event and specific characters or an extended story about a significant aspect of life such as school. A narrative researcher treats narrative as a distinct form of discourse. It is a way of making meaning retrospectively. It gives the narrator's point of view, which includes why the narrative is worth telling. The narrator is a protagonist either as an actor or as an interested observer of the actions of others. This point is very relevant if stories are used by experienced mental health nurses in teaching undergraduate mental health nursing students. Narrative research also highlights what is unique about each human action and human event, again something which is very relevant to the use of stories by experienced mental health nurses in educational situations (Chase, 2005).

Although narrative research is based on the tradition of collecting narratives and analyzing themes in these narratives, as is done in literary analysis, researchers rely on one broad question. Interpretive narrative research is guided more
A Narrative in Search of a Methodology

deliberately by the researchers who use a preplanned series of questions and use extra questions for clarification during the interview. The researchers are seeking dominant stories which are narratives put together based on the person’s cultural influences (McQueen & Zimmerman, 2006). Although Kear (2012) found, in a collection of narratives, that there are numerous threads that connect one to another, Hardy, Gregory, and Fabrie (2009) also noted that analyzing narratives can involve the search for patterns. For Kelly and Howie (2000), the final employed whole narrative was a construct which gave “meaning and understanding to the narrative data” (p. 141). However, from this collection of anecdotes, there will be no final whole narrative as they are too disparate.

Case Study Methodology

Although it would seem to suggest itself, narrative inquiry may not be the most suitable methodology for analysis of educational purpose of stories told by mental health nurses. Using case study methodology may provide the flexibility required. “The case study is a research strategy which focuses on understanding the dynamics present within single settings” (Eisenhardt, 1989, p. 334). Miley et al. (2012) define it as an “in-depth examination of a specific circumstance” (p. 28), so that it may focus on an individual, a community, an organization, or a practice, or an event. The Centre for Nursing Research and Practice Development at the University of Newcastle used a case study approach in a 1998 project to develop guidelines on the boundaries of professional practice. Stories described as short case studies were used to show how the guidelines could be applied in practice but the methodology used was case study (McMillan et al., 2006).

A case study investigates a contemporary phenomenon within its real-life context. This happens especially when the boundaries between phenomenon and context are not clear. It manages a situation where there will be many more variables of interest than data points. It relies on many sources of evidence using triangulation of data. It can benefit from development of theoretical propositions to guide data collection and analysis (Yin, 1994).

Tripp (1994) explains a case as being constructed by a set of features, which consists of a set of components: each of these components has an own set of properties. These properties are ascribed to the components by the observer, that is, they are not intrinsic to the component. There are five main categories of component, which are people, things, events, context, and relationships, which derive from “the fact that even at its most minimal, any social situation must at least consist of people participating in events with or without things in a particular place at a particular time” (p. 26). In a case study, the researcher must ask: Who? What? With what? Experiences what? When, where, and with whom? This gives the people, the things, the events, and the context; in other words, each part of the question is a separate component but is also in relation to the others. The categories are fluid, allowing people to exist as a component of a context rather than as a separate component of the situation itself.

The case study is an inductive approach, “perhaps even the ideal inductive approach” (Hamel, Dufour, & Fortin, 1993). In some of the accounts of case study, its meaning has overlapped with ethnography, participant observation, fieldwork, qualitative research, and life history. Its origins can be traced back to medical cases, or to casework in social work. In psychology, a case study aims not only to develop knowledge but also to look for a solution to some problem present in the case. Similarly, in education, a case study may be used to develop and test curriculum and teaching strategies. Today, case study implies a type of social research which contrasts with the experiment and the social survey (Hammersley & Gomm, 2009).

To allow focus on what may be different components of each story, it may be useful to use Mccormack’s Lenses that allows consideration of the whole story and of each component of the story from more than one angle. McCormack (2000b) felt that when codes are recombined into themes, we lose the context in which words were spoken or performed or heard, that is, the contextual, structural, and performance aspects of language, as well as the interpersonal part. She therefore preferred to analyze her data through multiple lenses that include active listening, narrative processes, language, context, and moments. Active listening requires immersing oneself into the story; the narrative processes used by the storyteller must be identified. The researcher pays attention to how the language of the text and acknowledges the context where the text was produced, and finally identifies the moments in the text where something unexpected occurs (McCormack, 2000b). The data are analyzed through each lens in turn, and allow interpretation of any type of individual story as well as comparison of themes common to several stories (Dibley, 2011). Eisenhardt (1989) also recommends cross-case searching to force researchers to go beyond their first impressions, especially by using different lenses on the data. Bazely (2009) warns against merely presenting main themes and supporting them with quotations from participants as the main method of analysis in a qualitative project. Thorne (2000) writes that the theoretical lens used by the researcher, the strategies used to collect data, and the researcher’s understanding about relevant and important data are all analytic processes that will influence the data.

A case study is both a process of enquiry about what has been chosen as the case, and a product of the enquiry. The researcher selects a case that is typical but prefers those cases that seem to offer “opportunity to learn” (Stake, 2005, p. 451). This is particularly relevant to an examination of the educational purpose of a collection of stories told to undergradu-
iates and new recruits in mental health nursing. Aristotelian phenomenology has a particular role in case study (Thomas, 2010), as it is about "understanding and behaviour in particular situations" (p. 578). In a later article, Thomas provides the following succinct definition of case study:

Case studies are analyses of persons, events, decisions, periods, projects, policies, institutions, or other systems that are studied holistically by one or more methods. The case that is the subject of the inquiry will be an instance of a class of phenomena that provides an analytic frame – an object – within which the study is conducted and within which the case illuminates and explicates. (Thomas, 2011, p. 513)

A major criticism of case study method is how case studies contribute to empirical generalization or to general theory. However, if the research aims to understand one particular case or to predict outcomes in a clinical setting where the uniqueness of the case is important to the adequacy of its treatment and not a weakness to be edited out, then it can be argued that case study is the only relevant method and the only relevant test of theory is fit to the same case (Batt, 2007).

(Each individual story in the collection becomes a different "case" and analysis of the whole collection becomes the case study.)

Yin (1994) advises that a case study approach is preferable when the researcher is asking "how?" or "why?" and has little control over events being studied. He differentiates the case study in research from the case study used for teaching, from ethnographies and participant observation, and from "qualitative methods." An exploratory case study is suitable for a "what?/" question such as the topic of this study, which investigates the educational purpose of stories told to undergradautes and new recruits in the mental health setting. Green and Thorogood (2004) say a case study is used where depth and accuracy are required and where naturally occurring rather than artificial phenomena are to be examined. A survey is appropriate where empirical generalizability is required, and an experiment where evidence of causal relationships is required.

"Case studies are undertaken to make the case understandable" ( Stake, 1995, p. 85). Making meaning out of the collection of stories and examining their educational purpose is undertaken to make the "case" (i.e., the whole collection) understandable.

In a study that collects stories from different nurses who have varying work experiences and different specializations, the stories may be from recent practice, from many years ago, or even have been told to the teller by somebody else. As not much is known about the purpose of telling these stories and as case study is useful for "what?/when" questions it is appropriate here. Although case study is bounded, it is not bounded by geography. Tripp (1994) defines the components of a case study as people, things, events, context, and relationships, and these five components are present in any story about mental health nursing practice. McCormack's Lenses (active listening, narrative process, language of text, context, and moments) (2000a) have some components in common with Tripp's, as well as some different ones, and when combined, these components allow investigation of a collection of stories from several different perspectives and angles. If, as Stake (1995) says, the case can be a classroom, then stories told by mental health nurses are part of the curriculum in this particular classroom where mental health nursing is being taught, but we do not know the reason for their use in the classroom. The experiences of individuals and the contexts of the action are important (Darke, Shanks, & Broadbent, 1998).

Implications for Nursing Practice and Education

The implications of the research for both nursing practice and ongoing education will influence the decision on choice of methodology. Stories told by mental health nurses are of their nature interpretative. They interpret a situation that the teller lived through, and offer the narrative to the student for further interpretation. What the meaning of the story is to the teller, and so what the teller's understanding of the story is, may be very different from the interpretations made by the students. What the hearer of the story remembers a year after it was first told may be very different from the story first heard. It is the purpose of the story told which is the focus, whether it is a single story told by a student or a collection of stories told to students by experienced mental health nurses.

Of the various qualitative methodologies briefly considered, case study methodology is the most suitable for a study of stories told by experienced mental health nurses to students. It has been used frequently in educational research and allows sufficient "organic flexibility" (Snyder, 2012, p. 19) for this exploratory question. Although it has been criticized for lack of rigor and inability to generalize, use of a facilitator, a focus group, and analysis using McCormack's Lenses (2000a), as well as Tripp's (1994) components, will strengthen the findings. The use of case study methodology is often referred to as telling stories, but Stake (1995) states clearly that case study reporting is not usually storytelling. He says that in a story characters have a problem, attempt to solve it, and the situation becomes worse; eventually "by extraordinary and climactic effort" (p. 127) the problem is resolved. In contrast, cases are not known by their problems although they may include problems and problem solving. The case study researcher examines the problems or issues involved through these issues, conditions, complexity, and coping contained in the case may be studied (Stake, 1995).

To explore the purpose of a collection of stories, the case study may be the most useful methodology, whereas for a
single "stand-alone" story like Kirstin’s, many other methodologies may shed light on its meaning. Not for nothing has case study methodology been called an "under-explored and under-traversed bridge across traditional knowledge paradigms" (Thorne, 2012, p. 281). The case study is of the phenomenon of storytelling by nurses to others in a mental health setting and each story becomes a case for cross-case analysis and conclusions (Yin, 2004). Stake’s "opportunity to learn" (2005, p. 451) directs us both to the single story told by Kirstin, and onward to the possibility of a collection of stories told by experienced nurses to undergraduates and new recruits to the mental health setting, and finally to exploring and understanding better the purpose of these stories in a variety of settings which may all be considered as the classroom of the nurses who are the hearers of the stories.

References
A Narrative in Search of a Methodology

Thorne, S. (2000). Data analysis in qualitative research. *Evidence-Based Nursing*, 3(5), 68–70. doi:10.1111/ebn.3.5.68


Anna Elizabeth Treloar