

## FROM THE EDITORS - Margaret McMillan and Jane Conway

### A REFLECTIVE PIECE

In comparing notes on experiences and issues with peers, one can get a sense of how a journal such as *AJAN* compares with others. Margaret has just returned from the International Academy of Nurse Editors (INANE) Conference in the Bahamas. Over 100 nurse editors from the USA, UK, Australia, Canada and South Africa met to discuss ideas on journals, editorial roles and responsibilities, and contemporary nursing. INANE was first established in 1981 and is representative of a group of nurses who edit both generic and specialty publications. Those at the meeting discussed issues the Editorial Board of *AJAN* has canvassed on numerous occasions. Matters examined included: how to best manage the editorial office and processes; the strengths and limitations of using technology to track manuscripts; the challenges in sustaining a quality and timely review process; the constraints among support for nurse authors in their attempts to write; the need to maintain reader interest and scholarly standards in the journal; marketing matters; and tensions in decision making about the specific or generic nature of a publication.

This is our final editorial for *AJAN*. In concluding our commitment to the journal, we wish to reflect on how we've approached the task. When we began three years ago, we asked questions about what *AJAN* itself was about and what the implications of it being published by the Australian Nursing Federation (ANF) were. We concluded that *AJAN* is a positive influence on Australian nursing and nurses are fortunate that the ANF has a vision for the advancement of nursing practice that is inclusive of diversity and acknowledges the need to integrate practice, research and scholarship.

For each issue of *AJAN* we have selected six manuscripts and extracted what we thought was their most important piece of commentary on nursing. We have tried to interweave the key ideas and construct our editorial pieces around these in order to capture the hearts and minds of our readers. The papers in this edition demonstrate the diversity of the scope of nurses' engagement in social issues. They range from a discussion of strategies related to practice in specific contexts, to critical review of social policy and dominant discourses and ideologies.

In this issue, Cole and Jasiak write about the need for a range of strategies to both prevent and manage the incidence of chlamydia among sexually active youth in Australia. Wand's paper identifies how the emergency department mental health liaison nurse role is consistent with Australian and State government policy and is valuable in contributing to enhanced capacity to meet the needs of those whose primary problems are related to mental health issues.

O'Connor and Pearson conduct an analysis of the discourse around care of the dying in order to examine the

potential dissonance between government policy 'Ageing in place' and the increased need for recognition for palliative care among those in aged care facilities.

Fowler and Lee use discourse analysis in their paper to explore the experience of learning to mother. In what the authors themselves acknowledge is an extreme example, the extent to which dominant discourses within literature related to motherhood can overwhelm the need to recognise, value and work with the individual experience of mothering is exemplified.

In addition to exploring issues related to society in general, in this issue elements of nursing's own social context are explored. In writing of one of the most publicised issues in health care work, Deans identifies the need for greater organisational support to limit the professional impact of workplace violence. He writes that there has been a focus on organisational rather than personal impact among nurse administrators and challenges the profession to 'acknowledge and claim ownership of the psychological injury experienced by its members'.

In a similar vein, Madison and Minichiello looked at the specific challenge of identifying and responding to sexual harassment in the workplace. Their paper highlights a need for greater alignment between educational preparation and workplace experience.

We have enjoyed the privilege of being able to 'indulge' our interests in examining nursing practice from the point of view of those who contribute to *AJAN*. In the last few years we have observed nurses making their way out of the administrative abyss, through the quagmires of boards and policy forming committees, along the corridors of restructures and realignments of processes, and into the challenges of 'working alongside' their contemporaries in a range of professions. We have noted the extent to which nurses appear to struggle with being centered in, but not overwhelmed by, the apparent complexity of giving the patient what they need in workplaces that are undergoing tremendous change. Therefore, in our editorials we have focused strongly on leadership in nursing. To this end we have invited Tuyen Tran, Manager of the Villa Maria Aged Care Centre, as the Guest Editor to share her story on the beginnings of her life in Australia and nursing.

As part of our personal journeys, our interaction with the profession through the editorial process has enabled us to develop our own capacity to identify a clear view of what we think nurses and nursing is really about today; and to extend and re-immerses ourselves in clinical practice issues - albeit vicariously.

It is our pleasure to welcome Jackie Jones to the role of *AJAN* Editor. We wish her much success and satisfaction in the role and trust that her experience is as positive as ours has been.

## GUEST EDITORIAL - Tuyen Tran, BN, Master of Science (OHS), Director of Nursing, Villa Maria Centre, Unanderra NSW

### AT THE HELM

I was asked to reflect on how I came to be at this point in time when I met the *AJAN* Editor at a Sydney, Australia, aged care conference.

It is a good time for me to think about my career and life experiences. For me, the key to success is to 'never give up' and I always look for new opportunities to be creative about dealing with challenges.

I am also a great believer in investing in others, empowering them, delegating and letting them get on with developing their skills - working with people. It is about learning to deal with challenges even if the situation is not easy. Where I am now, as a Director of Nursing, is only part of my story.

During my career there have been many challenges but one of my greatest personal challenges was to experience being a refugee from Vietnam. In the late 1970s I left my home country under very stressful circumstances. It was terrifying to board a fishing boat in the dark, to hide below deck out of sight of the authorities and take a huge risk to go to an unknown destination.

I arrived in Australia in 1979. I was only 23 years old. My son was born soon after arrival in Australia. I was one of 40 people on a boat going to Indonesia. Being in a boat from Vietnam to Indonesia was a frightening experience for a person who could not swim and the conditions on board were harsh. A stopover for a month on a small island in Indonesia allowed us to scavenge for food, mostly fish. When I look back now and think of the cramped space, no exercise and poor nutrition we were exposed to on the boat, it seems quite amazing that we survived that part of the journey.

We feared for our lives on many occasions. We spent five months in refugee camps in Indonesia before making further progress in an aeroplane on our journey to Australia, which was our choice of destination over America. My husband had relatives in Australia and we thought it was a place where we could find work and a lifestyle that we aspired to. We were overjoyed once our refugee status was confirmed in Jakarta, and we were permitted to fly to Australia.

I started life in Australia in a refugee hostel for five months with very little English to help me cope on a daily basis. I then moved to the inner city of Sydney and then on to Wollongong where my husband found work. I had learnt some English in high school - my choice of English over French turned out to be a good choice.

In Wollongong I was lucky to have a friendly neighbourhood centre nearby. I honed my English

language skills and became an interpreter. I still work as a casual health service interpreter today.

In the neighbourhood centre we learned many life skills other than English. I became a community 'helper' myself, for people needing legal advice, help to find housing, advice about child care and matters around women's health. Many people were on the dole and really struggled to fit into a different society. There were instances of racism but the women supported their men and the time here was full of promise of a better life.

In 1988, I commenced a nursing program because of an advertisement calling for applicants from a non-English speaking background. Interestingly, only a limited number of applicants came forward. Those who did were from an Italian/Macedonian background and I was the only person from a South East Asian background. The University of Wollongong program provided me with clinical experiences in a wide range of acute and aged care facilities.

On graduation in 1991, I worked in a residential aged care facility in the Illawarra region. At the time, I thought I needed to get experience in acute care settings. However, I soon came to realise that I needed to capitalise on the chances offered by the environment in which I worked. I was able to introduce ideas and practices that were novel to the setting. For example 'care planning' was new to the people with whom I worked. I quickly realised that I had some skills in management. Over a period of time I became a Deputy Director of Nursing and finally obtained a Director of Nursing position.

I have seen many changes in aged care, particularly since 1997 with the demands for better documentation and a change in accountability. At that time, residents were making more demands and were becoming very vocal. The system appeared to be letting them down, we needed to approach this challenge differently. Responding to their needs is very difficult when you have over 100 residents to care for and when nearly all of them are very frail. Their relatives cannot meet their needs and neither can we be complete carers for them in the way they hope as they live out their lives in residential aged care. I felt that if I had the answers I would be able to deliver the care they want, so I have constantly gone looking for answers to residents' needs.

In my present position, I have found I am able to bring my insights into the challenging demands for management of residential aged care in a contemporary way. I like what I do and I feel I still have a range of skills that can make a difference. I am thinking a lot about my registered nurse

colleagues, they are getting older so what will happen when they retire? I need a plan for the next generation. I wonder what my workforce will look like. I think my facility is a good example of ageing in place and I am very proud of that. I am pleased to be a leader to the nurses in my facility and am confident that my story models to them that nurses can make a meaningful contribution to enrichment of people's lives in many ways.

I am very goal driven and I could see that I could contribute a lot in the area of occupational health and safety. However, as soon as I feel comfortable with my job I look for a new challenge.

Interestingly, all those years ago although I saw opportunities for progression, I recognised that I firstly needed to convert my diploma qualification to a bachelors degree in order to have educational experiences that supported my practice and assisted me to achieve my goals. I observed that one serious omission in my practice setting was issues about occupational health and safety.

In the year 2000, I commenced my masters studies. I really enjoyed the challenge of meeting my new goal of providing better systems and processes within my organisation.

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# THE CONTEXTUAL ISSUES ASSOCIATED WITH SEXUAL HARASSMENT EXPERIENCES REPORTED BY REGISTERED NURSES

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## ABSTRACT

### *Objective:*

The study aimed to explore contextual conditions in Australian health care workplaces that make sex-based and sexual harassment (SB&SH) a relatively common experience for registered nurses (RNs).

### *Design:*

Unstructured, in-depth interviews with a convenience sample of Australian RNs.

### *Participants:*

The informants were 16 RNs (15 female and one male), working in health care, who were students enrolled in advanced tertiary preparation in nursing, counselling, and health care management at an Australian university.

### *Main outcome measure(s):*

Experiences described by the interview informants identified four conditions present in their workplace when they experienced SB&SH.

### *Results:*

Informants noted: 1) the silence that surrounds harassment; 2) that they could not expect support from their peers and professional colleagues; 3) that education did not exist in their workplaces regarding (SB&SH); and, 4) that traditional stereotypes associated with RNs were closely linked to the experience of harassment in the workplace.

### *Conclusions:*

Inadequate coverage of workplace issues related to (SB&SH) in undergraduate or postgraduate educational programs were identified.

## INTRODUCTION

Research into the experiences of RNs indicate that uninvited, unwelcome behaviour of a sexual nature in the health care workplace is not uncommon (Cox 1987; Cholewinski and Burge 1990; Donald and Merker 1993; Libbus and Bowman 1994; Kinard et al 1995; Finnis and Robbins 1994; Dan et al 1995; Madison and Minichiello 2001). Two widely quoted studies which have examined the problem across a wide range of occupations are the United States (US) 1981 and 1987 Merit Systems Protection Board (MSPB 1981; MSPB 1988) studies of 20,000 federal employees. These found sexual harassment was widespread with 42% of all female and 15% of all male employees reporting SB&SH. The targets were likely to be young, not married, educated, and/or members of a minority group (racial or ethnic). They were likely to hold trainee positions or hold non-traditional positions for their gender (eg. female law enforcement officer), and have an immediate work group composed predominantly of the opposite sex.

The MSPB studies showed that when women were working in 'traditional roles', four out of 10 women reported being harassed. However, a computerised search of Australian health care literature failed to find articles with RNs in Australia and sexual harassment in the title. In contrast to British or North American nursing, health care literature in Australia is unexpectedly silent on the topic of harassment of RNs. Using a quantitative approach Madison (1996; 1997; 2000) is one of the few Australian researchers to examine the topic.

Studies into SB&SH often focus on personal or professional characteristics or roles rather than interactional dynamics. There is a need for greater understanding of the experience of the harassed worker related to contextual conditions present in the workplace.

## METHOD

In-depth interviews of approximately one hour were conducted with a convenience sample of 16 volunteers. Interviews were based on the premise that SB&SH is a socially constructed symbolic phenomenon which can occur in interactions with others. The purpose of the interviews was to investigate how informants recognise and label their harassment experiences. University ethics committee approvals were obtained for the study. The informants are referred to using pseudonyms.

The informants were RNs practising in a variety of settings across Australia and enrolled in advanced tertiary preparation in nursing, counseling, and health care management at an Australian university. They had previously completed a survey on sexual harassment. The informants were between the ages of 29 and 46 and all but one was female. The informants had been employed as RNs from five to 29 years. Fifteen worked full time and the other part time. Ten informants identified their workplace as urban based and six as rural.

The interview data were reviewed and categories developed based on recurring themes or concepts.

## FINDINGS

The categories that became clear were: silence; lack of support; lack of education; and, perpetuating myths.

### Silence

The silence which shrouds harassment and the effect on RNs was notable. Mary's comment is typical:

*I feel very strongly about the issue of education and did my initial nursing education in a hospital based environment and we had absolutely nothing about issues like this.* (Metropolitan, community-based, RN for 13 years)

Another informant supported this view and explains her own silence:

*If you don't say you don't like what they say, I think they take your silence as permission to continue, so unless you say something, they don't stop. So maybe you should say, 'I'm sorry, I'm not finding that funny. Do you mind going elsewhere'. But I don't think, even as a unit manager, I don't know that I would have felt comfortable saying that to one of the obstetricians because it really was a small unit and you have to deal with them every day, so that you have to find some way of, you know, having some sort of working relationship. It wasn't like you could say, 'Oh, I'm not going to talk to him anymore because I think he's a rude person'.* (Metropolitan, hospital-based, RN for 15 years)

Another informant agreed that there is little discussion about 'incidents':

*... maybe that if like me nurses are probably reluctant to talk about the incidents. That they're covered over and*

*maybe they do happen and we don't hear about them or maybe they don't happen but I... judging... if you can take my experiences as an indication, then they do happen and nurses are reluctant to pursue further options about them.* (Regional/rural, community-based, RN for seven years)

Michelle described another reason why nurses are inclined to remain silent:

*I didn't tell anyone about it for a long time. I felt they might think that I'd invited it in some way, and I didn't think I had, but I wouldn't have liked people to think that I had.* (Metropolitan, community-based, RN for 13 years)

Certainly the fear of possible consequences of breaking the silence works to continue the silence. (Madison 1997; MSPB 1981; 1988). This is described by Helen:

*...you really felt disempowered as to, well, 'How hard am I going to make it on myself if I take it any further?'* (Regional/rural, nursing home, manager, RN for ten years)

### Absence of supportive behaviours

At the time of the harassing incident counselling was not offered or did not seem to be available or was not seen as necessary. The informants described the absence of supportive behaviours from colleagues in the work setting and revealed ways in which RNs are made to feel unsupported by other nurses and the nursing hierarchy:

*... probably fear of being ridiculed or not taken seriously, maybe again regarding, 'Oh, the patient didn't really mean to do that', you know, 'That's not an action that they'd do if they were in their right mind', and maybe, 'Oh, you're really stupid - you put yourself in that position in the first place, so how can you complain about it?'* (Regional/rural, community-based, RN for seven years)

Lucy perceived that her colleagues at work would 'ridicule' or see her as 'stupid', and somehow responsible for the harassment. The implications of this are serious. With this mindset, Lucy was unlikely to divulge or share her situation with professional colleagues and so discussions at a professional level were greatly reduced. Also individual as well as collective awareness strategies and action would therefore be limited.

One respondent describes how she was so sure that support would not be forthcoming from her organisation that she took the matter into her own hands and asked fellow workers of the harasser to 'take care of it':

*I did go and try and look for the sexual harassment policy, or procedure, and I created so much trouble just by mentioning the word in the hospital, because (laughs) they were all, 'What's going on? What's wrong with Jocalyn?' ... they all wanted to know why, why, why, why, and I just wanted to know: 'is there a policy, does it exist, how do you go about it, what are the procedures involved if you are sexually harassed' ... but to actually get the*

information, I was very much... interrogated, I guess... I think they were more curious than anything as to what was going on... and I wasn't prepared to give that information to them because I didn't think that they'd be able to handle it in the way that I wanted it to be handled. (Regional/rural, hospital-based, RN for 16 years)

Informants described unsupportive supervisors, efforts to limit or eliminate complaints or concerns, and being encouraged to smile and play a compliant role:

*Pretty much 'You must have done something to deserve it - you sort it out.'* I just gave up after that because I'd spoken to my charge sister, I'd spoken to my peers, and they all thought I was making a bit of a fuss about it. (Metropolitan, hospital-based, RN for 15 years)

*I still think that there are a lot of ramifications - you need to be prepared if you're going to confront something like that within a hospital you need to be ready, you need to be strong, because you're still going to handle a lot of problems to confront it and to deal with it. You may not be supported by your organisation. You could receive flak from other members of staff as well, so you need to be ready to deal with it.* (Metropolitan, community-based, RN for 13 years)

One person was not sure that 'management' really had, or accepted, ultimate responsibility. She suggested that the real responsibility lies with the harassed:

*... but I really feel for that behaviour to stop that it needs to really come from the people that the behaviour's directed to.* (Metropolitan/community-based, manager RN for eight years)

Another reflected a mixed responsibility and identified the importance of employers supporting employees with complaints, but also equivocated about the role of the complainant:

*... the people who need to be on top of it are the branch managers and I know that there are staff who have felt that when they have been harassed that they haven't been adequately supported by their managers.* (Metropolitan, community-based RN for 13 years)

It seems that neither a religious environment nor sexual preference can assure nurses of a supportive environment. One informant recalled a fellow student who left a Catholic nursing program because she was not believed following a rape. This experience happened many years before the interview yet her recall was vivid:

*And then, one girl was actually raped by the maintenance person... that was in a Catholic nurses' home the nuns didn't believe they could do such a thing, that she encouraged it, and she left, actually, and none of us ever heard from her again... he said she asked him to sleep with her, but she maintained she didn't. She was very shattered by the experience, so... it was really horrible.* (Metropolitan/community-based, RN for 24 years)

Another spoke of encountering harassment both as a heterosexual woman and a lesbian and commented on the generally unsupportive atmosphere in the workplace:

*... it's very strange... that women are so damaging to other women and I think nowhere more so is this demonstrated than in nursing, that we don't care and nurture each other at all, because I don't think we're terribly good at nurturing ourselves... to be selfish, to take time for themselves.* (Metropolitan, nursing home, manager, RN for 29 years)

Another informant described the homophobic harassment she endured in two different work place environments:

*... it's amazing how powerless you feel... like, I'm a pretty strong person and I've survived all sorts of things, and that just floored me... it's almost like they took advantage of me... feeling powerless because you're a woman and so therefore they pick on you, and being somewhat different... But, where I am now is certainly more accepting of my sexuality, so that isn't an issue for them. I was really surprised that women do it too, women harass, differently.* (Metropolitan, hospital-based, RN for eight years)

Not all informants described behaviours that were unsupportive. One of the informants had agreed to the interview only to describe harassment experienced by a younger RN colleague. She apparently had no experiences of her own to offer. She described, in an almost self-deprecating way, how she supported her colleague in a particular episode of harassment. A formal complaint was followed by a high-level formal hearing that required 'testimony' and substantiating 'evidence'. Paula willingly provided the necessary 'testimony' despite potential personal and professional repercussions. She continued by describing a personal ethos or professional commitment to an appropriate workplace, free of threatening or harassing behaviours:

*And if something continues, I'm not averse to taking someone aside and saying 'I don't like your behaviour and I don't want to hear that sort of thing again as far as the girls - young, old or me!' I guess a lot of people aren't able to do or say that so you've got to look after them, but you encourage them. I see that as part of my role - you have to be a patient advocate and you have to be a staff advocate.* (Metropolitan, hospital-based, RN for 14 years)

Unfortunately, this informant does not seem typical. The perception conveyed in the interviews indicated that when assertive confrontive strategies are employed, the trend is for the harasser to remain in their current position with the harassed person being removed. In an unsupportive workplace, when assertive or formal complaints are received, it seems that resignation, shift change or job transfer for the harassed person are the norm.

*I believe somebody did put in a written... a formal complaint, but he's still there. I think that particular person [the harassed] was moved to another area of the campus. (Regional/rural, nursing home, manager, RN for ten years)*

### Lack of education

No informants described an organised educational approach about harassment in the workplace. For these informants the topic is not covered in undergraduate education or in hospital orientation, other than occasionally under a general topic of professional relationships and behaviour or general equal opportunity discussions. Madison (1997) revealed that 45% of survey respondents either did not know if their Australian health care workplace had an organisational policy to deal with sexual harassment or thought that it did not have such a policy. This should not be construed as indicating that a policy did not exist. Rather almost half of the survey informants worked in an organisation in which they did not know or believe a sexual harassment policy existed.

In this study the male interviewee indicated he was unaware of any policy or educational programs on sexual harassment at his hospital, commenting:

*This hospital's notorious for having all these policies that sort of sit on the shelf and never get looked at until the situation arises, [laughs] and then there's a mad rush to find it. (Regional/rural, hospital-based, manager, RN for 13 years)*

Jenny talked about the failure of nurses to 'organise', which would suggest she believed sharing information about harassing incidents would educate nurses in developing strategies to help all nurses in dealing with harassment:

*I think sometimes we're... overrun when we shouldn't be... or it'll only be talked about in terms of: this particular incident pissed me off and I'll talk about it in the tearoom and it's gone over... we're often not very cohesive. (Metropolitan, hospital-based, RN for five years)*

She seemed to be saying that when nurses fail to confront, deal with and discuss harassment, it makes it easy for the harasser to continue with his behaviour:

*'Oh well, it's your problem', he will say, leaving the nurse to believe she is the only person who has a problem [with him].*

Education concerning harassment would reduce the sense of isolation and silence for the harassed.

Similarly, when a patient pulled Bess down onto his bed, prompting her to scream, Bess was not offered any counselling or education. She was reassigned so she would not work with that patient again. She describes the response from her employment setting as 'We'll think no more about it, and neither will you, you'll get on with your work'.

One respondent suggested that by educating RNs about the issues, addressing responsibility and empowerment, nursing in general may benefit:

*We're letting ourselves down because empowerment comes from within and somehow we're letting our nurses down by not addressing that issue of empowerment, we're not accepting personal responsibility or confronting issues and helping them deal with the issues. (Metropolitan, community-based, RN for 13 years)*

Jane described some education about SB&SH that was discussed at her place of employment under 'other EEO stuff'. When a complex topic is discussed under an already complicated umbrella (EEO), one wonders how it is unwrapped and presented to employees. However, one informant, an enlightened, contemporary manager, admitted that she had not assumed responsibility for a specific educational forum on sexual harassment. She was fairly certain that inappropriate behaviours on the part of patients would not be considered sexual harassment, suggesting that inappropriate patient behaviours should be considered simply as part of the 'patient role'.

### Perpetuating myths

According to Muff (1982), stereotypes and myths provide an easy solution to the complexities of human relationships. They obviate the need for men to understand individual women and are thus, according to Muff, tools of oppression.

These myths are entrenched in Western cultures and provide a way to think about nurses who often must transgress normal appropriate social distances and have to perform intimate procedures for patients. These myths serve to keep nurses 'in their place' and often impact on their professionalism. RNs in Australia were and sometimes still are referred to as 'sister', an acknowledgment of the religious roots of nursing and of a comfortable, sibling role for nurses. In this study, the myths associated with nurses as sexy, nurturing, differential, female, intimate carer, bath lady or battleaxe were described. The caring, 'mother' myth was identified:

*Woman, that's right. Mother, nurse, you know? Not professional, no. I mean, it'd be different if it was a doctor. (Regional/rural, hospital-based, RN for 16 years)*

*... my vision of a woman was the traditional one and they kept the house very nice and placid and soothing around the family and then all of a sudden I worked with these professional women and they were intense! (Regional/rural, hospital-based manager, RN for 13 years)*

Another was the popular stereotype of a dependent practitioner, unable to function without direction and orders from the doctor:

*I did not come out of my nursing education with a sense of nursing having any status as a profession and I did not feel that we were treated as professionals... my*

*perception was that we were still very much the doctor's handmaiden. I think these students coming through are going to find it very difficult because they're being taught that nursing is a profession, nursing has value, that we have ethics that we need to follow, that we are here, we are thinking, we are reasoning and we have standards we need to meet. And they are still walking out there into a nursing setting where they are part of the time still expected to be handmaidens and to swallow what's being given to them by the predominant medical situation.* (Metropolitan, community-based, RN for 13 years)

The stereotypical nurse in a tight, short uniform looking adoringly at the handsome young doctor is not an uncommon depiction of nursing and belies the work responsibilities of contemporary nurses. Several informants described the myth of the 'easy' nurse, 'available' and sexy:

*... the perception by the outside community that as a nurse you were 'easy' for an affair, was very annoying... I was the youngest of the occupational health nurses and there was a general perception that you were, fair game, you were available, you were ready, you were willing.* (Metropolitan, community-based, RN for 24 years)

*I wonder though whether that professional respect is existent in hospitals or whether it is like it was when I did my training and nurses were - particularly with the consultants - the nurses were just there to do the consultant's bidding and - I can remember the old ward rounds when the sister, the charge nurse, used to run after the consultants and pick up after them or that sort of stuff.* (Metropolitan, community-based, manager, RN for eight years)

## DISCUSSION

The in-depth interviews constituted an effort to recognise and understand the context in which the complex social interactions of harassment occurs in order to build awareness and a richer understanding of the issues (Taft 1987).

There seems to be little consensus about an identifiable SB&SH phenomenon. Stockdale and Hope describe it as a 'messy' concept (1997, p.355). Harassment challenges the way in which individuals think about themselves and others. Analysing SB&SH from a symbolic meaning perspective enables an understanding of the importance of interventions to reduce and eliminate harassment being based on knowledge of interactional and contextual issues. Contextual issues affect the way harassment is constructed as a personal and social issue with consequences that are not static, but continue to evolve.

The incidents of harassment, as well as the context in which they occur, vary with the harasser as well as the harassed. Informants were able to describe some common conditions that surround their experiences of harassment. The silence that surrounds SB&SH, the lack of

professional support and education, as well as the perpetuation of stereotypes and myths have been highlighted as particularly problematic.

Despite extensive research, national and international media attention, and onerous legal sanctions, RNs describe a silent, unsupportive workplace replete with negative stereotypical expectations. Nurses have been unable to translate the plethora of available information to the Australian health care workplace. Organisational policies and procedures do not seem appropriate or 'user friendly' to the RNs in this study. Few use them.

Consequences of assertive and direct action when confronted with sexual harassment are nebulous at best under the circumstances described. Despite their own discomfort and angst, informants felt abandoned, fearful and alone. This is not a good frame of reference for assertive action.

There is confusion among meanings that society has attached to SB&SH. On the one hand, the media sensationalise the issue causing people to link SB&SH with the courts, litigation and a few high visibility financial settlements. Not only are the issues often sensationalised, but they are dealt with superficially and generally. On the other hand, RNs in this study failed to see the efforts of most large organisations to promulgate policies and procedures regarding harassment and seemed able to disassociate themselves from the media hype.

For these informants there existed an articulate and almost passionate revulsion to the experience of harassment. Yet harassment evoked a passive inaction and what seems to be an almost disinterested response from others. RNs do not see the issue taken up by their professional journals, present in their educational curriculum, or on the agenda of workplace meetings.

Furthermore, construction of the event takes place in organisations that seem uninterested in reducing or eliminating harassment and within a hierarchy which is viewed as unlikely to support the harassed.

Informants described the many roles and stereotypes used to explain the harassing behaviour. Few of these roles and stereotypes are linked to contemporary nursing or society. Nurses may have moved beyond the myth of handmaiden, sex goddess and mother, but seem to remain in the process of reinventing or reconstructing themselves.

Not only are nurses talking about a high impact experience, but they are also struggling with words, descriptions, embarrassment and fear. To construct a meaning for their harassing interaction, much of their efforts needed to be directed toward minimising or explaining it away as not harassment. Given that their literature, professional organisations and employers did not speak to them about harassment and were seen as unsupportive, why would the RN 'confront' the issues, much less the harasser? When they did recognise 'something was amiss', they were usually overloaded

with emotional and physical responses. In the midst of personal physical and emotional anguish they were quick to develop rationalisations to explain their own behaviour as well as the behaviour of the harasser. Powerful entrenched socially constructed stereotypes provided a necessary framework to support the RNs' explanations. Possible strategies and appropriate tools to use when confronted with harassment were not part of the nurses' armamentarium.

### Implications for policy and change

Few would argue with the idea that structural forces are in place that impact on SB&SH. For the informants, the experience of SB&SH in the workplace was closely linked to male:female. Although the employer/employee relationship, the doctor/nurse relationship and other roles were a part of the harassing interaction, the meanings that these informants attached to their roles as women was the most imperative. During the interview process informants would be describing their behaviour as a nurse, employee or work mate, but would return or revert to their most familiar and comfortable base, 'female' and 'male', 'women' and 'men'. Men are in decision-making roles in most organisations, the legal system is predominantly male oriented, and our university hierarchies are male dominated. Health care organisations are led largely by male executives and medical practitioners. The scarcity of females in these roles contributes to a lack of understanding of the scope and impact of sexual harassment in the health care workplace. These structures must change to achieve a reduction or elimination of harassment in the workplace.

The current desire, not merely to tolerate diversity in the workplace, but to welcome it should help attenuate some of the entrenched patriarchal value system. Cultural and social diversity can work slowly to open up patterns of employment and work practices to new and more open ways of thinking. Legislation to this end should be supported and any effort to reduce or restrict diversity in the workplace should be exposed.

Many of the implications associated with this research project are not new. What may be new is the imperative to act. It is evident that much work remains to be done to rid the Australian health care workplace of sex-based and sexual harassment. This study has confirmed the

seriousness of the problem and identified the unmet need for extensive, high visibility education.

Education must begin in health programs that spawn our health professionals and continue in individual workplaces throughout Australia. Open discussion among and between professional groups is essential as an initial step in the educational process.

The starting point for education must be at the most basic level of information about harassment and proceed to the more complex social, cultural and interactional issues identified here. Research and publication on the topic must be encouraged and financially supported.

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# NURSES AND OCCUPATIONAL VIOLENCE: THE ROLE OF ORGANISATIONAL SUPPORT IN MODERATING PROFESSIONAL COMPETENCE

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Key words: occupational violence, organisational support, professional competence

## ABSTRACT

### *Objective*

Occupational violence as experienced by professional nurses has been extensively researched. However, the majority of studies have focused primarily on psychological and emotional outcomes and have not identified any interventions that may reduce the impact of aggressive behaviour on professional competence. The purpose of this study was to investigate the relationship between organisational support, occupational violence and perceived professional competence of professional nurses in Australia.

### *Design:*

A model testing research design was used to test the hypothesis that organisational support, as experienced by nurses, would moderate the relationship between occupational violence and perceived professional competence.

### *Setting:*

Nurses registered in Division 1 of the Nurses Board (Victoria, Australia).

### *Participants:*

A systematic random sample of 380 registered nurses from the target population of nurses in Victoria was identified.

### *Main outcome measure:*

The relationship between organisational support, occupational violence and perceived professional competence of professional nurses in Australia.

### *Results:*

The result showed that there was a significant effect of occupational violence on perceived competence. Analysis of the moderating effect of organisational support on the relationship between occupational violence and professional competence showed there was significant organisational support and

occupational violence interaction. Overall, the data analysis demonstrated the hypothesis was upheld that the negative effects of occupational violence on perceived professional competence will be moderated by perceived organisational support.

### *Conclusions:*

The failure to receive appropriate organisational support may result in lowering professional nurses' competence levels, causing a significant problem for the profession in that a reduction in professional competence has significant implications for patient care. The findings heighten the responsibility of the nursing profession to become more aware of the needs of professional nurses.

## INTRODUCTION

A report by Perrone (1999) for the Australian Institute of Criminology showed the health industry to be the most violent industry in Australia, with registered nurses (RNs) recording the second highest number of violence-related workers compensation claims in 1995/96, ranking higher than prison and police officers. Zernike and Sharpe (1998) reported that nurses at the Royal Brisbane Hospital, Australia, felt they had become acclimatised to aggressive behaviour and accepted it as part of the nature of nursing work. Wells and Bowers (2002) conducted a literature review and critical analysis on occupational violence and reported that the best available evidence indicates an incidence of more than 9.5% of general nurses working in general hospitals being assaulted in any one year.

The phenomenon of occupational violence as a stressor has been observed to have extensive detrimental effects on the psychological, social, emotional and physical wellbeing of nurses (Bowie 1996; Mason and Chandley 1999; Turnbull and Paterson, 1999). Of equal importance is the fact that negative effects of occupational violence have contributed to changes in how nurses perceive their own professional competence (Rippon 2000; Whittington and Wykes 1992; Wykes and

Whittington 1994). Nurses have been reported as experiencing different consequences to aggression than other health and non-health occupations, as nurses must continue to perform their duty of care and whilst so doing, maintain their professional competence while delivering health care to patients (Mason and Chandley 1999). Mason and Chandley also claim that although many nurses, despite wanting to talk to someone about being assaulted, felt unsupported by co-workers and hospital administration. Rippon (2000) draws attention to the difficulty of researching this sensitive topic as victims are frequently traumatised and emotional support has been limited or non-existent.

### The role of support

Accessing and utilising support has been identified as a key strategy for coping with stressors (DeLongis et al 1988; Lazarus and Folkman 1984; Folkman 1984). This body of knowledge supported the proposition that support has either a direct effect or a moderating effect on psychological distress across a variety of contexts. However, Paterson et al (1999) draw attention to the failure of organisations to provide support to nurses who have experienced work-related aggression. Rose (in Rippon 2000) reported that only 29% of nurses in an accident and emergency department reported physical assaults because they believed that reports by private citizens received more support than those of nurses. Paterson et al (1999) state that any attempt to provide support may need to overcome the attitude, historically prevalent in nursing, that to access support indicates a need for support, which is interpreted as professional failure. They suggest that the nature of the organisational response to the traumatised staff member can play a pivotal role in the process of recovery and, where the organisational response fails to understand or consider the needs of the victim, can constitute a source of secondary injury or trauma.

Given that support has been proposed as providing a potential moderating influence by several authors (Caplan 1974; Cobb 1976; House 1981), it was decided to test the moderating effect of organisational support on work-related aggression as it impacts upon perceived professional competence of RNs in Australia.

The definition for aggression utilised in this study was offered by Campbell and Landenburger (1996, p.732) as: 'those nonaccidental acts, interpersonal or intrapersonal, that result in physical or psychological injury to one or more persons'. This definition focuses on the relationships between people involved in occupational violence and may include the different roles and power relationships people have within the organisation.

### Types and sources of occupational violence

The sources of occupational violence include patients and their relatives, medical staff and co-workers including senior nursing staff (Farrell 1999; 2001). Occupational

violence may take the form of verbal abuse, (Cameron 1998) psychological bullying (Farrell 1996), sexual assault (Madison 1997; Madison and Gates 1996) or physical threats (Croker and Cummings 1995). It can come from a variety of sources, including patients and/or their relatives, doctors, administrators or colleagues (Carmel and Hunter 1991; Diaz and McMillin 1991; Holden, 1985).

Farrell (1999), in a survey of 270 Australian nurses in Tasmania, found that approximately 41% of public sector respondents and 62% of private sector respondents indicated that aggression caused them distress at work, with aggression from colleagues being most commonly cited by both groups of respondents.

### Impact of occupational violence

Occupational violence has been shown to have negative effects on individual nurses and on the nursing profession (Bowie 1996, 2000; Farrell 1997; Patterson et al 1999). Janoff-Bulman (1989) suggested that being a victim of occupational violence has the potential to destroy one's perception of, and ability to function in, a stable and orderly world. Consequently, when a violent incident occurs, the victim's professional and personal world no longer feels familiar; this has the potential to impact upon how nurses' perceive their own professional competency.

### Professional competency

Competency is a concept familiar to most nurses. To a large extent it becomes symbolic of academic and clinical achievement and can become enshrined as a professional ideal to which nurses must aspire. An understanding of how competency is applied to nursing in terms of standards is enhanced by consideration of competency as a psychological construct. Competence has been widely discussed in the psychological literature in terms of environmental mastery (Jahoda 1958), ability to cope with difficulties (Bradburn 1969), and self-efficacy or expectations of mastery (Bandura 1977). A competent person, according to Warr (1990, p.197), 'is one who has adequate psychological resources to deal with experienced difficulties'.

Competency is an important construct in professional training and registration in nursing. Potter and Perry (1993, p.327) defined competency in this context as the 'overall perceptions of nurses regarding quality of functioning in delivering effective, direct patient care'. The significance of this definition lies in the use of the words 'perceptions of nurses,' as it clearly moves the assessment of competence from an external source to the internal, subjective domain.

### Organisational support

A supportive work environment has been proposed as a coping strategy or moderator, buffering the individual from the damaging effects of work stressors such as occupational violence (Payne 1979, in Mackay and Cox

1979). For example, a study by Quine (1999), conducted on health workers in England, found that a supportive work environment can protect people from some of the harmful effects of bullying. However, in the health industry, the work environment is not necessarily supportive. Nurses who experience occupational violence may be encouraged to not report or discuss aggressive incidents, thereby closing off possible sources of support, and, as a consequence, suffer more intensely. Further, culturally based values and beliefs embedded in the nursing profession may inhibit nurses from reporting aggression and making optimal use of available coping resources.

### Conceptual framework

The stress model of cognitive appraisal (Lazarus and Folkman 1984) is integrated within a conceptual framework based on the notion of organisational support as a moderating influence on the relationship between nurses' experience of occupational violence and their perceived professional competence. The proposition that cognitive processes moderate the individual's responses to the environment has been widely accepted in the stress literature (Folkman et al 1986).

According to Gazzaniga (1988, p.996), threat has more to do with the idea of control: '...people can't, or think they can't, control their immediate environment'. DasCupta (1992) claimed that a perceived lack of control is just as important as an actual loss of control in causing us to feel threatened. A person's sense of control in any situation also comes from believing that it is possible to reach desired goals. Bandura (1977) similarly observed, that it is threatening for a person to feel that he or she lacks competence to cope with a particular demand.

The proposed moderating relationship between occupational violence, organisational support and perceived competence is represented in figure 1 as a path diagram.

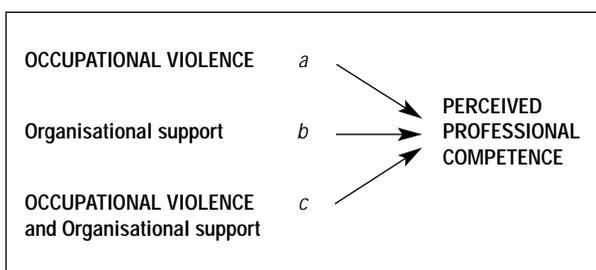


Figure 1: Model of the moderating effect of organisational support on occupational violence and perceived changes to professional competence

Figure 1 has three causal paths that feed into the outcome variable of perceived professional competence. The impact of occupational violence as a predictor (Path a), the impact of organisational support as a moderator (Path b), and the interaction or product of these two (Path c). The moderator hypothesis is supported if the interaction (Path c) is significant.

Examination of the literature suggested that while some studies have identified important physical, psychological and emotional aspects of how nurses respond to work-related aggression, the most significant gap in the research literature was the absence of studies investigating the role of organisational support in moderating the impact of occupational violence on perceived professional competence of RNs. As evident in the empirical literature in this field, there is a need to investigate the effect of organisational support in moderating the potential negative impact of occupational violence on perceived professional competence.

### Aims of the study

The purpose of this study was to test the hypotheses that organisational support, would moderate the relationship between occupational violence and perceived professional competence of professional nurses in Australia.

## METHOD

A survey was used to collect data that tested the moderating effect of organisational support on RNs perceptions of their professional competence following their experience of occupational violence. The researcher used Principal Component Analyses and a Content Validity Index to develop an instrument with 27 items requesting data on nurses experience of occupational violence, eight items on supporting behaviours from the organisation and 16 items on nurses' perceptions of their professional competence. Following a pilot study, 504 questionnaires were posted to registered nurses (RN Division 1) who were registered with the Nurses Board of Victoria, Australia.

### Sample of registered nurses

A systematic random sample from the target population of nurses in Victoria was identified. The researcher utilised a Power Analysis procedure to estimate that a sample size of 380 nurses in Victoria was sufficient to test the hypothesised model. Ethics approval was granted from the university ethics committee and consent was implied through the return of completed questionnaires.

## RESULTS

Results from the survey showed: the mean age of subjects was 39.18 (SD 10.61).

263 subjects (69.6%) were employed in urban facilities and 115 (30.4%) in rural communities. The mean years of experience as an RN was reported as 16 years (SD 9.61). 361 subjects (93% of the sample of 387), made a total of 2,755 responses to having experienced verbal, sexual and physical aggressive incidents from doctors, nurse colleagues and patients.

Verbal aggression (89%) was the most frequent type of work related aggression reported, followed by 77% reporting physical aggression, and 47% reporting sexual aggression. Patient initiated aggression was the most common source of aggression, with 88%, followed by 71% from doctors, and 61% from nurse colleagues.

There was an overall perception by 70 nurses who experienced occupational violence that nurse managers were 'not interested in their own [respondents] wellbeing', and 58 nurses perceived managers as 'not actively supportive'. For the aggregate score of organisational support the results showed that there was a significant effect [ $t(df=313)=2.54, p<0.025$ ], and that occupational violence impacted negatively on perceptions of supporting behaviours of key organisational staff.

A t-test was conducted between two categories of high and low scores for occupational violence and perceived professional competence. The result showed that there was a significant effect [ $t(df=382)=-3.05, p<0.002$ ] of occupational violence on perceived competence. Results of the regression analyses of the moderating effect of organisational support on the relationship between occupational violence and professional competence showed that there was significant organisational support and occupational violence interaction. Overall, the data analysis demonstrated that the hypothesis was upheld that the negative effects of occupational violence on perceived professional competence will be moderated by perceived organisational support.

Figure 2: Organisational support as a moderator of the relationship between occupational violence and perceived professional competence

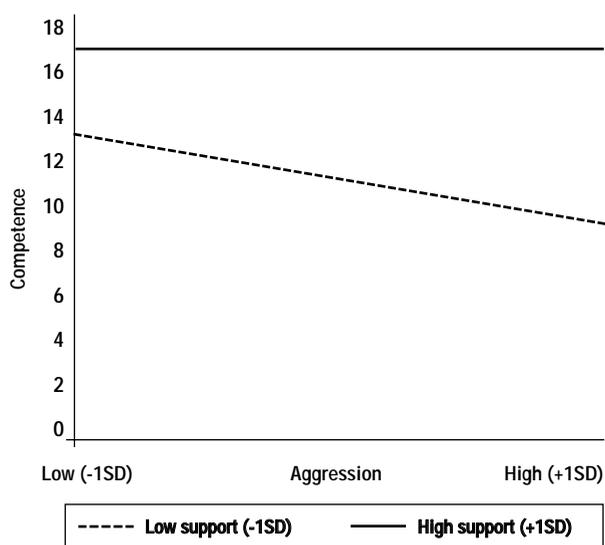


Figure 2 shows the occupational violence and organisational support interaction. For this graph, the effects of organisational support and occupational violence on perceived professional competence were plotted at two points: high and low. The slope for high organisational support was not significant [ $b= -0.02,$

$t(df=308)= 0.28,ns$ ], while the slope for low organisational support was significant [ $b=-0.26, t(df=308)=-3.68, p<0.001$ ]. As noted, the rate of effect of occupational violence on perceived professional competence is more at low organisational support than high organisational support. This suggests that organisational support moderates the effect of occupational violence on perceived professional competence.

When organisational support was received, it was provided mostly by nurse colleagues who were seen as very supportive. Doctors were generally considered to be either slightly or not at all supportive and scored lowest in organisational support. In the main, managers scored in the middle ranges of slightly to moderately supportive.

## DISCUSSION

These findings heighten the responsibility of the nursing profession and health organisations for the welfare of nurses employed in general nursing settings. Results have highlighted the importance of training nurses and nurse managers to provide organisational support to nurses who have been victims of occupational violence.

Nurse managers should receive comprehensive and carefully focused training in how to support the role of RNs; for example, by encouraging and promoting professional autonomy, decision making and control over practice.

The results in this study clearly show the provision of formal organisational support may prevent, or at least reduce, a decrease in nurses' perceived professional competence. Differences were found between high and low levels of organisational support, with high levels associated with higher levels of perceived professional competence and low levels associated with low levels of perceived professional competence, indicating that organisational support moderated the effect of occupational violence.

From the findings of this study, there is no doubt that the provision of organisational support plays an important role in moderating the impact of occupational violence on perceived professional competence, thereby giving further credence to the theory of cognitive appraisal postulated by Lazarus and Folkman (1984). Conversely, the failure to receive appropriate organisational support can result in lowering nurses' professional competence levels causing a significant problem for the profession in that a reduction in professional competence has significant implications for patient care. Nurses who have experienced occupational violence may become cynical about nursing, complaining about lack of collegial support from within the profession. They may become reluctant to establish and maintain contact with aggressive patients and staff and thereby compromise the quality of care delivered to patients regardless of whether they are perpetrators or not.

Perhaps the most important implication is that the profession, as a whole, should become aware of the extent of occupational violence and its impact on professional competence, and the role that nurse colleagues, nurse managers and medical staff play in its genesis. Some of the staff who have been implicated in this study as aggressors may have little or no understanding of the effect of their behaviour on others. It may be the case that nurse managers, who may well have been victims, are unaware of how to manage and support nurses who experience occupational violence. As a preliminary intervention, nursing administrators could make themselves more available to staff who have experienced occupational violence.

It is uncertain whether senior nurse administrators are aware of the extent of the problem of occupational violence and more importantly, aware of their own role in its perpetuation. Nursing administrators should become more aware of the personal needs of the victim, as well as the needs of the organisation or the profession. They should specifically consider the relationship between strategies utilised by managers for assisting new nurses to come to terms with aggressive behaviour from a variety of sources.

## CONCLUSION

Although it is unlikely the nursing profession will ever reduce occupational aggression to zero, reducing its professional impact should be a first priority for nursing administrators. Before this can be achieved there is a need by the profession to acknowledge and claim ownership of the psychological injury experienced by its members. Therefore, a professional nursing culture that acknowledges its own contribution to the problem can contribute to individual and professional recovery. Future research should be directed toward identifying and testing interventions which may prevent, or at least reduce the impact of occupational violence on nurses.

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# WHAT DO YOU GET WHEN YOU FALL IN LOVE?: WAREHOUSE YOUTH HEALTH CENTRE CHLAMYDIA AUDIT

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Key words: youth, chlamydia, screening, clinical guidelines

## ABSTRACT

### Objective:

The aim of the chlamydia audit was to determine the rate of positive diagnosis of chlamydia trachomatis in young people aged 12 to 25 years of age who were tested at the Warehouse Youth Health Centre, Sydney, Australia, in 2001 and to review current practice relating to chlamydia testing.

### Design:

A retrospective study was conducted on the medical records of clients identified through the pathology register as having a chlamydia test during 2001 from 1 January to 31 December 2001. The data were descriptively analysed.

### Setting:

The Warehouse Youth Health Centre, an FPA (Family Planning Australia) Health service which targets young people in Western Sydney, New South Wales, Australia.

### Results:

Chlamydia tests were performed on 194 clients at the Warehouse Youth Health Centre in 2001. Tests were performed on 179 (92.3%) female and 15 (7.7%) male clients. The overall positivity rate was 8.8% (17/194). Of the positive chlamydia tests 82.4% (14/17) were female clients and 17.6% (3/17) were male clients. The most common reasons for the clinician or client requesting the chlamydia tests were because the client was symptomatic, had unprotected sexual intercourse or had multiple partners.

### Conclusion:

The major recommendation from this audit is for chlamydia screening for all sexually active young people under the age of 25 years.

## INTRODUCTION

The Warehouse Youth Health Centre, a Division of FPA Health, services the Penrith, Hawkesbury and Blue Mountains local government areas, in New South Wales, particularly targeting those young people, aged 12–25 years, who are socially or geographically isolated. The centre offers a range of clinical, counselling and health promotion projects and works collaboratively with the local community (including young people) in the development and implementation of prevention, early intervention and intervention programs related to reproductive and sexual health.

Clinical staff (nurses and doctors) of the Warehouse Youth Health Centre were concerned about the number of positive diagnoses of chlamydia trachomatis in clients during 2001. Data from the Population Health Unit, Wentworth Area Health Service (WAHS), reported that the Warehouse chlamydia notifications for the period January to June 2001 represented 7.8% of WAHS total notifications for chlamydia (G. Truman, personal communication, 29 January 2002). The clinical staff undertook a retrospective chlamydia audit in order to improve current practice and review the FPA Health guidelines and practice for chlamydia testing and sexually transmissible infections (STI) management.

## LITERATURE REVIEW

### Young people and sexual health

The Australian Institute of Health and Welfare (Moon et al 1999) and NSW Health (2000) acknowledge the sexual health needs of young people. Australian research indicates that adolescents are at high risk of contracting sexually transmissible infections (STIs) due to inconsistent condom use and multiple short-term sexual partners as risk-taking behaviours. Contributing to their vulnerability is a lack of knowledge regarding STIs. A national study of 3,550 year 10 and 12 high school

students reported that although 45% of young people used condoms and 30% of young people identified chlamydia as an STI, less than 16% of young people believed they were likely to get an STI (Lindsay et al 1997). This combination of risk-taking and lack of knowledge contributes to young people's susceptibility to contracting chlamydia. Access to appropriate health services for STI information and screening is necessary particularly within services which are identified as being youth friendly (Silk 1999).

### **Chlamydia trachomatis: Definition and prevalence**

Chlamydia trachomatis is an intracellular bacterial infection, increasingly being identified in young people, with serious implications if left untreated. The complications in females include pelvic inflammatory disease, infertility and ectopic pregnancy and for males primarily infertility due to untreated epididymitis (Dayan 2000; Stamm 1999). Health promotion, through early detection and evidence based screening practices, is necessary to reduce the economic burden associated with treating complications (Philpot 1993) as well as reducing the psychosocial morbidity relating to the stigma and anxiety associated with a STI (Duncan et al 2001).

Nationally, chlamydia trachomatis was the most common notifiable sexually transmitted infection and third most common notifiable disease in Australia in 1999. However, since chlamydia notification commenced in 1998 the following data outlined needs to be interpreted with caution. In 1999, there were 74.2 chlamydia notifications per 100,000 population. Between 1991 and 1998 there has been an 80% increase in the population with young people aged 20 to 24 years identified at particular risk. Young people made up 60% of the national chlamydia notifications in 1998 (Moon et al 1999). In 1999, Indigenous chlamydia notifications were 882 per 100,000. A gender ratio of males to females of 1:1.5 exists (Roche et al 1999). Infection rates in males are thought to be artificially low due to a lack of males presenting for testing and the fact that current detection practices focus mainly on women. Literature identifies the underreporting of chlamydia among young women due to the asymptomatic presentation (Dayan 2000; Roche et al 1999).

National prevalence rates range from 2.5% to 14% in sexually transmitted disease (STD) clinics and 5% in family planning clinics (Mulhall et al 1995). Dayan (2000) argues that the true rate of infection is underestimated and reports prevalence rates of 6.5% to 7.2% in selective populations in rural and remote Australia.

Studies of chlamydia prevalence in Australian adolescents identify significant rates. Quinlivan et al (1998) reported a 27% prevalence rate in an antenatal population and Dhupelia and King (1993) reported a prevalence rate of 19.8% among university students. A recent prevalence study of chlamydia among adolescents in western Sydney at the High Street Youth Health Service (Johnston et al. [unpublished] cited by Kang

2002) identified a prevalence rate of 6.1%, all of which were asymptomatic. Kang (2002) highlights that homeless adolescents in western Sydney are at particular risk of contracting chlamydia and recommends further prevalence studies particularly for those adolescents under 16 years of age as well as program and screening development.

In the WAHS, it is of significance that chlamydia rates for females aged 0-14 years old and 15-19 years old are significantly higher than the state average (females 0-14: 16/100,000 versus 5/100,000 respectively and females 15-19: 431/100,000 versus 289/100,000 respectively).

### **Chlamydia screening**

Internationally, the United Kingdom (UK) and the United States of America (USA) have recommendations for national chlamydia screening. In the UK, the following target groups are identified for chlamydia screening: anyone with symptoms; all those attending genitourinary medicine clinics; women seeking termination of pregnancy; and, women under 30 using emergency contraception (Kettle et al 2002). Oakeshott et al (1998) from the UK recommend opportunistic screening particularly at the time of Pap smear in high-risk groups. In the USA, it has been recommended that sexually active teenage girls have six monthly chlamydia screening (Burstein et al 1998). Katz et al (1996) highlight the importance of chlamydia screening for reducing morbidity.

Currently there are no national chlamydia screening guidelines and Medicare does not fund chlamydia screening. However, the National Health and Medical Research Council Working Party on Pelvic Inflammatory Disease (1988) developed a protocol for chlamydial testing which recognised the following risk factors: age less than 25 years; more than one sexual partner; recent change in partner (ie. within the last two months) or a partner in this category; women using no contraception or non-barrier method or an unplanned pregnancy; cervical ectropia; and, patient request (p.ii). This report was rescinded in 1996 and national guidelines are needed for chlamydia screening particularly in high-risk groups.

The Chlamydia Strategy for Victoria, Australia, (2001-2004) (Victorian State Government 2001) recommends sentinel surveillance, targeted screening of high risk groups, increased health professional and community awareness of the significance of chlamydia as well as strengthening the process of partner notifications. This Victorian strategy outlines clinical indications for chlamydia testing which highlight teenage pregnant women and those seeking termination as well as those who are asymptomatic (p.22). The asymptomatic nature of chlamydia was noted by Australian researcher Hart (1993b), who reported asymptomatic presentation in females in 67% of infections and in males in 46% of infections. This asymptomatic problem of chlamydia as previously outlined is identified by the Communicable

Diseases Network Australia as being a major reason for the underreporting of the disease.

International and national (Fenton et al 2001; Pimenta et al 2000; Ramstedt et al 1992; State Government Victoria 2001; Dayan 2001; Hart a 1993; Garland and Johnson 1989) research identifies risk profiles for chlamydia and high risk populations. These risk profiles for chlamydia include; under 25 years of age; a sexually transmissible infection (STI) contact; single; nulliparous; not having steady partner; multiple sexual partners; recent change in partner; duration of current relationship less than 12 months; using an oral contraceptive pill; unprotected sexual intercourse; having vaginal discharge or dysuria. High risk populations have been reported in this literature as including: Indigenous; people of poor socioeconomic status; people attending sexually transmissible disease (STD) clinics; family planning clinics and gay men's health centres; women undergoing instrumentation of the uterus (termination of pregnancy; intrauterine contraceptive device insertion, ectopic pregnancy, dilation and curettage), semen donor; couples undergoing infertility investigation; pregnant women in the first trimester; and, people attending a general practitioner for STI screening.

Chlamydia infection has a high economic burden, and it has been suggested that at prevalence rates of greater than 2.1%, there are cost benefits to screening, which increase incrementally (Victorian State Government 2001).

## THE STUDY

### Aim

The aim of the chlamydia audit was to determine the rate of positive diagnosis of chlamydia trachomatis in young people aged 12 to 25 years of age who were tested for chlamydia trachomatis at the Warehouse Youth Health

Centre in the year 2001 and to review current practice relating to chlamydia testing.

## METHOD

A retrospective study was conducted on the medical records of clients identified through the pathology register as having a chlamydia test during 2001 from 1 January 2001 to 31 December 2001. The following variables were recorded: reason for attending clinic; gender; age; whether the chlamydia test was a clinician or client request; indications for chlamydia test; reinfection of chlamydia; whether client has current regular sexual partner; whether client or partner has multiple partners; recency of partner change; whether asymptomatic; presenting symptoms; use of condoms; form of contraception; use of emergency contraceptive pill (previous 12 months); parity; diagnostic pathology; termination of pregnancy history (previous 12 months); location of termination clinic; antibiotics at time of termination of pregnancy; chlamydia test result; client treatment for chlamydia; partner treatment for chlamydia; client awareness of contract tracing; whether follow-up visit was attended. The data were entered into Excel, then SPSS and descriptively analysed.

## RESULTS

Chlamydia tests were performed on 194 clients at the Warehouse Youth Health Centre in 2001. Female clients had 179 (92.3%) tests performed and 15 (7.7%) were performed on male clients. Overall, 72.7% of the clients were under the age of 20 years with the mean age 18.9 years (range=14 to 25yrs). The overall positive rate was 8.8% (17/194). Of the positive chlamydia tests 82.4% (14/17) were female clients and 17.6% (3/17) were male clients. The rate of positive tests was 7.8% (17/179) for females and 20% (3/15) for males. There was a total of 16 clients who had a positive chlamydia diagnosis as one client had a repeat test which was still positive four weeks

Table 1: Indications for chlamydia test

Indication	Clinician request		Client request	
	n	%	n	%
Partner chlamydia positive	3	1.5	4	2.1
Partner STI	3	1.5	7	3.6
Symptomatic	90	46.4	3	1.5
Unprotected sexual intercourse	37	19.1	45	23.2
Recent change in partner	5	2.6	5	2.6
Multiple partner	10	5.2	29	14.9
Sexual assault	9	4.6	6	3.1
Post-treatment	2	1.0	6	3.1
Intravenous drug use	9	4.6	10	5.2
Other	7	3.6	6	3.1

post treatment. Of those who were symptomatic, 7.8% (10/128) tested positive for chlamydia. The three main reasons for clients attending the Warehouse clinic were; sexually transmitted infection-information or tests, or results (36.1%, n=70), Pap test (18.0%, n=35) and for contraception information, issue, prescription or problem (12.4%, n=24). The most common reasons for the clinician requesting the chlamydia test was because the client was symptomatic, had unprotected sexual intercourse or had multiple partners (self or partner). The most common reasons for the client requesting the test was for unprotected sexual intercourse or had multiple partners. The major diagnostic pathology was cervical swab (71%, n=137 female), vaginal swab (33%, n=64 female) and urine (24%, n=47; 20%, n=36 females; 73%, n=11 males).

### Symptoms

Of all clients, 66% were symptomatic (n=128). Of the 179 female clients 68% had symptoms (n=122). Of the 15 male clients 40% (n=6) had symptoms. The following table depicts the principal presenting symptoms reported by females.

Symptom	n	%
Vaginal discharge	50	27.9
Dyspareunia	41	22.9
Postcoital bleeding	20	11.2
Intermenstrual bleeding	19	10.6
Abdominal pain	17	9.5
Dysmenorrhoea	12	6.7
Urinary symptoms (purulent discharge, dysuria or urethritis)	10	5.6
Irregular bleeding	10	5.6
Vulval itch	9	5.0
Pelvic pain	8	4.5
Premenstrual bleeding	6	3.4

The three main symptoms reported by females were vaginal discharge, dyspareunia and postcoital bleeding. Other symptoms with more than 5% reported incidence include; intermenstrual bleeding, abdominal pain, urinary symptoms, dysmenorrhoea and irregular bleeding. The males reported predominantly urinary symptoms (20%).

The mean number of symptoms for those without chlamydia was 1.13 (SD=1.14, n=175). The mean number of symptoms for those who tested positive for chlamydia was M=1.06, (SD=1.20, n=17). The difference between the two means was not significant  $t_{190}=0.23$ ,  $p=0.818$ . There was no significant difference between the positive and negative chlamydia test groups in the number of symptoms by Mann Whitney test ( $U=1411$ ,  $p=0.713$ ).

Therefore, according to two statistical tests, the number of presenting symptoms was effectively equal for clients testing positive and clients testing negative for chlamydia. For 66 (34%) of the chlamydia tests, clients reported being asymptomatic. Of these 57 (86%) were female and nine (14%) were male. Of the females, 32% were asymptomatic whereas 60% of the males were asymptomatic. Therefore, males were much more likely to be asymptomatic than females.

### Type of contraception used by the client

There was no contraception used by 6.7% (n=13) of clients. The following contraceptives were used by clients, in order of frequency; combined oral contraception (46.4%, n=90), condoms (27.3%, n=53), depo medroxyprogesterone acetate (2.1%, n=4) and contraceptive implant (1.5%, n=3). The use of contraception was not documented in 14.4% (n=28) of files. The use of emergency contraception in the previous 12 months was reported in 16.5% (n=32) of files. There were 15.4% (2/17) of the positive chlamydia clients who reported no use of contraception.

### Client treatment and contact tracing

The clients were aware of contact tracing in all positive chlamydia diagnoses. Of the 16 clients who had positive tests, 37.5% (n=6) of the clients had partners who were known to be treated and in 62.5% (n=10) it was not known whether the partner had received treatment. Client treatments for the chlamydia positive clients included; doxycycline (58.8%, n=10), azithromycin (5.9%, n=1), erythromycin (11.8%, n=2) and 17.6% (n=3) were referred for treatment to a general practitioner. A follow up visit was reported in 82.4% (n=14) of files of positive diagnoses of chlamydia.

## DISCUSSION

This retrospective audit illuminated a positivity rate of 8.8% (17/194) for chlamydia in a youth service setting where young people have predominantly presented with symptoms. This audit revealed a higher positivity rate of chlamydia than Garland and Johnson's (1989) finding of 4% at The Royal Women's Hospital, Melbourne, Australia. The average age of the population screened was 19 years, which is similar to the population in Johnston et al's unpublished study (Kang 2002) and the positivity rate is higher than their prospective prevalence rate of 6.1% among asymptomatic clients. Further prevalence studies of young people are needed which are consistent with the Chlamydia Strategy for Victoria 2001-2004 (Victorian State Government 2001).

The predominant reason for young people presenting to The Warehouse Youth Health Centre at the time of chlamydia testing was for STI - information, tests and results. However, the extensive research by Lindsay et al (1997) highlighted the knowledge deficits in young people regarding STI's, particularly chlamydia. Therefore, there is

a need for appropriate health promotion strategies in youth environments for both prevention and early detection in order to decrease morbidity.

The main reasons for chlamydia testing by clinicians was that clients were symptomatic (66%) or had a history of unprotected sexual intercourse (19.1%). These indications for testing are consistent with current recommendations for chlamydia testing (Victoria State Government 2001; Dayan 2000). The symptomatology reported in the audit is similar to the symptoms reported by Garland and Johnson (1989), however, in this audit, higher frequencies of vaginal discharge, dyspareunia and post coital bleeding were identified.

Of the young people having chlamydia testing, 34% were asymptomatic. This is similar to Garland and Johnson's (1989) finding of 35%. However, in Hart's (1993) study of chlamydia in South Australia, 67% of infections were asymptomatic, and 46% of infections in men were asymptomatic. Results like these suggest we may have missed a significant number of asymptomatic infections in clients who were not tested. Current debate articulated in the Chlamydia Strategy for Victoria 2001-2004 (Victorian State Government 2001) recommend screening of asymptomatic people with identified risk factors.

The clinician and client indications for chlamydia testing including being symptomatic, having had unprotected sexual intercourse or multiple partners are congruent with the risk profiles identified by international (Fenton et al 2001; Pimenta et al 2000; Ramstedt et al 1992) and national (Victorian State Government 2001; Dayan 2000; Garland and Johnson, 1989; Hart 1993) research.

The oral contraceptive was the most prevalent contraceptive used by female clients. Since Cottingham and Hunter (1992) reported an almost twofold risk of increase of chlamydia infection for oral contraception users, further promotion of safer sex strategies incorporating barrier methods in order to reduce risk is required.

The most frequently administered antibiotic for chlamydia positive clients was doxycycline (58.8%), which is consistent with current recommendations by the Therapeutic Guidelines Ltd. (2000) and Donovan et al (2002).

The predominant diagnostic pathology tests were cervical swabs, vaginal swabs and urine specimens for chlamydia PCR. These are consistent with the literature recommendations (Dayan 2000; Garland et al 2000; Donovan 1997).

### Implications for practice

Young people should be considered a high-risk group for chlamydia. Chlamydia testing especially at time of pregnancy counselling and testing, Pap tests and at time of consultation for emergency contraception and oral contraception in asymptomatic young female clients is recommended. Given the significant rate of asymptomatic infection with chlamydia, and the lack of knowledge many

young people have of this condition, consideration should be given to offering chlamydia testing to all young people under 25 years of age presenting to family planning clinics and youth health services worldwide.

### Recommendations for research

There is a need for research regarding the accuracy, appropriateness and accessibility of current information of chlamydia and other STIs which is distributed to young people. Further research is also required addressing innovative forms of communication which are youth friendly and target low literacy sub-groups of the youth population, specifically Indigenous and culturally and linguistically diverse populations and young people disadvantaged from socioeconomic reasons and those young people who are mentally ill and experience alcohol and other drug problems. The investigation of low literacy multimedia and Internet communication is suggested. In determining the true incidence of chlamydia in the young population, more prospective prevalence studies such as that by Kang (2002) on a larger scale comparing at risk populations with the general population of sexually active young people would be valuable for promoting national chlamydia screening.

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# MENTAL HEALTH LIAISON NURSING IN THE EMERGENCY DEPARTMENT: ON-SITE EXPERTISE AND ENHANCED COORDINATION OF CARE

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**Key words:** mental health liaison, emergency departments, waiting times, service integration, mental health promotion

## ABSTRACT

### *Objective*

To evaluate the Mental Health Liaison Nurse (MHLN) service based in the emergency department (ED) of a large, inner city teaching hospital in Sydney, Australia.

### *Design:*

Data were gathered over the first two years of the position. Information is presented regarding the length of time that patients waited to be seen by the MHLN. Results from two rounds of surveys conducted with ED nursing and medical staff are tabulated.

### *Results:*

Data obtained from the Emergency Department Information System (EDIS) demonstrates that the Mental Health Nurse Practitioner (MHNP) is able to see a majority of patients at, or close to, the point of triage. These findings are reinforced by ED staff who rate highly the readily available access to mental health assessment and enhanced coordination of care. The strong clinical focus of the role is acknowledged by the ED staff who perceive that patients are better supported therapeutically and spend less time waiting in the department due to MHLN intervention

### *Conclusions:*

This evaluation suggests that the MHLN role has significant benefit for patients presenting to the ED by reducing waiting times, streamlining transition through the department and improving follow-up. The MHLN is highly regarded by the staff as an on-site source of clinical expertise. The information obtained supports the established model and will be used to guide the direction of the service.

## INTRODUCTION

Following a process of de-institutionalisation, and an emphasis on enhancing the integration of mental health services with mainstream medical services, the general hospital emergency department (ED) has become a major point of entry for consumers with mental health concerns. There is no doubt that this patient population requires specialist skills in terms of assessment, management and disposition. ED staff are generally uncertain in their interactions with mental health clients and lack confidence in their assessment skills and understanding of the mental health services that are available (Wand and Happell 2001). Mental health nurses have worked as part of consultation-liaison (CL) psychiatry teams in Australia for many years and the benefits of these positions is well documented (Meredith and Weatherhead 1980; Sharrock 1989; Hicks 1989; Sharrock and Happell 2000; Sharrock and Happell 2001; Sharrock and Happell 2002).

MHLN is an initiative which has recently gained considerable momentum within the Australian health care system. This is especially true in New South Wales (NSW) where funding was provided in June 2000 to establish MHLN positions in EDs across the state, particularly in rural hospitals. There is a dearth of Australian literature related directly to the work of MHLNs within the ED. It is therefore necessary to determine principles germane to all MHLN services. However, it must be emphasised that individual EDs have their own local characteristics and demands, which will largely determine the type of liaison service that will suit a particular environment.

The distinction between general hospital CL psychiatric nursing and MHLN is unclear. Roberts (1997) prefers the term mental health liaison nursing as it evokes a positive approach to mental health promotion. CL nurses working in the general hospital have mostly assisted in the management of patients with a primary medical condition and co-morbid mental health problem

that influences the provision of medical care. In contrast to this, MHLN based in the ED involves the assessment and management of those who present with predominantly mental health presentations. However, as with general hospital CL nursing the role also entails ensuring equity of access to medical treatment for people with mental health concerns.

The most noteworthy Australian study related to mental health nurses working in the emergency setting was undertaken in Melbourne, Victoria, Australia, by Gillette et al (1996). Results from their nine month evaluation suggested that the mental health consultation-liaison nurse produced more positive outcomes including: increased client satisfaction with the services offered in the ED; decreased length of stay; more efficient management of aggressive and potentially aggressive occurrences; and, attitudinal changes in nurses when working with clients with mental health related problems.

### International perspective

There are basic descriptions of mental health services based in the emergency setting in the USA in the early 1990s (Snyder 1992; Kordilla 1994; Stutesman and Yohanna 1994). There are few recent international publications examining the MHLN role. However, there are some accounts from the UK of mental health liaison services that work from the ED. Brendon and Reet (2000) have developed a MHLN service 'parallel to, but independent of', the existing consultation liaison psychiatry service in the West Middlesex University Hospital. Their team consists of two nurses, a psychologist and a 'development post', whereby a nurse is seconded into the team for six months to acquire a number of skills that are focussed upon clinical competencies. The service includes after hours cover until 9pm 'most evenings'. The service concentrates on the ED and also extends to the general medical wards of the hospital. The authors purport that early response and intervention assist in reducing repeat episodes or attendances to the ED and prevent beds on the medical wards becoming filled with patients who are solely awaiting psychiatric or psychosocial input.

Callahan et al (2001) have analysed the work of an ED mental health service in East London. Their team comprises mental health nurses, social workers and psychiatrists on rotation. The service operates from 8am to 9pm midweek and 1pm to 9pm at weekends and is also available to the general wards of the hospital. Over a 14-month period data were reported on 949 people seen by the mental health liaison service. The information collected includes client demographics, time of arrival, time seen and waiting times. The majority of referrals (33%) were seen immediately upon arrival to the liaison service and the average waiting time was 10 minutes. The service aims to provide a speedy response to mental health presentations and to reduce the demands placed on health services.

Beech et al (2000) conducted a 12-week pilot project which explored the demand for an after hours on-call service delivered by two experienced psychiatric nurses in an ED of a large Midlands hospital. The nurse-led service was available nightly from 10pm until 8am. The aim was to provide an alternative to the on-call psychiatric service, thereby relieving the demands on junior doctors. This followed concerns over the long hours worked by junior doctors as well as the belief that nonmedical health professionals can deal with a wide range of mental health problems/disorders. The nurses recorded 88 occasions of service, an average of one per shift. Approximately 75% of the presentations involved patients already known to services and the psychiatric junior doctor on call was involved in 37.5% of presentations.

While these descriptive accounts of MHLN services are promising, they fail to present any data regarding the value and benefits of this initiative from those groups the role is designed to serve. ED consumers are major service beneficiaries and follow-up telephone surveys are currently underway. However, the main focus of a liaison service is to provide support and consultation for the staff of the particular facility. Consulting with the ED staff is therefore imperative, both in terms of appraisal and feedback and providing a sense of ED staff ownership.

### Healthcare directions in Australia

The three UK papers make reference to addressing the National Service Framework for Mental Health Services (1999). In Australia similar documents exist. The National Standards for Mental Health Services (1997) upholds the principles of prevention, early detection, early intervention and mental health promotion. The Standards require mental health services to 'identify and respond to mental disorders and/or mental health problems as early as possible' and provides as an example 'minimal waiting times for assessment' in locations such as the ED. The strategy also calls for services to share expertise with emergency departments to promote 'inter-agency collaboration' and to share resources.

At a state level, NSW Health (1998) have published recommendations for mental health care in EDs, which stipulate 'That mental health services will respond to emergency department consultation requests with equal clinical priority to other emergency requests'. Another recommendation from the same working group states; 'That where possible, designated mental health staff should be rostered to provide consultation to EDs, in order to foster a team working relationship'.

### The current model

Importantly, the MHLN service developed at Royal Prince Alfred Hospital (RPAH) is based in the department and viewed as a member of the ED team. The current model of MHLN at RPAH was developed from a pilot study conducted over four months in early 2000 (Wand

and Happell 2001). The purpose of the pilot study was to devise a MHLN model specific to the needs of the environment. It involved focus groups, questionnaires and a pilot study evaluation with ED staff. The model was also derived from synthesis of local and overseas literature and is consistent with both Federal and State Government initiatives that promote integration of mental health services with mainstream medical care. The overriding principles of the MHLN service are that:

- Overall ED care including triage, medical assessment, the process of consultation, referral and disposition is enhanced by MHLN intervention.
- The effectiveness and efficiency of the ED is improved by utilisation of MHLN assessment skills, therapeutic skills and care coordination.
- The MHLN coordinates a system of education and training for ED staff.
- Knowledge of mental health issues is improved through mental health promotion, guideline development, role modelling and clinical teaching by the MHLN.

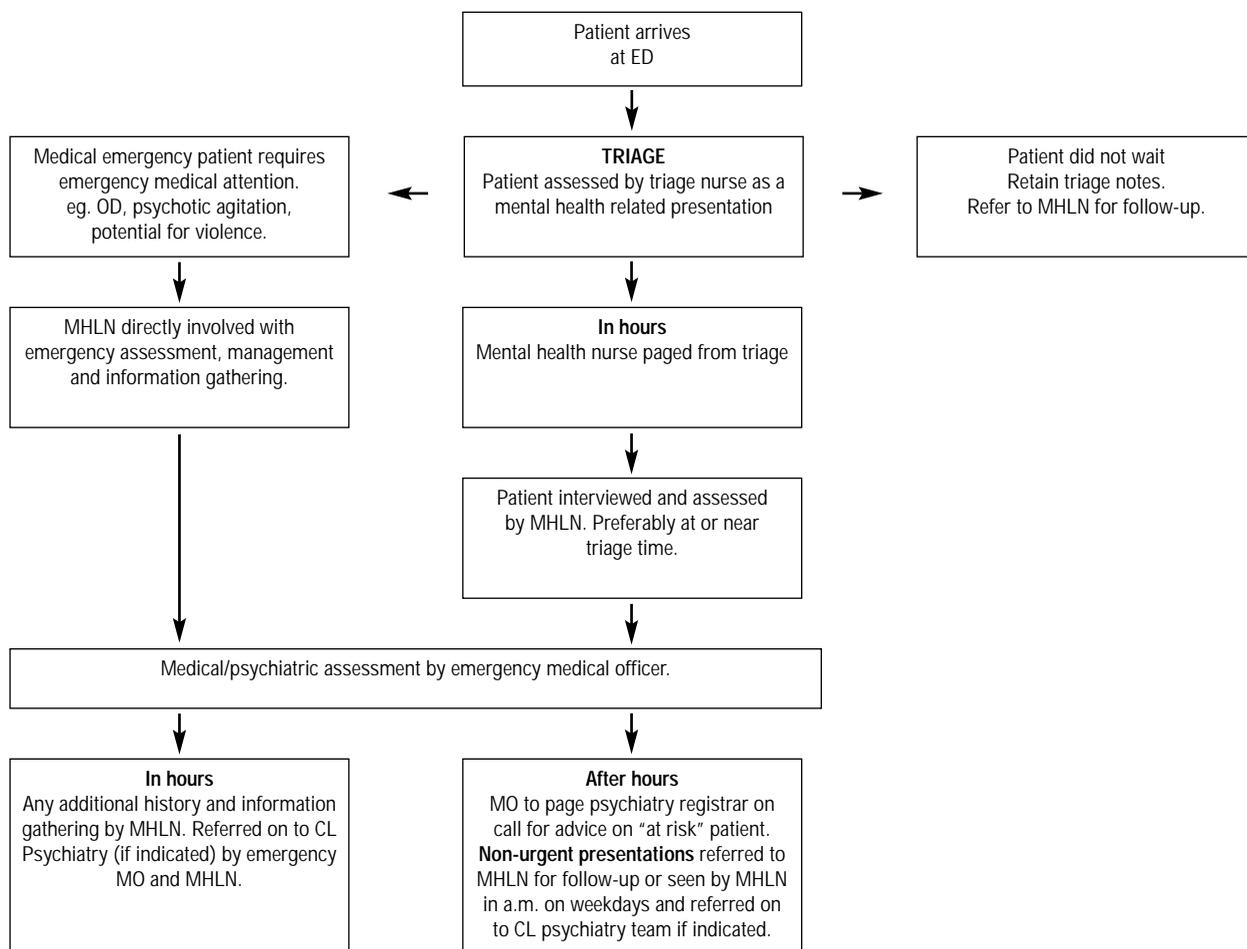
- The MHLN maintains regular communication with the consultation-liaison psychiatry team and the staff of the mental health service.

### Referral process

The MHLN sees patients of all ages with mental health concerns. This includes major mental illnesses and disorders as well as drug and alcohol problems, behavioural and emotional disturbances, psychosocial issues and patients having difficulty coping with physical illness. Referrals are made verbally by nurses, doctors and social workers. The MHLN is available Monday to Friday from 8am to 4.30pm. Although funded as an ED position by the Area Mental Health Service, the MHLN occasionally provides consultation to general hospital wards as there is currently no other nurse-to-nurse consultation available for mental health issues.

A flow chart outlining the pathway for mental health related presentations to the ED illustrates how the MHLN service adds considerably to the structure already in place. The flowchart clarifies how the position has become integrated with the routine management and follow-up of mental health related presentations to the ED and emphasises the clinical focus of the role.

Flow chart: Referral pathway for mental health liaison nurse in RPAH emergency department



## AIM

The aim was to evaluate the model of MHLN that is in place and to seek anonymous feedback from nursing and medical staff of the ED regarding the ongoing development of the MHLN service. It was also anticipated that the data would be consistent with Australian Federal and State Government expectations that mental health services respond promptly to requests for assessment in the emergency setting and therefore, also support an extension of the MHLN service to provide consultation in the department after hours and on weekends. Aspects of the evaluation are discussed below.

## METHODS

The data were presented to the Ethics Committee of RPAH and there was no objection to publication. The number of people seen by the MHLN in one year from October 2001 to October 2002 was identified. Information on occasions of service, the waiting times for patients to be seen by the MHLN and follow-up arrangements made in the community were entered into the ED Information System (EDIS) and then transferred onto an Excel spreadsheet so that triage times could be compared with the times that patients were seen by the MHLN.

The time patients waited to be seen by the MHLN from the time of triage was quantified. There was then an assessment of the number of mental health presentations occurring in the department outside of current MHLN hours.

### ED staff evaluation of the MHLN service

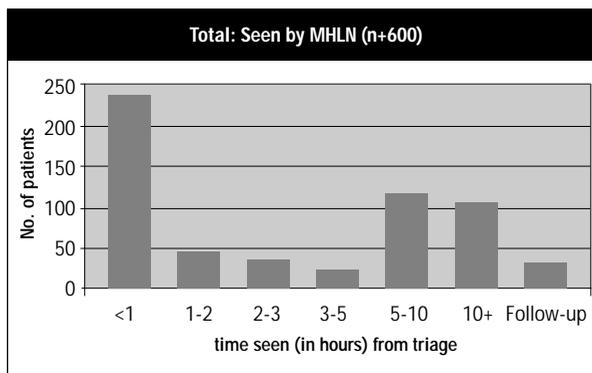
Surveys were conducted in January 2001 and October 2002. Feedback has been sought on the development and direction of the MHLN service and as part of the quality improvement process. Surveys were distributed on both occasions over a two-week period to nursing and medical staff. Participants were handed the survey in an envelope, and a box labelled 'mental health liaison evaluations' was placed in the staff base of the ED for the return of completed surveys. The survey consisted of six questions. Three related to gender, experience in the ED and professional designation. The ED staff were then asked to rate the effectiveness of the MHLN using a Likert Scale adapted from Gillette et al (1996). The effectiveness rating was 1= not at all, 2= somewhat, 3= fairly, 4= very. If a particular aspect of the mental health liaison service was not utilised the participant indicated this with a N/A. The last three questions asked the staff to identify what the MHLN had done to positively influence the care of mental health presentations through the ED, what staff perceived as their own deficits in the management of mental health presentations and finally, any comments or recommendations. The data were analysed using the Statistical Package for the Social Sciences (SPSS) version 11.0.1 for Windows.

## RESULTS

### Waiting times for patients

Figure 1 illustrates that from October 2001 until the end of October 2002, 600 occasions of service were recorded by the MHLN on EDIS. Most significantly, 40% (n=235) of patients were seen within an hour of triage and 14% were seen within three hours of arrival in the department. The rise in the 5-10 hours (n=118) and 10+ hours (n=110) category represent those presentations that arrived after hours and were seen by the MHLN the following day. The bar labelled 'Follow-up' refers to those patients who were referred to the MHLN for follow-up and therefore were not seen on that particular presentation.

Figure 1: Occasions of service (n=600) for MHLN in RPA ED, October 2001-October 2002

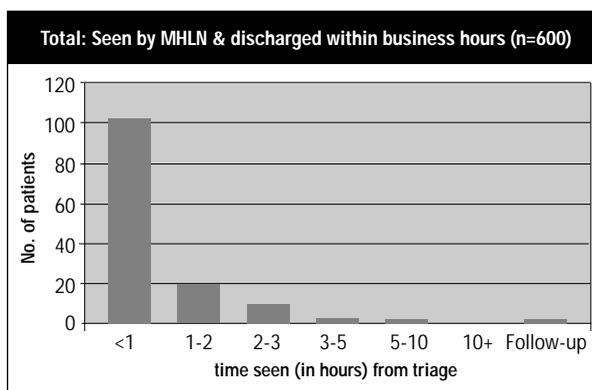


Follow-up refers to those patients who were referred to the MHLN for follow-up, but were not seen in the department.

### Occasions of service for business hours only patients

Figure 2 represents all occasions of service for the MHLN that were seen and discharged within business hours. This data is of interest as the MHLN has the greatest influence over the transition through, and disposition from the department for people who present and are discharged during business hours. A total of 138 patients in the sample were seen and discharged within business hours, and of this number 75% (n=103) were seen by the MHLN within an hour of triage.

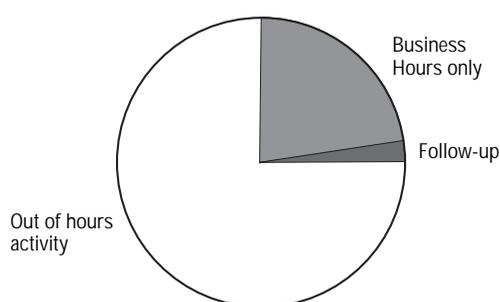
Figure 2: Occasions of service for MHLN in RPA ED, October 2001-October 2002. Patients admitted and discharged within business hours only.



## Emergency department activity

The following pie chart represents the same 600 patients (2001-2002 occasions of service) and illustrates the significant amount of activity in the department out of business hours. The 'out of hours activity' section refers to all patients who either arrived or were discharged outside business hours. This represents a sizeable period of time, from 5pm until 8am Monday to Friday and across the whole weekend. The pie chart highlights the significant workload placed on the ED when the MHLN is not available. During this time there is also only one psychiatric registrar available for the whole hospital. This places a heavy burden on ED staff and the psychiatric registrar and is in marked contrast to the service provided for mental health consumers during business hours.

Figure 3: Pie chart representing ED activity.



## Emergency department staff surveys

In January 2001, 70 surveys were distributed to staff of the ED and a total of 46 surveys were returned providing a response rate of 66%. Twenty-six of the respondents were nurses and 20 were medical officers. Experience of working in the ED ranged from 15% with less than six months experience to 17% with more than five years experience in ED. The largest group in the survey were those who had worked in ED for one to five years, 44%.

In October 2002, 65 surveys were distributed and a total of 50 were returned, a response rate of 80%. In this survey 27 respondents were nurses while 23 were medical officers. ED experience in this survey was similar to the 2001 survey. Sixteen percent had worked in ED for less than six months and 24% for more than five years. Again the largest group in the survey, 38%, had worked in ED for one to five years. Both surveys achieved a convenience sample that is a significant representation of ED nursing and medical staff.

## Rating effectiveness of the MHLN

The mean scores listed here show that the MHLN's expertise has been consistently viewed as fairly effective to very effective. Assessment of mental state and aspects related to the management of challenging behaviour were the most highly rated attributes of the MHLN. The relatively low scores for education can be explained by the number of medical staff who responded with N/A, as formal MHLN education sessions in the ED is conducted mainly with nursing staff.

Table 1: Rating of MHLN effectiveness

(Effectiveness rating 1= not at all, 2= somewhat, 3= fairly, 4= very)	Jan 2001	Oct 2002
	Mean scores	
Information about past history	3.4	3.6
Assessment of mental state	3.7	3.8
Risk assessment	3.7	3.7
Management of agitated and aggressive patients	3.5	3.7
Working with self-harm patients	3.6	3.8
Therapeutic communication	3.4	3.5
Symptoms of mental illness	3.4	3.6
Treatment of mental illness	3.5	3.5
Community resources	3.4	3.5
Mental Health Act/Legal Issues	3.4	3.4
Informal education	3.4	3.4
Formal education	3.2	3.2

## MHLN and patient care

In the first survey, participants were asked; 'what has the MHLN done to positively influence the care of mental health presentations through the ED?' The ED staff were given space to respond to this open question in their own words. Several themes emerged from these written responses. This information was then grouped under a number of thematic clusters. The responses to this question are presented in table 2.

Table 2: What has the MHLN done to positively influence mental health care in ED? 2001 survey.

Most common responses Jan 2001	Nurses	Doctors	Total %
Readily available mental health consultation	15	6	46
Management of difficult presentations	8	3	24
Support for patients	4	6	22
Liaison with CL psychiatry team	3	7	22
Increased mental health awareness amongst ED staff	6	4	22
Decreased waiting time for patients	5	2	15
Enhanced communication with community teams	5	1	13

From these initial groupings the survey conducted in October 2002 was modified to reflect the benefits that were originally highlighted in the 2001 survey. In the 2002 survey, participants were asked to circle one or more of a number of MHLN interventions that they thought positively influenced the care of mental health presentations to the ED. The results are presented in table 3.

**Table 3: What has the MHLN done to positively influence mental health care in ED? 2002 survey.**

Most common responses Oct 2002	Nurses	Doctors	Total %
Readily available mental health consultation	19	22	82
Management of difficult presentations	23	16	78
Support for patients	23	17	80
Liaison with CL psychiatry team	20	21	82
Liaison between ED and mental health unit	21	18	78
Increased mental health awareness amongst ED staff	19	11	60
Decreased waiting time for patients	18	20	76
Enhanced communication with community teams	9	16	50

### ED staff perception of their own deficits

The ED staff were also asked; 'What do you perceive are your own deficits (if any) in the management of mental health presentations?' In both surveys the response rate to this question was comparatively low. However, the information gleaned from the responses that were given provides direction for educational and training initiatives.

The main difficulties expressed by ED staff relate to lack of confidence and skill in managing challenging presentations and behavioural emergencies. There is also a perceived knowledge deficit in areas such as mental health assessment, the Mental Health Act, psychiatric diagnoses and the community resources that are available to consumers.

### Recommendations from the ED staff

Staff were given the opportunity to make additional comments or recommendations in relation to the MHLN service. Respondents were unanimous in their support for the MHLN service. The single most prominent recommendation in both rounds of surveys was to have the service expanded to cover the ED after hours.

## DISCUSSION

Results from both ED staff surveys indicate that staff are enthusiastic in their endorsement of the MHLN service at RPAH. Their approval demonstrates that the benefits of this initiative were rapidly realised. The model that emerged from the pilot study has been validated. Readily available access to expert assessment and management of difficult mental health related presentations is of greatest value to ED staff. This is reinforced by the quantitative data obtained from the EDIS database, which demonstrates that the MHLN is able to see a majority of patients at, or close to, the point of triage. The strong clinical focus of the role is clearly recognised and appreciated by the staff who believe that patients are better supported therapeutically and spending less time in the department because of MHLN intervention.

Enhanced communication between services is highly rated by ED staff. There is a perception from both nurses

and medical staff of the ED that the MHLN improves the relationship with the CL psychiatry team as well as the mental health unit attached to the hospital.

## LIMITATIONS

This paper presents the perspective of a developing service, which has not at present been benchmarked with any other similar ED mental health liaison service. It is essentially a short-term review. Further evaluations will add greatly to the perspective of MHLN services in EDs.

Asking ED staff to list their 'deficits' has assisted greatly in developing relevant programs and guidelines however the wording of the question may account for the low number of responses. Deficit may have connotations of incompetence whereas 'difficulties with mental health presentations' may have been a more appropriate term.

## CONCLUSION

The development of the MHLN role in the ED is consistent with tenets of Federal and NSW government mental health policies and is supported by evidence from overseas literature attesting to the benefits of MHLN in relation to the provision of specialised psychosocial nursing care in the general hospital setting.

The MHLN service has the potential to considerably enhance the coordination and continuity of care between general hospital and mental health services by placing an emphasis on minimal waiting times for patients, clinical expertise and mental health promotion. The MHLN is a highly valued resource and support for ED staff, improving their access to information and mental health/psychiatric services.

The success of the MHLN service in the ED appears to be based on ongoing transparency and collaboration between all staff, a positive attitude and equity among disciplines. These working principles are upheld by all members of the ED team.

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# AGEING IN PLACE – DYING IN PLACE: COMPETING DISCOURSES FOR CARE OF THE DYING IN AGED CARE POLICY

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**Key words:** palliative care, aged care, discourse, policy

## ABSTRACT

**Australian Government aged care policy documents emphasise healthy ageing. Even though death in the aged care setting is a common occurrence, minimal policy exists to underpin activities that surround dying in this setting. Issues and practices about caring well for the dying remain a hidden discourse in aged care policy, the literature and therefore in practice.**

**A discourse analysis of aged care and palliative care policy documents for the period 2000-mid 2001 was undertaken. The analysis highlighted competing discourses about care of the dying in residential aged care. This paper describes the main discourses, explores competing and hidden discourses, and raises questions about the disparities found.**

**The conclusion is that care received by the dying person in Australia is dependent upon the setting in which this care is delivered. 'Dying in place' should be attached to the Government's policy slogan - 'Ageing in place'.**

## INTRODUCTION

**D**eath is a common occurrence in residential aged care (RAC) facilities. Despite this, little is known about how dying actually happens or how facilities deal with the issues of death and dying, particularly in Australia (Wilson and Daley 1998; Irvin 2000).

Palliative care practice espouses access to expert care for all people facing the end of life. People in the final stages of life in RAC should expect comfort and care that is aimed at enhancing the quality of their remaining life. However, significant evidence in Australian and overseas literature indicates that care for the dying in this setting causes concern (Hudson 2001; Froggatt 2001; Avis et al 1999; George and Sykes 1997; Komaromy et al 2000; Lloyd 2000; Melding 2002).

Although 31% of those admitted to RACs die within six months, and 43% within 12 months (Australian Institute of Health and Welfare 2000), aged care facilities are not equipped to provide the sort of care that a dying person might need. Given the emphasis on healthy ageing in recent Australian Government Aged Care Policy documents this is hardly surprising. Consequently, issues and practices about caring well for the dying in the RAC environment remain hidden in policy, the literature and probably in practice. A major impetus for this study was exploration about why there is little written about care of the dying in RAC.

A discourse analysis of aged care and palliative care policy documents was undertaken for the period 2000-mid 2001, utilising a broad range of documents - mainstream media, academic literature, press releases and formal Australian Government policy documents.

The study involved a review of recent literature about ageing, death and related issues, in order to place the particular issues in their historical and social context. Additionally, articles on the care of people in RACs were sought from the national newspaper *The Australian* from

1999 to mid 2001, in order to paint a broad picture of influences and developments that have contributed to policy in the public arena. Finally, Australian Government policy documents, press releases and speeches on palliative and aged care from the same time period were examined.

This analysis highlights the competing discourses about care of the dying in RAC found in policy. This paper outlines the methodology utilised to report on the competing discourses.

## DISCOURSE ANALYSIS

A starting point in the analysis of discourse is a recognition that language is socially and culturally situated. Language can be indicative of values contained within, or symbolised by, words, and language can alter in content and meaning depending on the setting of words. Discourse has been used in helping to construct social relationships and contributing to systems of knowledge and belief, thus assisting us to understand each other. The link between policy and society is noted in the work of Green (1993), who states that policy reports are a 'major means of reality and knowledge construction in modern society'(p.xiv). He argues that the connection between words and their meaning, within the milieu in which they are spoken or written, contributes to a particular discourse.

As a research tool, discourse analysis is concerned with producing meaning from talk or texts to reveal aspects of cultural understandings, which may have been hidden. If society is symbolised by the words that are used to describe it, then language is an important part of that society's social construction. Fairclough (1992(a), p.5) argues that something becomes a social reality only in its linguistic representation and the use of language. He makes a two-layered distinction in the construction of discourse - it is influenced from the outside by such things as culture, context and political theories, as well as from the inside by the textual meaning that is applied. A social theory discourse becomes clearer and more distinctive through the process of political debate, comment, writing and referencing (Fairclough 1992(b)).

Discourse analysis challenges the dominant knowledge about a particular issue or phenomena, and seeks to disrupt easy assumptions about the meanings and organisation of social life. It seeks to examine how 'public attitudes... are shaped, reproduced and legitimised through the use of language' (Seale 1998, p.253).

## METHODOLOGICAL APPROACH

Roe (1994) suggests that 'the starting point of (narrative) policy analysis is the reality of uncertainty in the polarised issues and controversies of today' (p.10). The relevance of this statement is heightened by the contentious political climate of aged care, which is characterised by publicity designed to demonstrate

Australian Government efforts to improve systems of delivery. Despite these efforts, the community's perceptions about care in aged care facilities remain critical.

The study utilised discourse analysis as described by Fairclough (1989; 1992(a)) and Seale (1998; 1999), building on particular interpretations of Foucault (1970; 1977; 1978).

Seale (1999) suggests that while it is good research practice to be faithful to a text's overall meaning, there is no necessity to account for every text on a particular subject; indeed it is legitimate to be selective and, for the purposes of the analysis, to focus on those sections which provide the best source of material for analysis (p.253).

Themes within discourses were identified and used as the main analytic tool. Words and themes were drawn out manually, by continual questioning of the texts to determine variation in a text and among texts, seeking emphasis and detail. Vague, difficult to challenge, language and descriptions like 'the good death' or 'the team' were also sought. Dominant themes emerged.

## FINDINGS

Through thematic development, different discourses about this one issue have been developed from different perspectives - the many 'truths' of the issue. The method is reflective, open-ended in the questioning of text, rather than seeking solutions or developing a particular dominant view. Issues often develop through the push and pull of conflicting discourses, communicated to the community in different ways, raising awareness of an issue and forcing political debate. Four competing discourses emerged from the study:

- what is the purpose?
- there's no place like home,
- the burden of dying; and,
- bold self sufficiency.

### What is the purpose?

Two conflicting discourses emerge about the purpose of RAC - a focus on living to maximise independence for the majority of residents, while providing comfort and supportive care for those approaching death. The different focus of care between the dying and other residents involves a shift, from the promotion of independence to promoting quality and comfort in the life remaining.

Engle (1998) describes the difference between 'maximum function' - prevention of falls, independence in activities of daily living, treatment of illness - and 'comfort care' - assessment of mental status, function, mood, symptom control, spiritual pain and withdrawal of food and fluids as requested (p.1172). Parker-Oliver (2000) makes a distinction between different constructions of illness - 'the sick role', and the accompanying behaviours and responses required to get better.

In contrast, an emerging 'dying role', for the terminally ill person, frees them of responses demanded of the sick role and allows a focus on tasks concerning the end of life (p.495). This is applicable in aged care, where the dying person may need to be freed from activities of daily living, in recognition of the different requirements for the journey to death. Additionally, Komaromy, Sidell and Katz (2000) suggest that:

*'The protection of the residents who live in the home from the sight of a departing corpse appears to contradict a frequently expressed belief... that residents who are very old are more accepting of death. Home staff frequently stated that residents accepted death because they had seen so much death during their long lives. Also they were at an age where they expected to die, and others expected them to do so'. (p.310)*

Recent palliative care policy changes for in-patient services (or hospices) have targeted shorter length of stay, for specific reasons like symptom management, respite and care in the final days of life (Aranda et al 1998). If long-term care is not regarded as the purpose of in-patient palliative care, the flow-on effect may be pressure on RAC to admit people with vague or lengthy prognoses. In comparison, the National Council for Hospice and Specialist Palliative Care Services in the United Kingdom (UK) recommended that hospices should offer nursing and respite care for older people rather than being limited to their current restrictive practices (Clark and Seymour 1999). Thus, the effect on the Australian system is like the bubble in the carpet - one part of the health care system policy is clarified, refined and appearing to work well, but an impact is felt elsewhere in the system. In reflecting on these different levels and costs of care, is the person pushed to the least expensive option?

### There's no place like home?

The major qualifying factor for admission to aged care is assessment of the need for continuous nursing care, or chronic illness not requiring acute hospital care (Australian Law Reform Commission 1995). Assessment is based on the inability of care to be provided in the community (in the person's own home), implying a high level of dependence, usually because of increasing frailty, dementia or chronic illness. Over recent years, people entering RAC are arriving with increased dependencies due to a range of factors, (but perhaps significantly because of improved community support systems. Sixty two percent have high-level care needs, compared with 38% needing low-level care (Australian Law Reform Commission 1995).

In keeping with long-standing Australian Government policy (Australia, Commonwealth Working Party on Nursing Home Standards (CWPNHS) 1987), aged care facilities are required to present an ambience that emphasises the 'home-like' environment, rather than a clinical one. This means that 'although the provision of high quality nursing care is essential, a nursing home is not a

hospital... A homely, personalised environment in which residents are able to retain their identity, values and individuality adds greatly to their quality of life' (CWPNHS 1987). The contradiction is, that while residents who live in this setting are often dependent and frail, with the majority requiring high level care, aged care policy continues to emphasise this sense of homeliness, implying less requirement for nursing and medical care (CWPNHS 1987).

Thus, there are conflicting discourses in calling an aged care facility a 'home', which, despite the best endeavours to create a 'homelike' environment, belie the intensive caring required by most residents. Is the facility set up as a 'home' with connections within the local community that make it an important part of the community? Or are the facility and its residents sequestered from the life of the community, with a subjective posturing about what occurs inside? What are the opportunities for interaction within the surrounding neighbourhood - visitors, volunteers, fundraising, church interaction, or open days?

Further, Mannix (1998) queries the symbolism of more recent changes in the name of a nursing home to an 'aged care facility'. The title 'nursing home', together with the policy of homeliness, implied a balance of both the need for professional care and the sense of being homely. The newer title removes the implication of the requirement for nursing. Requiring aged care facilities to be homelike implies that people are not sick and downgrades levels of dependency; if this is their 'home', perhaps nursing care is not needed.

In challenging the dominant discourse of 'home', Wilson and Daley (1998) describe the social context of nursing homes compared to the acute health sector. There are different staff ratios, unskilled workers provide care, there are 'limited physician involvement, more deaths from chronic and prolonged illnesses, limited family involvement and often, less opportunity for the resident to communicate their needs and preferences'. All these factors influence the picture of the facility as perhaps not as 'serious' as the acute environment, thus impacting on the way care and, in particular dying is regarded in the aged care environment (p.22).

There may be ambivalence on the part of staff, about the level of involvement of other residents in the dying process (Komaromy 2000). Participation in 'usual' home rituals that surround dying and death - explanation about and involvement in the dying, saying farewells and even being informed of the person's death, do not appear to be routine in the fabric of life in the RAC, or at the very least are regarded as 'nice additions'.

Australian Aged Care Standards (Commonwealth Department of Health and Aged Care 1998) require working toward single room accommodation for all residents over the next few years, but is this always appropriate, especially for the dying? The physical environment may serve to encourage involvement or to

separate the person (Komaromy 2000). For example, areas for privacy for the dying person and their loved ones are needed, as well as flexible areas to accommodate the 24-hour involvement of families as appropriate. However, the dying person ought not be too isolated from the main institutional activity - creating a sense of being 'put away', such as the routine removal of a dying person to a single room. Komaromy (2000) regards these practices as contributing to an environment of denial of dying. With the development of new building standards, such sensitive issues may be appropriately addressed by individual facilities.

Is the RAC facility the preferred place of death for the older person, over and above their home? Despite the availability of some in-home support programmes, do older people really get the same equitable choices as dying people of other ages, about where they wish to spend their final days? Or is it just assumed that because a person is old, they become increasingly dependent and frail, demand more carer time, and therefore need institutional care? Clark and Seymour (1999), examining care and dying in the home, suggest that even though most people state that home is where they would like to receive care, this could be understood as 'a critique of the hospitalised and medicalised death' (p.89). Wishes about the place of dying for an older person then, are complex and cannot be viewed in isolation outside the fabric of the community, which by its support or not of such care, places a value on the lives of residents.

### The burden of dying

As stated, caring for a terminally ill person is not an uncommon experience in RACs. Komaromy (2000) has examined the institutional practices that support hidden death - the removal of the dying person to a single room, the pulling of screens around the bed (which are not sound proof) when someone has died, the removal of the body at mealtimes so no one sees it, not informing other residents that the person has died, the removal of the body as quickly as possible. Perhaps it is this commonality that belies articulation of what dying means and how it occurs? Thus dying and death and the role of staff in these events becomes so 'normalised' as to become a hidden discourse.

Caring for dying residents and their families can be stressful for staff - and a lack of recognition of the need for bereavement can become an issue, especially for untrained staff. Komaromy et al (2000) found staff preferred sharing the care among themselves for these reasons. Staff also stated that they did not like working at night because of a fear of death as well as the additional work this involved when staffing levels are at a minimum. Staff support, embedded in the team philosophy of palliative care practice in recognition of the stressful work, is not as evident in the aged care environment.

Komaromy et al (2000) also note, 'residents of nursing homes were more dependent and often had multiple needs associated with extreme old age, so the care required by

many of these residents was intense' (p.193). The final phase of life may involve physical, psychosocial and spiritual needs compared to the needs of other residents. Extra medication, different equipment and the increased work involved in caring for someone in the terminal stages of illness, can be a significant strain on an already stretched staff. This care may easily become considered both burdensome and disproportionately expensive in this setting.

Palliative Care Australia (1999) notes the difficulties in translating principles of palliative care into a nursing home environment. Of particular concern are the principles of care for the terminally ill person and their family. Other issues reported were the staffing skill mix, the educational needs of staff, the burden of staff stress, the facility's budget, the limited availability of expertise in low care settings, and the lack of resident choice of general practitioner.

Additional evidence of the difficulties manifests in the reluctance of some managers to take on this additional care, particularly in relation to costs. For example, there may be a lack of understanding of the need to bring in the consultant palliative care nurse, who may charge a fee for additional nursing advice. Miller et al (1998) and Watt (1997) suggest that money will be the downfall of alliances between palliative care and aged care in the United States, which are regarded only in terms of the possibility for additional income. In Australia, there is similar disquiet about who pays for the provision of palliative care support to a resident, since government does not fund such 'cross sharing' of care through either aged or palliative care budgets.

Additional anecdotal concerns about the limited availability of equipment in the aged care setting also exists. Flexibility with items such as a particular bed and the call-bell system may be needed as the person approaches death. Access to items like softer mattresses, syringe drivers, and low beds may be limited, with the aged care facility regarding the local palliative care service as a source for the lending of equipment - at times, this has caused conflict between services. Local service relationships require strengthening in terms of this access.

Recognition of this ending phase of life shifts the focus of care away from maintenance of independence to a focus on palliation the management of the final stage of life, and its accompanying symptoms, from ageing in place to dying in place. Komaromy et al (2000) note that when a resident withdrew to his or her room, this was often a sign to others that the dying process had begun. Similarly viewed, was the appearance of the pastoral worker/chaplain, if the RAC did not routinely use these services. Key and Schonwetter (1998) also note that residents, their families, and physicians are 'becoming increasingly aware that the terminally ill may be more comfortable and may receive more comprehensive and satisfying care when palliative measures, rather than life-prolonging goals are pursued' (p.491).

Because of the belief that palliative care ought be available to all Australians wherever they live, there needs to be an ongoing commitment to seeking ways that expertise can be made available to those aged care residents who need it. Perhaps palliative care workers (reflecting community attitudes) have a poor impression of care in RACs, so the impetus to work collegially assumes less importance than other areas of responsibility.

### **Bold Self-Sufficiency**

Komaromy, Sidell and Katz (2000), in their 1997 English study, report being most surprised by the lack of familiarity of nursing home staff with palliative care, a consequent lack of knowledge of what palliative care can achieve, or where to access such expertise. The predictable result was less than optimal terminal care in these homes. Counsel and Care for the Elderly (1995), a charitable organisation in the UK providing advice and practical assistance for older people and their carers, described this as 'bold self-sufficiency' - a lack of staff awareness of what can be done for a dying person and a lack of willingness to seek such expertise. Few policies for palliative care practice were found in nursing homes, suggesting that 'the gap between nursing homes and hospices is greater than one would think' (p.13). Parker's Australian study (1999) also revealed resistance to palliative care, in terms of perceptions about the 'myths' of palliative care - the administration of narcotics, feeding and hydration, and transfer to acute care. Melding (2002) noted concerns about the under-diagnosis and under-treatment of pain in RACs in Australia.

It appears that, for the additional care required, inadequate staffing levels adversely affect the availability and quality of the care that staff is able to give a dying resident (Palliative Care Australia 1999). The use of unqualified staff, perhaps unused to caring for the dying, may make the staffing additionally difficult. There are specific educational needs required to cover areas such as assessing and managing pain, promoting comfort using both pharmacological and non-pharmacological interventions, communication skills, spiritual needs, and family and staff grief support.

Dowding and Homer (2000) and Steel et al (1999), both addressed particular needs in relation to the education of unskilled staff. In providing such education the role of the unskilled worker is valued, since it is often that person and not the registered nurse who spends most time with a particular resident; thus dying becomes a human experience more than a medical event. Dowding and Homer (2000) noted that 'the philosophy and principles of palliative care are an appropriate and necessary educational focus for nursing home care staff' (p.163). Keay and Schonwetter (1998) suggest that the enduring myth that older people are resigned to death will persist without education to assist workers to appreciate what palliative care can achieve.

Resistance to additional expertise may also be because of a perceived invasion of the relationships between residents and staff. There is a paternalistic and protective sense to these relationships that staff may note as deeply significant, even replacing family in terms of importance (Wilson and Daley 1998). So the palliative care team may be regarded as 'outsiders' who arrive to provide end of life care, which is seen as interfering with these relationships. How are more equitable relationships between staff in these settings able to be more effectively facilitated for mutual benefit?

The issue of inequitable relationships, is symptomatic of the lack of system connection between aged and palliative care services rising from separateness in policy. A lack of expertise in the aged care sector is compounded by a lack of connection to places where this expertise can be found. Keay and Schonwetter (1998) found that, even in nursing homes that have contact with a palliative care program, the services may not be regularly used, with neither sector having established policies and procedures for ensuring routine referral for patients who need such care. In particular, a lack of access to the expert knowledge of caring for the dying is resulting in discrepancies in how nurses understand and practice such basics as the principles and practice of pain management.

Accreditation changes in Australia in 1998, requiring demonstration of the provision of palliative care are beginning to impact on this separatist picture (Commonwealth Department of Health and Aged Care 1998). The major criticism of the relevant standard however, is its limited description of a philosophical approach, which assumes staff understands the practice of palliative care. Anecdotal reports suggest that meeting this standard has required facilities to seek palliative care educational support.

## **DISCUSSION**

These four competing discourses illustrate the disparities between policy and practice in care of the dying in RAC, suggesting a false disconnection between aged and palliative care policies, which ultimately serves to disadvantage those people who need the expertise of both disciplines. This analysis of policy has, at the very least, exposed this complexity.

There are many common characteristics about the client groups who are either in RACs or in receipt of palliative care, most obviously that both groups are reaching the end of life - they are 'finishing' (Knepfner 1989). However, there are inequitable and inappropriate disparities - in staffing, care models, funding and services available, like grief support - depending on the setting in which the dying person finds themselves. Counsel and Care for the Elderly (1995) highlight the position in the UK, which like Australia appears to require 'more continuous dialogue between hospices on the one hand and nursing homes on the other, but the functions of the

two sorts of agencies are further apart than might be supposed' (p.13).

Dying in RACs contests the discourse that the facility is the person's 'home' (which subtly negates the nursing needs of the dying person) and conflicts with the purpose of maximising the independence of residents. There is evidence that even in this setting, dying and death are hidden, and support systems for staff and residents are discounted. A person who is dying represents a marginalised discourse in this setting.

The discourse about dying has mostly been the domain of the family, experienced outside the influence of medicine; thus the more recent development of care of the dying as a specialist area reflects a discontinuity. Rooted in beginnings that sought to be different and separate from other parts of the health care system, palliative care has developed an exclusiveness that has resulted in a lack of community understanding of what palliative care is, excluding language and services being somewhat hidden within health care. The resultant model of palliative care is often regarded as special care for the few, and many that fall outside selective criteria are disadvantaged in terms of access to such care. People dying in RACs often appear to miss out on benefiting from palliative care knowledge and practice.

Particular service linkages, based on geography for example, need to be promoted, as well as educational support for all levels of staff like that being developed by the Australian Government's Australian Palliative Aged Care Project (Australian Government Department of Health and Aged Care 2003). Exploration of combined models of aged and palliative care expertise is required, models that provide the most appropriate care in the person's 'own home'. Strengthened linkages would alleviate the need to move the person elsewhere when it was felt that more expert care was required. More fluid funding models would enable the person to receive the expertise they need.

This study highlights the need to understand the impact of policy on the practice area. Nurses who work in aged and palliative care need to be confident of their voice and to develop skills in advocating for the needs of the vulnerable people with whom they work - in many situations, their's is the only voice such people have. The development of a watchful eye on movements in government policies in these areas can only serve to strengthen the nursing voice.

Because of the competing discourses, dying in an aged care facility may still remain hidden and unacknowledged by the community. The challenge for nurses is to find avenues for developing collaborative practices that will benefit those people needing both aged care and palliative care expertise.

## CONCLUSION

It seems that care received by the dying person in Australia is dependent upon the setting in which this care is delivered. How to support the dying older person, with access to as much expertise and support to which any other dying person in the community is entitled, remains a challenge. 'Dying in place' ought to be attached to the Australian Government's policy slogan - 'ageing in place', to make a complete model of care. 'Dying in place' is surely the preferred model of care - in a person's final home, with a possibility of being surrounded by familiar places and things and providing continuity of staffing. Newer accreditation requirements provide an opportunity for aged care services to become more skilled in the provision of palliative care and to develop appropriate localised relationships to facilitate this ideal.

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# RE-WRITING MOTHERHOOD: RESEARCHING WOMEN'S EXPERIENCES OF LEARNING TO MOTHER FOR THE FIRST TIME

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**Key words:** motherhood, learning, memory, discourse analysis

## ABSTRACT

### *Objective:*

The aim of this paper was to examine one woman's experience and memory of learning to mother during pregnancy and the first postnatal year.

### *Design:*

Narratives of experience and memory were elicited through three in-depth interviews: during the third trimester of pregnancy; at four to six weeks postpartum; and, when the infant was nine months old. Feminist poststructural approaches informed the interview process. Through discourse analysis the detail of this woman's experiences was read closely in terms of the constructions, tensions, gaps, absences and contradictions as she reflected on what and how she learned to mother.

### *Setting:*

The woman was interviewed in her home.

### *Participants:*

The larger research study from which the data in this article are drawn was an extended interview study of 15 women over a 12-month period.

### *Results:*

The close analysis of the data exemplifies the outcomes of the larger study from which it was drawn, in its demonstration of the complex and often contradictory processes of maternal learning. An understanding of this complexity is argued to be an essential condition for effective and inclusive nursing and midwifery intervention.

### *Conclusions:*

Norms of 'good' mothering have been traditionally narrow within nursing literature. Although this is changing, these norms still serve to shape and also restrict possible positions women can take up to make sense of their experience. They provide background to the complex, and sometimes contradictory, processes of learning that take place during the perinatal period.

## INTRODUCTION

Descriptions of constantly attentive and protective mothers who provide nurturance and unconditional love to their infants have traditionally dominated discourses of motherhood in nursing and midwifery and hence they have a powerful impact on practice. The lack of a critical exploration of these dominant motherhood discourses can blind nurses, midwives and parent educators to the complexity and diversity of mothering experiences. This may especially be the case when women's early experiences have resulted in traumatic or 'deviant' memories.

There is limited exploration of maternal learning within the other health-professional literature. This is often subsumed into discussions about the development of maternal competence (eg. Marja-Terttu 2003), which frequently discusses the process of becoming a mother in ways that suggest a consistent, generalised outcome for all women (eg. Barclay et al 1997; Rogan et al 1997), rather than acknowledging that learning outcomes are influenced by and influence all aspects of women's life-long experiences to varying degrees. The literature usually foregrounds learning through the evaluation of parent education groups and the achievement of learning outcomes as part of a formal learning approach (eg. Hanna et al 2002; Huebner 2002). Rarely does this literature identify or explore 'incidental learning', the learning that happens through the normal business of everyday life and experience and the transformation of memory into new meaning (Fowler 2002).

Incidental learning is the richest, most widespread and also often the most problematic type of learning. This literature does not acknowledge the complex, sometimes contradictory, and problematic nature of maternal learning as women try to make sense of their own memories of being mothered nor how they overcome the disjunctures that may exist between their experiences and the dominant motherhood discourses. An exception to this is the work on some infant and mother relationship intervention programs that focus on the development of maternal 'insight', where the focus goes beyond the group or interaction structure of an

educational experience to the psychological and social reasons for implementing these programs (eg. McDonough 2000; Erickson and Kurz-Riemer 1999).

Incidental learning is defined as learning which is ‘...incidental to the activity in which the person is involved, and is often tacit and not seen as learning, at least not at the time of its occurrence’ (Foley 2000, p. xiv). Incidental learning can be closely linked to the understandings gained from psychology and neuroscience about the development of implicit or non-declarative memory systems (Siegel 1999), which enable us to know more than we can say. Non-declarative memories are unconscious memories of knowledge and skills that are usually available as somatic knowledge about how to interact with people and how to do things without conscious recollection (Siegel 1999).

When early experience is traumatic, however, conscious and somatic memories are created, lying dormant ready to be awakened by powerful new somatic experiences that have links to previous experience. Providing women with opportunities to bring these memories into consciousness enables women to use their somatic knowledge as they learn to mother. Importantly, incidental learning does not have a pre-given or pre-defined outcome. Women do not always learn what might be assumed that they learn, nor can it be determined in any a-priori way how they are to learn or what will count as learning. Much learning could best be described both as a process of *unlearning* (critical and often anxious engagement with the normalised discourses of motherhood and the cultural norms of the ‘good’ mother) and of *re-writing* (appropriating or investing in enabling discourses within which memories can be transformed meaningfully into the present). Rarely is it linear, purely rational or predetermined.

The absence of a focus on maternal learning and specifically on the significance of memory in learning to mother in parent education literature has led to the conduct of a large research project from which the material in this article is drawn. In what follows we excerpt a section of data and attempt to demonstrate the importance for effective nursing and midwifery intervention in early mothering of an understanding of this complexity of the learning processes. In this sense, it is hoped, the notion of ‘re-writing motherhood’, critically examining and reconsidering the dominant discourses of motherhood and of learning to mother, might emerge as a central task for the nursing and midwifery professions.

We would argue for an urgent need to expose the always complex and sometimes dark sides of women’s experiences and memories of mothering, as they proceed through the crucial first-time perinatal period. This is not to pathologise such memories but rather to enable women to imagine different possibilities and, if necessary, to re-write their understandings of motherhood. This writing and re-writing of mothering memories is, we argue,

central to maternal learning and the ability of women to position themselves appropriately as mothers.

## METHODOLOGY

Discourse analysis is becoming a powerful emerging tool in nursing, midwifery and health related research (eg. Schmied and Lupton 2001; Barclay and Lupton 1999). Discourse analysis informed by poststructuralist understandings was used to explore women’s constructions of maternal subject positions and the development of new and more acceptable (to them) meanings of motherhood. The term discourse has a complex genealogy; for the purposes of this discussion we use the term ‘...as a way of attempting to capture regularities of meaning used by those positioned as members of particular institutions, regularities which serve both to make sense of, but also to continuously effect, such positionings’ (Poynton and Lee 2000, p.6).

According to these understandings, women experience themselves as multiply positioned by others through multiple discourses, through regimes of surveillance and normalisation. In turn, women actively work to make sense of their experience and memories and to construct their identity. It is through positioning in discourse that women learn to construct who they might be and sometimes also the impossibility of that being (Dormer and Davies 2001). To speak from a ‘self’ invariably situates or positions the speaker within the world; it results in engaging with others in a process of production and exchange (Hanks 1993). These discourses frequently reflect the cultural and social rules of a society in which people live (Poynton and Lee 2000).

Fifteen women were recruited through antenatal classes and ‘by word of mouth’, resulting in a broad range of social and personal experience. The study did not seek to differentiate or systematise differences in social positioning but rather to focus on processes of learning. Ethics approval was granted by the University of Technology, Sydney and Central Sydney Area Health Service, New South Wales, Australia. Pseudonyms were used to protect confidentiality. The small number of subjects was necessary due to the depths of the exploration and sufficient due to the primary research aims: to garner and question the detail of women’s memories, and to read closely the constructions, tensions, gaps, absences and contradictions in the accounts, as women reflect on what and how they learn to mother during this major change period in their lives.

### Data collection: The generation of spaces for engagement

Three in-depth interviews with each subject were conducted: during the third trimester of pregnancy; at four to six weeks postpartum; and, when the infant was nine months old. The women were invited to attend a final group to discuss their participation within the

research and to provide an occasion of closure at the end of the series of interviews.

The study methods were conceptualised and designed within well-established feminist and post-structuralist frames, where the research practices of interviewing and analysis were understood as social practices, partial and situated activities which were subject always to processes of interpretation and re-interpretation within specific circumstances (Usher 1996; Georges 2003).

Interviews were based on a dialogue or conversation with the women, rather than an 'interrogation' using a scripted interview schedule. The use of a dialogue as an appropriate interviewing technique is perhaps most powerfully supported by Cotterill's (1992, p.294) assertion that the '...best way to find out about women's lives is to make interviewing an interactive experience'. The interview practices draw strongly on Oakley's (1993) principles of intimacy and equality between participants. These feminist principles minimised hierarchic difference and optimised trust and richness of disclosure (Fowler 2000).

The first interview explored women's initial construction of themselves as mothers and their expectations of motherhood. During the second interview, questions were asked about the women's childbirth memories and their early weeks of motherhood. The third interview provided an opportunity for the women to focus explicitly on their experience of maternal learning. During each interview the women frequently asked about issues of concern to them such as breastfeeding, infant behaviour and emotional and physical changes they were undergoing. Open exchange on these matters helped to realise Oakley's egalitarian principles of open and honest information exchange.

Each interview was at least an hour and a half in length. The audiotaped interviews were transcribed verbatim and an unedited copy of the interviews was sent to the woman for verification, to make further comments and to remove any information she did not want included as research data.

A series of discourse-analytic questions was used to work with the transcribed interview data. These questions included: how the women were positioning themselves as subjects; whether there were contradictions and tensions within the stories that are told; and which discourses were being spoken. Analysis included a systematic assembling of regularities and irregularities in utterances, within each sequence of three interviews and across the interview field. These regularities, as well as the irregularities and internal contradictions, were then matched against discursive regularities and taken-for-granted understandings - dominant discourses - of motherhood. A picture of learning emerges, where each woman participates as an active member of a culture, working to make sense of the specificities of personal experience within regimes of intelligibility and cultural norms.

In this article, we discuss a series of extracts from the three interviews with one woman. Through a close reading of the extracts, we seek to illustrate the method of interrogation of the interview material. Specifically, we seek to highlight the difficulty one woman had in constructing a maternal position that was not alienating and disabling. The particular purpose of this is to demonstrate the incidental learning that is involved in the construction of an acceptable maternal position and the process of re-writing that takes place in order to effect such learning.

## DISCUSSION

### Meredith's story (name changed)

Meredith is a 30-year-old woman who is pregnant for the first time. As a teenager she had been a victim of father-daughter rape. When Meredith tried to tell her mother about the rape, her mother refused to believe it had occurred. This experience left her with memories of her mother as many things other than the nurturing, protective mother of normalising cultural discourses.

At the time of the interviews, Meredith had stopped all contact with her parents and did not anticipate seeing them again. Making the decision to become pregnant was difficult for her. In the first interview, she reflects on the shape or colour of her anticipatory thinking: *'blackness, that's what I thought of motherhood for a long time and I was never going to have a child'*. This thinking seems to indicate trauma and only partially integrated memory of her past trauma. Her decision was further complicated when she found out her baby would be a boy. Meredith had desired a daughter and had used techniques related to timing in her menstrual cycle to try to conceive a girl.

During her pregnancy, Meredith began to engage with her emotional dilemma by actively and consciously naming her unborn child in a manner defiant of, or alternative to, normative discourses of masculinity for her unborn son: *'I called my baby "Little Fem" and that's how I felt very positive about him...That I was growing a feminist'*. Meredith's belief that she was 'growing a feminist' appears to signal a significant beginning step in emotionally attaching to her unborn son. Thinking in this way possibly indicates her desire to ensure her son did not have the negative masculine characteristics of her own father in her memory. By calling her unborn child 'Little Fem', Meredith not only is consciously constructing a viable subject position or identity for the growing entity within her, she is possibly also beginning to allow herself to consider an alternative position for men and ultimately a viable position for herself as a mother. In this she is articulating and transforming traumatic memory and working to construct a discourse of possibility for herself.

## Rejecting the term 'mother'

The following story demonstrates Meredith's struggle to contend with the contradictions inherent in the discourses of motherhood and the lack of a 'speaking' discourse about her memory of being mothered.

Meredith explicitly rejects the position within a dominant pregnancy discourse of 'joyful anticipation'. Indeed, she rejects the use of the term 'mother' altogether. It seems that the stresses of being unable to reconcile memory of her actual experience with the 'joyful anticipation' version of pregnancy resulted in an initial refusal of a motherhood discourse at all. Through the next nine months, however, Meredith learns to make sense of, and gradually reconstructs or re-writes, the term 'mother' for herself, reconciling contradictions and constructing practical possibilities. Half way through the first interview Meredith was asked if she could imagine herself as a mother. Meredith's response identifies the difficulty she is experiencing discursively constructing a subject position using the term 'mother':

*'I suppose, first of all, I should say, I'm not sure that I really like the word mother anyway. So I have ambivalent feelings about putting that label on myself anyway and so tend... well, tend not to think in those... those terms... And so, when I think, when I think about myself having a child, I think... I think there'll be that I'll find there's plenty of frustrations involved... As well as hopefully, lots of joys. But that I'll have to be careful not to let my... my nature of being well organised and... having been a control freak, to getting, to be (giggle) a bit more realistic about life.'*

For Meredith, the term 'mother' has mainly negative attributes that have come from her particular memories of being mothered. Meredith's rejection of the term 'mother' can at this stage be seen as a rejection of all the good that might normally be assumed to be embedded within the term. This ambivalence about the term 'mother' could equally be the acknowledgement of the existence of feelings of loss, sorrow and separation (Parker 1997) felt by Meredith about the missing relationship with her mother. In any case, normatively positive discourses of motherhood cannot be simply assumed to be available to Meredith, and her learning process has to be active and critical as she engages with the problem.

Meredith does not directly answer the question about imaging herself as a mother, but articulates the emotions of having to care for a baby - *frustration* and *joy*. Her comments about the emotions are provided in a considered manner, which is emphasised by the pauses in her statements. In her response Meredith balances the inevitable *frustrations* of mothering with the *joy* of a baby; her words give an impression that she is working to construct a positive stance towards the prospect of caring for her baby. Through partial disassociation - the separation of the process of anticipating caring for her baby from the unwillingness to identify with her position of mother - Meredith seeks to integrate traumatic and

contradictory positionings of self. At this point in her story she is in an unstable subjective space.

## Developing a hybrid name

During the second interview, four weeks after the birth of her son Daniel, Meredith is asked if she felt like she was a mother now. In her response Meredith talks of how she has started to construct a mothering position through the use of a hybrid name:

*... that was the tricky part from our, from our first interview about not wanting to be called a mother and not, not really wanting to own... that, that name. I suppose... well we sort of... we overcame that because Thomas [partner] came up with, Thomas came up with the name while I was still in hospital... of calling me Merrimum, cause lots of people call me Merri anyway. It's short and... and I like that and that's the way I refer to myself now so I guess the distance from my own mother and the negative experiences there and what I didn't want to relate to... and align myself with that... that. I can still use part of that name but it's very much just about me, about how I want to be as a mother or as a parent and differentiate that from how a lot of other people... parent.*

Meredith's initial response provides an impression of welcoming the question as something that she has considered and is ready to talk about. Meredith reflects back to the first interview and recalls the discussion about her feelings toward the term 'mother'. With the support of her partner Thomas, Meredith seems to be starting to make sense of how she might position herself within a discourse of motherhood. Constructing a new name that does not have the same connotations for her that the term 'mother' held has provided a solution. A process is occurring of constructing new and positive understandings of the idea of 'mother', which no longer constrain her through her memories of her previous experiences and meanings. The new name *Merrimum* allows Meredith to position herself in a way that is familiar. Rather than saying 'mother', Meredith states *I can still use part of that name* but it has now been constructed to be about her and not her own mother.

## Construction of a new subject position as mother

During the third interview, when Meredith's son Daniel was seven months old, her response to a question about whether there had been anything really difficult for her to learn as a mother was:

*... I think it's probably been the more the mental jump of... calling and naming myself as mother, is the... has been the biggest thing for me. Rather than the physical... caring sort of aspects... that mental sort of... identification... process has been... the slowest and the biggest sort of... hurdle... I suppose if you want to call it that.*

When asked whether she had maintained the name 'Merrimum', Meredith replied:

*I'm still really happy if he'd rather call me Meredith or Merri than Mum, but I don't find it offensive any more when other people call me a mum or a mother or whatever. Which... which I did find difficult... to begin with... I suppose now that I've super-imposed... my positive image of what it is to be a mother for me... to that - you know. When I read it on forms and all those kind of things, well I have that image to put in my mind now. Rather than a bit more negative one that I had, I had before he was born.*

Meredith acknowledges the difficulty of *calling and naming myself mother*, that this process requires a *mental jump*. She differentiates between *calling* and *naming* as if there is a subtle difference; possibly, *calling* does not carry such a sense of permanency and acceptance, whereas *naming* indicates a considered act of acceptance, legitimacy and finality. Meredith talks about the process of *calling* and *naming* using words which denote a physical effort - *jump, slowest, biggest, hurdle*. These words offer some insight into the struggle faced by Meredith, in naming herself as a mother, as being a difficult act. She compares this struggle with learning to manage the physical aspects of caring for her baby that contributes an understanding of this physical care as much easier to learn. This realisation provides a powerful contrast to the emphasis on physical tasks of mothering that overwhelm the material for learning within parent education courses (Fowler 2000).

The question about maintaining the name *Merrimum* is answered in a seemingly more relaxed manner than in previous interviews, as indicated by the confident tone of her voice and her relaxed body posture (from the interviewer's notes). There is also acknowledgement of her acceptance of being positioned as a mother by others. The use of offensive to describe her reaction offers an understanding of the difficulty Meredith had faced in taking up the position of mother. Meredith highlights the use of positive images to assist her reach an acceptance of her various mothering positions.

A new understanding of what it means to be a mother has emerged for Meredith, which could be posed as being a significant learning experience and could have come out of using the conscious and unconscious knowledge of her traumatic memory of rape and abandonment to explore the discomfort, disappointment and anger she felt about her mother's lack of support. This occurred over an extended time period and will probably continue throughout her life as new challenges and conflicts trigger unconscious and conscious memories of being mothered and the need to continue to work to rewrite those memories into a positive subject position for herself.

## CONCLUSION

The mismatch between the dominant discourse of motherhood and a particular woman's actual memories of being mothered was problematic for her at the time of the

interviews, resulting in tensions and contradictions. This dominant discourse of motherhood construing mothers as for example willingly 'laying down their lives' to protect their children, is not available for Meredith. Indeed such a discourse does not accord with the experience of many mothers (Blaffer Hrdy 1999; de Mause 1974; Oakley 1981). As Meredith's experience demonstrates, her mother was unable to protect her from her father or even to believe her father was perpetrating such an act as rape on their daughter.

Using the understandings gained from this story, a major learning task some women need to attend to is the development of alternative constructions for the literally unspeakable constructions of past traumatic memories. These discourses are unspeakable for at least two reasons: firstly, the experience of incest does not provide a discourse in our culture that can be used to construct a nurturing mothering position. The second is that talking about incest, in most instances, remains a taboo within western society. For actual women like Meredith, learning to mother her baby involves surfacing, articulating, and transforming unspeakable memories, thus unlearning disabling positions and re-writing a positive mothering discourse for herself.

Meredith's experience is perhaps extreme but in terms of its complexity was consistent with the other mothers in the larger research project. What was common was that each woman underwent a complex struggle to make sense of and transform memories of personal experiences, come to terms with the complex actuality of family life as they began to learn about what it would mean to become a mother for the first time.

The research from which this article was drawn was a serious attempt to come to terms with the complexity of experience, memory and learning undergone by women becoming mothers for the first time. In seeking to account for complexity and contradictions, the silences and gaps in their stories, such research inevitably fails to reach a simple conclusion that would lead to a simple construction of a new theory. Experience, memory and learning by their very nature are not easy to reduce to models and formulae. The implications for practice are similarly complex and involve a maturing of the discipline to encapsulate the fullness of the human experience.

We would argue there is a real and practical need to challenge and go beyond the top-down, homogenising normative discourses of motherhood which pervade the nursing and midwifery literature. Such discourses potentially silence, marginalise and pathologise actual women. Opportunities are needed for women to start to develop an account of their mothering that is far more richly complex and that generates spaces for women who do not immediately connect with the dominant discourses of motherhood. Women learn a great deal during this period, making sense of memory and experience and transforming that experience into a viable position for themselves within this powerful cultural discourse.

Learning theories such as incidental learning, which attend to the conscious and unconscious processes of making sense of memories, offer a great deal to nursing and midwifery practice, supporting a necessary shift of focus from rectifying maternal deficits to actively support maternal learning.

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