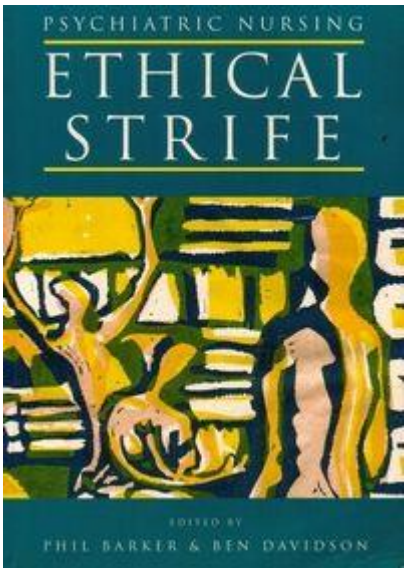
Society, disturbance and mental illness



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This is a non-edited version of this paper published in the book above. Obviously, the final product was more polished.

This chapter deals with the construction of dangerousness. It balances intrapsychic and social interpretations of what makes people violent and asks to what extent 'dangerousness' is in the eye of the beholder. It shows what a compromised position nurses are in trying to balance control and care against the backdrop of all sorts of barely compatible pressures and influences: professional, legal, social, political and ethical. Clinical case study material provides specific illustrations of the particular challenges faced by nurses working in the prison setting.

More often than not deviant behaviour attributable to mental disturbance is benign in nature, but sometimes it poses a real danger to the physical safety of self and others. For some the conceptualisation of unusual experience/behaviour as dangerous is automatic. Societies are challenged by such unusual phenomena. They pose a challenge to social order, the predictability of daily life. Prejudice and fear surface, as do calls for containment and control. Nurses who choose to work with the dangerous individual are faced with numerous ethical dilemmas in daily practice. They are faced with sometimes paradoxical mandates to care and control, in environments that are often not conducive to caring or therapy. A matrix of organisational, political, legislative, social and ideological pressures impinge on and shape each personal encounter, challenging the ideals of nursing.

This paper considers the issue of care and control. It suggests how such a dilemma has arisen and causes ongoing ethical strife for nurses and society.

Mental illness and mental health public policy, has over the last few years become a regular feature of discussion in the popular press here in my home country of New Zealand. In 1992 the Mental Health Act was rewritten to support the compulsory treatment of people in the least restrictive environment. People can now only be forced to receive treatment if their mental disorder gives rise to a seriously diminished capacity to care for themselves or their behaviour poses a serious danger to themselves or others. Large, rural psychiatric hospitals which have been the mainstay of psychiatric treatment for over a century are being closed to free resources for community care.

Over the last two decades smaller acute psychiatric facilities have been built with the objective of providing short periods of respite, stabilisation and treatment when needed. The bulk of care and treatment is provided by community teams. Sheltered accommodation in the community with varying levels of supervision is offered to people who are unable to manage living independently. These changes have occurred against a backdrop of under resourcing, public fear, resistance, and a string of tragic events involving 'psychiatric patients' that have effectively overshadowed any positive benefits to either society or individuals from these changes.

A perusal of a local Sunday newspaper illustrates the extent of public concern over recent and pending changes in the mental health system and how strongly dangerousness is seen to be associated with mental illness. Recently a man captured the nation's attention and ultimately a fatal bullet, after breaking into a sports store and shooting indiscriminately at passers by. Shortly before his death it was disclosed that he had been treated for schizophrenia for some twenty years or more. In recent weeks, family members and the salvation army had spoken to the community psychiatric nurse involved about the need for secure treatment due to disturbing changes in the man's mental state. There were no facilities available (short of a prison cell) in the immediate vicinity, even had the nurse and the psychiatrist judged that the man posed an immediate danger to others.

A psychopaedic hospital is closing in a nearby town and residents being relocated to smaller, family like, sheltered accommodation. The tragedy outlined above has added more fuel to the already brightly burning fire of community resistance to the move. Parents of residents at the hospital talk of their fears that their children will not get the support and supervision they need in the community, and staff are reported to warn about the risks of releasing residents, "who include paedophiles, sociopaths and arsonists" (Martin, 1995). Their claims are leant an air of credibility in light of several highly publicised cases involving people previously incarcerated in psychiatric hospitals for paedophilia under older legislation who upon release went on to be convicted for molesting children. The newspaper warns that Health authorities who have failed to provide adequate care and prevent seriously

mentally disturbed people committing violent crimes may face legal action (Guyan, p.1).

Dangerousness is an emotive issue, with public perception of the mentally ill as being violent, influencing the acceptance of people with mental illness in the community. In the same newspaper, Guyan (1995b) cites figures from police national headquarters, which she claims reveal that 13 of the “worst murders” between 1992 and 1994 were committed by people with psychiatric conditions. Violence by some people with mental illness adds to the stigma and fear associated with mental illness, effectively making victims of the majority of the non-violent majority. Bowler (1995), a resident of a psychopaedic hospital for 17 years stated in a letter to the editor entitled "Let inmates have their say", “I don't think it's true what they're saying about the people in there. They are not all bad. I would like to see them have a chance...”

The assessment and labelling of someone as dangerous, whether justified or not, is a moral judgement with far reaching implications and consequences for that person. These might include the deprivation of personal freedom and sometimes compulsory treatment for a mental disorder. This is often justified as being in the best interests of the patient or society. The labelling of someone as dangerous by health professionals is both a socio-political and an ethical judgement. An extreme example of the dangerousness as a socio-political judgement is commitment of political dissidents to psychiatric institutions (Szasz, 1994) because they are deemed to pose a danger to the state and social order. If dangerousness is taken only as a prediction of the likelihood of an individual to cause serious physical violence to another, then the rights or good of the individual must still be weighed against the rights or good of society. Psychiatry has a legally sanctioned mandate to identify and treat those whom are deemed dangerous because of a mental disorder. It is arguable however, whether much violence can be attributed to mental disorder or indeed whether anyone can accurately predict most violent behaviour.

Health professionals have been shown to be poor in their predictions of future dangerousness. Bootzin and Acocella (1984 p, 557) claim that “every study of predictions of dangerousness has yielded far more false positives than negatives”. That is health professionals are far more likely to falsely identify someone as dangerous that falsely identify someone as benign. This assertion stems from a large number of research studies since the 1960s which followed the course of patients released by court order from maximum security psychiatric facilities into civil hospitals or the community against psychiatric advice. Within a four year follow-up only 20 percent of a group of 1000 such people known as the "Baxstrom" patients were assaultive to others and only three percent of the released patients were readmitted to maximum security facilities (Fisher, 1995, p.39). It is from studies such as these that the conclusion has been drawn that for every one person that health professionals correctly identify as dangerous they incorrectly identify four or more others. It is likely that given the shift of focus of mental health legislation towards patient rights that much fewer clearly non-dangerous people are

compulsorily detained today. However the numbers of dangerous people at large in the community appears to be of greater concern to the public and ensures that pressure is maintained on health professionals to identify, detain and control dangerous individuals.

The concepts of power and control pervade psychiatry, psychiatric treatment and indeed society in general. Szasz (1994) argues that the issue of power is inherent in all psychiatric treatment, that a covert function of psychiatry is social control. Stuart and Sundeen (1987, p.219) suggest that this idea is supported by the various behavioural disorders that justify commitment e.g. drug addiction and sexual offences. They suggest that assessment of dangerousness is highly subjective and that the underlying issue is one of nonconformity in ways that offend others. Indeed, it may be argued that mental illness itself is a highly subjective phenomena. Conrad and Schneider (1980) in tracing the ascendancy of the medical model of madness point out that the various approaches to managing deviant behaviour throughout history have largely been to control those that did not conform to society's dominant values and posed a threat to the established social order. Both criminal justice and mental health systems perform social control functions. They have a responsibility to protect society from fearful events (Fisher, 1989, p.13). The standard of dangerousness to self or others has increasingly become the criterion which is used to justify social control in the interests of protecting society (Mulvey and Lidz, 1995).

The responsibility of predicting future violence is one which nurses and clinicians cannot shirk. It has been estimated that at least half of all health professionals will be assaulted during their careers (Blair & New, 1992) so such predictions become a matter of personal safety. The possibility of legal action should the health professional fail to predict future violence also provides further incentive to refine the decision making process. The nurse faces the challenge of having to work in close proximity, and often for long periods of time, with people who have been labelled as dangerous. Some settings such as prisons, by their very nature constitute high levels of restrictiveness, together with a climate of suspicion and mistrust. Discussion of the clinical challenges faced by nurses working in such an area is included in the case study later in this chapter. Research into the nature, causes and effects of violence, has the potential to lead to improved interventions to reduced violence, greater precision in the prediction of violence and a reduction in the negative consequences of violence. Research will have served the nurse well if it assists in the assessment of the individual's antecedents of violent behaviour and leads to interventions which reduce risk while facilitating therapy in the least restrictive environment.

The relationship between mental illness and violence

A great deal of research attempts to answer questions about the relationship of violence to mental illness. Monahan (1992) after reviewing the epidemiological studies on violence, concluded that the presence of mental illness is a modest but significant risk factor for violent behaviour. However, the studies in this area are plagued with inconsistencies which make

generalising from the results difficult. For example, in most western countries, including New Zealand, danger to self or others is a main criteria for commitment, or compulsory treatment. Studies on the incidence of violence in the mentally ill, based on samples of committed patients are flawed because people may be labelled as mentally ill because they are violent, whereas the benign individual may avoid being labelled, or more likely avoid inpatient treatment despite having similar cognitive or affective disturbances.

Studies of violent behaviour after discharge from hospital are inevitably confounded with the eligibility criteria for admission, the nature and length of treatment given, the eligibility criteria for discharge and the degree of support offered after discharge. Lack of consensus on what constitutes violence and mental illness, as well as the lack of comparative statistics on the prevalence of violence in well people and those not selected for hospital treatment, make determining the true incidence of violent behaviour amongst the mentally ill almost impossible.

Despite these problems there is some consistency among findings related to the relationship between some signs of mental illness and violence. There appears to be a significant relationship between drug and alcohol abuse or dependence and likelihood of violence (Swanson and Holzer, 1991; Morrison, 1994). Diagnosis such as schizophrenia and bipolar affective disorder are more commonly found in people with a history of violent behaviour. But by far the single greatest predictor of violence is a past history of violence (Blomhoff, Seim, & Friis, 1990).

Recent research suggests that current psychotic symptomatology is predictive of violence. When such factors as alcohol abuse were controlled for in a comparative study between psychiatric patients and those never hospitalised, the only variable that accounted for differences in the rates of violence was current psychotic symptoms (Monahan, 1992). That is, when a person was experiencing such symptoms as hallucinations and delusions, they were more likely to be violent than a non-hospitalised group. However, when not actively experiencing such symptoms the risk of violence was not appreciably higher than a demographically similar group in their home community.

The results of empirical studies allow people to make estimates of the likelihood of future violence based on the presence or absence of symptoms of mental illness. The inherent assumption in all such studies is that violence is a function of individual pathology. While useful for determining the probability of violent behaviour in groups, such measures are crude and inaccurate predictors of violence when applied to individuals (Gunn, 1982). After all, the majority of people who experience symptoms of mental illness are not in fact violent.

Some violence however may be a function of individual pathology. Garza-Trevino (1994) reviewed numerous studies on neurobiological factors which contribute to aggressive behaviour. Damage to certain centres of the brain such as the limbic structures, temporal lobes, and frontal lobes have been found to be associated with aggressiveness and rage. Homicidal, suicidal

and impulsive behaviour have been associated with deficiency or dysregulation of serotonin. Other factors such as endocrine dysfunction and brain injury may contribute to paraphilias and sexual aggression.For some medical conditions the link between neurobiological factors and violence is clear, for example, it is estimated that some ten percent of people with temporal lobe epilepsy may have outbursts of unprovoked violent behaviour (Bear and Fedio, 1977; Pincus, 1980).

Testosterone levels are correlated with increased violent behaviour in humans as well as in other species. According to Kalat (1992, p.433) the highest incidence of violence, as measured by crime statistics, is in men 15 to 25 years old, who also have the highest serum testosterone levels of any age group. Testosterone levels may contribute to a predisposition towards violence but clearly other factors are involved - not every young man is violent. A belief that aggression and violence is a result of biochemical or structural abnormalities in the brain is a comfortable position because it implies a lack of individual, or societal responsibility for violent behaviour, and the promise of a cure in the form of a biological treatment. While aggression and resulting violence does arise from biological factors in some individuals, at this time biological explanations can at best only partially account for some violence by those with mental illness.

Might there be then, a specific cluster of symptoms that is optimally predictive of latter violence? Lowenstein, Binder and McNiel (1990) examined the relationship between symptoms at admission and later violence. They concluded that patients who showed higher levels of thinking disturbance, hostile-suspiciousness, and agitation-excitement (as measured at admission by the Brief Psychiatric Rating Scale) were at greater risk of becoming assaultive during hospitalisation. Blomhoff, Seim and Friis (1990) found that after history of violence, a high level of aggression at referral but an absence of anxiety at admission were the best predictors of later violence. It will not be a great surprise to many to find that aggression, hostility and agitation are linked to violence. These terms are to varying degrees synonymous with menace and violence and are not in themselves indicative of mental illness. Hallucinations and delusions on the other hand, are often considered a feature of psychotic illness.

Schizophrenia is considered by many to be a biological disorder and has long been associated with violence, although we know that statistically the likelihood of a schizophrenic individual being violent is less than someone with a drug or alcohol dependency problem (Swanson, Holzer, Ganju, Tsutomu and Jono, 1990). Blomhoff, Seim and Friis (1990, p.775) suggest that "Investigators need to identify subgroups of violent patients and sub-group specific indicators." The schizophrenic patient population is one such group. Juninger (1995) undertook a study examining compliance with command hallucinations, one symptom which people with schizophrenia may experience. Juninger (1995) reported that patients who were able to give an identity to a hallucinated voice, or who identified less dangerous commands, were more likely to comply with the command hallucination. Those that experienced command hallucinations were at risk of dangerous behaviour.

Significantly, as individuals reported less dangerous command hallucinations and a greater degree of non-compliance with commands when in hospital, the authors also concluded that the "...level of dangerousness resulting from compliance with command hallucinations may be a function of the patient's environment" (Junginger, 1995, p.912).

This study is interesting in that it suggests some aspects of the environment have a moderating effect on symptoms which many believe to arise from a biochemical disturbance. In this case the hospital environment appeared to have a positive effect on symptoms, which has far reaching implications for hospital based assessment of dangerousness based on command hallucinations. As Juninger (1995, p. 914) proposes, "... it may be the post-hospital environment that determines the dangerousness of command hallucinations and thus the potential for violent or criminal behaviour." Violence cannot be merely a function of individual pathology in these cases but rather as Davis (1991) suggests, it is a result of a complex interaction between various types of factors..

Controlling: A response to, and precipitant of violence.

Harrington (1972) suggested that violence is a reaction to the situation in which a patient finds himself and more often than not is a symptom of disturbance in the hospital itself rather than a symptom of a patient's mental state. In 1960 Goffman identified the adverse effects of the asylum on its inmates. Since then many of the large 'total institutions' that he spoke of have been closed down. Some features of these total institutions such as the ethos of control still persist in many otherwise enlightened treatment settings. The notion that the mentally ill are out of control and that violence is a symptom of individual pathology leads to the natural conclusion that people need to be controlled. Mechanical and chemical restraints and use of seclusion are overtly controlling practices that arise from these beliefs. In a small number of cases such interventions may be justified but the ethos of control permeates many settings in more subtle ways such as in the use of language and subtle coercion.

Morrison (1990, p.33) undertook a nine month grounded theory study in an inpatient unit in which the the key concept which emerged from the data was a "tradition of toughness" amongst the staff who worked there. She identified the main values of the unit as being derived from the medical ideology with its emphasis on control and safety, which in turn led to norms of behaviour such as enforcing the rules, controlling and restraining patients and showing strength rather than facilitating therapy. Much of the violence she observed was linked to the tradition of toughness and the patently unprofessional nursing care that arose from this tradition. The model arising from the data was used to explain why some violence occurred and why some staff were victims of violence. Morrison (1990, p.35) concluded that, "Policies and enforcing the rules aimed to control patients inevitably leads to violence through the process of confrontation and escalation of the violent situation". Watson (1991) came to similar conclusions in his phenomenological study on the experiences of adults hospitalised with acute mental illness which they

consider contributed to the stress of, coping with mental illness. Watson (1991, p.14) suggests that based on the data from his study, controlling practices might in fact "provoke the very behaviour they are designed to contain."

Roper and Anderson (1991) in their ethnographic study examining the interactions between staff and patients on a psychiatric ward also found that the concept of control was pervasive. Patient violence was conceptualised as a loss of control requiring the application of external controls. They found that controlling through denial of requests and using the ward structure to maintain control were typical practices which led to patient violence. However the question remains as to why controlling practices lead to a violent response in some individuals and a submissive or accepting response in others. Further research by Morrison (1994) suggests some possible answers.

Morrison (1994, p.249) found that "... the primary characteristic which seemed to differentiate violent from nonviolent persons was the presence of an exploitive style with others, i.e., using others for self gain." The violent individual used coercion and violence as a tool to get what they wanted, whereas the non violent person was not at all exploitive and used an interactional style which she labelled "accommodation". Morrison (1994) proposed that such styles of communication are learned through the process of social modelling and reinforcement.

The theoretical assumptions underpinning Morrison's (1994) explanatory model are based on Patterson's (1982) theory of coercive family processes. Patterson was in turn influenced by Bandura's (1973) analysis of aggression using social learning theory. The major assumption of the social learning view is that "... man is neither driven by inner forces nor buffeted helplessly by environmental influences. Rather psychological functioning is best understood in terms of continuous reciprocal interaction between behaviour and its controlling conditions". (Bandura, 1973, p.43). Such an approach examines and attempts to explain how "... patterns of behaviour are acquired and how their expression is continuously regulated by the interplay of self-generated and external sources of influence." (Bandura, 1973, p.43)

Violence then may be used in a purposeful way by people to get what they want. Someone who characteristically exercises a coercive interactional style might not surprisingly respond violently when placed in a controlling environment. Sheridan, Henrion, Robinson and Baxter (1990) examined precipitants of patient violence leading up to the use of physical restraints in a psychiatric inpatient setting. They found that violent behaviour was more likely to relate to external situations such as enforcement of rules by staff, denial of privileges or conflicts with other patients than to internal psychiatric symptoms such as delusions or hallucinations. Of 73 violent episodes only 8 occurred after internal events only. Such findings tend to challenge the popular notion that the mentally ill person is typically out of control and a victim of internal symptoms which lead to uncontrolled violence. Morrison (1993) argues that violence is primarily a social problem and only a very small

number of violent incidents maybe accounted for as symptoms of mental disorder.

Nurses: Co-creaters of dangerousness?

A colleague recently commented to me that violence is never acceptable and asked the question, “If a person is violent in a controlled setting, what are they likely to do in an uncontrolled setting?" A considerable body of research suggests that it may be the controlled setting which precipitates much violence. As to the second part of the question, research alone does not provide a sound enough basis on which to make predictions about future dangerousness of most individuals. As a consequence subjective definitions of dangerousness abound which tend to reflect “... the individual idiosyncratic values of the clinicians and the various political pressures they experience.” (Fisher, 1995, p.194)

Health professionals must consider that their response to those they perceive as dangerous may play a part in creating dangerousness. Dangerousness is not an empirical reality, but rather a social construction although the effects of the label of are tangible. Controlling practices, in response to the label of dangerousness may precipitate or provoke violence in predisposed individuals. The person then has a history of violence which may be viewed as justification for previous and future controlling practices. The label of dangerousness is remarkably sticky and adheres to an individual long after any empirical evidence of dangerousness subsides. The distance that others place between themselves and others they perceive as dangerous may engender a sense of alienation in those labelled that may for some, become one of the multitude of antecedents which contribute to violence.

Those with mental illness are often perceived as unpredictable, frightening and different from other individuals (Levey and Howells, 1995). This may contribute to the stigma associated with mental illness and the perception of those with mental illness that they are indeed different from others. Mulvey and Lidz (1995) point out that clinical decision making takes into the conditional nature of violence e.g. one person may be violent when intoxicated while another is likely to be violent in an emotionally charged home environment. It is likely that the effect of perceiving oneself as being different and separate from others is a condition that may predispose some people towards violence. Combine this factor with a coercive style of relating to others and a highly controlling environment and violent behaviour may be reinforced, or be the only means available to get needs and wants met. Could it be that at least some of the violence associated with active psychiatric symptomology is due to an interaction of individual factors and others’ response to what is seen as unpredictable and frightening behaviour?

Many actions might attempt to be justified under the umbrella of maintaining social safety including social control. Forensic nursing can be a particularly challenging area for nurses as many clients of forensic services have been prejudged as dangerous and such institutions have a mandate to protect society, provide compassionate care and maintain the personal safety of all

who work within the institution. These conflicting demands are a source of ethical strife for nurses working in these areas. While care without coercion does happen, a multitude of pressures impinge on health providers to control certain groups identified as dangerous. What part do nurses play in co-creating dangerousness and what effect does being labelled as dangerous have on nursing care? Research suggests some answers. Clinical exemplars and narrative from practice provide further sources of reflection.

In Brenda Curzon's narrative which follows it is readily apparent that the nurses' perceptions of those in their charge as being "dangerous prisoners" adversely affected the care which was provided and arguably reduced the individuals to non-person status. The elasticity of the concept of dangerousness is also apparent in the differences in perceptions between the nurse educator, students and prison nurses. How moral can nursing care be if controlling has primacy over caring and care is withheld in order to punish?"

Case Study: When control has primacy over care - By Brenda Curzon.

This case study is about the prison nurses' role conflict as I perceived it and was eventually caught up in. The context of my experience was that of a Nurse Educator, supervising registered nurses who were completing the clinical component of a forensic psychiatric nursing course at a prison complex of both maximum and medium security. I found myself in a situation where I was ashamed to be known as a nurse and eventually retreated into identifying myself with my other profession, an educator and academic.

Maximum and medium security prisons are punitive in concept and practice. Those incarcerated in these institutions experience the full force of the justice system whilst doing their 'time' and have no expectations of any other treatment from the prison officers and administration. The custodial role of the guards is contrasted by other professionals working in prisons and of these, nurses are an important group.

Confidentiality is closely identified with the nursing profession and is so integral to my nursing practice and teaching that it is incomprehensible to me that nurses should violate it. Context as always, is however a powerful moderating factor and the prison environment with its own culture, rules and regulations proved to have such an effect for the prison nursing staff.

I had been aware of legislation changes relating to prison nursing staff that had been made in order to comply with the United Nations standard minimum rules for the treatment of prisoners. These respectively raised nursing staff levels and created an occupational class of nurses who had no custodial function. It was therefore surprising that the prison nurses my students and I met had become part of the prison establishment with the associated punitive ethos.

The prisoners, who knew we were nurses, seemed at first to be wary of our 'new faces' and did not interact or communicate beyond a polite greeting. The

reason for their behaviour soon became obvious as their relationship with the (prison) nurses was observed. Power was a salient factor in this relationship as they practised their own particular form of nursing that included; lack of confidentiality, withholding drugs, delaying medical referrals and ignoring medication orders. Three nurses in particular created strong impressions and I will now share these with you.

'The Nurse Counsellor'

I will begin with the nurse who had developed an interest in counselling, although unfortunately not enough of an interest to pursue any training or education in this area. She was a genial and friendly person, who showed me her office with pride and told me she always had the door open during sessions with her 'clients' and a prison officer posted outside. A very large poster was positioned by the door giving the ground rules for counselling; these included no 'aggro' (aggravation), no shouting, standing or swearing. Considering the limited literacy and vocabulary of some prisoners which was often restricted to four letter words and that also some had English as a second language, poor social skills and often seemed very angry, it is a wonder any sessions ever got 'off the ground'. Everything said was reported back to those in charge at the prison, so why would the prisoners make the effort to go through this (humiliating) charade? Apparently, it was important to demonstrate that one had made an effort to learn and improve one's behaviour and life skills whilst in prison for the parole board hearings. Attendance at 'counselling' sessions was a way of doing this.

'The Nurse with the X-Ray Vision' or 'Supernurse'

My experience with this nurse began with her lecture to me about how the men were always making up injuries and illness and the need to 'aware of these practices'. However, I was unprepared for the total rejection of their complaints as she would just look at them and say 'no, nothing wrong' or words of similar effect. The men rationalised her behaviour in their own way by attributing it to her 'x-ray vision'. They laughingly told me that if they went with a sore nose, she would just look hard at it and say 'no that's alright'. This assessment practice was used for whatever and wherever the problem was from stomach ache to football injuries, she had 'x-ray vision'. It seemed that this nurse was able to assess and diagnosis without touch and that she was always right. One Monday morning one of the men attended doctor's clinic with a dislocated shoulder, injured whilst playing football on Saturday morning. The doctors are a phone call away and seemed willing to attend when called but this nurse had decided that the injury could wait until the clinic on Monday morning and that's what
happened.

The 'Psychiatric Drugs Are Only Attention Seeking' Nurse

The contribution of a nurse who had very definite ideas about psychiatric drugs and the reasons the men took them literally took my breath away. I attended an admission session of a man who had been transferred from another prison. The usual practice of having a prison officer present appeared humiliating for this man and as I was beginning to explain my presence to him I was interrupted and told that I didn't need to do that, and it didn't matter what he thought. His medical chart was a catalogue of attempted suicide and self mutilations and in large writing the psychiatrist from the other prison had noted the 'cocktail' of drugs that he was on, and why it was important for him to stay on them as they seemed to be effective. With a triumphant smile she said "well he won't get them here, they only take them to get attention". This breathtaking statement was followed by a proud explanation that her monthly reports to the head of the prison included an exact description of how many drugs had been given. I couldn't resist and had to inquire about these drugs. 'Two paracetamol" she said. "What, for each man, as an average, is that what you mean" I gasped. "No for the whole prison" was the answer. I had of course no way of verifying this statement but I really believed her, when one considered the other nursing practices that had been observed. Withholding nursing care appeared to be used to further 'punish' the men within the role of a nurse.

'Compromised Nurses' or a 'Compromising Situation'

The compromised position of these prison nurses and consequently myself and my students was not an enviable one. The pressures and influences they were subject to, and which effected their nursing practice I believe reflected powerful forces at work. Obviously the isolation they experienced as a small group of Caucasian, professional women within a hostile and male dominated environment created difficulties for them. The issues of 'dangerousness' and 'fear' appeared to undermine their nursing practice as it was used as the reason for violating confidentiality, withholding nursing care, medication and advocacy. The symbiotic relationship they had with the prison officers also related to the 'dangerousness' and 'fear' issues with the guards protecting the nurses and the nurses cooperating with prison rules.

Who's Dangerous ?

My participation in life-skills workshops, anger management groups and drug and alcohol meetings provided an opportunity to get to know the men without the prison officers being present. These sessions were always held in the Chapel and the prison officers reluctantly remained at the glass doors looking in. I felt quite safe in these groups despite the fact that I was always the only female and frequently the only Caucasian person there. One particular group had all killed a significant female in their lives; wives, girlfriends, mothers, sisters or daughters but I felt my personal safety was never an issue. However, when I was around the nurses I not only felt unsafe but was careful of what I said and to whom, whilst feeling sad that nursing

was given such an image. It needs to be noted that at that time the mentally ill population of the prison was demonstrable.

In order to communicate with the men I joined in with whatever activities they were involved in (no I didn't play football). This served two purposes, it was difficult to be overheard when working together and the men developed confidence in myself and my students. I was helping to paint a stage backdrop for a Polynesian music competition when one of the men expressed the concern he had about being able to return to live with his wife and daughters because of his acknowledged anger management problem. On inquiring of him what help he could get in prison, he said that if he talked about it, it would be difficult get parole. His problem identified the issues of concern I had about the lack of confidentiality within the prison. Without the help he obviously needed he would someday go home and be unsafe and even dangerous to his family. He talked to me about his childhood and it was clear he too was a victim, not helped as a child and unable to get help now, it was tragic. However, I was not prepared for what happened next when there was a demand from a prison officer to divulge the content of the conversation; "We want to know, because he never speaks to anybody". Upon telling them politely that it was private, the Head Prison Officer repeated the request explaining that nothing in prison is private and the men have no right to confidential communication. This therefore meant that the nurses had no right to confidential communication either. The authorities were obviously used to getting information from nurses about what the men disclosed to them and this was confirmed when I asked the nurses.

The following statement from a recent New Zealand nursing journal highlights the ongoing dilemma's experienced by prison nurses. As nurses, we are in the fortunate position of not being part of the custodial system and therefore considered safe people to talk to. On the other hand, we tell inmates that there are limits to our confidentiality and any issues that affect inmate or unit safety must be passed on to the officers. (Manchester 1996, p.25)

References

Bandura, A. (1973). Aggression: A social learning analysis. New Jersey, USA: Prentice-Hall.

Bear, D.M., & Fedio, P. (1977). Quantitative analysis of intricately behaviour in temporal lobe epilepsy. Archives of Neurology, 34, 42-48.

Blair, D.T., & New, S.A. (1991). Assaultive behaviour: Know the risks. Journal of Psychosocial Nursing, 29(11), 25-29.

Blomhoff, S., Seim, S., & Friis, S. (1990). Can prediction of violence among psychiatric inpatients be improved? Hospital and Community Psychiatry, 41(7), 771-775.

Bootzin, R.R., & Acocella, J.R. (1984). Abnormal psychology: Current

perspectives (4th Edi.). New York: Random House.

Bowler, M. (1995). Let inmates have their say (Letter to the editor). Sunday Star-Times, Oct 1, C4.

Calhoun, G.L. (1980). Hospitals are high-stress employers. Hospitals, 54, 171-175.

Conrad, P., & Schneider, J.W. (1980) Deviance and medicalisation: from badness to sickness. St Louis: C.V. Mosby.

Davis, S. (1991). Violence by psychiatric inpatients: A review. Hospital and Community Psychiatry, 41(7), 771-775.

Fisher, A. (1995). The ethical problems encountered in psychiatric nursing practice with dangerously mentally ill persons. Scholarly inquiry for nursing practice, 9(2), 193-208.

Fisher, A. (1989). The process of definition and action: The case of dangerousness. Phd Dissertation, San Francisco: University of California.

Garza-Trevino, E.S. (1994). Neurobiological factors in aggressive behaviour. Hospital and Community Psychiatry, 45(7), 690-699.

Goffman, E. (1960. Asylums. London: Penguin.

Gunn, J. (1982). Defining the terms. In J.R. Hamilton, & Freeman, H. (Eds.) Dangerousness: Psychiatric assessment and management. (pp. 7-11). Oxford:
Alden Press.

Guyan, C. (1995). Families may sue over lack of care. Sunday Star-Times, Oct 1, A1.

Guyan, C. (1995b). Police warn of tragedy with patients. Sunday Star-Times, Oct 1, A1.

Junginger, J. (1995). Command hallucinations and the prediction of dangerousness. Psychiatric services, 46(9), 911-914.

Kalat, J.W. (1992). Biological psychology (4th edi.). Belmont, California: Wadsworth, Inc.

Levey, S., & Howells, K. (1995). Dangerousness, unpredictability and the fear of people with schizophrenia, Journal of Forensic Psychiatry, 6(1), 19-39.

Lowenstein, M., Binder, R.L., & McNiel, D.E. (1990). The relationship between admission symptoms and hospital assaults. Hospital and Community Psychiatry, 41(3), 311-313.

Martin, Y. (1995). Shooting alarms parents of Templeton patients. Sunday Star-Times, Oct 1, A3.

Monahan, J. (1992). Mental disorder and violent behaviour: Perceptions and evidence. American Psychologist, 47(4), 511-521.

Morrison, E.F. (1994). The evolution of a concept: Aggression and violence in psychiatric settings. Archives of Psychiatric Nursing, 8(4), 245-253.

Morrison, E.F. (1993). Toward a better understanding of violence in psychiatric settings: Debunking the myths. Archives of Psychiatric Nursing, 7(6), 328-335.

Morrison, E.F. (1993b). The measurement of aggression and violence in hospitalised psychiatric patients. International Journal of Nursing Studies, 30(1), 51-64.

Morrison, E.F. (1990). The tradition of toughness: A study of nonprofessional nursing care in psychiatric settings. Image: Journal of Nursing Scholarship, 22(1), 32-38.

Mulvey, E.P., & Lidz, C.W. (1995). Conditional prediction: A model for research on dangerousness to others in a new era. International Journal of Law and Psychiatry, 18(2), 129-143

Manchester, A., (1996) Kai Tiaki: Nursing New Zealand, Co-editors Manchester, A., O'Connor, T., New Zealand Nurses Organisation, Wellington. , Vol 2 No 2 March, p. 31,.

Roper, J.M., & Anderson, N.L.R. (1991). The interactional dynamics of violence, part 1: An acute psychiatric ward. Archives of Psychiatric Nursing, 5(4), 209-215.

Sheridan, M., Henrion, R., Robinson, L., & Baxter, V. (1990) Precipitants of violence in a psychiatric inpatient setting. Hospital and Community Psychiatry, 41(7), 777-780.

Stuart, G.W., & Sundeen S.J. (1987). Principles and practice of psychiatric nursing. St Louis: C.V. Mosby.

Swanson, J., & Holzer, C. (1991). Violence and the ECA data. Hospital and Community Psychiatry, 42, 79-80.

Swanson, J.W., Holzer, C.E., Ganju, V.K., & Tsutomu Jono, R. (1990). Violence and psychiatric disorder in the community: Evidence from the epidemiologic catchment area surveys. Hospital and Community Psychiatry, 41(7), 761-770.

Szasz, T. (1994). Psychiatric diagnosis, psychiatric power and psychiatric abuse.

Journal of medical ethics, 20, 135-138.

Watson, P. (1991). Care or control: Questions and answers for psychiatric nursing practice, Nursing praxis in New Zealand, 6(2), 10-14.