A Narrative History of Psychiatric / Mental Health Nursing in the Asylum / Mental Hospital System in Ireland from 1940 to 1970.

'Always remember they are some mother's child'

By

Eithne Cusack

RPN, RGN, MSc Psychotherapy, MSc Healthcare,

PG Dip Professional Supervision

Research Supervisors: Prof Joe O'Hara & Dr Elaine McDonald

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of EdD is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed: 

ID No: 16211649

Date: 6th January, 2021

Dedication

I dedicate this work to the patients who were admitted and resided in Irish mental hospitals / asylums and who educated us regarding social and human vulnerability.

&

To my psychiatric nursing colleagues who worked within these institutions and responded with courage, compassionate and dedication.
They crafted the cornerstone of the profession of psychiatric nursing in Ireland.

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To my children Caitríona, Ciarán, Fergal and Brian for all their help, support, love and friendship, they are a constant source of sustenance for me and I am so proud to be their mother.

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List of Abbreviations

ABA	An Bord Altranais
ACMHN	Australian College of Mental Health Nursing
ANA	American Nurses Association
CAQDAS	Computer-assisted qualitative data analysis software
CPN	Community Psychiatric Nurse
EEC	European Economic Community
ECT	Electro Convulsive Therapy
FPRN	Female Registered Psychiatric Nurse
GNC	General Nursing Council
IIMHN	Irish Institute of Mental Health Nursing
ITGWU	Irish Transport and General Workers Union
MRPN	Male Registered Psychiatric Nurse
NMBI	Nursing & Midwifery Board of Ireland
NUI	National University of Ireland
RD	Research Diary
RGN	Registered General Nurse
RMS	Resident Medical Superintendent
RPN	Registered Psychiatric Nurse
UK	United Kingdom
WHO	World Health Organisation

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Eithne Cusack

Abstract

Walk (1961) stated that a history of psychiatry that did not include the history of mental nurses was incomplete. Nursing in our mental health system in Ireland from a historical perspective has not been examined. The purpose of this research is to achieve narrative accounts of life, nursing care and changes across time from 1940 to 1970 from nurses who worked within the asylum system. The origins and history of nursing in this context is required to amplify the role and contribution of nurses which has rarely been described. The research will provide insight and information into life within the institutions in the mid-1900s, along with the social and psychiatric presentations of patients, the treatment modalities available, the role of those employed in nursing roles and the leadership within the sector. The historical roots of Irish psychiatric nursing have remained subsumed within the realms of the history of psychiatry. The majority of publications in this area with a few exceptions tend to focus on the structural and legislative frameworks that established firstly the Asylum system and subsequently the community approach to care.

A qualitative design was chosen to conduct a narrative inquiry which involved the conduction of interviews with nurses who worked within the asylum/institution system between 1940 and 1970 nationally. Grounded in interpretive hermeneutics, narrative inquiry involves the gathering of these nurses' narratives: oral and visual— and focusing on the meanings that people ascribe to their experiences.

The findings indicate that the history of care for the mentally ill carried out within asylums and later mental institutions provided an institutional base for the establishment of the profession of nursing. Nursing was introduced into and inherited a culture influenced by the patriarchal structures which existed at that time. The study highlights how the profession of psychiatric nursing was socially constructed. It provides an insight into the context of care, the impact of social stigma on the profession, a lack of professional voice and how nurses strived to develop professional agency. The development of the profession and their influence on the preparation for and transition of care to the community is also captured. How through their practice with patients, these nurses made the asylum walls porous and contributed to the construction of a bridge between asylum care and community care, to lay the foundations for contemporary community mental health care in Ireland. The study defines the ontogenesis of psychiatric nursing.

Chapter One

1. Introduction

The 20th century has witnessed significant change in the type of service delivery and treatment options available for individuals with a mental illness, both nationally and internationally. The history of psychiatric care in Ireland has primarily been written by psychiatrists and has focussed mainly on the history of the asylum system, their role in Ireland's social history, the contribution of psychiatrists, changes in diagnosis and policy and legislative changes. Nurses, while comprising the majority workforce within the asylum system during that period, receive scant attention with little, if anything, being known of their contribution to the care of individuals within the mental asylums. This lack of knowledge and primary evidence is particularly evident for the decades of the 1940s, 1950s and 1960s when significant changes; legislative, pharmacological and structural, were occurring within the asylum system and to the care of individuals with a mental illness.

Mental Health services in Ireland are changing and evolving in a more recovery and user focused way since the publication of A Vision for Change (2006). However, little has been written in Ireland on the professional and institutional factors that influenced this development. While some historical accounts exist of deinstitutionalization, and the development of mental health services in Ireland, little is known about the delivery of care within Irish mental health settings during the first half of the 20th century nor of the role of nurses within those settings during that period of time. The role of psychiatric nurses in the development of Irish mental health services has to a great extent been overlooked in the literature. While psychiatric nurses embrace the recent developments within mental health services, the roots of their practice lies within the asylum system and little record of it exists. It is unclear why nurses have been reluctant to examine this history. We have no evidence of how their practice evolved, how the profession developed, or what influenced it along its transitionary journey. Likewise, evidence of how historical nursing practice informed contemporary practice and policy is also absent.

2. Context of emergence of the area of research

The care and treatment of the mentally ill has been predominantly the domain of historiographers in medicine, public policy, sociology and psychiatry. Perspectives from these vantage points place focus on aspects other than nursing. Most historical accounts have viewed nursing as an integral part of psychiatry with no separate existence from it. The annals of psychiatry reveal that it was doctors who employed nurses to work in the asylums, who initiated the first training schemes for attendants, taught nurses during their training, examined them and decided what the role of nurses should be (Nolan, 1993). The history of nursing in Ireland however requires amplification from the histories of another profession and other groups who worked in the field of mental health in order for it to be properly understood.

The historical roots of Irish psychiatric nursing have remained subsumed within the realms of the history of psychiatry. The majority of publications in this area tend to focus on the social, structural and legislative frameworks that established the asylum system and subsequently the community approach to care. According to Nolan (1993, p1) having a nursing history confirms the legitimacy of the service one provides, mere inclusion in the history of another group implies mere subordination. It is not clear why psychiatric nurses have been reluctant to examine their history and their role and describe their contribution to patient welfare within the asylum system. Attempting to extricate the experiences of nursing staff who worked in caring for the mentally ill is a difficult task. Capturing the individual narratives of nurses who worked within the institutional mental health settings during that time provides knowledge and insight into the experiences and practices of psychiatric nurses, their influence on care, and the changes over time in mental health care. In addition, it will provide information about the presentations of patients, the treatment modalities available, the role of those employed as nurses, leadership practice within the profession of nursing and the social environment.

3. Rationale for this study

Capturing individual narratives of nurses who worked within the institutional asylum systems during the decades from 1940 to 1970 provides an insight and information into the role of nurses along with the changes which occurred during that period. This is a study that has particular urgency as it seeks to capture the accounts of participants who are an aging population. While it is recognized that the history of nurses is intertwined with that of other asylum workers, particularly doctors, the aim of this study is to give Irish psychiatric nursing an identity of its own, separate and distinct from that of psychiatry. This should situate the nursing profession within the history of the mental health care, thus enabling the profession to advance into the future with a history, professional confidence and professional agency.

According to Fealy et al (2012) nursing derives its social legitimacy, in part, through its history, including reliable accounts of the legacy of nursing work in the untold aspects of the daily work of nurses and midwives and how they contributed to care and the development of healthcare systems. According to Fealy (2012), knowing our history helps all divisions of nursing to understand our past, our cultural awareness and moral understanding of the world we work in. Studying nursing history allows nurses to understand more fully problems currently affecting the profession, such as pay, regulation, shortage, education, how skills develop, defining practice, autonomy, and unity (Ogren, 1994). Henry & Deady (2001) maintained that mental health nursing in Ireland is largely absent in its commentary on the discipline's development. Walk (1961) declared that a history of psychiatry which did not include the history of psychiatric nurses was incomplete. While it is difficult to examine the role of the nurse in the asylum system in isolation of other professions, it is nevertheless critical to ensure that their contribution to care is identified and examined in order to describe psychiatric nursing from the point of view of nurses as opposed to that of psychiatrists.

In the distant recesses of time, as a nursing student, the Victorian attitude that characterized Florence Nightingale’s writings justified the scant attention we gave to them. However, in more recent generations, her writings have come back into vogue. As a nursing ancestor whose strong grasp for how practice competencies might

interact to inform the science of nursing, I think some of our psychiatric nursing ancestors' ideas about what constituted psychiatric nursing may also make a unique and distinctive contribution to our profession. Perhaps now is time to shake off that dust, and visit what might have been worthwhile in our nursing ancestor's contribution and practice. The history of psychiatric nursing in Ireland in the asylum system has often been labelled as negative and bad while contemporary care in mental health services is viewed as good and positive. Hunter & Macalpine (1974, p.3) state that ''lack of appreciation of the past tends to foster over-evaluation of modern achievements and the assumption, so stultifying to progress, that what is present is good and what is past is bad''. No evidence has been acquired to challenge this labelling and stereotyping of the profession historically.

According to George Santayanas (1905) a professor in philosophy at Harvard, history repeats. He maintains that those who cannot remember the past are condemned to repeat it. The history of asylums provides us with significant intelligence of our previous mistakes and misdeeds, it is critical to understand the history of nursing in order to understand change, politics, the power that lies within our profession and to prevent repeating any such mistakes or misdeeds again.

4. Purpose of the Study

The history of psychiatric nursing is to a large extent one that remains obscure. .A certain amount of this history remains locked in documentary evidence of hospital records, many of which have been lost during the deinstitutionalisation process. However a significant portion lies in the memory of those who are and were psychiatric nurses. This study sheds a light on something that has not been captured to date, and gives voice to a professional group that has not been heard to date and their contribution marginalised within the negative history of the asylum system, largely viewed as places of containment rather than care. The study was conducted nationally in Ireland.

The purpose of this research is to capture the individual accounts of nurses' experiences who worked in the mental asylums during the mid-1900s. A narrative inquiry was selected as the research design of choice to report these stories. This perspective facilitated giving a voice to a group and profession which have been silent. It also provides information and insight into the contribution of psychiatric nurses as a distinct profession. This research assists in describing and articulating nurse's memories and understandings of their experiences as well as providing an insight into the lives of patients along with information on the social and psychiatric presentations of patients.

The researcher, using a qualitative narrative inquiry approach that relied on the nurse's memories and views, makes knowledge claims with the intent of determining their experiences and developing themes. These claims are based primarily on the social constructivist perspectives of nurses (i.e. multiple meanings of individual experiences, meanings socially and historically constructed) (Creswell 2003, p.8). The study aims to capture information which should inform the rightful place of psychiatric nurses in the care of patients in mental asylums in the mid-1900s. Psychiatric nursing is a unique profession with an identity of its own, separate from that of psychiatry, yet its contribution as a distinct profession has not been recognised

5. The scope of this study

Nursing had become established as a reputable and respected profession by the beginning of the 1900s due to the work of Florence Nightingale during the Crimean war. In the UK, the registration of the profession was introduced in the House of Commons in 1919. This resulted in reciprocity of recognition for nurses and the establishment of the General Nursing Council (GNC) in Ireland in 1919 under the auspices of the Nurses Registration (Ireland) Act 1919 (Scanlan, 1991). Training schools were established in all of the main acute voluntary hospitals in Ireland. This act led to considerable training and the registration of both general nursing and midwifery in Ireland. However, psychiatric nursing was not afforded the same

attention by the GNC as general nursing. According to Robins (2000, p36) the public perception of mental hospitals at that time was that they were places of containment and detention rather than places of therapy. According to Robins (2000) since there was an absence of effective therapies for patients, the registration of nurses gave little impetus to the improvement of nursing standards or to any significant decrease in their numbers in asylums. Many of the staff were untrained and recruited for their physical attributes and their capacity to restrain. In the early 1940s, the Department of Local Government and Public Health introduced a number of statutory instruments regarding the professional status of nurses and officers working in Irish asylums. The Mental Hospitals Officers (General Trained Nurses) Order (1942) stipulated that only qualified nurses in mental nursing could work in Irish mental hospitals.

Every holder of the office of general trained nurse in a district mental hospital who is appointed to such office after the date of this Order, shall cease to hold such office at the expiration of three years after such appointment unless before such expiration such holder has been registered in the supplementary part of the register kept under section 2 of the Nurses Registration (Ireland) Act, 1919, containing the names of nurses trained in the nursing and care of persons suffering from mental diseases (Mental Hospitals Officers (General Trained Nurses) Order (1942).

The impact of the order was that it established a professional basis in the Irish legal system for all staff working in mental hospitals. The qualification of nurses altered significantly with legal emphasis on education, training and certification of staff. Any nurse who did not hold the qualification from the General Nursing Council for mental health nursing could not work in an Irish mental hospital after 1945-46. The culmination of the orders came in 1944 with the Mental Nurses (Qualification) Order (1944). It established the basis for all nursing expectations in Irish mental hospitals by stating that every person qualified as a mental nurse (male or female) had to:

(a) Be of good character.

(b) Be free from any defect or disease which would render such person unsuitable to hold the said office, and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.

(c) Male nurses had to be at least five feet eight inches in height.

(d) Female nurses had to be at least five feet four inches in height.

The order also stated that any woman should be either unmarried or a widow to hold the office of mental nurse.

During the 1940's and 1950's new legislation and methods of treating mental illness also emerged that gradually transformed the care of persons with mental illness. The introduction of the 1945 Mental Treatment Act and the introduction of phenothiazine's in the 1950s made a major impact on treatment choices and outcomes. While psychiatric nursing was slow to develop and did so later than other disciplines of nursing, this specific period in the early 1940s saw the birth and development of psychiatric nursing within asylums until their planned closure with the appointment of Community Psychiatric Nurses (CPNs) in the early 1970's.

The researcher has decided to focus this research on the experiences of nurses working in asylums during this period from the 1940s, 1950s and 1960s to inform this study. The rationale for selecting this period of time captures when the profession of psychiatric nursing originated in the asylum up until the publication of the Report of the Inquiry into Mental Illness in 1966, introducing deinstitutionalisation and the transfer of mental health care to the community. This policy however was not implemented in the vast majority of mental health services until the late 1970s and well into the 1980s when community care became the location of choice for treatment of mental illness. The implementation of this policy was influenced by Ireland's membership of the European Economic Community (EEC) and was required to meet EEC terms (Sheridan, 2000). This study covers this period from when psychiatric nursing commenced as a profession in the early 1940s to 1970 to when nurses were being appointed into community and psychiatric nursing started to diversify from these institutions and specialise.

6. Contribution of this study

The history of psychiatric nursing in the asylum system in Ireland has not been researched. This study will trace the ontological development of the profession of psychiatric nursing from its inception to when it began to move out of the asylum system. While this study will build on the scholarship of Waters study (2020) into the working lives in an Irish Asylum. The exploratory nature of this study (Pridemore, 2006) is that it explores how nursing was conceived and how nursing developed as a profession in the Irish Republic. This study does not seek to test any hypothesis, it will shed a light on something that has not been captured to date within the profession; the structural and contextual factors that influenced it along with the social and professional challenges it faced during its development to professionalisation. This study will also provide an insight into the types of treatment and services patients received and give voice to a professional group, marginalised within the history of psychiatry and the asylum system, a voice that has not been heard to date within psychiatry.

7. Language

The use of ‘language’ in this research study needs to be addressed from the outset. The terminology progresses throughout the thesis are according to the period under review and in line with the use of language in primary sources. Chapters with reference to the early 1940s, prior to the introduction of the Mental Treatment Act 1945 uses the words: ‘asylum’ ‘lunatic’ etc. As the chapters move from that period the phrases are brought in line with the language used in mental health legislation in Ireland including ‘mental hospital’, ‘mentally ill’, ‘patient’ and ‘psychiatric nursing. Brennan (2014) states such phrases reproduce the experience of stigma and the oppression of individuals perceived as fitting such categories. However the terms such as ‘asylum’, ‘lunatic’, ‘madness’, ‘insanity’, ‘mental patient’, and ‘mental illness’ are used within this research study only as a means of exploring the context of their social constructions.

A number of terms are used to refer to people who avail of the mental health services. I do not differentiate the individuals who were patients in the

asylums/mental institutions from those of the general populace who were in general hospitals, and therefore I refer to them as “patients”.

Throughout the thesis I refer to nurses who worked in the mental health system from the 1940s to 1970 as “psychiatric nurses”. I am aware of the various opinions on what terms should be used to refer to nurses working in the field of mental health. As this debate is not the focus of this study I have deferred to the term used by the statutory body that governs nursing in the Irish republic, the Nursing & Midwifery Board of Ireland.

I propose to write in the first person (Porter 2000), throughout this thesis. This is in order to lend as much reflexivity (Porter 2000) as possible to my description of the study. Reflexivity is that process whereby the researcher acknowledges and considers the pros and cons of any personal stake holding, subjective opinions and/or values with regard to the research and its subject matter. Writing reflexively has positive implications for trustworthiness and credibility of research findings (Hall & Callery, 2001), and this aspect is discussed in relation to the study design and methodology in Chapter Three.

8 Structure of Thesis

This thesis comprises of an introduction and five chapters, which organise and present the main stages of the study.

In the introduction to the study I introduce the purpose and rationale for the study. I identify the research problem and frame it within the existing literature. The research design approach is also presented. The language used within the study is also contextualised in this chapter.

Chapter Two comprises of literature informing the background and the history of containment in Ireland, the birth of the asylum system, the physical environment

along with the social influences. Literature relating to nursing and psychiatric nursing in particular is included. Relevant literature is reviewed in the Irish context in order to further contextualise this research.

In Chapter Three, I discuss methodology and explore the importance of having a framework for designing the research. The chapter provides an overview of the paradigms, explanation and justification of the choice of the study's philosophical orientation. The selected research methodology of a narrative inquiry approach is presented. The data collection methods and the rationale for these associated components are also discussed along with the demographics of the participants. The ethical issues arising within the study is also addressed here.

Chapter Four presents the findings of the study in thematic form.

Chapter Five presents the discussion of the findings with reference to relevant literature. This chapter also concludes the thesis outlining the contribution of this research to the existing body of knowledge within nursing, the considerations for psychiatric nursing, the profession of nursing, policy, education and research.

Chapter Two

Literature Review

2. Introduction

This chapter will provide a narrative overview of the background and history of the asylum system and containment in Ireland. It will also provide the social theory of the establishment of asylums and their role in Ireland. I propose to present this literature in thematic form with the associated history relating to each theme presented in each section. In this chapter within the theme of nursing, an insight into the history of nursing with particular reference to psychiatric nursing will be presented, including literature relating to the development of the role, professional education of psychiatric nurses historically, along with regulation of the psychiatric nursing profession and nursing policy will also be explored. The literature will review the historical role of the nurse during that period within Holland and the UK.

In this literature I have drawn on nursing and wider literature from the relevant decades, paying particular attention to seminal pieces of work that have informed this particular historical study, a significant amount of literature was reviewed predominantly through a historical lens. This is considered appropriate due to the focus of this particular research. The literature search was applied to all resources published.

In qualitative research one of the chief reasons for conducting a qualitative study is that the study is exploratory (Creswell 2012). This literature review will provide a useful backdrop for the topic being researched, that has led to the need for the study. The objective of this literature review, therefore, was to gather the relevant literature on a topic for the benefit of the reader and form a justification for future research in that area (Cronin et al. 2007).

2.1. Literature review methodology

The literature in the review was identified after completing a systematic search of the literature using PubMed, CINAHL and MEDLINE electronic databases. Keywords used in the search included asylum, containment, caring, nursing, psychiatric nursing, mental health policy. Manual searches of the reference lists of relevant research were also carried out to augment the literature.

The literature will be reviewed as a thematic rather than a chronological analysis of the developments and issues that impacted on psychiatric nursing in Ireland along with the contemporary issues which influenced the profession.

2.2. Background and Context

Historical accounts of the management and treatment of the mentally ill in Ireland are provided by Finnane (1981), Malcolm (1989) and Robins (1986). Finnane (1981) and Prior (2003) outline how up until the founding of the Irish State in 1922, acts passed in 1817 & 1843, along with amendments made to the Lunatic Asylums (Ireland) Act of 1875 centralised overall responsibility for Irish asylum provision and firmly set the tone for asylum care in nineteenth century Ireland. Irish asylum provision developed at an earlier time and within a different set of social dynamics than those experienced in most other European countries (Finnane 1981, Robins 1986; Malcolm 2003, Prior, 2003). Kelly (2016) in 'Hearing Voices: the history of psychiatry in Ireland' provides a comprehensive history of the history of Psychiatry in Ireland. In it he discusses the emergence of the asylum system and the conditions under which doctors and their patients lived, the main personalities of the psychiatrists who shaped the discipline and highlights treatments available and the influences and features of psychiatry in Ireland. He also addresses the changes in the policies and practices of medicine and psychiatry, almost exclusively from a psychiatrist perspective. Brennan (2014) in his publication 'Irish Insanity 1800 to 2000' critically considers the construction and classification of and responses to madness, insanity and mental illness in Ireland with particular reference to institutional residency at that

time. Elizabeth Malcolm (1999, p18) examined the issue of confinement in the asylums stating ‘families, police, magistrates, clergy and doctors co-operated to take advantage of lax procedures so as to rid their communities of those deemed troubled or troublesome’ and that the committal records should not be taken as indicative of the level of mental illness in Ireland.

2.3. The Asylum System in Ireland

Prior to 1845 in Ireland, the inspection of asylums came under the responsibility of the Inspector of Prisons. Asylum managers were not required to have a medical qualification; however, what were considered to be important was the moral character, temperament and disposition of those appointed to such positions (Brennan 2014). These asylum managers often referred to as ‘moral superintendents’ were appointed by the Lord Lieutenant and in operational terms they were answerable to the asylum boards of management. These managers had overall responsibility for the day to day management of asylums; however, the physical needs and ailment of patients were attended to by medical staff who were appointed on a visiting basis. The importance of asylums as locations of professional power was not realised by medics until during the mid-nineteenth century. According to Nolan (1993) the medical profession were keen to carve out a prime place for itself within the newly emerging branch of medicine. The disease model, with its claim to scientific respectability, was the approach then uniting all branches of medicine and became fundamental to thinking about mental illness (Mitchell, 1984). This branch of medicine was to become known as psychiatry. According to Mitchell (1984) doctors saw cure as their objective, not prevention of illness, health education or the understanding of the complex interaction of relationships affecting any individual in society. The perceived power to cure placed doctors at the centre of the mental illness stage, doctors had created a legitimizing ideology which strongly underpinned their power and prestige (Brennan, 2014).

In 1846, an Office of Lunacy was created in Dublin Castle and with it the posts of Inspectors of Lunatics in Ireland (Culliton, 2009). These officials were also ex-officio

governors of district asylums. The first Inspector was Dr Francis White — joined a little later in the Inspectorate by Dr John Nugent, formerly travelling physician to Daniel O'Connell. Francis White became a key player in professional politics and was the first person to successfully secure appointment as Inspector of Lunatic Asylums in Ireland. He was subsequently followed by John Nugent, a medical graduate of Trinity College. Since 1845, the role of Inspector of Lunatic Asylums /Inspector of Mental Hospitals was held by a medic (men in all cases), it is a role that has continually existed until the passing of the 2001 Mental Health Act (Govt. of Ireland) which established an Inspector of Mental Health. Such professional politics were the key drive to the establishing of a medical monopoly over both control and inspection of Irish asylums for the insane. Once established this arrangement was systematically reproduced up until the close of the 20th century (Brennan, 2014).

Mitchell (1984) argues that there is a connection between the supremacy of the medical model and the relegation of nursing to a low status occupation. He maintains that to 'cure' was the all-important goal in psychiatry, 'caring' became a mere adjunct to this activity. Caring, he maintained, did not require professional expertise. One could be cared by anyone, family or friend; it was about looking after people on the way to being 'cured' or who were unfortunately incurable.

The first purpose built accommodation for lunatics in Dublin was built in 1728 when the then Lord Mayor of Dublin directed that 12 cells would be erected in the Dublin Workhouse. Although clearly inadequate to meet the needs of the population of Dublin, it was almost 20 years before St Patrick's Hospital, generously endowed by Jonathan Swift, opened its doors for 54 lunatics in 1746 (the second asylum in the UK) (Malcolm, 1989). A second asylum was later commissioned at Grangegorman and opened in 1815. The erection of lunatic asylums was legislated for in the Lunatic Asylums for the Poor Act (1821) and this empowered the Lord Lieutenant to direct the erection of asylums 'making more effectual provision for the establishment of asylums for the lunatic poor and the custody of insane persons charged with offences' (Nolan and Sheridan 2001 p 37). This Irish asylum system was established through colonial social policy and entailed the building of a national network of publicly funded institutions in Ireland. The mental hospital in Ardee was the only

psychiatric facility built in the early twentieth century in Ireland by the Government of the Irish Free State. It was established to relieve pressure on the Richmond asylum in Dublin because it was a district asylum which catered for a specific region including the mentally ill of County Louth, County Wick low, Dublin city and the borough of Dublin.

In 1922 the new Free State Government in Ireland took over the Irish Asylum System. According to Brennan (2014) the only change was an altering of the administration system, under the Ministers and Secretaries Act of 1924 which placed asylums under the control of the Minister and Department of Local Government and Public Health. Further expansion of the overall system took place in the form of new buildings and the extension of those existing asylum buildings. This expansive programme reflected the continual rise in the level and rate of residential occupancy of the 'mentally ill' in Ireland up to 1956. The rate of asylum committals of the Irish in Ireland was higher than those in England, Wales and Scotland and by the mid 1950's resulted in Ireland having the highest rate of psychiatric bed availability and committal rates internationally. By 1956, 21,720 individuals were contained within the Irish Asylum system: 11,207 males and 10,513 females (Inspector of Mental Hospitals Report 1956). In parallel with the steady and alarming growth of public asylums in Ireland, a network of private asylums also emerged and carved out a role within Irish medicine and society (Kelly 2016).

The presence of an asylum within a community provided a major source of social security. While the main function of the asylum was to cure and or care for the 'mentally ill', the asylums took on a spectrum of other roles and functions as physically and economically the largest structures in many of the towns they were situated in (Brennan 2014, p.68, Kelly, 2016, Prior, 2012).

2.3.1 The social / physical environment of asylums

Asylum buildings were physically surrounded by high walls with large locked gates to prevent patients from escaping. Entering through the large gates, the gate man's lodge was inside where everyone entering was registered and observed. Each asylum had a large round water tower, a Roman Catholic chapel and many had Church of Ireland churches. Large blocks of buildings containing kitchens, laundries, workshops, recreation halls and administration which were visible to all entrants.

The asylums had long corridors (some corridors stretching a half mile long from one side of the asylum to the other) connecting large Nightingale wards. The wards, where the sexes were rigorously separated, housed up to 100 patients. As many as 50 patients slept in one dormitory with their beds close together. Patients ate in large communal dining halls. Male and Female attendants were as strictly segregated as their patients and some lived out their lives on the asylum sites.

Most asylums were self-contained. They had farms, orchards, tailors, workshops, ball alleys, bowling greens, croquet lawns, pitches and entertainment halls. In 1866 the physician Sir George Paget (1809-1892) hailed the asylum as 'the most blessed manifestation of true civilisation the world can present' and 130 years later a historian described the asylum as 'museums for the collection of the unwanted' ((Historic England 2020).https://historicengland.org.uk/research/inclusive-heritage/disability-history/1832-1914/the-growth-of-the-asylum/ 280420).

Prof Ivor Browne in his biography (2008) describes this social environment when he took up duty as the Senior Administrative Medical Officer in a large Dublin Asylum in 1962. At that time he described an asylum as depressing with '*long sombre corridors leading to large wards full of forlorn human beings. There were old dilapidated wooden huts where the most disabled of the mentally retarded were housed….. full of small, gnome like creatures in long black coats sitting and standing around on floors impregnated with years of urine'* (p103). He states there were approximately 4000 patients residing in the two largest asylums in Dublin, a considerable proportion of whom were mentally retarded (p102). Browne maintains that the railway system built in 1902 which was used to transport materials and provisions to Portrane using Donabate Railway Station was used for the purpose of transferring patients from Grangegorman there by train. He described how the Resident Medical

Superintendent ruled like a 'feudal lord (p 103) When patients arrived to the asylum, he described the RMS as ' *he had a rather novel method of diagnosis, he would review a parade of new arrivals, selecting patients according to their strength, this one for the coal yard, another for the laundry, pig yard and so on*' (p103) Browne (2004) also described how if two nurses were proposing to get married they had to present themselves to the Resident Medical Superintendent for permission (p 103).

All of the asylums had been built in the proceeding century (Figure 2.1) and the mores and traditions of that era still governed their daily operation and culture (Prior, 2003).

Figure 2.1 Asylum Construction Programme in Ireland

1728 12 cells would be erected in the Dublin Workhouse

1746 St Patrick's Hospital opened generously endowed by Jonathan Swift

1815 Richmond Lunatic Asylum opened. (In 1830 the Richmond became a district asylum catering for Dublin city, the borough of Dublin and Counties Louth and Wicklow.

1824 Armagh District Lunatic Asylum opened

1827 Limerick District Lunatic Asylum opened

1829 Belfast District Lunatic Asylum opened

1829 Londonderry District Lunatic Asylum opened

1832 Carlow District Lunatic Asylum opened

1833 Connaught District Lunatic Asylum opened

1833 Maryborough District Lunatic Asylum opened

1834 Clonmel District Asylum opened

1835 Waterford District Lunatic Asylum opened

1845 Cork Lunatic Asylum became Cork District Lunatic Asylum

1850 Criminal Lunatic Asylum opened in Dundrum, County Dublin

1852 Kilkenny District Lunatic Asylum opened

1852 Killarney District Lunatic Asylum opened

1853 Omagh District Lunatic Asylum opened

1855 Mullingar District Lunatic Asylum opened

1855 Sligo District Lunatic Asylum opened

1866 Letterkenny District Lunatic Asylum opened

1866 Castlebar District Lunatic Asylum opened

1868 Ennis District Lunatic Asylum opened

1868 Enniscorthy District Lunatic Asylum opened

1868 Downpatrick District Lunatic Asylum opened

1869 Monaghan District Lunatic Asylum opened

1902 Portrane Lunatic Asylum opened in North County Dublin offering more accommodation for the Richmond District Lunatic Asylum

1933 Ardee Mental Hospital opened

2.3.2 Asylum administrative structures

Collectively the asylums constituted one of the earliest, largest and most enduring forms of institutional social intervention ever to have taken place on the island of Ireland. They were administered through an overarching central bureaucracy (Brennan, 2014) directed by the Lord Lieutenant, Chief Secretary and Under Secretary at Dublin Castle. The Lord Lieutenant had the power to fund, regulate, and restructure the national system. Each asylum was locally administered by a Board of Governors, which attended to the administrative responsibilities of the institution (Walsh, 2017).

This progressed in the late 19th century to medical superintendents exercising almost total control over the day to day lives of both patients and staff in asylums. The prevalent attitudes of physicians of the time are well illustrated in the pages of the Journal of mental Science, the periodical of the Medico-Psychological Association. The President Dr Yellowlees, argued that ‘as a matter of asylum discipline, one ought often to dismiss instantly’ He also inserted a new clause whereby Medical Superintendents could dismiss staff upon such evidence or information as may seem

to the Medical Superintendent to be sufficient. These medical men sought control of attendants and nurses lives (McCabe & Mullholland, 2012).

As early as 1875, the rules of the Richmond Asylum stated that 'all violence or ill treatment of the patients is strictly prohibited, under any provocation, and shall be punished in the most exemplary manner' (8th Asylums report, 1857). These sentiments were repeated in the code of practice for care in district asylum as laid out in the Privy Council Rules. While these rules applied to all staff in the asylum, it was the responsibility of the RMS to apply and implement them. Report from the Inspectorate show that while abuse or neglect of patients did not seem to be rampant in any of the asylums, the prevention of abuse and neglect by attendants and nursing staff did feature in their reports (Kelly 2016, Prior, 2012, Brennan, 2014).

Joseph Robins (1987, p.174) referring to asylum management committees after the establishment of the Irish Free State maintained that 'the ascendancy governors had for so long based their parsimonious management of the asylums on the just right of property and on the belief that , in any event ,institutions for pauper patients should reflect the grimness and discomforts of poverty. Reports of early twentieth century meetings of the new committees reveal a preoccupation with financial matters, opposition to wage increases, questioning of expenditure and a remarkable lack of concern for the living condition of patients themselves'. In some cases the inspectors' reports seem to indicate that asylums actually improved as a consequence of care staff removing their services during strike actions. An example referred to in the report of a strike at Clonmel Asylum in 1921 cited by Brennan (2014, p. 75) appears to indicate that the general health and indeed survival of patients was actually enhanced during the strike within the asylum: "'*The most noteworthy event in the administration of the asylum during the year was a strike amongst the attendants, which lasted three months. Notwithstanding that the entire work of the institution during that period had to be carried on by the higher officials, with the assistance of patients, it was kept on the whole very clean and in good order… the health of the patients was wonderfully good and the death rate was only 7.4 per cent of the average number resident during the year, which is 1.9 per cent lower than the average of all the Asylums. The greatest credit is due to the Medical*

Superintendent, and the other superior offices, who, under extreme personal strain and risk, managed to maintain as tolerable as state of affairs; and it is especially surprising that no suicide or fatal accident occurred, the only event of importance being the escape of about 37 patients. Apart of from the consequences of the strike, the Asylum was maintained in excellent order throughout." (Inspector of Lunatic Asylums 69th Report on the District, Criminal and Private Lunatic Asylums in Ireland 1921: Page xx) The main focus of the inspector's report was social control within the asylum and its maintenance.

The absence of reference and or acknowledgement of staff providing care was notable in these reports as there is scant mention of details regarding the day to day running of the asylum other than disciplinary issues and security breaches. However, it must be remembered that these reports were constructed by a Consultant Psychiatrist/ RMS, written for government use and political reasons and were generally bureaucratic in tone and nature.

2.3.3 Legislation and Policy

This asylum system along with the committal legislation of the Dangerous Lunatic Act of 1838 (www.irishsatuebook.ie) allowed the direct committal to prison of people designated as dangerous lunatics. This Act formed the basis of the judicial committal procedure which became the most important mode of admission to Irish asylums The primary purpose of the Act was to safeguard the public from the dangers allegedly posed by the mentally ill, these people initially confined to a barracks or county prisons were legally transferred to a district asylum. Families or relatives using this Act did not require a commitment to take the lunatic back following treatment. (Reynolds, 1994, Cox, 2018). This led to the proportion of dangerous lunatics increasing towards the end of the 19th century. In 1867 this law was changed and under Section 10 of this Act anyone suffering from 'derangement of mind' which might 'lead to him committing a crime', could be committed directly to an asylum by two justices of the peace. As shown by Prior (2010), Finnane (1989) Kelly (2016) and Brennan (2014) this did not stop the tide of dangerous lunatics admissions, it

increased it. According to Finnane (1989), Cox (2018) and Prior (2017) the main reasons for the use of this method of admission was the fact that there were three obvious advantages to families who used ‘dangerous lunacy’ admission procedures, rather than ‘ordinary’ admission procedures. Firstly, the police transported the patient from home to the asylum regardless of the distance, secondly the asylum could not refuse admission to someone legally deemed dangerous and thirdly, the family was not responsible for the ongoing maintenance of a patient admitted in this way. The subsequent Dangerous Lunatic Act of 1875 (www.irishsatuebook.ie) amending the 1838 Act provided powers of asylum authorities to detain inmates and retake them in the event of escape (reception orders and certificates) firmly set the tone for asylum care in the nineteenth century Ireland. The experience for these patients was inherently stigmatising and their removal from society was total (O’Sullivan & O’Donnell, 2012). This legislation provided no route back into society (Cox, 2018). This act along with the 1883 Trial of Lunatics Act: criminal lunatics legislating for pleas of insanity in criminal cases developed throughout the 19th Century, remained in practice until 1945 when the Government of Ireland introduced new mental health legislation. In 1925 a Local Government Act: changed the name of lunatic asylums in Ireland to mental hospitals. This term was also used in the 1945 Mental Treatment Act.

During the mid-20th century a confluence of changes occurred powerful enough to reshape the structures, systems and social practices that were enabling this mass institutionalization of Irish people in asylums (Brennan, 2014). The 1945, Ireland’s Mental Treatment Act (Dept of Health, 1945) which came into operation on 1 January 1947 dealt with a spectrum of issues relating to the administration of Irish mental hospitals and psychiatric services, which included asylum financing, administration, pension arrangement for staff, and a system for admission and discharge (Brennan, 2014, Kelly 2008).This new Act led to significant changes by strengthening the practice and delivery of appropriate care to individuals with mental illness (Kelly 2008). This act theoretically reversed the impact of the Dangerous Lunatics Acts where more patients were going in to asylums than were coming out. The Act also saw the removal of the term ‘lunatic’ from mental health legislation; this was replaced with terms such as ‘person of unsound mind’ (Dept. of Local

Government and Public Health, 1945). This Act also consolidated medical authority over all admissions. The Act introduced for the first time a Voluntary Admission statue whereby individuals could for the first time volunteer to be received within the institution for treatment, on the recommendation of a medical officer be received not as a person of unsound mind and on their recovery, be discharged. The involuntary admission statues were under two new procedures, one for 'person of unsound mind' the other for 'temporary chargeable patients'. Both procedures required a family member, relative or other person make an application for involuntary status to allow for admission to a hospital to take place. The key difference however between these admission categories was that the former category: Person of Unsound Mind (PUM) referred to individuals who were not under proper care or control, neglected or cruelly treated by another or were of no fixed abode. An individual detained under a Person of Unsound Mind reception order was detained (known as PUM patient) for an indefinite period of time without any legal entitlement to review. The latter reception order of a Temporary Chargeable order (known as a Temporary patient) referred to individuals who when medically assessed on admission satisfied the medical officer that the person was of unsound mind and required a detention period for up to six months, this detention period for up to six months, legally required to be reviewed by the six month period by a medical officer in order for it to be extended (Section 189 MTA 1945). As the vast majority of patients until the early 50s were committed involuntarily (Walsh & Daly, 2009), by the early 60s more than 80% of patients were admitted as persons of unsound mind (O'Sullivan & O'Donnell, 2012). It demonstrates how slowly admission practices changed.

In Mental Hospitals Officers (Attendants) Order (1944) removed the term 'keeper' that had been applied to those entrusted with the care of the mentally ill within the asylums. This, too, subsequently changed and the preferred term became 'attendants'. The Health Authorities Bill (1959) served to remove asylums and their administration from the county councils and transfer their administration to the new health authorities in the larger catchment. This according to Dermot Walsh (2012) an Inspector of Mental Hospitals broke down the statutory barriers between mental health services and other health services and integrated psychiatry more closely into general health services. He believes it was hoped that this transfer of

responsibility to a wider health administration would break down the stigma of mental illness also (p74)

.

In 1958, the World Health Organisation (WHO 1958) indicated that internationally, Ireland had a disproportionately high level of mental hospital beds, in proportion to its population. In 1959 the World Health Organisation which had become the most powerful health organisation in the post war period, in a speech published in the Irish Times (7th April, 1959) by Dr Candau reported that, “Psychiatry is now accepted by the public on a par with other major branches of medicine and gone are the days when the mental asylums main purpose was to ‘protect society’ by keeping patients indiscriminately shut away where they could do no harm. If treatment is begun early enough, between 70% and 80% of mental patients can nowadays be restored to a useful place in society ... there are more and more voluntary patients at mental hospitals. In this way, Candau acknowledged the shift in attitude among governments from institutional care to a non-traditional model of care focusing on temporary and voluntary admission to mental hospitals. Candau’s comments highlighted that psychiatric professionals identified the importance of early intervention in cases of mental illness whereby the faster an individual was treated for an illness, the greater their chances of making a full recovery (Butterly, 2014, Unpublished thesis)

A Commission of Inquiry on Mental Illness was established and reported in 1966 (Dept. of Health, 1966). This commission had two main functions: 1) to examine and report on the extent and state of provisions for mental health and recommend measures to improve services and 2) to review the legislative provision concerning mental illness in Ireland. This inquiry expressed concern at the level of patients contained in Irish asylums: ‘…Statistics in respect of different countries may not be directly comparable, but, even if allowance is made for this, the number of in-patients in Ireland seems to be extremely high – it appears to be the highest in the world. It is hard to explain this.’ (Commission of Enquiry on Mental Illness 1966, p.24).

2.4. Social Theory of Asylums

Foucault (Foucault (1961) in ‘Madness and Civilisation’ locates madness within a social context and discusses the social construction of insanity with reference to a spectrum of social events, structures and representation. He proposes that the perceived common sense of insanity, and responses to it, may be understood in the context of the production and reproduction of structures and practices. These structures and practices are embedded in social norms, professional occupational security, economics, law and the built environments in which particular practices are formed and reproduced. Within such structures and practices a belief in the ‘truth’ of insanity emerges and consequently the authority, respect and perceived altruism of those who respond to insanity becomes unquestionable (Brennan, 2014).

The intersection between the history of confinement and the history of medicine constitutes an area where Michel Foucault has made a major contribution. In the Histoire de la folie cited by Finzsch & Jutte (1996, p. 56) Foucault sets the construction of insanity within the wider political and institutional context of the so-called Great Confinement of the poor into general hospitals in the 17th and 18th centuries. Foucault (1979) goes on to argue how the emergence of the lunatic asylum in the late 18th century was linked to the creation of an institutional setting for the sick person through the ‘medicalisation’ of the hospital milieu. Foucault inserted this process into the broader perspectives of an emerging disciplinary society (Foucault 1979).

For Foucault (1961) the history of psychiatry is anything but the history of the gradual liberation of the insane from their fetters of iron and the shackles of superstition. Quite the contrary, his version of that history first offers us a romantic portrait of the Middle Ages, an era where folly flourished largely free of pernicious social restraint; and then contrast this with a picture of the period of mid-17th century onwards as marked by a grand internment, a ‘great confinement’ of the mad and of other social undesirable whose very existence constituted an affront to bourgeois sensibilities; before he finally concludes with an assessment of the dawn of the 19th century as corresponding to the imposition of an ever more thorough going ‘moral uniformity

and social denunciation' – the historical moment at which the medical gaze secures its domination over the mad, launching 'that gigantic moral imprisonment which we call the liberation of the insane by Pinel and Tuke' (Foucault 1961). Pinel and Tuke had advocated for moral treatment and better healthcare facilities for the mentally-ill through social political and moral improvements (McClelland 1988) (Section 2.6 provides a more in-depth analysis of Pinel & Tuke's approach).

Foucault (1961) observes that at the commencement of asylum construction, there was no specialist expertise within medicine that placed this profession in a special position to claim governance over these institutions. Brennan (2014) states that this takeover of this governance role of asylums by medics was the later development of psychiatry as a specialised area of medicine in the asylum system. Essentially, Foucault maintains that the medical takeover of asylums had little to do with professional competence, rather it was a political process revolving around medical occupational interests and professional power. According to Brennan (2014) a later consequence of this medical takeover of asylums was the development of psychiatry as a specialised area of medicine within the asylum system (p.7).

According to Finzsch & Jutte (1996, p.4), the asylum was not invented by those who had to live in them. They maintain that long before it became a medical necessity, the hospital was an asylum for the dispossessed due to unregulated economic and social forces. Brennan (2014) concurs and maintains that the increase in Irish 'insanity' and the expansion of the asylum system in the mid nineteenth and early twentieth century was a period of considerable social deprivation in Ireland.
Scull in Arthur Still and Volody (1992) states that Foucault's theory, provocative though it may be, rests on the shakiest of scholarly foundations. According to Roy (1990, p51) Foucault's claims will not withstand scrutiny, in relation to the contention that 'kind' psychiatry is worse and more repressive than 'cruel' confinement. Scull (1993, p8) regarding Foucaults' judgement, on whether one can fairly assess the moral treatment era as marking a gigantic moral imprisonment' states it is a question with no single answer. Scull (1993) maintains that to reduce moral treatment to a species of imprisonment, a form of repression, is to mask an important truth behind a screen of rhetorical excess. Instead he suggests there are good grounds for

preferring the tactful manipulation and equivocal ‘kindness’ of Tuke and Pinel to the more directly brutal coercion, fear, and constraint that marked the methods of their predecessors. However Scull (1993, p 8) also states that one must recognise that it was the less benevolent face of moral treatment that come to the fore, its strength as a mechanism for inducing conformity. Rock (1973, p156) concurs and states that, “‘modes of social control exerted in the past become part of the moral and definitional context (of the present). This propensity to preserve earlier moral reactions means not only that much contemporary deviance is a fossilized or frozen residue from the past, but that contemporary control is constrained and oriented by the past. Each new generation does not rewrite the social contract’ he maintains.” Goffman (1974, p.11) referred to an institution as a place of residence and work where a large number of like situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life. Goffman (1974) in his essay focuses on the world of the patient and how institutions impact on the sociological version of the structure of the ‘self’. He critiques life in institutions particularly from an involuntary status. The institutional practices in institutions of the confiscation of the individual’s property on admission, undressing, disinfecting, haircutting, issuing institutional clothing, being assigned to a quarters as personal defacement which prevented the individual from presenting his usual image of himself to others is also highlighted (Goffman, 1974 p29). He goes on to state that inmates of institutions undergo mortification of the self through contaminative exposure of a physical kind to treatments such as ECT, other medications, unpalatable food, forced interpersonal contact and forced interpersonal relationships. Goffman refers to the impact of an admission of an individual to an asylum as realisation that they have been deserted by society and turned out of relationships of those closest to them resulting in avoidance of talking to others and withdrawal into self. He states that in response to this stigmatization and to the sensed deprivation that occurs when the individual enters the hospital the patient frequently develops some alienation from civil society, sometimes expressed by an unwillingness to leave the hospital. This alienation can, he maintains, develop regardless of the type of disorder for which the patient was committed, constituting as side effect of hospitalization that frequently has more significance for the patient and his personal circle than do his original difficulties (pg.310). “‘A basic social

arrangement in modern society is that the individuals tend to sleep, play and work in different places, with different co-participants, under different authorities and without an overall rational plan. The central feature of total institutions can be described as a breakdown of the barriers ordinarily separating these three spheres of life'.
(Goffman, 1961, pg.17)

Within the asylum environment individualised existence was suppressed and of secondary importance to the overall functioning of the institution often resulting in the social disconnect between the individual and society outside the institution. Barton (1959) observed a common human response within the total institution which he described as a set of experiences and social realities that includes the eventual passive acceptance of the logic of the institution, as loss of social skills, a lowering of personal self-esteem and general social withdrawal which he described as 'Institutional neuroses' (pg.7). While these experiences are attributed directly to the effect of the institution, they can be held as actual signs and symptoms of a bio-medically constructed mental disorder, and consequently be used as justification for the necessity of continued institutionalisation.

According to Nolan (1993) the emergence of the asylum system reflected the increasing power of the State over the life of individuals in the mid-19th century. He asserts that while asylums wrapped their aims in medical rhetoric, as state funded institutions their purpose was essentially social and lay in welfare administration. Baldwin (1971 pg.45) maintains that powerful political and economic forces lay behind the growth of the asylum system. Its justification on moral grounds – bringing medical aid to deranged and powerless people, was always weak because of the total disrespect for the freedom of the individual which the system embodied tended to contradict its appeal to humanitarianism.

2.5 Historical Social Context

A review of sociology literature provides valuable insights into the way in which sociological thinking can ultimately affect and impact on the role of the asylums in Ireland and that of nursing and care within such institutions. The everyday interpretations and understandings of the social world in which nurse's practice, including the law, political climate, family, education and social class all contribute to and provide valuable insights into the way in which sociological thinking ultimately influenced access to and experience of nursing care for patients (Birchenall & Birchenall (2000). It also influences and affects the care and interactions of mental health practitioners (Handsley & Stocks, (2009).

Sociology is a study of social facts, which are ways of acting, feeling and thinking common to a society which coerce individuals in that society to conform (Smith, 1981). It is the scientific study of human society through the investigation of the social behaviour of man (Hannay, 1988).Sociological knowledge enables us to look at society and human relationships in a certain way and to understand, explain and make predictions about members of that society (Pinikahana, 2003).

In Ireland the ruling ideology was familial; the family was held to be the natural building block of society. Children were practically the personal property of their parents, and social worker supervision of dysfunctional families scarcely existed (Garvin, 2005, Ferriter, 2005). By extension and analogy, priests, brother and nuns in *loco parentis* had similar unchecked and unsupervised powers over the children committed to their charge.

2.5.1 Containment

The word 'Asylum' came from the earliest religious institutions which provided asylum in the sense of refuge to the mentally ill. One of the oldest such institutions was Bethlem, which began in 1247 as part of the Priory of the New Order of Our Lady of Bethlehem in the city of London. The prevailing attitude in Victorian times was that the purpose of care in the asylums was confinement, since there was little effective treatment for mental illness (Commission on Nursing, 1998).

Mental asylums were one part of Ireland's architecture of containment which encompassed an assortment of interconnected institutions. Others included reformatory and industrial schools which opened in 1850s and 60s in Ireland respectively. Right from their establishment their welfare record was dismal – between 1869 and 1913, 48,664 children were admitted to industrial schools in Ireland, with 2,623 dying while in custody (Ferriter, 2005, p49). Magdalen laundries were also included, they were charged with the reform of Ireland's 'fallen and immoral' girls (Smith, 2007). Up to 30,000 young women and girls are estimated to have been sent to such laundries, the last one in Drumcondra, Dublin closed in 1996. Many women sent there for the 'crime' of being unmarried mothers, simple minded, assertive, pretty or even having suffered rape and talked about it (Ferriter, 2005, p.538). Their stay in these institutions was sometimes indefinite and their existence a measure of the social values of the era. Smith (2007) maintained that these institutions concealed citizens already marginalised by a number of interrelated social phenomena: poverty, abuse, sexual abuse, illegitimacy, neglect and infanticide. Smith (2007) also maintained that that the operation of these institutions in Ireland took on a distinct character after political independence. This architecture of containment was enshrined in legislation that inscribed these issues. He maintained that Ireland's institutions increasingly served a recarceral and punitive function. Viney (1966, p.101) states that the one really distressing aspect of these 'secret service' homes was that Irish society should have made such conspiracy necessary. .

2.5.2 Economic Context

In 1922 the Irish Free State was established along with our economic history following the signing of the Treaty with England in 1921. It brought to an end the War of Independence which was then followed by a bitter and traumatic Civil War between the pro Treaty supporters and the anit Treaty supporters. This war lasted until May 1923, this period of violence and disruption caused a great deal of economic damage (Gray, 2010). The establishment of the Irish Free State gave rise

however to a serious attempt to develop the economy of the South of Ireland. Farming became orientated around pasture rather than tillage with the increased processing of products and export business. Farmers comprised 44% of gainfully employed men in 1926 (Breen et al 1990, p.5) and just over half the farms were less than thirty acres in size, a proportion that had changed little from the previous century (Turner, 1987). Agricultural labourers comprised 14% of employed men. For those who did not take over family farms, emigration provided an alternative strategy (Gray, 2010, Ferriter, 2005, Garvin, 2005).

Ireland largely agrarian economy with exports of dairy and beef traded almost exclusively with the UK. The Irish economy fared fairly well during the early years of the 'depression' until Ireland initiated an economic war with the UK through demanding discontinuance of payment of land annuities. Britain put tariffs on Irish beef and Ireland retaliated by putting tariffs on British goods. The economic war continued to 1938 (Barry & Daly, 2011, Girvin 1989, Daly 1984, Ferriter, 2005, Garvin, 2005).

Ireland of the 1930s and 1940s was characterised by a combination of poverty, low marriage, high marital fertility and high levels of emigration (Walsh, 2004, Ferriter, 2005). The total population of the Free State from 1926 to 1936 was under three million. In 1926 the population was identified at 2,971,992 in the census of (https://www.cso.ie/en/media/csoie/census/census1926results/volume10/C_1926_V10_Chapter_II.pdf) population with: 61% of the population living in the countryside outside small country towns. Ireland at this time was a poor country; the levels of poverty in many isolated rural areas were exceptional by western standards. Overcrowding in domestic housing was rampant with almost 23,000 families living in one room dwellings, almost 40,000 families living in two room dwellings. This census identified that the most overcrowding existed along the western seaboard and in counties Dublin and Kildare. The population by 1936 had decreased slightly (.2 968,420) with the housing situation unchanged.

Juvenile unemployment was recognised as socially corrosive; in the 1940s, 30% of boys between 16 and 17 were unemployed compared with 11.3% in England, Dublin

city's unemployment quadrupled to 96,000 at the height of the emergency in the early 1940s. . Unlike the 1930s when distinctions were still being made between the 'deserving' and the 'undeserving' poor, with the personal morality of the individual often being blamed for the existence of poverty, this decade witnessed the beginning of a more realistic approach to poverty (Ferriter, p. 397). Following the depression and the Second World War which had a significant impact on the economy of Europe, in Ireland, there was renewed optimism. The political agenda started to shift in the 1940s from Irish Civil War politics, which had dominated politics, to focus on domestic and social issues, in particular issues like employment, health and housing came to the fore. The office of Minister for Health was created as a separate "Minister of the Government" by the 1946 Ministers and Secretaries (Amendment) Act; (Ministers and Secretaries (Amendment) Act, 1946) This act also created the Minister for Social Welfare. Problems such as high infant mortality rates of almost eighty per thousand at one stage (Barrington, 1987) and high mortality rates of mothers particularly in the country areas with no dedicated maternity hospitals, led to an increase in support for health reform.

In 1948 Dr Noel Browne, who led on the screening and management of tuberculosis (Garvin, 2005, Ferriter, 2005) attempted to set up a comprehensive, free medical care system for women and children. Significant opposition to this development came from the Irish Medical Association and the Archbishop of Dublin, John Charles McQuaid, and it was ultimately resolved in favour of the bishops. While fear of clerical ire permanently weakened the determination of many older political leaders to forge ahead with creative policies such as health education and social welfare, this issue did profound long term damage to the Catholic Church's standing with the new emerging Catholic middle class in Irish society. (Garvin, 2005, Ferriter, 2005).

Concern about Ireland's economic sluggishness continued into the late 1940s, and continued to be voiced during the 1950s (Garvin, 2005). Garvin maintains that this sluggishness went hand in hand with a political paralysis in the face of lobbies headed by the Catholic Church, the farmers, the unions, noisy cultural ideologies and professional bodies such as the Irish Medical Organisation, a lobby whose power had been highlighted by the mother and child crisis.

Ireland in 1960 was still a very poor country, even by the standards of some communist countries of the time (Garvin, 2005). The Irish economy continued an inward focused approach, with the industrial policies adopted concentrating on the imposition of trade barriers and the preservation of ownership of industry at national level. The industrial workforce, less than one-tenth of the workforce in 1922, was only about 15 per cent in 1961. In the 1970s the economy became clearly non agrarian for the first time and the task of governing an increasingly urban country began. Ireland by 1980 had 30% of the population working in industry, modern Ireland had arrived (Garvin, 2005, p.250). Michael Viney writing in the Irish Times (1966) highlighted the social developments of the 1960s and while there was economic success (not very high by European standards (Ferriter, 2005)), it was certainly the case that national poverty no longer sufficed as an excuse for social neglect (Viney,1966).

2.5.3 Education

The School Attendance Act of 1926 required every child to attend school from 6years to 14 years of age. Sanction for noncompliance ranged from visits to formal warning to fines on parents and ultimately committal to industrial schools where children could be detained up to the age of sixteen years (Fahey, 1992, p.379). The dependence of juvenile labour in agriculture highlighted by Kennedy & Power (2010, p. 126) determined the compulsory leaving age of school in Ireland to remain at fourteen until it was changed in 1972 to sixteen years of age. However, the requirement of the small farm household economy potentially conflicted with the education requirements of the Irish Free State at that time. Fahey (1992) maintained that factors other than these economic requirements may also have resulted in poor school attendance including lack of transport to get to and from school, widespread use of corporal punishment, along with doubtful education value. Corporal punishment was permitted and was common as a general device to be used (illegally) for the social control of minors Education was top-down and authoritarian;

memory work and grammar favoured over encouragement of initiative and conversational skills (Garvin, 2005)

Rafferty & O'Sullivan (1999) states that by the 1900s, a massive seventy-one schools in Ireland were detaining children. Daly (1973, p170) states that this number peaked in 1946 with a total of 6,800 being incarcerated to 4,300 in 1960 and 1,740 by 1970. Rafferty & O'Sullivan (1999, p.l64) quoted PJ Murray, the first Inspector of Reformatory Schools in Ireland, as stating that Irish reformatory schools were designed for the children of the poor who were perceived as a threat to the social order, and in particular to young girls.

2.5.4 The Catholic Church

The post independent struggle to restore Ireland to a state of peace was one which witnessed the increasing influence of the Catholic Church in areas of social policy such as education and health (Barrington 1987). The character of modern Ireland after partition has long been the subject of debate, John Whyte (1980) referred to this transition process by what he called the 'Catholic moral code' that became enshrined in the 'law of the state'. This summarised the 'remarkable consensus' which was achieved in the years 1923-37, a time when there was 'overwhelming agreement that traditional Catholic values should be maintained, if necessary by legislation (Whyte, 1980),

In the immediate post-independence period, the then head of the Irish government considered giving the Vatican the power of veto over legislation contrary to faith and morals in return for papal recognition of the new state (Cooney1999). John Charles McQuaid, later to be appointed Catholic Archbishop of Dublin in part at De Valera's behest, had a significant input into the social and familial ideological features of Irish life and subsequently in the 1937 Constitution (Garvin, 2005). As catholicization of the Free State proceeded, the Roman Catholic hierarchy became influential in prompting the government to introduce legislation aimed at preserving the moral character of the citizens of Ireland. A censorship law on films was approved in 1923;

however, additional laws curtailing the consumption of strong alcoholic drink were passed in 1924 and 1927 at the prompting of the bishops (Sheridan, 2006).

In 1927, at the synod of Maynooth, the bishops complained about dance halls, bad books and indecent papers, and motion pictures and immodest fashion in female dress (Cooney 1999). Ultimately, a Censorship of Publications Act was passed in 1929 in response to the synod. Female sexuality was considered particularly problematic and in need of strict surveillance and control. Women who strayed for the narrow path of approved behavior risked incarceration, the arbitrary judgement of a parish priest on a women's moral status was all that was needed for her to be locked away in an asylum (Titley, 2007). According to O'Sullivan & O'Donnell (2012, p266) men of the cloth were the arbiters of sexual decency, and when their theological formation saw sexuality as deviant unless explicitly procreative and within the bound of marriage, this bred intolerance and severity.

A committee was established by the Minister for Justice in 1930 under the chairmanship of William Carrigan to consider various sexual offences and the possibilities of new legislation, in the wake of anxieties expressed by Ireland's governing elites concerning matters of sexual behavior. Finnane (2001) maintains its terms of reference were ambiguous enough to lead it down the path of an extended inquiry into the moral order of a new and independent state. The laws enacted following this report, according to Smith (2004, p.221) 'disembodied sexual practice by obscuring social realities, especially illegitimacy, in discursive abstractions which concealed sexual crime (especially rape, infanticide, and abuse) while simultaneously sexualizing the women and children unfortunate enough to fall victim to society's moral proscriptions'. Smith maintains that the Carrigan Report (1931) , served to sanitize state policy with respect to institutional provision. According to Luddy (2011) it was evident from the late 19th century that asylums were used by Catholic parents to hide the 'shame' visited on their families by wayward or pregnant daughters.The use of institutions to address what was perceived as socially objectionable issues at that time is a finding in this study and is discussed further in Chapter four and five of this study.

Accordingly, one part of the legislation introduced by the Free State Government was the Criminal Law Amendments Act (1935). The act is remembered principally for its suppression of brothels and prostitution, the inclusion of a ban on contraceptives, raising the age of consent in carnal knowledge, the age of consent to sexual intercourse and included a public indecency provision which aimed to protect the 'morals of the community' (Finnane, 2001, p.521)..

According to Finnane (2001, p. 536) the 1935 act was a statute which confused serious crimes with much less harmful sexual practices, and had as its companion piece another statute (the Public Dance Halls Act) that attacked a modernising popular culture. These he maintains were the outgrowth of a political culture that placed a high emphasis on the appearance of things, sweeping aside a more open attention to the conditions of a changing world in which independent Ireland found itself. That culture was increasingly authoritarian in its approach to the ordering of the nation; and a preference for autarchy in not only economic but cultural affairs emerged as the dominant mode of the de Valera years. Finnane (2001) maintains that the Garda as part of these post-independence structures also played a central role in the shaping of a Catholic social order and consolidating the moral authority of the Catholic Church

In relation to nursing, influential Roman Catholic clergy who ensured adherence to Vatican policy acted as advisors to government in all state matters. Nurses were at the forefront of health services and as such were seen to be the front line in defending Catholic values, particularly those relating to traditional family values and to sexual relationships (Robins 2000). To consolidate the influence of the Roman Catholic Church's teachings within nursing, the church hierarchy was influential in determining both the content of the ethics syllabus and the teaching of ethics a situation which prevailed until 1985 (Robins 2000).

Likewise, the influence of the Catholic hierarchy and its antipathy to communism and socialism extended to areas such as behaviourism and psychoanalysis. This antipathy was important in influencing both the nature and pace of change within psychiatry in Ireland. The Roman Catholic Church worldwide was hostile to dynamic

psychologies, with the proscription on hypnosis remaining in place until 1955 (Healy 1996). In the Netherlands, the Catholic community viewed therapy as a threat to Roman ethics and during the 1950s psychotherapy and psychoanalysis became the main areas of conflict between clergy and conservative doctors on the one hand and psychiatrists and psychologists on the other (Oosterhuis 2005). The rejection of dynamic psychologies by the Roman Catholic Church was associated with the focus of therapy on self-directedness, autonomy and self-regulation vis-à-vis sexuality in particular; a position at variance with the church's teaching on obedience and adherence to rules. Thus, Ireland's position as a devoutly Catholic country, and the dominance of the Roman Catholic Church in all state matters continued to militate against the introduction of a range of therapies in Ireland which were becoming accepted practice elsewhere. In Ireland, academic psychiatry did not emerge until 1971 (Sheridan 2006).

Kelly (2016, p108) a Consultant Psychiatrist and historian on the other hand in his publication: Hearing Voices – the History of Psychiatry in Ireland, refers in particular to the limited role played by the Roman Catholic Church. His reference refers to the provision, development and governance of services concluding that the Roman Catholic Church is notable by its general absence from the history of the systematic provision of psychiatric services in Ireland (p109). He states that the field of mental health was not dominated by the church and for many decades their only role lay chiefly in the provision of chaplains to the state run asylums that emerged in the 1800s and early 1900s. Kelly does not refer to the influence of the church on medical ethics and the clinical practice of doctors in psychiatry While Kelly (2015, p170) does acknowledge the Church's influence on the delay in the introduction of psychoanalysis and its potential for options in treatment regimens and its potential to patient recovery, discharge and the modernisation of mental health services, he also contributes this omission in treatments available to patients to the absence of a medical lead at that time in Ireland.

The socio- cultural influences on mental illness and its causes in the mid-1900s have received scant attention in the history of psychiatry. This may have been because the governance of asylums was historically committed to a medical patriarchy which

embraced psychiatry as an exclusive biomedical approach and the driving force in the diagnosis and treatment of psychopathology and/or that there was not a willingness for flexibility within this biomedical model to facilitate other options and treatment approaches. .

By reviewing our social history, it is reasonable to focus and gain insights into the psychological impact of these sociological issues and how individuals coped; the high importance rural families placed on land and inheriting property, the impact of disinheritance, unemployment, poverty, neglect and all types of abuse. including sexual abuse. The prominence of the socio cultural and religious beliefs and teaching of the catholic church; how families from a variety of social backgrounds coped with members exhibiting socially unacceptable behaviours, homosexuality and women who had babies out of wedlock, with society's judgements and the overwhelming consequences for every member of the family. As Helman (1981, p.182) describes: 'in understanding why a particular individual gets a particular disease, at a particular time, a much wider range of factors (genetic, physical, socio-cultural and psychological) must be taken into account, as well as the interrelationships between them. This multifactorial explanation of ill health is often more useful than postulating a simple cause-effect relationship between one risk factor and one type of disease.

There is a significant relevance of the sociology in this study to the practice of psychiatric nursing in particular. The social context in which this study was carried out can provide an understanding of social influences on the health and illness of individuals and groups. However, the nurses ethical responsibility is to provide quality person centred care, to do so nurses need to develop a relationship with the patient to allow for an understanding of the individual's socio cultural beliefs and practices, in their clinical decision making processes. Sociology can offer a deeper understanding about the consumers of care and the environmental factors associated with both the patient, their illness and nursing care (Pinikahana, 2003).

Social history with focuses on the history of societal groups and the cultural behaviour and expressions of the population offers an understanding of relevant information about life events, social class, religion, and occupations and provides a backdrop to the findings in this nursing study.

2.6. Historical Treatment Approaches in Asylums

Throughout the 19th century ‘moral management’ was employed in most Irish asylums (Malcolm, 1989). Moral treatment was the cornerstone of mental health care in the late 1800s in Europe. The idea it rested on was humane but paternalistic: moral treatment’s advocates believed that an asylum patient had a better chance of recovery if treated like a child and not an animal. The use of restraint jackets, dresses laced from behind, gloves and padded cells for hyper mania and difficult behaviour was to reduce aggressive behaviour. Moral treatment was introduced by Quaker asylum director William Tuke (1732 – 1822) at the end of the 1700s/early 1800s. Moral treatment rejected orthodox medical treatments used in asylums of the time which mostly involved blood-letting, purging using emetics and purgatives and physical restraints such as chains and manacles. William Tuke’s revolutionary ideas in York asylum were to make his asylum a strict, well-run household (Kabria & Metcalfe, 2014). He aimed to provide care for the mentally ill in a humane and nurturing setting and patients were allowed to access the grounds, housed in comfortable settings and generally treated with sympathy (Edginton, 1997). Regulation of diet along with regular exercise and gainful occupation was also part of this approach. Sanity was to be restored through self-discipline. Described as the ‘Period of Humane Reform’, his work coincided with the emergence of similar approaches in France, most famously by Philippe Pinel (1745–1826). It was Pinel’s sympathetic writings about the mentally ill, portraying them as unfortunate persons deserving of respect and sympathy that likely had the greatest impact on public perceptions of the mentally ill in France and other parts of Europe (Weiner, 1992).

In the 1800s, moral treatment and medical treatment came together. However, critics (Charland 2007; Borthwick, Holman & Kennard 2001; Vatne & Holmes 2006) argued

that moral treatment did not cure patients. They maintained it made patients dependent on the doctor and the asylum. The practice of moral treatment also relied heavily on the quality of the attendants particularly as numbers in the asylums increased (Bonwich, 1995) Later in the 20th century historians argued moral treatment replaced the actual chains of early asylums with invisible chains, making them even harder to escape from.

In the 1800s while bloodletting, purging and chains were used to treat patients subsequently followed by moral management, new 'medical treatments' were being introduced in the mid-1900s in Irish asylums: Insulin therapy, malaria fits inducement (achieved from the bite of a mosquito generally brought from a mental hospital in England) (Walsh, 2012) Electro Convulsive Therapy (ECT) devised in 1938 (administered to upwards of sixty patients trice weekly in Grangegorman in the 1960's) psychosurgery (introduced in 1946 in Grangegorman) and chemotherapy in the late 1950s. These developments had a significant impact on the care of patients in asylums as well as the role of the psychiatric nurse. It is impossible to say with any degree of precision how many psychiatric patients were mutilated as a result of psychosurgery, traumatised by ECT, or suffered other iatrogenic complaints, but we do know that large numbers (around 11,000 each decade during the 1930s, 1940s and 1950s) did not make it out alive and a significant fraction of those who were discharged were unchanged, from a mental health perspective at least ((O'Donnell & O'Sullivan, 2012). The search for effective medical treatments in psychiatry began in earnest in the 1960's (Walsh, 2012).

Baruch and Treacher (1978, p 50) in reviewing insulin coma therapy, psychosurgery, ECT and drug therapies, contend that there was a general failure even to conduct the simplest of trials to confirm their usefulness. According to Dermot Walsh cited in Prior (2012, p92) an Inspector of Mental Hospitals, these new treatments were based on doubtful evidence and given indiscriminately without clear indication for suitability in particular cases. Baruch & Teacher also argue that the alacrity with which psychiatrists welcomed new drugs and treatments has been equalled only by their uncritical acceptance of the claims of drug companies and their lack of rigour in observing the side effects of drugs. According to Nolan (1993) they were

administered by staff who were very unsure about what they were doing, however he maintained for psychiatrists to have a drug that would cure mental disease in the same way as doctors in other disciplines had, was immensely attractive to those psychiatrists who felt that their scientific credibility would thereby be enhanced. However one dissenting voice, that of Aubrey Lewis, addressing the first International Conference on Neuropsychopharmacology in 1958, emphasized that non-interventionist approaches to care, such as ward activity programmes and occupational therapy could produce results comparable to those of Chlorpromazine. Clark (1964, p 32) writing in the UK, stated that these treatments had very little evaluation and that both medical and nursing staff were ill informed of their supposed advantages let alone possible hazards. He maintained clinical staff had to live with ambiguity at that time, claiming that clinicians lived with the reality that care for such patients was not therapy but custody, which involved strait jackets, padded cells and force feeding. This he believed impacted on nurses' professional belief of themselves as a carer and healer.

2.7. The History of Nursing

In the UK, Florence Nightingale, known as the founder of modern nursing, transformed the world of nursing through her work in the later Victorian period of the 19th century. In her classic: Notes on Nursing: What it is and what it is not (Nightingale, 1859, p16), she speaks of nursing as a reparative process of nature through the proper use of fresh air, light, warmth, cleanliness, quiet and the proper selection and administration of diet. She describes nursing as the care that puts the patient in the best possible condition for nature to act. Nightingale refers to 'the faculty of observation'. Thus she maintained it was through controlling the environment, providing a wide range of personal services, careful observation and taking charge, that the nurse aids the reparative process of nature.

In the UK, the Society of Medical Officers for the Insane founded in 1841 changed its name in 1865 to the Medico-Psychological Association (MPA) (Journal of Mental Science, 1896) (https://www.rcpsych.ac.uk/about-us/library-and-archives/our-

history/the-mpa) The MPA represented the views of asylum superintendents of Great Britain and Ireland, and provided a medium through which knowledge and ideas about insanity could be shared. Walk (1965, p1-18) as President of the Medico Psychological Association presenting his inaugural speech choose the theme of the history of mental nursing for his presentation. He did so in an attempt 'to place on record something of the history of mental nursing' and to initiate '*a full-scale discussion on the training of the psychiatric team*'. Walk acknowledged; '*the almost complete neglect of mental nursing in the current histories, whether of nursing or of psychiatry; there is no reference at all in Anne Austin's otherwise excellent History of Nursing Source Book; Jensen's recent History of the Nursing Profession also ignores mental nursing*'. Walk noted that this disregard and lack of interest in mental nursing was shared by Florence Nightingale; '*Florence Nightingale took no interest in the training of mental nurses, especially as in her published works and her letters she repeatedly stressed the psychological aspects of nursing in general. She took a prominent part in breaking up the all-purpose workhouse infirmaries in London and she also promoted the use of trained nurses in the reformed infirmaries, but it does not seem to have occurred to her that the mentally ill and defective patients removed under the 1867 Act to the new institutions provided by the Metropolitan Asylums Board were equally in need of skilled nursing care'*.

The MPA attempted to establish a programme of education and training for attendants of asylums. At its annual conference in 1875, a paper presented by Dr. Stewart recommended increasing the number of ''intelligent nurses in asylums' and discussed the possibility of establishing a formal system of training for asylum nurses (Walk 1965). Stewart (1876) further identified the absence of an adequately trained staff within the asylum system as one of the primary causes of the lack of advancement of psychological medicine in Ireland. However, it was not until 1889 that a special committee of the MPA was formed to examine the issue. The committee was of the view that, once established, training should be of "'the highest possible standard but not so exacting as to deter attendants from formally entering it; [and] be of 2 years' years" duration with practical instruction provided by matron/head attendant' (Henry 1989, p55). This committee identified the need for systematic training of asylum attendants; the granting of certificates following

examination of proficiency in nursing, and the keeping of an efficient register of these nurses and attendants (Henry 1989). The first examinations leading to the award of the Certificate of Proficiency in Nursing and Attending on the Insane were held in 1892 (Sheridan 2005).

By the beginning of the 1900s in Ireland nursing had become established as a reputable and highly respected profession. Robins (2000) maintained that in the early 1900s, training schools for nurses had been established in all of the large general hospitals operated by religious orders. He maintained it was the voluntary sector rather than the state run institutions that was developing the quality and status of nursing and establishing the social standing of members of the profession of nursing. The development of outdoor nursing (later called district nursing) added to the social enhancement of the profession. Nurses who had trained in voluntary hospitals were selected mainly by Queen Victoria's Jubilee Institute for Nurses and the establishment of the Lady Dudley (the wife of the viceroy in Ireland) scheme and given additional training to nurses to work in the homes of the poor. This linkage with the Viceregal court ensured that the nursing associations were perceived as fashionable charities (Robins, 2000, p.12). In many areas the district nurses became a familiar and highly respected personality pedalling around on her bicycle.
Outside cities the public hospital services were almost entirely based on the poor law workhouses. According to Robins (2000) the poor laws stigmatised both the patients and their care staff. The staff in the workhouse wards and associated units were mainly untrained pauper assistants. Registered nurses only started to appear in the county institutions of the new Irish Free State.

The origins of psychiatric nursing first began to emerge in the first institutions charged with the provision of care to the insane poor in Ireland i.e. the asylums. As a distinct division of the nursing register, psychiatric nursing has been recognised in Ireland since the introduction of the Nurses Registration (Ireland) Act 1919. Initially the title was that of 'Mental Nurse' from the 1942 Mental Hospital Officers (General Trained Nurses) Order however, this was subsequently changed to 'Psychiatric Nurse' in the Mental Treatment Act of 1945 and remains so to date. Psychiatric nursing emerged form the first institutions charged with the provision of care to the

insane poor in Ireland. The profession of psychiatric nursing emerged from the training of staff that were responsible for day to day care of patients. According to Nolan (1993) and Finnane (1981) in order to understand the factors that determined the culture and issues associated with the emergence of the discipline of psychiatric nursing within Ireland it is necessary to appreciate the significant influence of its close association with psychiatry, the developments in social policy, economic policy and international law (Nolan, 1993; Finnane, 1981, Garvin, 2005, Prior, 2012, Walsh, 2016).

2.8. Policy Reports Pertaining to Psychiatric Nursing

The 1960 Mental Hospitals Officers (Tutors) Regulations Act provided for the appointment of nurse tutors in mental hospitals in Ireland. The subsequent report of the Commission of Inquiry on Mental Illness published in 1966 was the first policy report in Ireland to acknowledge the role and potential contribution of the nurse in the provision of health services in the asylums. In relation to nursing however, this report highlighted the serious shortcomings in the quality of nursing in the mental hospitals and it criticised the stewardship of An Bord Altranais in relation to psychiatric nursing. This report recommended a more forceful approach to education and the improvement of standards and education in nursing. It also recommended an intensification of its inspection system and the removal of training schools not achieving acceptable standards within a reasonable timeframe. It recommended recruitment criteria other than physical attributes and stated that nursing requires a high standard of general education, minimally an Intermediate Certificate (1966, p 116-120).

Further reports to influence Psychiatric nursing practice included the Report of the Working Party on Psychiatric Nursing Services of Health Boards (1972) established by the Dept of Health, which was set up ‘to examine and report on the psychiatric nursing services of health authorities and to make recommendations in regard to change and improvement considered necessary’ (p.5). This report provided a strategy and framework for psychiatric nursing service development and was

significant in determining the future of psychiatric nursing. It is the only Irish Government report to classify the functions of the Psychiatric nurse. It also made recommendations in relation to professional nursing development as well as organizational aspects of psychiatric nursing including recruitment, selection, training and education of both pre and post registered nurses.

The report's recommendations in relation to integration of staff and patients, changing the staffing and promotional structure as well as the concept of multi-disciplines had a profound impact on the way nursing services later evolved. From the 1970s onwards the change in psychiatric nursing was gradual, but fundamental, as the policy in mental health became focused on the rehabilitation of long stay patients and on the development of services within the community for individual with mental health difficulties (Robins, 2000). The later report, Planning for the Future (1984), reproduced many of the core features of the social policy recommendations made in the earlier in the report of the Commission of Inquiry (1966). It identified that most hospitals provided domiciliary consultation on request, but in general, the number of such consultations is very small. The report recommended a service development strategy: the setting up of a comprehensive community mental health service and the scaling down and closure of the mental asylum institutions. This report impacted, albeit obliquely, more directly on nursing practice with the introduction of community care and its resultant process of de-institutionalisation. This new development dramatically altered the psychiatric landscape including the role, function and scope of practice of the psychiatric nurse and the approaches to treat patients, although this development was particularly slow relative to other countries in Europe to implement the recommendations.

"A Vision for Change" (Department of Health and Children, 2006) also had some influence on service development and role development for nurses. This document details a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible community based specialist services for people with mental illness. It asserts "mental health recovery" as "the cornerstone" (p. 15) of mental health service delivery and "recovery" is mentioned

115 times in the document. Psychiatric nursing is mentioned 20 times largely in the context of staffing numbers for particular kinds of services, but it is clear that this policy clearly directs a change in emphasis from institutions, bed numbers and healthcare facilities toward individual care, service values and outcomes. This policy along with other documents (Mental Health Commission, 2005) repeatedly asserts that recovery requires different kinds of relationships between helpers and those seeking help and that such relationships have not always been available.

According to Sheridan (2006) the changes in psychiatric services and psychiatric nursing taking place in Western Europe and the United States began to impact on psychiatric practice in Ireland during the decade of the 1970s. This move away from the predominantly ‘introspective’ nature of Irish society, psychiatry, and psychiatric nursing, was inextricably linked to and facilitated by Ireland's accession to the European Economic Community (EEC) in 1973. For Ireland, she maintains, that accession to the EEC brought with it the commitment of the Irish government to bring its policies in line with those already established within the community of Europe; this necessitated far-reaching changes in existing social, health and employment legislation.

2.9. Psychiatric Nursing

2.9.1. The profession of Psychiatric Nursing

The General Rules for the Governance of all the District lunatic Asylums in Ireland 1843 (Inspectors General 1844) cited by Brennan (2014, p.74) set out the duties for ‘Nurses’ referring to female staff, and ‘Keepers’, referring to male staff who had similar responsibilities. They were directly responsible to the Resident Medical Superintendent and observed the habits of cleanliness, order, and subordination (p. 16). As the medical superintendent decided what the role of nurse should be, this close link and control by medics has influenced the history of nursing and its autonomy as a profession. Mitchell (1984) argues that there is a connection between

the supremacy of the medical model and the relegation of nursing to a low status occupation in asylums. He maintains that to ‘cure’ was the all-important goal in psychiatry, ‘caring’ became a mere adjunct to this activity. Caring, he maintained did not require professional expertise. One could be cared by anyone, family or friend; it was about looking after people on the way to being ‘cured’ or who were unfortunately incurable.

Very few staff who worked within these institutions wrote of their experiences and the roles nurses played within these institutions at that time. O’Sullivan & O’Donnell (2012) find that the silence of these staff then and now difficult is difficult to fathom. However, two nurses did carry out a historical review of nursing within their respective countries; Peter Nolan (1993) in the UK and Geertje Bochma (2003) in Holland.Nolan (1993) maintains that this close alignment of nursing to the practice of psychiatry has caused nursing to suffer from similar frequent therapeutic shifts which have taken place within the discipline of psychiatry over the decades. He maintains in its 19th century manifestation, psychiatry founded itself upon a medical model, attributing all mental illness to errors of biology, in the early 20th century, it was diverted from this model by practitioners in the newly emerging field of psychology who took it first in the direction of psychoanalysis and then towards behaviourism. Latterly, psychosocial models favour the reskilling and empowering of patients to live their own lives. Nursing got caught up in the changing fashions of theory and practice, and have experienced confusion about their own role. This uncertainty, he believes is reflected in the different names which nurses have been called over the decades. Nolan (1993) refers to the terms used to refer to these staff charged with the care of patients in these institutions and have changed from ‘keeper’, ‘servant’, ‘attendant’, ‘nurse’, ‘asylum nurse’’, ‘mental nurse’ and ‘psychiatric nurse’.

In analysing the social relationships of class, gender and religion that structured asylum care in the Netherlands around 1900.Bochma (2003, pg 15) outlines a similar trajectory for mental healthcare and nursing. Bochma (2003, pg. 15) maintains asylum management was characterized by paternalism and hierarchical subordination. Care of the mentally ill was part of the nineteenth-century poor relief system. Nursing emerging from the role of attendants to a distinct occupational field

of nursing in the late 19th century. Based on a new understanding of mental illness and new forms of treatments, Dutch asylum psychiatrists legitimised and initiated the role of a trained nurse to refine and improve psychiatric care. Unlike Ireland, their aim of establishing a nursing staff in the asylums created new opportunities for women. They perceived that women would facilitate the instilling of class-based values such as discipline, punctuality, and obedience to the profession and to services.. While at the same time restricting the role of men in nursing, these attempts she states were to create a disciplined and respectable workforce. The architects of this system considered a humanitarian, refined attitude to be a characteristic not only of gender but also of class.

Some reasons for why nurses did not write of their experiences and the role nurses played within these institutions in Ireland at that time will be presented in the findings and discussion chapters of this work.

2.9.2 Defining the role of the Psychiatric Nurse

Psychiatric nursing is difficult to define and understand as it requires patterns of care with focus on psychological, spiritual and social wellbeing as well as a physical aspect of care (Cowman, 1997). Psychiatry's limited availability of objective biological tests and diagnostic guidelines, alongside the intercultural differences in the mental health experiences of individuals and social determinants makes it difficult to quantify. The delivery of nursing care entails the involvement of interpersonal and communication skills which are also difficult to quantify

The 1885 General Rules for the Government of District lunatic Asylums in Ireland (Lord Lieutenant and Council of Ireland 1885) cited by Brennan (2014) does not set out the duties of nurse and keepers but does so for 'Attendants and Servants': "They are to be present when the patients are at meals. They shall pay particular attention to the clothing and becoming appearance of the patients. They shall, in their communications with the Medical Officer and Matron, state all the circumstances relating to each patient within their knowledge, and study, as much as possible the

character and peculiarities of the different lunatics under their charge'" (Lord Lieutenant and Council of Ireland 1885, p16)

The asylum rules placed a large cohort of staff under the direct control of the Medical Superintendent. According to MacGabhann (2014, p.30) the nurse's role was to assist doctors in their work, principally by looking after the patients' physical body, being a mediator between patient and doctor and ensuring a safe environment. Everything about their role was either dictated or provided by the discipline of medicine via training as a prescribed ritual. MacGabhann goes on to state that nurses neither controlled their own work nor set their own terms of reference. The average number of work hours per week was 82 ½ for a day shift and 75 hours for the night shift (Fuller Torrey & Miller 2007, pg137). In one asylum it was claimed in a petition that one day's duty could run to sixteen hours. According to Fuller Torrey & Miller (, p137) 'merely keeping count of the increasing numbers of patients strained the system. At the Richmond Asylum, some patients still on the hospital register were probably dead because they 'could not be found''. With the extreme overcrowding and understaffing violence on the wards was inevitable. By the late 19th century, in 1896, it was reported that there were over 700 staff employed in asylums in Ireland (Journal of Mental Science, 1896, p467). The number of patients in the Grangegorman hospital in 1914 was 3,240 and in 1925 the total was 3,413. The number of nurses and attendants increased from 331 in 1914 to 454 in 1925 (Weekly Irish Times, 29th Nov., 1930).

Historically Finnane (1981), Malcolm (1989, 2003), Robins (1992) and Prior (2012) all refer to attendants and psychiatric nurses and they also highlight the challenges they encountered within the asylum system since the 19th century, such as lack of training, poor working conditions, low wages, overcrowding, their lack of authority and voice within the institution (McCabe & Mullholland, 2017). Walsh (2017) however, on the other hand, maintained that nurses exercised a tremendous authority over patients at practical levels, she stated that despite them occupying a somewhat ambiguous professional position, in that they were relatively poorly paid and poorly educated (Sweeney, 2011) she states it is likely that if asked who held the reins of power, many patients would unhesitatingly have pointed to this group,

She acknowledged that this group had limited opportunity however, to alter the manner in which the asylum functioned.

Kelly (2016) and Brennan (2014) along with McCabe & Mulholland's (2012) historical research capture how attendants and nurses became organised within the workplace. The first such event entailed a 'revolt against the authority of the local Joint Committee and the Resident Medical Superintendent' in the Monaghan asylum (p37) in 1919 to form a trade union and find voice. Further examples of this collective voice appeared in strikes in Clonmel in 1921 and in Letterkenny in 1924. This development influenced improved pay and conditions and led to a national bargaining structure for all asylum nurses along with equality and equal pay for women. It led to a reduction in the working hours from over seventy hours per week to fifty-six. This reduction in the working week meant that a larger amount of staff was required to keep Irish mental hospitals operating twenty-four hours a day, every day of the year. They also negotiated that all staff should attain the MPA certificate of proficiency as a condition of permanent employment. This was the only reference to how nurses achieved a voice and was heard within the institution.

In Ireland the role of the psychiatric nurse was described as a series of tasks: getting patients up each morning, ensuring the ward is in proper order, ensuring patients are clean, serving food at meal times and reporting to and carrying out the instructions of the medical superintendent – as 'doctors handmaidens'. The key role of the nurse was imparting skills to assist patients in contributing to the upkeep of the asylum or to gain employment. Many psychiatric nurses tended to come from rural areas in Ireland, many with agricultural backgrounds and could converse with patients in English or Irish (Nolan and Sheridan, 2001) MacGabhann, 2014, Brennan 2014). Nolan (1993) maintained in the UK three types of people were representative of mental nurses; those with the ability to control, those who controlled through fear and lastly the compassionate and caring sort

However there is very little known or written on how nurses interacted with patients and carried out nursing along with their therapeutic role, if they had one? This area is under researched and almost absent within the historical writings.

Bochma (2003, pg. 115) refers to the 'invisible role of nurses'. She states that nurses were most intimately involved with patients but left almost no evidence of their work behind. Psychiatric nurses responded to the dependency of patients created by their mental illness, but she states they know little about how nurses managed. Competent nursing facilitated the introduction of a medical regimen, characterized by cleanliness and order. It built on the disciplinary system of close supervision and inspection already introduced in the era of moral treatment (Bochma, 2003, pg.118).

Medical treatments and regimes, developed and introduced in the mid-1900s in Irish asylums: insulin therapy, malaria therapy, ECT, psychosurgery and chemotherapy, influenced the role of the nurse. In 1952, the introduction of the neuroleptics changed the face of psychiatry and had a major impact on nursing practice. Largactil was a major tranquilliser announced that year in 1952. Initial clinical trials supported that this drug was effective in controlling psychotic excitement (Anton-Stephens, 1954; Charatan, 1954). Hunter (1956) expressed concern that chemotherapy and physical treatment for psychiatric patients would diminish the mental nursing profession. He questioned whether nurses were becoming mere dispensers of medicines and assistants to doctors in the administration of treatments.

The major tranquillisers were followed by minor tranquillisers and then by anti-depressants Pharmacological intervention were seen as the panacea for addressing mental illness, remaining to this day the bedrock of psychiatric treatment and a continued preoccupation of psychiatric nursing discourse (Lakeman and Cutcliff, 2016). According to Hensey (1988) while some treatments were becoming available for patients in asylums, these years seen saw no change in the system of care for patients. Nevertheless, he maintains the nomenclature associated with insanity and the insane began to change; gradually asylums became hospitals, insanity became mental illness and lunatics became patients

A number of studies were carried out in the mid to late 1900s in the UK looking at the nature and status of Psychiatric nursing with Hunter (1956), John (1961), Altshul 1972 and Towell 1975 all examining the role of the psychiatric nurse and concluded that psychiatric nursing encompassed a cluster of roles and tasks which varied depending on the practice setting, resources, staffing and skill mix.

Hildegard Peplau, known as the "mother of psychiatric nursing, was a true pioneer in the development of the theory and practice of psychiatric nursing, she created psychiatric nursing theory of interpersonal relations (1952). She defined psychiatric nursing for the American Nurses Association (ANA) (1980, pg.9) by making a clear distinction between medicine and nursing: 'Nursing is the diagnosis and treatment of human responses to actual or potential health problems'. She believed the nurse's primary responsibility was to nurture and aid patients in their personal development through nursing services; helping guide patients in the direction of understanding and resolving their human dilemmas. In this publication she refers to the psychodynamic theory of psychiatric nursing and defines it as "being able to understand one's own behaviour, to help others to identify felt difficulties and to apply principles of human relations to the problems that arise at all levels of experience" (Peplan, 1952/1991 (p.9). More simply, she wanted talking with patients legitimated.

McKenna (1994) described psychiatric nursing as a mental or diagrammatic representation of care, which is systematically constructed, and which assists practitioners in organising their thinking about what they do, and in the transfer of their thinking into practice for the benefit of the patient and the profession. Barker (2009, pg.4) on the other hand in Psychiatric and Mental Health Nursing – the craft of caring' attempted to clarify the concept of psychiatric nursing and what it involved in practice. They asked academic and clinical nurses from a variety of different countries *what is psychiatric and mental health nursing and how do nurses do nursing?.* Few of the nurses in this study referred to caring or care except in very general terms like 'nurses give nursing care'. Barker (2009, pg4) refers to one respondent who divided nursing into two distinct camps:

1) A subservient discipline and an extension of psychiatry's social control mechanisms, for the policing containment and correction of already

marginalised people, which carried out a number of defensive, custodial, uncritical and often iatrogenic practices and treatment, based on a false epistemology and misrepresentation of what are, by and large human problems of being rather than some called ‘mental illnesses’.

2) A specialty craft that operates primarily by working alongside people with mental health problems: helping individuals and their families find way of coping with the here and now (and past): helping people discover an ascribe individual meaning to their experiences; and exploring opportunities for recovery, reclamation and personal growth- all through the medium of the ‘therapeutic relationship’.

It is clear from Barker’s polarised definitions that nurses conflated the containment and custodial function of the asylum with how nurses did nursing. Nurses and many authors found it impossible to separate the professional role of the nurse from the governance and culture of the institution.

2.9.3. The Role of the Psychiatric Nurse

In Ireland the first research into the role of the psychiatric nurse and what nurses do on a daily basis with patients was carried out by Cowman, Farrelly, and Gilheaney (2001) concluded that an immediate challenge at that time was to determine the knowledge and skills required for independent therapeutic roles in psychiatric nursing. They assert that psychiatric nursing occupies a pivotal role in all mental health care settings but suggest that “new visions of psychiatric nursing” (p. 752) must be built, alluding to changes in the way mental health services are evolving.

Those new visions for the future of psychiatric nursing were later articulated in the first nursing strategy document published within the HSE for psychiatric nurses in Ireland, ‘A Vision for Psychiatric/Mental Health Nursing – a shared journey for Mental Health care in Ireland’ (Cusack & Killoury 2012). This strategy was a collaborative

endeavour between large numbers of stakeholders. This report is the first nursing report nationally to call for a review the title of registered ‘psychiatric’ nurse to reflect the ‘health’ role related to the spectrum of mental health care delivered by nurses within contempory mental health services.

From an extensive consultation, this report also indicated a drive to break with the dependent relationship nursing has inherited with psychiatry/medicine and to carve a niche of its own in a more holistic, recovery orientated and person centred way. It also highlighted the requirement to realign the health service structures and mental health legislation to enable a more equitable interdisciplinary approach to clinical decision making in the current model of mental health care services in Ireland.

NMBI (2011) defines the role of the Psychiatric Nurse, as one of support for the individual to achieve recovery and optimum mental health and to promote excellence in psychiatric nursing.

2.9.4 Perceptions of psychiatric nurses

The silence surrounding the role of the nurse in the asylum and the impact of their practice not only relates to the nurses who provided the service but also to the experiences of patients who were the beneficiaries of nursing services within the institutions. This reticence may be as a result of the marginalised nature of the patients in question and the stigma associated with their ‘sins’ or ‘crimes’ or ‘afflictions’, public disbelief at their stories, low levels of literacy, a scarcity of publishing outlets and high rates of emigration (O’Sullivan & O’Donnell, 2012). From a staff’s perspective, their silence then and since, evidenced in this study is more difficult to fathom. Very few insider accounts exist of life within the asylum system and unlike other containment institutions in Ireland, very few have come forward to tell their story of their experience as a patient.

One insider's account recalled in 'It Happened in Ireland' (Duffy, 1944) cited by Kelly (2015) refers to a six month period of confinement that the author; the Reverend Clarence Duffy endured in Monaghan Mental Hospital. In his account Duffy describes the arrival of three Gardaí to his home in May 1937 accompanied by the local curate; he describes his transfer to the hospital following an examination by a local dispensary doctor in the local barracks. He recalls being placed in a dark, poorly ventilated cell with an unpleasant odour. He wrote that the treatment of patients was brutal and rough, describing an altercation with an attendant where he was placed in solitary confinement and threatened with an injection. Throughout this period Duffy described how he saw a doctor for around five minutes each day, he described the attendants who had the greatest influence on his day as untrained, poorly educated men who treated the patients like animals or slaves and, on occasion, beat them. Some of the attendants were more compassionate but while kind in manner and seemingly aware of the injustices endured by patients, even these attendants appeared to him to be powerless to remedy matters in the overall scheme of the asylum.

Hannah Greally (2008) a woman who spent over eighteen years confined to St Loman's asylum in Mullingar wrote of her experiences in her autobiographical story of those years 1943 – 1962. During those years she describes her incarceration, how she was moved to a number of locked areas, worked in a number of areas within the asylum and subsequently spent time in a rehabilitation unit. She describes how her treatments consisted of being confined to the 'big hole', in a padded cell, received insulin coma therapy and was administered ECT without anaesthetic. Within her memoirs, Hannah refers indirectly to the role of nurses who cared for her. In all of her years there within her references to nurses, one negative experience is articulated where one nurse spoke rudely to her on a regular basis. With the exception of that nurse, all other references refer to compassionate practice: 'her comforting presence, she walked slowly with me, talking- gentle words, comforting words'. (p81) she described how nurses assumed an advocacy role; 'Nurse Best was nice to me, in fact I am inclined to think that it was she who used here influence to have me reinstated again in Long Trench' (p108), how nurses demonstrated justice and integrity: 'Nurse Goodson the charge nurse was a very fair, efficient

person' (p108), she described how nurses guided her skill development and supported her confidence building towards her rehabilitation and ultimate discharge from the institution.

Both these patients were admitted to rural institutions, one in the late 1930s and the other in the early 1940s. Patients present very different accounts of their experience of their detention and in particular the relationship they had with nurses. It is notable that the patients experience differed by their gender and the gender of the nurses who cared for them. Because of the limitation of documented experiences from patients it is not possible to elicit if abuse was a symptom of workplace aggression or a cultural norm. This theme is further addressed in the findings and discussion chapter.

In another qualitative Irish study the views of thirty eight service users, who had been admitted to and lived in the mental institution and were rehabilitated and deinstitutionalised to community residences, were captured (Cusack, 1994). The span of years the respondents in that study had spent in the institution ranged from 4 years to 43 years, an average of 23 years. While the focus of the study related to the views of the patients on their transfer from the institution to the community, their responses denoted the extensive and wide ranging role adopted by nurses to meet their individual needs as they arose in this transition from the institution to community and their adjustment and integration within it. Nurses expanded their role to support this transition and integration, to provide a family atmosphere in their residence, to support and develop each individual's independence, freedom and personal autonomy. All of the respondents in this study reported their confidence in the nurses and how their contribution improved their quality of life.

Alexandra Walk President of the Medico-Psychological Association (MPA) from 1960 to 1961 paid tribute to mental nurses in his inaugural speech. While he views may not have been shared by the majority of his colleagues within the MPA, he used this opportunity to 'pay a tribute to our sister profession, a profession which has had to contend with many handicaps and many frustrations, but whose splendours far outshine its shortcomings' (Walk, 1960). He referred to mental nurses as 'our friends

and allies', and quoting Dr John Connolly, MPA, he stated 'they are the instruments through which every great and good purpose is brought into hourly practice'

2.9.5. The language of Psychiatric Nurse V Mental Health Nurse

Barker (2009, p. 5) make a distinction between psychiatric and mental health nursing. When nurses help people explore their distress in an attempt to discover ways of remedying or ameliorating it, they are practicing psychiatric nursing. When nurses help the same people explore ways of growing and developing, as persons, exploring how they presently live with and might move beyond, their problems of living, they are practicing mental health nursing. Emerging psychosocial approaches of providing care became an integral part of the role of the psychiatric nurse; the Stress Vulnerability model (Zubin and Spring, 1977) of mental illness located it in the lived experience of the individual and their level of vulnerability, as well as their level of resilience to cope with life's stresses. This psychosocial approach opened up greater opportunities to nurses to engage in therapeutic interventions central to service user engagement (Gamble and Brennan 2000).

The Australian College of Mental Health Nurses (ACMHN) define a mental health nurse in their standards of practice as a, "'A registered nurse who holds a recognised specialist qualification in mental health. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual" (Australian College of Mental Health Nurses (ACMHN), 2010, p.5). Lakeman (2012) states that the practice, theory, and preparation associated with nursing people with mental health issues has changed in profound ways in recent decades. This has in part been reflected by a shift in nurses identifying as being mental health rather than psychiatric nurses. He maintains that context, theory, and values shape what it means to be a mental health nurse. According to a study carried out with nurses, mental health nursing is defined as a professional, client-centred, goal-directed activity based on sound evidence, focused on the growth, development, and recovery of people with complex mental health needs. It involves

caring, empathic, insightful, and respectful nurses using interpersonal skills to draw upon and develop the personal resources of individuals and to facilitate change in partnership with the individual and in collaboration with friends, family, and the health care team. This, Lakeman states, appears to encapsulate the best of what it meant to be a psychiatric nurse, but challenges remain regarding how to reconcile or whether to discard coercive practices incompatible with mental health nursing.

Mental health care in Ireland entered the 21st century with the promise of and aspiration to a new discourse: 'recovery' (Higgins, McDaid, 2014). In 2005, prompted by the service user representative voice, the Mental Health Commission (MHC) in Ireland published a discussion paper titled 'A Recovery Model in Mental Health Services' (Mental Health Commission, 2005). An Expert Group was subsequently convened subsequently convened by the Dept. of Health, informed and published a new mental health policy: A Vision for Change: The report of the Expert group on Mental Health Policy (Govt. of Ireland, 2006). This is consistent with international trends of recovery becoming a core part of mental health policy in Ireland. This policy recognises that recovery does 'not necessarily imply cure' in the traditional sense of absence of symptoms and that 'it is more about the individual's ability to 'live a productive and meaningful life, despite vulnerabilities' (Gov. of Ireland. 2006 p 13). Higgins & McBennett (2007) identified the core principles of recovery relating to mental health as follows:

2.10 Recovery's Core principles

Figure 2.2 Recovery's core principles

Having optimism and hope about recovery	Believing in the person's capacity to recover and develop personal resourcefulness irrespective of medical diagnosis or symptoms. Developing hope inspiring relationships that acknowledge the common humanity of the practitioner, service user and family member.
Valuing the person's voice and personal meaning	Locating the person's own narrative explanation, fears, hopes and wishes at the heart of the therapeutic process.
Respecting personhood and uniqueness	Viewing he person as having rights to the same pleasures, passions and dreams as the rest of society and treating the person as an active participant in their own care with a right to self determination.
Mobilising the person's own resources	Developing a culture of partnership and respectful dialogue that emphasises strengths rather than deficits, pathology or symptoms.
Supporting partnerships between peer networks and mental health services.	Incorporating peer support and self help as an integral part of recovery journey as opposed to an optional extra.
Respecting expertise by experience	Involving people with self-experience in decision making at all levels, including service planning, development and evaluation of services.
Enabling meaningful participation and inclusion	Challenging wider social, economic and attitudinal barriers to social integration, such as stigma, access to education, housing, work and friendships.
Respecting and embracing multiple perspectives	Embracing social, psychological, biological and spiritual perspectives, including the persons's perspecitve.

(Higgins & McBennett, 2007)

2.11. Origin, Education and Professional Training for Psychiatric Nurses

2.11.1. In the 1800s

The asylum system was associated with the emergence of medical doctors showing interest in the clinical and legal aspects of the care of the insane. In the UK, there was huge growth of asylums following the enactment of the 1845 Lunacy Act, which necessitated the recruitment of large numbers of staff. These attendants received little or no formal training for their work. They were normally recruited from the working classes and then left to learn on the job, guided only by their colleagues and sometimes lengthy rule books (Sheehan 1998). While the asylums were established at the beginning of the 1800s, it wasn't until 1884 that a a sub-committee of the Medico Psychological Association was appointed to prepare a handbook in the hope of teaching attendants on the insane to a due understanding of the work in which they are engaged (Rollin, 1986). The Handbook for the instruction of attendants on the insane known as the 'Red book' was prepared and published in 1885 by the Royal MedicoPsychological Association (MPA). In the 1890s, the then medical superintendent of the Richmond Asylum (Grangegorman) insisted that attendants seeking promotion should pass an examination, but the Richmond Asylum was not typical and up to the end of the century there were few trained staff in the asylum system. Most of the medical superintendents appeared indifferent to the need for formal training of the attendant staff. In 1894 the Richmond Asylum instituted training, leading towards the examination for the certificate in mental nursing of the Medico-Psychological Association (MPA) (Reynolds, 1992). This early history of mental nursing is one that has only been partially researched (Chatterton, 2004). It is unclear the reasons why the MPA initiated training other than to respond to the increasing significance of the asylum system in dealing with an increasing population, and with the recognition that the job of 'caring' or being custodian of mentally disordered individuals required a level of training that needed to be provided

Examination of the registers of the Royal Medico-Psychological Association records the first registrations from staff in Irish hospitals in 1895. In that year a total of 27 registrations, 21 male and 6 females are recorded (Register of certificate of Proficiency in Nursing and Attending on the Insane 1895-1935). Of this 27, 13 males came from the Richmond Asylum in Dublin, with 8 males and 6 females from Limerick. In 1895 the number of Irish attendants successful in the examination of the MPA had risen to 98, representing 11 asylums (Sheridan 1999). 1896 also saw the beginning of a trend in which the number of women presenting for examination from Ireland outnumbered men, a trend that continues to present times. The number of nurses who undertook training in Ireland continued to increase, and by 1900, 334 nurses trained in Irish asylums had been awarded the certificate (Sheridan 1999). Nurses from Irish asylums continued to undertake the examination of the MPA and by 1914, within 20 years of its introduction, a total of 945 nurses from Irish asylums had successfully completed the examination, with women continuing to outnumber men (Medico-Psychological Association/Royal Medico-Psychological Association 1914). This ‘red book’ was used up until the 1920’s when the Royal MedicoPsychological Association (MPA) provided courses for training and issued certificates by participation in the training depended largely on the encouragement given by the Superintendents. It is notable however, that when Stephens a Consultant Psychiatrist was asked on behalf of the MPA to carry out a review of the ‘Red Book’, in an editorial article he stated:: "We are not quite sure ourselves whether it is necessary or wise to attempt to convey instructions in physiology, etc., to ordinary attendants. Will they be the better equipped for their duties for being told that the brain consists of grey and white matter and cement substance? Despite the recognition of the need for training of attendants and its introduction by the MPA,, negative attitudes to the individuals who worked as attendants and mental nurses prevailed and had not changed by the 1930s, when Stephens offered this opinion, almost fifty years later.

2.11.2. In the 1900s

The impact of the political situation in Ireland following the War of Independence and the subsequent establishment of an Irish State, heralded the beginning of a process of separation of Irish nursing from its counterparts in the remainder of the UK (Sheridan 2005).The General Nursing Council (GNC) in Ireland was established in 1919 under the auspices of the Nurses Registration (Ireland) Act 1919 (Scanlan, 1991, Fealy 2006). According to this act the Council was required to establish and maintain a register having general and supplementary part. The general part was to contain the names of all general trained nurses while the supplementary parts included male nurses, mental nurses and nurses trained in the care of the sick. The training and registration of nurses was an important step in the professionalisation of nursing, however in the care of the mentally ill, there was still a long way to go (Robins, 2000). By the beginning of 1924, 2,373 general nurses had been registered with the Council and there were 633 mental nurses (Robins, 1986). In the early 1940s, the training situation had not improved greatly and the Department of Local Government and Public Health introduced a number of statutory instruments regarding the professional status of nurses and officers working in Irish asylums. The Mental Hospitals Officers (General Trained Nurses) Order (1942) stipulated that only qualified nurses in mental nursing could work in Irish mental hospitals. This was to improve the numbers qualified and introduce a particular standard of education.

Psychiatric nursing was recognised as a specialist division on the nursing registrar by the General Nursing Council (GNC) in Ireland in 1919 under the auspices of the Nurses Registration (Ireland) Act 1919 (Scanlan, 1991).. An apprenticeship style of training was introduced in this Act (1919) This model ensured that student nurses were employed to learn on the job and their education needs were seen as subordinate to the needs of the service (Scanlan, 1991). The apprenticeship model, which was first established by Nightingale in the 1840s, survived in Ireland for over 100 years. Under this model service demands superseded educational needs as Student Nurses were part of the hospital workforce. Hospital certificates of training had no external educational recognition or accreditation (McCarthy 1989, Scanlon 1991). Psychiatric nursing as an occupation had been traditionally and inextricably tied to public institutions such as asylums and hospitals rather than a distinctive body of theory, research, or philosophy (Nolan, 1993).

Formal training for those individuals caring for patients in asylums emerged later than for other cohorts of nurses in other divisions of nursing. The Report of the Commission on Nursing (1998) states that this was due to the absence of scientific progress in psychiatry in the early 1900s, which happened in medicine and surgery. This absence, contributed to the later emergence of formal training for those caring for the mentally ill in Ireland. In the early 1950s most psychiatric nurse training took place in the local health authority hospitals, where untrained staff were recruited as attendants. Staff were rostered through all units in the mental institution, including the refractory, geriatric, acute and ancillary units and the infirmaries (where a full range of medical and surgical procedures and care was provided for patients). Attendants who showed promise or were interested were entered on the nurse training programme. They took the 'Prelim' after 18 months, the same exam as general nursing students and their finals after a three year period. It was the Matron who was responsible for the education of Nurses and the Doctors who carried out the orals. Doctor's lectures were given in the early morning or at night when staff came off duty (Chavasse, 2000).

In 1960 a specific psychiatric nursing syllabus was introduced informed by nurses, arguably indicating that nursing could now forge elements of its own destiny (Sheridan, 2000). This revision of the Boards first syllabus was coincided with the training programme becoming mandatory in all schools of psychiatric nursing. Two further revisions of the syllabus were completed in 1982 and 1986. One significant aspect of the 1982 revision was that all examiners were to be nurses, not psychiatrists, thus achieving a nursing orientation in contrast to a medical one. The review in 1986 was in response to the publication of the policy document 'Planning for the Future'. The trend was to recognise nurses as practitioners which specific psychiatric nursing skills, able to participate fully in multidisciplinary teams in the community as well as in hospitals (Chavasse, 2000).

The report 'The Future of Nurse Education and Training in Ireland' (An Bord Altranais,1994) recommended a new model of nurse education and training through the formation of links with higher education institutions and accompanying educational validation and accreditation for nurse education for Nurses. Education in

psychiatric nursing began to gain in status in 1991, when the EU Commission started discussion on a Directive for 'specialist training' which was to include psychiatric and sick children's nursing. In 1994, a diploma in nursing programme was set up in the former Western Health Board, in conjunction with the National University of Ireland, Galway (NUI Galway), and was extended to all schools of nursing, including psychiatry. During 1995 twelve students in Galway undertook the training programme, which in 1998 became the preparation for the Registered Psychiatric Nursing (RPN) division of the Register Diploma programme.

For the purpose of this study, the introduction of the Mental Hospitals Officers (General Trained Nurses) Order (1942) and the Mental Nurses Qualification order (1944) stipulating that only qualified nurses in mental nursing could work in Irish mental hospitals, was the commencement and origin of the profession of psychiatric nursing in Ireland.

2.11.3. In the 2000s

The Report of the Commission on Nursing (1998) recommended that the future framework for the pre-registration of nurses is based on a four year degree programme in each of the disciplines of general psychiatric and intellectual disability nursing to commence at the beginning of 2002. In 2002, along with general and 'mental handicap' nursing, the first pre-registration degree programme commenced in psychiatric nursing (O'Shea 2008). Currently to be eligible to be registered as a "psychiatric nurse" (RPN) by the Irish Nursing & Midwifery Board of Ireland (NMBI), students undertake a specialist 4 year honours degree programme in partnership between a university and sponsoring health service. For the first time psychiatric nursing students were being educated in third level colleges, side by side their contempories in general and other divisions of nursing.

2.12. Regulation of the Profession

In the early decades of the twentieth century concerns were raised regarding the importance of having a well-regulated profession of Midwives (Robins, 2000). The Midwives (Ireland) Act' 1918, and a subsequent bill: The Midwives Act' 1944 was passed, establishing the Central Midwives Board to maintain a roll of Midwives and to regulate their training. The registration of other categories of Nurses followed with the introduction of the 'Nurse Registration (Ireland) Act 1919, establishing a General Nursing Council for Ireland and a register for Nurses which had supplementary parts for male Nurses, Mental Nurses and sick children's Nurses. This act also succeeded in setting standards for the recruitment, training and supervision of general nursing practice in Ireland. The general training hospitals required a relatively large fee from the student nurses; effectively this meant that nursing became a middle class occupation as a fee created an obstacle for those from poorer families (Robins, 2000). Such a fee was not a requirement to work within asylums. The psychiatric staff of a public mental hospital at that time would have been considered to exist on the lowest rung of the professional laddercompared to their exalted colleagues in a general hospital or in one of the private mental hospitals (Browne, 2008, p.99). While registration of Nurses was seen as an important step in the reform of the care of the mentally ill, mental hospitals continued to be seen largely as places of detention with many untrained staff. While the Mental Hospitals Officers (General Trained Nurses) Order (1942) and the Mental Nurses Qualification order (1944) stipulated that only qualified nurses in mental nursing could work in Irish mental hospitals little progress was made by the services or the profession of nursing. In making recommendations for a more comprehensive service for the mentally ill involving greater multidisciplinary involvement within a family and community based model, the report of the Commission on Mental Illness (1966, p.116) recommended that;" The greater responsibility now devolving on nurses has led the Commission to the view that psychiatric patients should not be nursed by persons other than fully trained psychiatric nurses." This report (1966, p.118) also criticized An Bord Altranais and noted that "...from observations and discussions during its visits to mental hospitals in Ireland, the Commission considers that the nurse training programmes and facilities could be improved in most centres. Training schools should be regularly

reviewed or inspected and pressure maintained to ensure that they reach the required standard. When a hospital has not attained the requisite standard it should be given a period of grace in which to do so. Should it fail to come up to this standard it should then be struck off the list of training schools? The Commission feels that a forceful approach is required to stimulate this process of improvement. It is aware that An Bord Altranais has an inspection system and that it should expand and intensify this system." The Commission noted in particular that many hospitals had failed as yet to implement satisfactorily the introductory course for newly recruited Student Nurses. The Commission recommends that, 'where hospitals fail to provide suitably organised courses within a reasonable period, consideration should be given to the provision of such courses for groups of hospitals at suitable regional centres'.

The Nursing and Midwifery Board of Ireland (NMBI), formerly called An Bord Altranais, has two main objectives: to protect the public and to ensure the integrity of nursing and midwifery practices (https://www.nmbi.ie). NMBI is the statutory body which sets the standards for the education, registration and professional conduct of Nurses and Midwives. Through a fitness to practise function, NMBI is responsible for considering complaints against Nurses and Midwives. They also establish procedures and criteria for assessment and registration. Additionally, they approve education programmes and further education programmes as well as setting standards of practice and provides support for registered Nurses and Midwives. This includes developing, publishing and reviewing a code of professional conduct and ethics, guidance on all aspects of professional conduct and guidance on maintaining professional competence.

2.12.1 The Profession of Psychiatric Nursing

This study examines the ontogenesis of the occupation of psychiatric nursing as a profession in the mid 1900s. There are a different set of criteria and schemes of classifications that are used to define professions. the major milestones which may mark an occupation being identified as a profession include: the occupation is a full-

time occupation, with a designated training school or university programme, have a dedicated association, have an established code of professional ethics and licencing/ regulation laws (Perks, 1993, Sager, 2003 and Waddington, 1990). According to the relevant literature on professionalism in nursing practice, the criteria of professionalism in nursing were first determined by Miller et al (1993). These, he maintains, are educational preparation, research, and publication, participation in professional organizations, community service, competence and continuing education, code of nurses, theory, and autonomy. Additional attributes of professionalism are defined as commitment to a profession and professional identity level (Hwang et al. 2009) a dynamic process (Adams et al, 2001), professionalism leads to improvement of knowledge and skills in a profession, having a positive impact on institutional productivity and quality Professionalisation is the pattern of how a profession develops and arises when any trade or occupation transforms itself through the development of formal qualifications based upon education, apprenticeship, and examinations, the emergence of regulatory bodies with powers to admit and discipline members, and some degree of monopoly rights (Bunkenborg et al, 2012, Bullock & Trombley (2000). A professional is described as a member of a profession (Cruess et al 2004) and they are governed by codes of ethics, and profess commitment to competence, integrity and morality, altruism, and the promotion of the public good within their expert domain. Professionals are accountable to those served and to society.

Nursing has struggled for acceptance and legitimacy as a profession in its own right (Narelle 2001) and psychiatric nursing possibly slower than general. Defining professionalism in nursing has been a difficult feat. For many years, scholars in other fields identified nursing as a semi profession because of the lack of a university-based education as the entry level, the lack of autonomy, and a paucity of theory and research to serve as a foundation for the field (Etzioni, 1969). The journey to professionalisation was an incremental one for psychiatric nursing within this study since the introduction of the General Nursing Council in 1923. Psychiatric nursing fulfilled a number of behaviours indicative of professionalism; nursing was a full time occupation, had a professional registration body and their qualifications depended on training, apprenticeship and examination with a code of professional conduct. No

evidence however, existed of the ongoing commitment to competence within the profession at that time; no requirement existed for continuous professional development, ongoing competence assessment by either the registering body or the employer or research. The initiation and development of a body of knowledge specific to the evolving science of nursing contributed significantly to the professionalisation of psychiatric nursing and the attribute of accountability to those served. However, the promotion of the public good possibly requires further clarity, as society's understanding of 'the public good' is questionable in relation to containment and the role of asylums and whose benefit they served. The findings of this study may shine some light on this aspect of professionalism within psychiatric nursing.

The Report of the Commission on Nursing (1998) was the first professionalising strategy for nurses; it attempted to separate the historical connection between nurse education and health service delivery. It recommended that a forum be established by the Minister for Health and Children to agree a strategy for the implementation of degree level pre-registration education. The report recommended that the future framework for the pre-registration of Nurses is based on a four year degree programme in each of the disciplines of general psychiatric and intellectual disability nursing to commence at the beginning of 2002. In 2002, along with general and 'mental handicap' nursing, the first pre-registration degree programme commenced in psychiatric nursing (O'Shea 2008). The transfer of nurse education to universities along with the additional provisions relating to the regulation of nurses and midwives in the 2011 Nurses Act enhances the protection of the public in its dealings with the profession, while ensuring the maintenance of competence and the integrity of the practice of nursing. In 2009, the profession established the first professional association for psychiatric nurses; the Irish Institute of Mental Health Nursing (IIMHN) to promote excellence in the provision of mental health nursing and mental health delivery. This was the final prerequisite in the professionalisation process.

2.13 Conclusion

In concluding this review of the literature, I have attempted to map significant developments relating to psychiatric nursing in an Irish context. It is essential to reconsider the literature in relation to the study's aim as outlined in chapter one. The first section of the review explores the background and context of this study as well as the asylum system in Ireland. Section two concentrates on the containment policy and the social theories which influenced asylums, their culture and expansive development as well as their role and function. The final part of the literature review widens the scope to consider policy pertaining to both healthcare and professional nursing. It highlights the history of psychiatric nursing and how it became the 'Cinderella' of nursing, the literature outlines how it lacked political and professional support to keep it abreast of developments in nursing generally. The review outlines the wide variation of themes that impact on psychiatric nursing and the profession and outlines the contemporary issues influencing the profession.

Chapter 3 Methodology details the research design chosen to conduct this research study to capture the experiences of nurses who worked within the institutional settings during the mid-1900s, to provide knowledge and insight into their experiences and the practices of psychiatric nurses, their influence on care, and the changes over time in mental health care.

Chapter Three

Methodology / Research Design

3 Introduction and background

The purpose of this study is to capture and report on the individual accounts of nurses who worked in mental asylums during the mid-1900s. This exploration will inform and provide insight into their roles within the asylum, the social and psychiatric presentations of patients, as well as the treatment approaches available and used during that period. It will also provide knowledge and insight into the functions of those employed in nursing roles along with leadership within the sector and the changes which occurred in mental health care across the time period of the study. This chapter provides rationale for using a qualitative approach to this study, an overview of paradigms, explanation and justification of the choice of the study's philosophical orientation (social constructionism often combined with interpretivism (Mertens, 1998)) and selected narrative research methodology (narrative inquiry) in light of the overall purpose of the research. The chapter will also outline how hermeneutics and interpretivism along with narrative methodology shaped the study. The population sampling, data collection methods, the rationale for these associated components are also discussed as is the data analysis approaches. Subheadings within each section provide detailed descriptions including the role of researcher, assurance of confidentiality, interview, protocols and questions along with the data analysis methodology.

3.1 Overview of Paradigms

The first consideration in the execution of this study was to identify an appropriate paradigm to address the purpose of the research and the chosen methodology for

the topic. The term ‘paradigm’ refers to a worldview or all-inclusive way of experiencing and thinking about the world, incorporating beliefs about ethics, values and aesthetics (Kuhn 1962, 1970), or general perspective on reality (Khun 1962, Polit & Beck 2012). No one paradigm or philosophical framework is ‘correct’ and it is the researcher’s choice to determine the correct paradigmatic view, and how this informs the research design to best answer the question under study (Weaver & Olson 2006). Agee (2009) stated ‘...It was important for this study to select a philosophical paradigm that not only informs the research aim but also unites the research to the mental health nursing field (Agee 2009).

Each paradigm is informed by philosophical assumptions. Creswell (2003, pg16) citing Crotty (1998) provided a framework for carrying out research: 1) what epistemology or theory of knowledge embedded in the theoretical perspective informs the research, 2) what theoretical perspective or philosophical stance lies behind the methodology, 3) what methodology or strategy or plan of action links the methods to outcomes and governs our choice and use of methods and finally 4) what methods, techniques and procedures do we propose to use for research’ (p.4). The philosophy of hermeneutics, using narrative inquiry involving storytelling methodology which is an interpretative approach was deemed the most suitable paradigm in the conduct of the study. The story becomes the object of study.

3.1.1 Social Constructionism

Social Constructionism with its multiple truths and its focus on subjectivity in worldview seems more capable of addressing this particular research study which needs to incorporate culture. Creswell (2012) states that assumptions within this paradigm hold that individuals seek understanding of the world in which they live and work. They develop subjective meaning of their experiences, meanings, directed toward certain objects or things. These meanings are varied and multiple, leading the researcher to look for the complexity of views rather than narrowing meanings into a few categories or ideas. Creswell (2012) maintains the goal of qualitative

research is to rely as much as possible on the participants' views of the situation being studied (p8).

Hence, I needed to know how this group came to understand themselves and their profession and how this reveals itself through the study of narrative within the postmodern, social constructivist perspective. I am able to meet this objective due to my position in the field of study as I am considered to be 'one of us' by the participants. However, while the researcher is able to meet this postmodern thought, it is argued that 'knowledge is contextualized by its historical and cultural nature' (Agger, 1991, pg.117) therefore Agger states it is important for me to expose 'their own investment in a particular view of the world' (pg.118) I am interested in the participants narratives, how meaning is coordinated, and how they come to understand themselves and their roles within the asylum and not in an abstracted factual account of 'the truth' of a life story.

Narrative or storytelling positions narrative research largely within the social constructionism paradigm. Social constructionism is defined by Crotty (1998, p. 42) as 'the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context'. This theory came into use in the late 20th century and questions the modernist philosophical assumptions of rationality and universal truth and the application of scientific empirical methods of problem solving. Instead it emphasizes that knowledge is value laden and reality based on multiple perspectives. Context plays a crucial role in the social construction of reality and knowledge. Within this social constructionism paradigm, this study is guided by a philosophy of hermeneutics using narrative inquiry.

3.1.2 Hermeneutics

A number of studies carried out by nurse researchers have used hermeneutics a methodological basis to guide research on various aspects of nursing practice and

human experience. A review of nursing literature indicates that the following are an example of some such studies: ordinariness in nursing (Taylor 1991), critical thinking in nursing (Eberhart 1992) living with postpartum depression (Beck 1992) nearing death (Gullickson 1993) surviving incest (Kondora 1993) voices of elderly (Kock 1993), women's stories of being strong (Moloney 1995), quality of life (Draper 1997) practice knowledge in mental health nursing (Geanellos 1997) and cross cultural nursing experiences (Spence 2011).

Hermeneutics is considered to be a philosophy of interpretation of meaning (Bleicher 1980, Grondin 1994). The term Hermeneutics is derived from the Greek work 'hermeneuein' which means to interpret. While originally hermeneutics was developed in an attempt to interpret biblical texts, the domains of hermeneutics have expanded to include' ''…a science of linguistic understanding, a methodological foundation for the human sciences, a phenomenology of existential understanding and a system of interpretation'' (Allen and Jensen, 1990, p241). Over time hermeneutics developed as a systematic means of interpreting oral and written texts and into a general philosophical methodology for the human sciences. Key influencers of the hermeneutic movement include the work of Schleiermacher (1977, 1990), Dilthey (1990) Heidegger (1927, 1962) and Gadamer's (1975).

According to Moran (2000) and Schleiermacher (1977, 1990) , there was a need to uncover the original meaning of texts through revealing the intentions of the author, which consisted of getting into the mind-set of the author so as to create an understanding of what has been said and what has been written, Mueller –Vollmer (1985, p84) makes reference to a key development to hermeneutics in the work of Schleiemacher (1977, 1990) when he suggests that complete knowledge always involves an apparent circle, that every part can be understood only out of the whole which belongs, and vice versa.

Dilthey's (1990) writings were on 'life'. He considered man as having an internal world comprising of self-awareness, feelings, thinking and evaluating, while the outer world comprised of an awareness of external material and nature (Young, 1983). He viewed life as the totality of inner experience as it is lived and considered this to be

the subject of historical inquiry. According toTuttle (1969, p.15). Dilthey's description of life is summed up as follows: "All life is a coherent whole of parts. The parts take their meaning only with respect to the whole, and the whole is what is it's only by reference to the parts''.

Similar to Schleiermacher (1977, 1990) Dilthey (1990) expanded the notion of hermeneutic circle in an effort to maintain a connection with the past, bringing it to the present and guiding though to the future. Developing an understanding of human being and expressions of being are drawn from life and from this comes major sources of valid knowledge generation. Dilthey retained an epistemological stance, a focus on a way of knowing rather than on a way of being.

Heidegger (1967) on the other hand took an ontological stance, a focus on the nature of 'being'; he proposed that it was not possible to understand the person in isolation from his/her world. He believed the most fundamental way of understanding his work is from a practical point of view rather than being detached from it. Heidegger (1927/1962) provided the analogy of an expert carpenter using a hammer to clarify practicality in the world. He argues that the carpenter uses a hammer without consciously thinking about it and uses it in an appropriate way, at an appropriate time and under appropriate circumstances. The central tenets of Heideggarian philosophy include the following components: 'dasein', temporality, structure of the question, preunderstandings, interpretation and understanding and the hermeneutic circle.

'Dasein' has been defined as 'being – there', it is considered by a number of authors as encompassing 'human being' (Cooper 1990, Dreyfus, 1991). It is also concerned with the 'being' of what is under investigation, which is brought to consciousness through experience. Temporality on the other hand, is considered by Benner and Wrubel (1989) as being anchored in the present, which has been made meaningful by past experiences and the person's anticipated future. Temporality forms a part of the context, the context of the person's reality. The cohesion of the researcher's pre-understandings in this particular research study facilitates the researcher to interact with the world in which 'being' is investigated.

Interpretation and understanding are key issues which influenced Heidegger (1927/1962) in the development of hermeneutics. Understanding occurs contextually and within historical and temporal relationships (Peden-McAlpine, 2000). Its presence also enables individuals to engage in the interpretation of human activity so a decision can be made regarding the possible courses of action to take within a given situation. Understanding is a prerequisite for interpretation. Accordingly, interpretation does not occur without having preconception of the phenomenon, which is an essential precondition of our understanding (Munhall, 2012).

Ricoeur (1974, 1981) focused on textual interpretation as the primary aim of hermeneutics and developed a theory of interpretation which took into account language, reflection, understanding and the self (Ricoeur 1974). According to Geanellos (2000) researchers are increasingly using hermeneutic philosophy to inform the conduct of interpretive research. Congruence between the philosophical foundations of a study, and the methodological processes through which study findings are actualised, obliges hermeneutic researchers to use (or develop) hermeneutic approaches to research interviewing and textual analysis. Geanellos (2000) states that Paul Ricoeur's theory of interpretation provides one approach through which researchers using hermeneutics can achieve congruence between philosophy, methodology and method. Ricoeur's theory of interpretation acknowledges the interrelationship between epistemology (interpretation) and ontology (interpreter).

The research paradigm for this research is guided by a philosophy of hermeneutics, using narrative inquiry, which is an interpretative approach involving storytelling methodology. The story becomes the object of study. It focuses on how individuals experienced and made sense and meaning of events in their lives.

The social constructionism paradigm and the philosophy of hermeneutics, using narrative inquiry was deemed the most suitable methodology in the conduct of this study within psychiatric nursing. To understand and interpret the underpinnings and ramifications of nursing practice, it is essential to understand how nursing has been conceptualised by several theorists who have provided a solid foundation for nursing practice.

3.2 Theory of Nursing

Before the advent of development of nursing theories, nursing was subsumed under medicine. The initial work of theorists was aimed at clarifying the complex intellectual and interactional domains that distinguish expert nursing from the mere doing of tasks (Omrey, Kasper, and Page, 1995). It is widely believed that the use of theory offers structure and organisation to nursing knowledge and provides a systematic means of collecting data to describe, explain and predict nursing practice. Theories make nursing practice more overtly purposeful by stating not only the focus of practice, but specific goals and outcomes. Theories define and clarify nursing and the purpose of nursing practice to distinguish it from other caring professions by setting professional boundaries. Finally, the use of a theory of nursing leads to coordinated and less fragmented care (Alligood and Tomery, 2002, Chinn and Dramer, 2004 McKenna, 1993

The nature of Nursing is one that has been examined from a number of perspectives. Florence Nightingale is considered to be the founder of nursing. Stemming from her experiences of the Crimean War, Nightingale's views of what constituted nursing centred on health and illness nursing (Nightingale, 1992). In attempting to differentiate nursing from medicine Nightingale emphasized that the central focus of nursing should be on prevention and health oriented care as opposed to curative care which she considered to be the function of medicine (Reed and Zurakowoski, 1996).

Numerous attempts were made by theorists who attempted to further clarify the discipline of nursing. Among them Peplau (1988), Henderson (1991), Johnston (1990), Orem (1995), Roy (1999) and Benner (1984). The following are a brief overview of these theories which demonstrates the complexity of nursing.

3.2.1 Peplau's theory of Nursing

Peplau (1952/1988) was one of the first to attempt to theorise the nature of nursing, where she considered interpersonal relations to be central to nursing. The goal of interpersonal relations is one where '…...the nurse and patient respect each other as individuals, both of them learning and growing as a result of the interaction' (Belcher and Fish, 1990, p 44). Interpersonal relations consist of four phases, namely the orientation phase, identification phase, exploitation phase and resolution phase. Peplau (1988) considered that progressing through these phases in a nurse patient relationship facilitates the patient to address and identify problems and utilise the nurse in solving these problems. Finally, the resolution phase of interrelationships signifies an ending of the patient's problems.

3.2.2 Henderson's theory of Nursing

Henderson (1991) highlighted fourteen functions of the Nurse to help patients maintain independence, while working as part of an interdisciplinary team. While she acknowledged the role of the Nurse in caring, she also highlighted this role as one that encompasses carrying out the physician's orders while maintaining the individual's dignity.

3.2.3 Johnston's theory of Nursing

Johnston (1990) views nursing as a discipline that is distinct from medicine. While she views nursing as being complimentary to medicine and other health care professions, she views nursing as making its own contributions to the care of the patient. According to Johnston (1990, p 29), nursing is

'…an external regulatory force that acts to preserve the organisation and integration of the patients behaviour at the highest possible level under those conditions in which the behaviour constitutes a threat to physical or social health, or in which illness is found''

Johnston maintained the focus of nursing is on supporting a behavioural system when there is a disruption of the individual's ability to function or when prevention is needed to avoid a breakdown in an individuals' functioning. The patient in Johnston's (1990) view is one that is composed of systems; hence the focus of nursing is to maintain functioning systems for patients.

3.2.4 Orem's theory of Nursing

Orem (1995) considered that the focus of nursing is that of assisting the patient in maintaining self-care created by the presence of an illness. She considered nursing to be a human and a helping service with the main focus of the nurse being on continuing therapeutic care.

3.2.5 Roy's theory of Nursing

Roy (1999) on the other hand provided an alternative theoretical perspective to the nature of nursing. Roy (1999) considered the focus of nursing is on helping the patients to adapt to illness. Roy (1999, p.l54) describes the goal of nursing as''….to contribute to the overall goal of health care, that is, to promote the health of individuals and society'. Nursing practice based on the focus of adaptation, is centred on helping people.

3.2.6 Neuman's Systems theory

Systems theory is concerned with changes caused by interaction among all the factors (variables) in a situation. Interactions between the person and the environment occur continuously thus, the situation is complex and constantly changing. Systems theory provides a way to understand the many influences on the whole person and the possible impact of change of any part on the whole. This

theory can be useful in nursing to understand, predict and control the possible effects of nursing care on the client system and the concurrent effects of the interaction on the nurse system (Hood and Leddy, 2003, p.184).

In Neuman's Health Care Systems Model (1982), Neuman specifies that the purpose of nursing is to facilitate optimal client system stability. The terms of this model are that the normal line of defence: is an adaptational level of health considered normal for an individual. Neumans model, organised around stress reduction, is concerned primarily with how stress and the reactions to stress affect the development and maintenance of health. The person is a composite of physiologic, psychological, sociocultural, developmental, and spiritual variables considered simultaneously. 'Ideally the five variables function harmoniously or are stable in relation to internal and external environmental stressor influences' (Neuman, 2002, p.17). According to Neuman 'no one part can be looked at in isolation….just as the single part influences perception of the whole, the patterns of the whole influence awareness of the part' (Neuman 1982, p.14) Thus the functioning of any subsystem or part of a system must be evaluated in the context of the entire system. The environment includes 'all internal and external factors or influences surrounding the identified client or client system' (Neuman, 2002, p.18) Client and environment have a reciprocal relationship.

Neuman intends for the nurse to 'assist clients to retain, attain, or maintain optimal system stability' (Neuman, 1996, p.25) The major concern for nursing is in keeping the client system stable through accuracy, both in assessing the effects and possible effects of environmental stressors and in assisting client adjustment required for an optimal wellness level. Optimal means the best possible health state achievable at a given point in time (Neuman, 2002, pg. 25).

3.2.7 Benner's theory of Nursing

Patricia Benner presented a theory on the development of clinical nursing practitioners to the level of expert practice in the context of direct patient care. She elaborated on the power of observation of the nurse and how these develop over

time and experience to enable the ‘expert’ nurse to exercise ‘clinical judgment’ based on their experience and observation and to develop clinical wisdom. Benner identified that nurses pass through five levels of skill performance in clinical practice. Benner (1984) characterised these as: novice practice, advanced beginner practice, competent practice, proficient practice and expert practice. Experience was seen as a critical element in the progression of a nurse through the levels of practice, Benner claimed experience is the platform from which specialised nursing develops.

While nursing is embedded in the beliefs and values of the above theorists and theoretical frameworks to view nursing, these and other nursing theorists have influenced nursing practice throughout the world. The practice of nursing however remains nebulous and a complex phenomenon and requires further clarification.

The above theorists provide a broad description of the nurse’s role and highlight its multi-dimensional aspects. However, as Leininger (1984) points out: caring is synonymous with nursing. Therefore, there is an inherent quality in each theory of nursing that is common to all theories of nursing. As nursing is conceptualised as encompassing these multi-dimensional functions and roles it is necessary to examine the caring concept so as to make explicit the elements of nursing practice to assist in the interpretation of the respondents role in this study.

3.3 Conceptual Framework

This section addresses several views of caring in an attempt to explore the nature of caring as it occurs in the context of caring for patients in the asylum system in order for nursing to be understood within this context.

3.3.1 Caring

Within nursing, caring as a concept has received much attention in nursing and philosophical literature. While it may appear to be a straightforward concept, it has been explored from a number of perspectives and has been demonstrated to be

quite complex. There is a need to explore the nature of caring as it occurs in the context of caring for patients in asylum care. The nature of caring for individuals with mental health problems is one that involves the development of relationships and supporting individuals as they progress thorough their illness/ life journey.

3.3.2 Mayeroff's theory of caring

Mayeroff's theory on caring (1971) describes caring as helping someone else to grow and reach a stage of self-actualisation. He assumes caring means: '' to care for someone else in the most significant sense… to help him grow and actualise himself'' (Mayeroff, 1971, p 1). He contends that in the context of nursing, the person is the focus of the caring relationship. According to Mayeroff (1971) caring is made up of a number of elements which include: knowing (the person) and knowledge (about the person), alternating rhythms, patience, honesty, trust, humility, hope and courage.

Knowing and knowledge are necessary constituents of caring. Knowing is an essential element to the caring process. It includes an understanding of an individual's needs, an ability to respond effectively to these needs and an aptitude to determine was it conducive to personal growth as well as defining personal and patient limitations. Knowledge on the other hand is considered to include information about the person, who forms the centre of the caring relationship, knowing the individual's past and implanting changes in the caring act to maintain and or modify behaviour.

Patience allows a sense of freedom, it allows '...the other to grow in its own time and in its own way' (Mayeroff 1971, pg. 17). Honesty involves openness with the person being cared for, trust promotes independence and responsibility in the person being care for, humility promotes learning as a reciprocal process between the care and the person being cared for, while it also allows for the realisation of limitations in the process of caring.

3.3.3 Campbell's theory of caring

Campbell's theory on caring (1984) is based on skilled companionship as forming the notion of caring He views caring as the central focus of nursing and sees companionship as the centrality of caring. He expresses companionship as a: 'closeness that is not sexually stereotyped, it implies movement and change: it expresses mutuality and it requires commitment, but within defined limits' (Campbell, 1984, p 49).Nurses come in close bodily contact with patients (Lawler, 1991) and this distinguishes nursing from other healthcare disciplines. According to Campbell (1984) the closeness of contact between the nurse and patient involves 'being with' in a special way and not just 'doing to' the patient. While companionship is less than friendship it involves risk taking on the part of the nurse, especially in interacting with demanding and ungrateful patients. Hence the quality of 'being with' the patient is embedded in the skills of companionship. Campbell advised that the type of companionship that is applicable to nursing requires a limited commitment which ceases as the onward journey proceeds to the restoration of health or to death.

3.3.4 Watson's theory of caring

Watson's Theory on caring (1988) complements that of Mayeroff (1971) and considers caring to be a moral ideal of nursing and a unique transaction between the nurse and the patient. Watson describes the foundation of care as being based on three motives: a) the will to care, b) the intent to care and c) the caring actions. Watson identifies caring as an art and a science as well as an interactional process that occurs between a patient and a nurse. Morse et al. (1990) suggest that true caring is not possible to achieve for short term patients and patients who are unable to interact, or are cognitively impaired, as a true caring relationship does not develop in these situations. Therefore, it is questionable if caring is actually taking place where a caring relationship does not develop.

Caring involves the facilitation of growth and actualisation that occurs through the nurse patient interaction and the nursing relationship. The above highlights the complexity of caring. While no single theoretical perspective captures the diversity of practices that caring involves, the ill-defined nature of caring proposes difficulties for nurse theorists, educationalists and practitioners. As the focus of this study is on nursing and the experiences of nurses, the origin and development of psychiatric nursing and the contribution to care given by nurses to patients who have mental illnesses within the asylum system, the concept of care is central to the interpretation of roles and relationships.

3.4 Research Design

A qualitative approach was chosen using narrative inquiry to conduct this research. Qualitative research seeks to access the inner world of perception and meaning-making in order to understand, describe, and explain social process from the perspective of the study's participants. Qualitative research is a holistic approach which takes account of contexts within which human experiences occur and is thus concerned with learning from particular instances or cases. This approach does not commence with a prior hypothesis to be tested and proved but with a focus of inquiry that takes the researcher on a voyage of discovery. Creswell (2012) defines qualitative research as '...an inquiry process of understanding based on methodological traditions of inquiry that explores a social or human problem' (p15). Table 3.1 summarizes the different phases of the study as follows:

Table 3.1: Elements of Inquiry:

Characteristics	Approach
Philosophical Basis	○ Social Constructionism / Postmodernism ○ Interpretivism
Theoretical Basis	○ Theory of Caring ○ Theory of Nursing
Methodology	○ Qualitative Research Design ○ Narrative Inquiry ○ Unstructured interview (open questions aimed at inducing narrative) ○ Field Notes ○ Critical Friend ○ Hermeneutic analysis of categories across narratives
Strengths	○ In depth exploration of personal lived experience as created and recounted through narrative ○ Facilitates an understanding of the historical and socio cultural context. ○ Hermeneutic/Thematic Analysis
Challenges	○ Risk of over complex data generation ○ Snowballing could create tendency towards homogeneity
Researcher's Role	○ To recognise the part they play in narrative account and engage in a reflective process re researchers own experience and attitude

3.4.1 Rationale for Qualitative research design

One of the chief reasons for conducting this qualitative study is that the study is exploratory (Creswell, 2012, p.30). A quantitative methodology used to generate numerical data, by employing statistical, logical and mathematical techniques would be inappropriate for this particular study. The researcher provides no hypothesis in relation to this study, deductive reasoning and the quantification of opinions; behaviours or other variables are not relevant as numerical results are not required. The author chose a qualitative approach to this study as the advocacy, participatory, self-reflective perspectives and rich nature (Bogdan & Biklen 1992, Elliott, 2005, Marshall and Rossman, 1999 and Rossman and Rallis 1998) of qualitative inquiry as well as its exploratory and inductive nature was appropriate. The following characteristics of qualitative inquiry also influenced its choice and application:

- Qualitative research takes place in the natural setting.
- Qualitative research uses multiple methods that are interactive and humanistic.
- Qualitative researchers look for involvement of their participants in data collection and seek to build rapport and credibility with the individuals in the study.
- Qualitative research is emergent rather than tightly prefigured.
- Qualitative research is fundamentally interpretive.
- The qualitative researcher views social phenomena holistically.
- The qualitative researcher systematically reflects on who he or she is in the inquiry and is sensitive to this or her personal biography and how it shapes the study.
- The qualitative researcher uses complex reasoning that is multifaceted, iterative, and simultaneous.
- The qualitative researcher adopts and used one of more strategies of inquiry as a guide for the procedures in the qualitative study.

(Creswell 2003, p182)

This inquiry uses a qualitative approach to establish an understanding of the way people think and feel. The researcher was interested in the participants narratives, their opinions, how meaning is coordinated by them, and how they came to understand themselves and their roles within the asylum and not in an abstracted factual account of the 'truth' of a life story.

3.4.2 Narrative Research

Riesman (1993) in describing narrative research states that 'the purpose is to see how respondents in interviews impose order on the flow of experience to make sense of events and actions in their lives' (pg. 2). Narrative research explores how language reflects the social worlds of people and in so doing constitutes their very identities.

Ackinson (2002) defines a life story as 'the story the person chooses to tell about the life he or she has lived, told as completely and honestly as possible, what is remembered of it and what the teller wants others to know of it, usually as a result of a guided interview by another' (p. 8). Mitchell & Egudo (2003) state that there is some indication that narrative approach is gaining recognition in disciplines including those outside the social sciences. The approach is said to enable social representation processes such as feelings, images and time. They maintain it offers potential to address ambiguity, complexity and dynamism of individual, group or organizational phenomena.

3.4.3 Narrative Inquiry

A useful distinction has been made by Bamberg (2012, p.77) between 'research on narrative' and 'research with narratives.' This research study is a study with narratives. A narrative is characterized as follows: 'First the initial situation is outlined ('how everything started'), then the events relevant to the narrative are selected from

the whole host of experiences and presented as a coherent progression of events (‘’how thing developed’’), and finally the situation at the end of the development is presented (‘’what became’’)’. (Hermanns 1995, p. 183)

Narrative inquiry is set in human stories of experience through which they can investigate the ways humans experience the world, depicted through their stories. Narrative is well suited to addressing the complexities and subtleties of human experience: while at the same time, exploring holistic views holds valuable potential for researchers. Narrative is not an objective reconstruction of life; it is a rendition of how life is perceived. Narrative inquiry attempts to capture the ‘whole story’ whereas other methods tend to communicate understandings of studied subject’s phenomena at certain points, but frequently omit the important intervening stages.

Narrative inquiry functions at the interface of personal and social identity and of the very social world which is constitutive of such identities. Narratives reveal, sometimes consciously and often unconsciously, the meanings, conventions, dominant beliefs and values of the time and place in which a person lives and develops an identify (Duffy, 2012) cited in Munhall (2012). Polkinghorne (2007) states ‘storied evidence is gathered not to determine if events actually happened but about the meaning experienced by people, whether or not the events are accurately described’ (p479). Bruner (2004) says ‘that we seem to have no other way of describing ‘lived time’ save in the form of a narrative’ (pg. 692). Therefore, this methodology will provide the researcher with a rich framework through which they can investigate the way nurses experienced their world depicted through their storied truth (Bruner, 2002 p.692).

Flick (2014) maintains that narrative has become a major approach in qualitative research. This development has been supported by three developments: 1) Barthes (1977, pg. 79) has argued that narrative plays a central role in social life:
‘’……The narratives of the world are numberless. Narrative is first and foremost a prodigious variety of genres, themselves distributed amongst different substances – as though any material were fit to receive man’s stories. Able to be carried by articulated language, spoken or written, fixed or moving images, gestures and the

ordered mixture of all these substances, narrative is present in myth, legend, fable, tale, novella, epic, history, tragedy, drama, comedy, mime, painting, …stained glass windows, cinema, comics, news items, conversation. Moreover, under this almost infinite diversity of forms, narrative is present in every age, in every place, in every society; it begins with the very history of mankind and nowhere is nor has been a people without narrative. All classes, all human groups, have their narratives. …Caring nothing for the division between good and bad literature, narrative is international, trans historical, transcultural: it is simply there like life itself'. Secondly, narrative has become prominent as a mode of knowing and of presenting experiences and finally, narratives are being increasingly analysed in psychology (Sarbin 1986, Bruner 1990, 1991; Flick: 1996: Murray 2000, McAdams, 2008,).

Narrative inquiry is a form of qualitative research that uses a collection of stories as its source of data. According to Clandinin &Connelly (2000) narrative as a form of qualitative inquiry have deep roots in the social sciences and the humanities (Polkinghorne, 1988, Casey, 1995, Casey & Schaefer, 2016, Kim, 2015, Casey et al 2016). For Clandinin and Connelly (2000), stories report personal experiences in narrative inquiry (what the individual experiences) as well as social experiences (the individual interacting with others). Narrative inquiry is a form of qualitative research that uses a collection of stories as its source of data. The researcher captured the participant's stories through interview techniques. This method is said to be well suited to study subjectivity and the influence of culture and identity on the individual's human condition.

Nursing is largely an oral narrative culture (Sandelowski 1994, Wolf 2008, Adamski et al. 2009).Nurses are immersed in stories; our own nursing stories and the stories of people in our care. Nurses engage in clinical narratives of actual nursing practice provided to a patient or a family. We hear patient narratives or stories told in their own words of how they are affected by the issues that are important to them. These narratives provide meaning, context, and an understanding of patient's experience of their illness and their experiences. Within healthcare we order our life experiences into stories with temporal and logical sequences and this narrative mode of thinking helps us to organize and make sense of disparate life events (Bruner 1990). The

conduct of nursing, narrative inquiry and oral histories are inextricably linked as they are concerned with interpreting stories told to practitioners. Nursing engage narratives and oral histories as part of education, research and policy (Diers, 2004, Glerean et al., 2017, Gifford et al 2014, Engal, 2008). Many contemporary nurse researchers argue that the sharing and exploration of narratives reveal phenomenological and socio-cultural insights which in turn contribute to the development of nursing/healthcare knowledge and research practice (Chan et al. 2013). Capturing the individual narratives of nurses who worked within the institutional mental health settings during that time will provide such insights. Webster & Mertova (2007) maintain that traditional empirical research methods cannot sufficiently address issues such as complexity, multiplicity of perspectives and human centeredness; they maintain that these issues can be more adequately addressed by using narrative inquiry.

3.4.4 Oral History

Oral history and life stories are based on listening to and recording people's memories and life experiences (Thompson, 2000, Errante, 2000, Yow 2014, Ritchie, 2014). It involves the collection and study of historical information about individuals, families, important events or everyday life. These interviews are conducted with people who participated in or observed past events and whose memories and perceptions of these are to be preserved, most of these oral histories cannot be found in historical writings. Nkala et al (2015) maintains that the knowledge presented by oral history is unique in that it shares the tacit perspective, thoughts, opinions and understanding of the interviewee in its primary form. Hailed as a legitimate method of research for social historians to discover, make and conduct 'history from below', it is used to uncover the histories of those on the margins including women, workers, indigenous peoples, ethnic minorities and members of marginalised or oppressed social groups (Beard, 2017, Portelli , 2006, Caunce,1994, Baker, 1998,Thomson, 1999, Llewellyn & Ng-A-Fook, 2020) and is a methodology used by community workers, researcher, educationalists, historians, anthropologists, sociologists, ethnologists, psychologists and nurses. Oral histories focus and capture

individual experiences, interpretations, reactions and aspirations and facilitates human agency (Kiely & Leane, 2008, Loughrey, 2019, Altenbaugh, 1997 , Armstrong, 2003, Summerfield 1998). It carries critical knowledge from one generation to the next, tells creation stories for communities and nations, provides markers of identities for families and groups and records and archives eye witness testimonies and lived experiences (Llewellyn & Ng-A-Fook, 2020). Duckwork (2014, p110) describes it as a path to conscious raising, learning from the experiences of the past is relational and demands people 'see the Other in full human moral complexity'.

Some authors warn of the limitations of oral histories and identify some complex dangers in the work of oral history as a form of truth telling about historical harms, its purpose in justice movements and the use of oral history in the reclamation of silenced pasts and what is required for oral history to be a path for the disruption of unjust relations (Llewellyn & Ng-A-Fook, 2020). King (2003) warns that while stories are wondrous things, they are also dangerous. Oral histories can be dangerous because remembrance is 'a strategic practice in which memorial pedagogies are deployed for their socio-political value and promise (Simon et al, 2000, p3). Simon encourages oral history to be about 'remembering well', a pedagogy of living in relation with the past when the wounds still bleed' (e.g. post-Apartheid in South Africa), oral histories may not always be reparative. Oral histories can also be complicit in restorying or reproducing a historical consciousness that resides in the metaphorical (Tuck & Wayne Yang, 2012), they maintain that oral history can be used to reconcile guilt and complicity and rescue futurity.

However, Beard (2017, p.259) maintains that the value of oral history is most appreciated when it is accepted as a narrativised discourse in which historians should strive to understand the processes and epistemological forces that underlay and shape the narrative-making process. She argues that oral history is a highly distinctive example of historical narrative-making, created by 'ordinary' people and contextualised by the professional historian, providing us with a fascinating alternative to constructing and imagining 'histories' beyond more conventionally understood 'texts'.

The use of oral history in this study serves to reclaim a silenced past and provide a lens for viewing a difficult knowledge in the profession of nursing and in Irish society. The personal narratives in this study were solicited by the researcher. While the nurses who participated in this study provided subjective accounts of their experiences, their oral histories captured the 'why' and 'how' they experienced past events, how they made sense of and authored the past (Jordanova, 2000, p.91), not just resurrecting the past. In analysing why many nurses refused to engage in this study and tell their stories, the researcher believes it may have been because they processed and experienced past events in different ways to those nurses who did participate (Beard, 2017). The oral histories in this study primarily strived to understand the processes and epistemological forces that underlay and shaped the nurses narrative-making process (Beard, 2017, p.529).

3.4.5 The Voice of Memory

One of the factors that impacted on the use of oral history in this study is the interpretation of memory. There are a proliferation of studies from the 1980s concerned with the relationship between history and memory (Thomson, 2007). The processes of human memory and recall are basic to narrative methodology and oral history and the researcher wondered due to age and time lapsed, are the informant's memories an accurate representation of their experiences in terms of reliability and validity of information Cornelius Ryan, author of 'The Longest Day', the story of the D-Day invasion, offered some criticism of the interview process. He stated "In my kind of writing, one fact stands out more than any of the others—the very worthlessness of human testimony. Unless"—and he said he wanted to underline the word unless—"unless it can be substantiated by documents supporting the testimony."(pg. 3). While there is significant documentation supporting the asylums administration and governance system to support these narratives, there is a paucity of any documentation relating to nursing and the day to day nursing work.

Murphy (2005) in reviewing the use and reliability of oral sources in informing history, maintains that 'oral history is worth consideration because its peculiar characteristics – notably those relating to language, memory and interpretation – are

well placed to throw light on historiographical problems in general' (pg. 157). He goes on to state that 'oral recollection provides particular opportunities to examine the role of memory in reconstituting the past, as a process which occurs in and through language'. The sociologist Michael Schudson has argued that memory can only be expressed through the 'cultural construction of language in socially structured patterns of recall' (1995, p.346).

In a study on the reliability and validity in oral history and the case for memory, Hoffman & Hoffman (2008) maintain that within the range of human memory it is possible to reliably and accurately recover past events and to amplify and extend the existing written record. However, she states memories are not accurate with respect to exact dates'. They go on to identify one element they found in their study of memories is that 'they are so stable, they are reliable to the point of being set in concrete. They cannot be disturbed or dislodged. It was virtually impossible to change, to enhance, or to stimulate new memories by any method that we could devise. We think, therefore, that we have a subset of memory, here called autobiographical memory, which is so permanent and so largely immutable that it is best described as archival' (pg. 18). They state that 'archival memory, as we conceptualize it, consists of recollections that are rehearsed, readily available for recall, and selected for preservation over the lifetime of an individual. They believe that the organization schema of archival memory seems to be such that unless you know exactly what those additional memories are, it is very, very difficult to find the appropriate cues' (pg. 18) to find them. They advise that 'One of the major categories of organization seems to be chronological. Thus, taking a person in a time sequence through the events in which you are interested may lead to considerably richer memories for those events' (pg. 20). The researcher in this study used such a chronological approach to accessing memories as each narrative in this research commenced with 'Tell me about when you started nursing?

As these nurse's narratives have a special character to the memories that I was tapping into, the consistency and similarity of the nurses' narratives about the asylum system in different locations around the country were remarkably consistent with a high level of conformity between the narratives of events experienced. Such a high

degree of consistency and conformity supporting a significant scale of reliability of information and validity of the nurses' narratives.

Figure 3.2 Overview of the Research Design

3.4.6 Role of Researcher

Creswell (2012) defined the role of the researcher in qualitative research as follows: 'The researcher builds a complex, holistic picture, analyses words, reports detailed view of informants, and conducts the study in a natural setting' (pg. 15).), Yin (1994), Patton (1990) and Hatch (2002) cite the role of the researcher in qualitative research as a data collection instrument. Data collected by the researcher in this study includes interviews and observation during interview. With the help of a transcriber, the researcher transcribed all digital interviews verbatim. This process was completed to enhance familiarity with the data and to add to the rigor of the study.

Particularly in qualitative research, the role of the researcher as the primary data collection instrument necessitates the identification of personal values, assumptions and biases at the outset of the study (Creswell 2003). My perceptions of psychiatric nursing and the role of the nurse in the asylum have been shaped by my personal

experiences. From 1977 to 1995, I worked in the mental health services, at the beginning of the period of deinstitutionalisation of the asylum system from 1977 to 1985. The researcher trained and graduated as a Psychiatric Nurse and worked in a variety of nursing roles in both the hospital and community mental health services between the late-70s to the mid-90s.

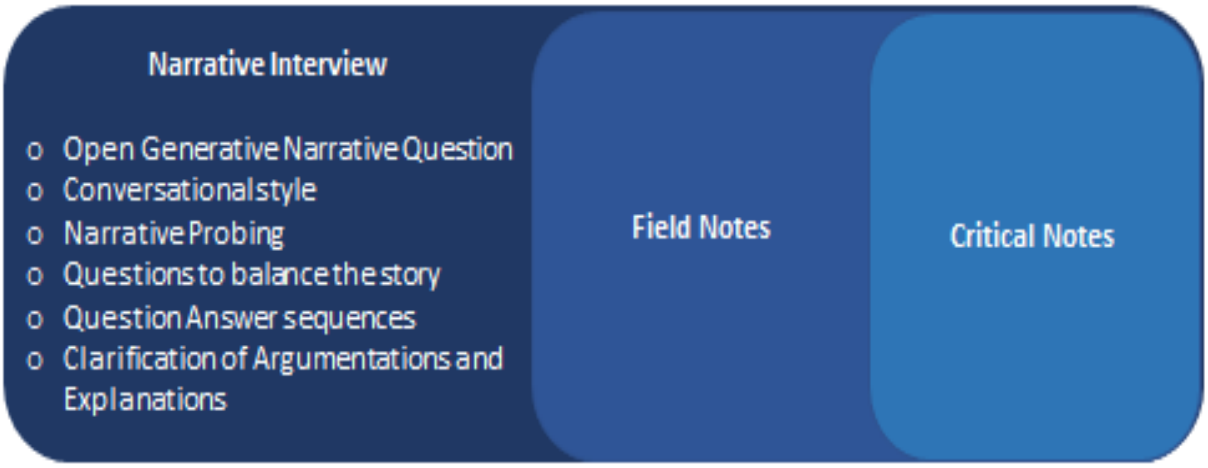
According to Agger (1991) I need to expose my 'own investment in a particular view of the world' (pg. 117), therefore I must consider the concept of reflexivity (Duffy, 2012) as an essential component to ensure the integrity of the study. Porter (2000) maintains that reflexivity is that process whereby the researcher acknowledges and considers the pros and cons of any personal stake holding, subjective opinions and/or values with regard to the research and its subject matter. I believe this understanding of the context and role enhances my awareness, knowledge and sensitivity to many of the challenges, decisions and issues encountered as a nurse. I bring to this study knowledge of both the asylum system, mental illness and the role of the nurse.

Due to this experience, I bring certain biases to this study. Although I will make every effort to ensure objectivity, these biases may shape the way I view and understand the data I collect and the way I interpret my experiences. I question how much power the nurse had to influence policy and change and how they could provide leadership within the profession in the asylum system. In addressing this personal bias, the use of a critical friend to share self-reflection will assist in creating an open and honest narrative (Creswell, 2003). Hatch (2002) defined reflexivity as the researcher's ability 'to keep track of one's influence on a setting, to bracket one's biases, and to monitor one's emotional responses' (pg. 10). It is imperative that the researcher admits her attitude about her experiences in the setting in which the study is taking place, albeit at a different time. Duffy (2012) defines reflexivity as the 'bending back on oneself. I will address this issue further in the data analysis section.

3.5 Data Collection Methods

The following figure outlines the data collection methods employed within this study:

Figure 3.3 Data Collection methods



3.5.1 Interview

Data collection methods are the means used for gathering data. It is important to choose the most appropriate methods based on the chosen research aim, philosophical paradigm, research design and methodology of the topic that is being examined (Crotty 2003). In this study, a qualitative design was chosen to conduct a narrative inquiry which involved the conducting of interviews. This method was chosen as the purpose of the study was to investigate the nature of psychiatric nursing in the asylums in the mid 1900's, in an attempt to trace its origins and development and the type of care given to patients within asylums.

Alternative methods of data collection were carefully considered, including focus groups, but evidence has shown such groups may lack anonymity and outlying opinions may be suppressed due to group dynamics and strong personalities dominating discussions (Polit & Beck 2012). Thus, focus groups would not have addressed the purpose of this research as well.

Interviews are a widely used instrument for data collection in qualitative research studies. Kvale (1996, pg. 14) defines an interview as an interchange of views between two or more people on a topic of mutual interest. Cohen et al (2011) maintains that interviews enable participants – be they interviewees or interviewees - to discuss their interpretations of the world in which they live and to express how they regard situations from their own point of view. They state in these senses the interview is not simply concerned with collecting data about life: it is part of life itself; its human embeddedness is inescapable (pg. 409). Walford (2001 p. 90) remarks that 'interviewers and interviewees co-construct the interview'.

3.5.2 Narrative Interview

The basic principle for the narrative interview for collecting the data for this study was as follows: the interview began with an open generative narrative question e.g. ''I would appreciate if you could tell me about your life and experience as a Psychiatric Nurse, when you started nursing, why you decided to be a nurse, and what life was like for you as a nurse working in an asylum in the mid-1900s', you can take your time in doing so because for me everything is of interest that is important to you''? This refers to the topic of the study and is intended to stimulate the interviewee's story. The format of the interviews was conversational (Riessman, 1993) in which I asked follow up questions to obtain more detail if the participant's experience of what happened in their work. As outlined by Schutze (2007, p.159) this stage of the interview is followed by narrative probing in which narrative fragments, that were not exhaustively detailed before, are completed e.g. ''….you told me you moved from a particular area, can you tell me how that came about''? The final stage of the interview is the ''balancing phase, in which the interviewee may also be asked questions that aim at theoretical accounts of what happened and at balancing the story, reducing the 'meaning' of the whole to its common denominator'' (Hermanns 1995, p. 184). Accordingly, this means the interviewees were asked questions about why they thought something developed in the way it did in their lives, about relations between events, or their general or specific viewpoints about some relevant issues. At that stage the format changes from narration to question-answer sequences, then

according to Flick (2014, p.266) the aim is argumentations and explanations, not just narrations.

According to Hermanns (1995, p.185) with narrative interview – a technique for eliciting narratives of topically relevant stories has been created that provides data that cannot be produced in other forms of interviewing for three reasons; 1) the narrative takes on some independence during its recounting, 2) people know and are able to present a lot more of their lives than they have integrated into their theories of themselves and of their lives. This knowledge is available to informants at the level of narrative presentation but not as the level of theories, and 3) Flick (2014) states that an 'analogous relationship between the narrative presentation and the narrative experience is assumed.'(pg.268).

Schutze (2007) maintains that the retrospective narrative of experiences, events in the life history (whether actions or natural phenomena) are reported on principle in the way they were experienced by the narrator as actor. This was the approach adopted within this study; the narrator set the agenda and narrated their experiences. The interviewer did not influence, attempt to lead or guide any aspect of their story, only to facilitate it. Historical literature was not used to inquire into the narrators experiences, only to inform the study. This allowed for true experiences to transpire. This approach was intentional so that the themes, narratives and oral histories that emerged were authentic and pure. As this was a national study, the emergence of themes were analysed for their similarity and consistency to demonstrate reliability.

3.5.3 Interview Process

The researcher arrived at an agreed venue about 15 minutes before the time, the interviews were conducted almost always at the interviewee's place of domicile, which was the most convenient place for the participants. Each interview was audio recorded. The interviewer completed the necessary forms and paperwork: the consent forms, the study information leaflets and a broad outline of the questions

were made available to each interviewee. Emphasis was placed on facilitating participants to talk freely about their experiences in the context of a shared open discourse (Parahoo 2014).

3.5.4 Research Questions

In qualitative research interviews or conversations are often the way researchers collect material from research participants. Munhall (2012) states that if researchers adopted an 'unknowing' stance, we would not write questions with content information. The questions would reflect that we are the 'uncover', e.g. 'could you tell me about…? What was it like for you…? With supportive comments to follow like…' Go on…' and clarification comments like 'that sounds …? For the purpose of this study, the interview serves a very specific purpose: it is used as a means of exploring and gathering experiential narrative material that can serve as a resource for developing a richer and deeper understanding of a human experience and it also served as a vehicle by which I developed a conversational relationship with the participant about the meaning of their experience (Van Manen, 1990, p66).

The structure of questions is considered by Heidegger (1927/1962) to be a crucial element in hermeneutic enquiry. He considers that questions seek out certain information by addressing themselves to something about something for some purpose. Heidegger (1927/1962) highlights the value of scrutinizing the question so that it does not conceal or distort the answer: it needs to be flexible, broad and allow the respondent to be able to connect to the past, present and to be projected into the future., hence the questions are open ended and unstructured (Geanellos 1997).

Josselson & Lieblich (2003) say that a research question in narrative inquiry must be clearly stated, 'not as one that can be answered, but as one that calls for exploration' (pg. 265). So, according to Jeong-Hee (2016), the research questions had a 'how' or 'what kinds of' that prompts exploration or discovery rather than a simple answer.

The intention of the researcher was to engage with the participant to facilitate an interactive explorative dialogue. The art of listening was critical for the researcher to hear just what is being said. It was critical to be aware of the participant's mood: their body language, posture, intonation of words. My background in psychotherapy and nursing prepared me to listen to hear as opposed to listening to respond and allowing the participant space and silence to think, recall and reflect on their memories (Munhall, 2012). Becoming comfortable with silences also enabled the narrator to reflect and probe deeper. The interviews were carried out in locations suitable for the participants, in almost all cases their own homes.

The researcher has significant experience in interviewing, and significant experience both as a nurse and psychotherapist in listening to hear, probing when I deemed the detail was necessary along with allowing the nurse time to reflect, recall and reminisce within their respective stories. I allowed the nurse narrate their story, I made no effort to direct, guide or influence the content, my questions were conducive to stimulating the interviewee's main narrative to reflect the research topic and narrative inquiry chosen only.

There are, however, a number of disadvantages associated with interviews, including the fact that they can be demanding and time-consuming in relation to the interviewer's skills (Holloway & Wheeler 2010). In this research, these issues were overcome by planning the interview schedule with the participants well in advance of the conduct of the interviews. Holloway & Wheeler (2010) maintains that participants may respond in a way that might be considered socially desirable or will please the interviewer. However, in this study this was not a concern as I was not studying a strange tribe (Robinson, 1992). While the respondents in this study related to their experiences in the asylum in the 40s, 50s and 60s, they were aware that I was not a naïve researcher and that I had worked within the same asylum system albeit in different decades. The participants in this study were reassured by my knowledge and familiarity with psychiatric nursing and the institutional context and I believe it contributed to the emergence of rich data that was neither socially desirable nor said to please.

3.5.5 Participants Selection Process

The study selection process emerged from the dearth of information on the experience of this professional group and an absence of both their voice and the patient's voice in the history of asylum's in the 1900s. The study was conducted nationally in Ireland. In the mid-1990s Ireland there were 25 large asylums in Ireland where nurses lived and worked. The lack of research documented in the review of the literature as well as the work experience and particular interest of the researcher also influenced the study selection process. The researcher was fortunate to have worked at every level within the mental health services: at a clinical, managerial, educational, policy and national lead for mental health nursing within the Health Service Executive. The combination of the dearth of literature along with the researcher's work experience framed the study selection process.

According to Patton (1990) utilizing more than one sampling method contributes to sample reliability. In this study a three staged sampling strategy was employed. Purposive sampling as defined by Bryman (2012, pg. 458) was used to identify appropriate participants in this study: 'such sampling is essentially strategic and entails an attempt to establish good correspondence between research questions in a sample of non-random participants, selected for a specific purpose. In other words the researcher purposely selected psychiatric nurses who were relevant to the research question'.

Along with purposive sampling, criterion sampling was also employed to select participants for the study. Criterion sampling is a quality assurance approach that allows the researcher to study cases that meet certain predetermined criterion of importance. The researcher established specific criterion for participation in the study. Firstly, the participants must have been employed within the Mental Hospital/Asylum system at some time between 1940 and 1970. The participants must have provided a caring role to the patients within their respective areas/hospitals for a minimum period of three years.

Snowballing was also selected as a method of sampling for this study. Snowballing is a non-probability sampling technique i.e. it cannot depend on the rationale of probability theory. Snowballing sampling relates to where existing study subjects recruit future subjects from among their acquaintances, thus the sample group is said to grow like a snowball. Snowballing sampling is a useful tool for building networks and increasing the number of participants – this sampling technique is often used in hidden populations which are difficult for researchers to access. Snowballing sampling uses recommendations to find people with a particular knowledge, set of skills or characteristics that have been determined as useful to this particular study. It is an approach used for locating information rich key informants. It is not a stand-alone tool, for the purpose of this study it is being used in conjunction with interviewing. There are two stages of Snowball Sampling:

1. Identify potential subjects in population – often only 1 or 2 may be found initially who met the criteria for inclusion in the study.

2. Ask those subjects to encourage others to participate. The participants are made aware they do not have to provide other names, they are asked to encourage others.

Participation was on a voluntary basis. The advantages of this sampling process is that it allows for this study to take place that otherwise may be difficult to conduct because of a lack of access to participants. It will also help discover characteristics about a population that has never been captured.

It was necessary for the researcher to make contact with some interviewees who had expressed an interest in participating in the study, to another interviewee. This was necessary to continue the snowballing and ensure diversity with contacts (by widening location from regional to national).

However, it was difficult to determine the sampling error, or make inferences about the population based on this sample as initially subjects tend to suggest people they know well and because of this it is highly possible that they share the same traits or beliefs and characteristics, thus it is possible that the group is a small subgroup of

the entire population. Due to the limited number of potential participants who meet the criteria, I had little control over the sampling method. Participants recommended and referred various individuals to me who they think would be of interest to and be interested in this topic of research. Some of these referrals declined to participate in the study. When I met these potential respondents I noted their reasons for not participating in the study. I retained a note of their reasons in my research diary (RD). These notes are identified in the findings

3.5.6 Profile of Participants

The following outlines a brief profile of those nurses who participated in this study (Appendix 3). Fifteen nurses told their stories, seven male and eight females who worked in the 1940s, the 1950s and the 1960s. The graph indicates their years of experience and the various decades in which the participants worked. Their area of employment i.e. whether rural or urban and their nursing qualifications are also indicated. .

Figure 3.4 The decades the respondents nursed in

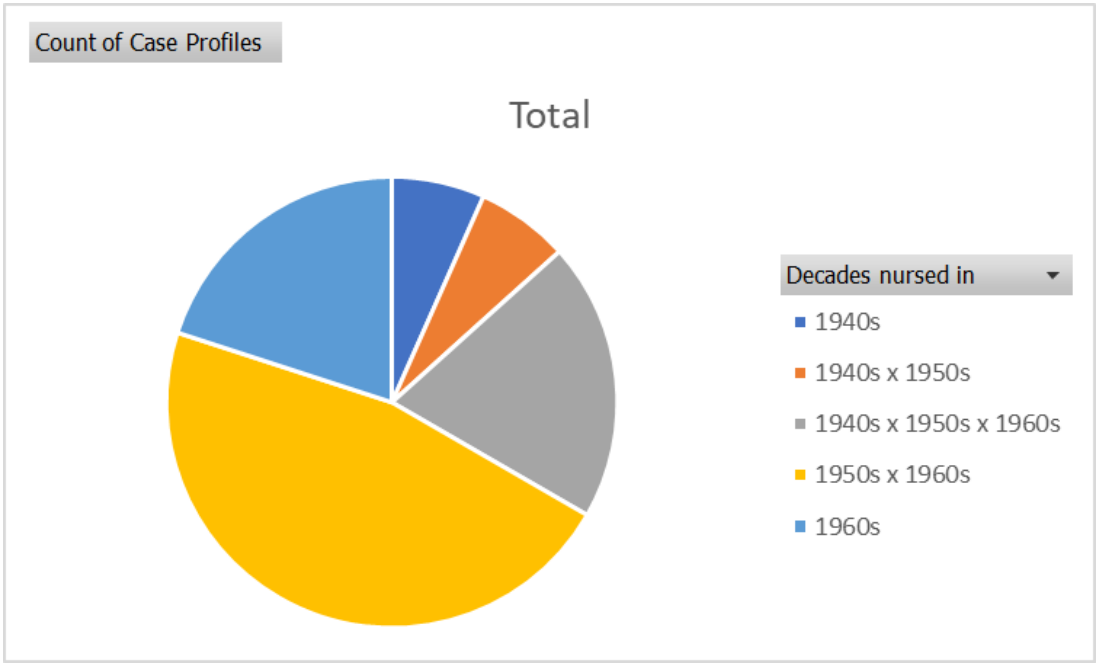


Figure 3.5 The number of years of experience the respondents have

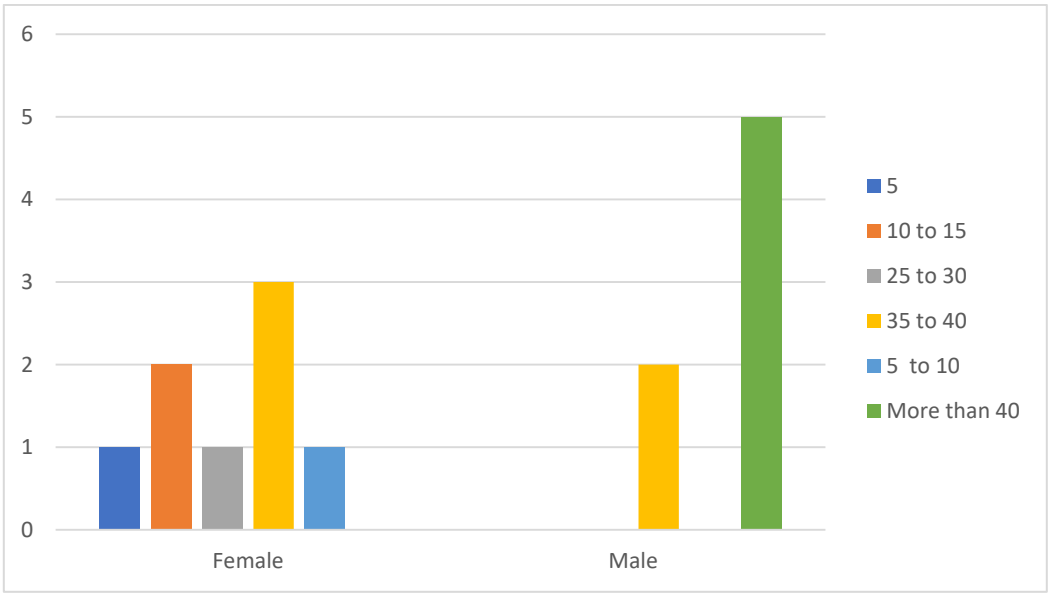


Figure 3.6 The Respondents Nursing Qualifications

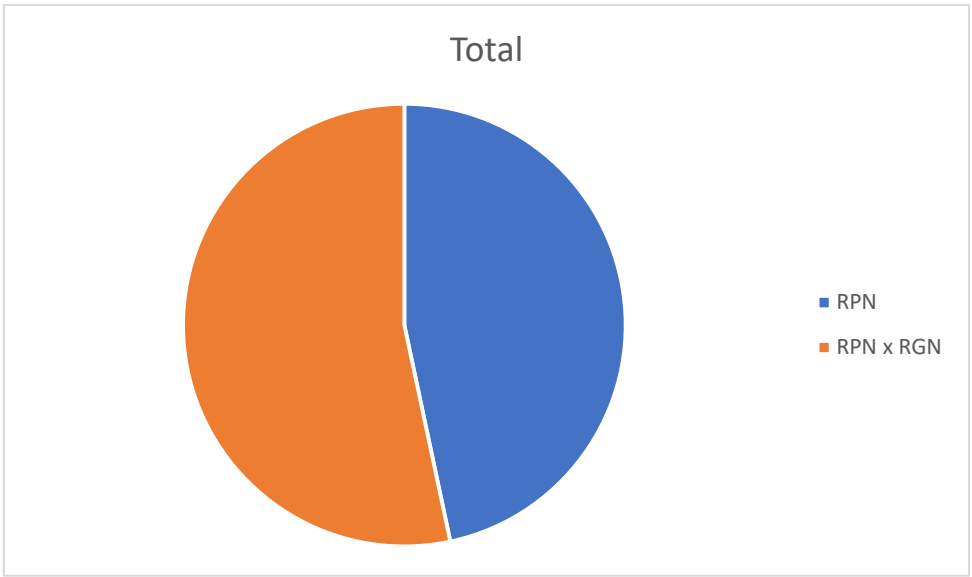
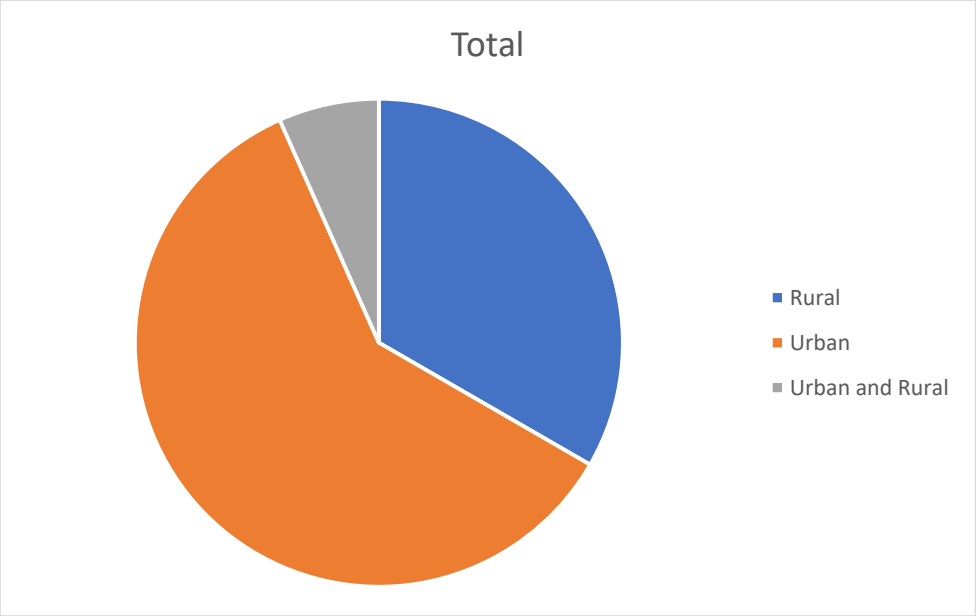


Figure 3.7 Place of employment of respondents



3.6 Ethical Approval

3.6.1 Ethical Review

As all of the participants were over the age of 75 years of age this research required an application for an ethical review by the Research Ethics Review Committee of Dublin City University (see Appendix 1). The ethical process, involved the completion of all the ethical forms to the ethical committee, This process required a review of all decisions made during the course of the research process, in order to ensure that the principle of “do no harm” was employed throughout. The researcher was aware that through the process of recalling past memories, people may get tired and/or emotional. The researcher as an experienced nurse and psychotherapist was cognizant of the potential for this and was vigilant throughout the interviewing process. The researcher was aware of the guiding principles that addressed issues such as confidentiality, privacy, integrity, and respect for people's rights, dignity, beneficence and non-maleficence (An Bord Altranais 2007). The ethical principles of

the Helsinki Declaration (World Health Organization 1964) governing research with human subjects and the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (Nursing & Midwifery Board of Ireland 2014) were the ethical frameworks that guided the research. In this study the ethical issues concerned ensuring informed consent, personal privacy and confidentiality in so far as it was possible and the researcher's role. This brought integrity to the project. Ethical approval was granted in Oct 2018 (Appendix 2).

3.6.2 Confidentiality

Prior to conducting the study, the researcher reviewed the ethics and procedures for conducting qualitative research by Miller et al (2012) and Dowling (2005). The researcher provided assurance of confidentiality as much as possible (including in study publications); however, by virtue of the sampling methodology, it would not be possible to assure anonymity for the participants.

Potential participants were provided with information in verbal and written format. Information was provided on the purpose, process of study entry, potential benefits, participants rights under the Freedom of Information Act, data collection procedures, time commitment, voluntary participation, their right to withdraw without prejudice to care, assurance of confidentiality as far as is possible, the researchers contact details and an offer to answer any questions which they participants may have. When the researcher was satisfied that the potential participant was clear about what they are consenting to do, the time and venue for the interview was arranged. Consent was viewed as an ongoing process, and was negotiated with participants at each phase. Formal written consent was obtained prior to each interview regarding participation in interview and regarding the recording of the interview... A copy of the consent form was given to each participant.

Snowball sampling may have ethical issues to navigate: when potential participants are named, if the researcher had to engage in cold calling to make contact with

them. However, in this study the topic relates to their work experience, the participants are a homogenous group of nurses working in a particular area at a particular period of time, cold calling was not engaged in by the researcher to access individuals and therefore the risk or potential for embarrassment or other ethical dilemmas are reduced but not eliminated.

All data will be retained in a secure storage facility by the researcher for at least 5 years after the completion of the research.

3.6.3 Data Collection Procedures

In order to recruit participants for this study an advert about the study was sent to staff organisations (e.g. Psychiatric Nurses Association) and relevant retirement groups with a request to pass on the information to anyone that they consider might meet the criteria for inclusion. This information included the purpose of the research and the contact details of the researcher. In addition, people who volunteered were encouraged to pass on the information to other potential colleagues. Once potential participants made contact, they were given written information about the study (Appendix 1) including the purpose, process, potential benefits, data collection procedures, time commitment, voluntary participation, the right to withdraw without prejudice, assurance of confidentiality as much as possible (including in study publications), and the researcher's contact details. Participants had a maximum period of time (1-2 weeks) to peruse the information before consenting.

3.6.4 Trustworthiness & Credibility of data

According to Webster & Mertova (2007) reliability in narrative research usually refers to the dependability of the data, while validity typically refers to the strength of the analysis of data, the trustworthiness of the data and ease of access to that data. Polkinghorne (1988) also states that the validity of narrative is more closely

associated with meaningful analysis than with consequences; he maintains it is not satisfactory to apply the previous criteria of more traditional approaches, the measures of validity and reliability, to narrative. Rather what is sought are new measures such as access, honesty, verisimilitude, authenticity, familiarity, transferability and economy (Huberman, 1995). The researcher triangulated different sources of information by examining evidence from the sources, using it to build a coherent justification for themes (Creswell 2012). The researcher will involve the participants in this research study through providing an opportunity to reflect and comment upon their story recording to validate that their story reflects the narrative truth of their experiences. Any changes, concerns, amendments or objections were incorporated into the story of the research and are included in the narrative, along with an opportunity to review their narrative again and the findings.

A further criterion for assessing the trustworthiness of narrative data is whether the narrative research evokes emotion in the participant (Mulhall, 2012). This was captured and analysed through analysis of data and observation by the researcher and noted in the researcher's field notes. The narrative product has all the voices of the participants as well as the researcher's. An ethical posture here is to ensure no one is marginalised (Creswell, 2012).

Some challenges facing narrative inquiry research outlined by Gergen & Gergen (2003) relate to 'crisis of validity' and the 'rights of representation'. If we accept there is no one truth, narratives are co constructed between the participant and the researcher in a particular context, this raises issues in which the findings can be seen as valid and whether or not the researcher can legitimately represent the research participants. This issue will also be captured and analysed through the use of a critical friend and the researcher receiving feedback.

3.6.5 Field Notes

The inclusion of Field Notes was considered important in this study as they helped in the research process. Specifically, Field Notes made it possible for the researcher to

reflect on the interview outside the research area and write them at home or immediately following the interview in the car. These were places that were conducive to thinking about what was pertinent to the interview and the specific story overall since, according to Hammersley & Atkinson (2007), Field Notes have 'the power to evoke the times and places of the "field" and call to mind the sights, sounds and smells of "elsewhere" when read and reread at home' (pg. 176).

3.6.6 Critical Friend

The researcher, through the employment of a critical friend, created an open and honest narrative through shared self-reflection (Creswell 2003). The critical friend asks questions about the qualitative study so that the account will resonate with people other than the researcher. Costa & Kallick (1993, p.49) states that it is only when you change the lens through which you view learning or your own practice that you discover whether a new focus is better or worse. However, they state that by not changing the lens you limit your vision. By identifying and using 'a critical friend' who continually challenged the researcher's focus and pushed the researcher to look through multiple lenses, the researcher engaged in reflection on data gathered to a greater extent.

3.7 Data Analysis

Braun and Clarke's (2006) six phase analytical strategy using a hermeneutic narrative analysis of identity was applied using NVivo 12 to analyse the data from this study. There was constant interaction between each of the steps described.

3.8 Description of the approach to analysis used in this study

The process undertaken in conducting the analysis is outlined below. As I collected the data and transformed it in to text, I read the transcripts a number of times so as

to develop an understanding of the composite of experiences in nursing in the asylum system in the mid-1900s.

3.9 Analysis of Data

According to Creswell (2012) the process of data analysis involves making sense out of text and image data. Analysis is an ongoing process involving continual reflection about the data, asking the above questions and referring to field notes throughout the study. Creswell (2003, pg.193) advised that qualitative researchers analyse their data for material that can yield codes that address topics that readers would expect to find, codes that are surprising and codes that address a larger theoretical perspective in the research. Bogdan & Biklen (1992, pg.166-172) provide a list of possible types of codes: setting and context codes, perspectives held by participants, subject's way of thinking, process codes, activity codes, strategy codes, relationship and social structure codes and preassigned coding schemes. This coding system was used to generate a description of the setting or people as well as categories for themes for analysis. This description and themes were advanced and represented in the qualitative narrative e.g. using a narrative passage to convey the finding of the analysis. A final step in data analysis involved making an interpretation or meaning of the data (Guba& Lincoln, 1994) e.g. what were the lessons learned?

3.9.1 Framework for analysis

Thematic Analysis was employed as the analytical framework for the qualitative data of this study. Braun and Clarke (2006, p.6) define 'Thematic Analysis' as 'a method for identifying, analysing, and reporting patterns (themes) within data'. Since it is not tied to any particular theoretical framework, Thematic Analysis is an adaptable and accessible for analysis. Critics of Thematic Analysis have questioned its reliability and its propensity to result in a descriptive rather than a critical report (Bazeley, 2013). Bazeley identifies unsatisfactory practice in qualitative research as follows:

“too often, qualitative researchers rely on the presentation of key themes supported by quotes from participants’ text as the primary form of analysis and reporting of their data” (Bazeley, 2009, pg.6).

3.9.2 Narrative Data Analysis

Narrative data can be analysed in several ways:

1) Structural Analysis, which involves coding the narrative according to its structural elements. Labov (2006); Labov & Waletzky, (1997) developed a schema for examining the narrative identifying different components namely the abstract (a summary of the story), orientation (story context), complicating action (an event that caused a problem), evaluation (justification or meaning of the event), result (resolution of the conflict) and coda (a final section that brings the narrator and the listener back to the present). Burke’s (1969) structural analysis with a focus on identifying the act, scene, agent, agency and purpose could also be used. Both structures are followed by the researcher retelling or fashioning a new story.

2) Narrative analysis from a psychological perspective which moves towards examining the meaning people attach to their lives and behaviours, how they use language to talk, describe themselves and others, and it attends to the use of metaphors of self-description an intentionality that are revealed in people's stories and discursive patterns.

3) Narrative analysis of identity development, which is almost the opposite of the psychological analysis, starts with the outside stories of the culture and explores how those outside stories create the inside story of the self. The social constructivist view regarding the self as relationally constructed (Duffy, 2012). Bruner (2004) maintains that life is conceptualised as

narrative in order to analyse the meaning and narrative construction of reality.

According to Duffy (2012), cited in Munhall (2012), I must also clearly identify who is the narrator of the story. She states the narrator could be the person who experienced the set of events or it could be a witness to the experiences. She suggests that the narrator of a story does not always represent the authorial voice, even when that narrator is the person who experienced the events. The authorial voice, especially in examining scripts of identity, is more likely to be the dominant discourse of the culture as represented by key figures in the person's life. Weingarten (2000) shares an example of this whereby her mother's impending death describes the dominant discourse or the authorial voice, as the belief that silence and secrecy were the appropriate moral responses to the plight of a middle aged woman with terminal cancer. Duffy cited in Munhall (2012, pg. 429) states that authorial voice does not mean the voice of authority in the strictest sense, but rather the voice of the dominant values, beliefs, and attitudes of the culture that are internalised by the person who is providing an account of their experience.

3.9.3 Data Analysis Using Qualitative Data Software

Computer-assisted qualitative data analysis software (CAQDAS) has been developed to help in the handling, storage and manipulation of the data in studies (Bazeley 2002, Bringer et al. 2004, MacMillan & Koenig 2004). When applied to this study, NVivo 12 was the chosen CAQDAS, as it allowed for a greater efficiency in managing the data collected from the narrative interviews conducted for this research. All datasets (interviews and field notes) were imported into NVivo for analysis and the processes are enclosed in Appendices 4 – 7 inclusive.

The six-phase analytical strategy as outlined by Braun and Clarke (2006) was applied using NVivo 12. The following process was applied:

I read through the entire interviewee's narrative for a sense of a whole to acquire a sense of their person, and a feeling for what they had to tell Once the researcher had become completely familiar with the data during the initial stage, open coding of all interview transcripts commenced, so that the preliminary interpretive process involving the systematic analysis and categorizing of the raw research data could begin (Matthews and Price, 2010, pg.155).

Figure 3.8: Overview of Analysis Process from Raw Data to Findings, (Adapted from Braun & Clarke (2006, p. 86))

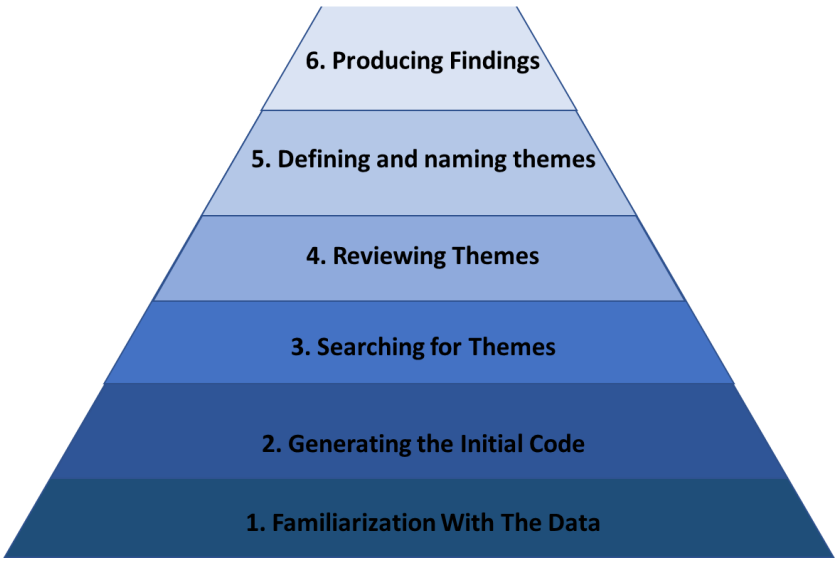


Figure 3.8 represents the initial stages of analysis which involved generating initial codes. These codes were refined and narrowed down throughout the analysis process to generate the final themes.

Figure 3.9 Phase One of thematic Analysis

Phase 1 - Generating Initial Codes (50 initial codes were developed at this phase of the project)	Interviews Coded	Units of Meaning Coded
Asylum Environment	17	202
Asylum culture	12	85
Nurses Reflections	18	140

physical environment	14	60
Working conditions	9	25
Community Nursing role	6	50
Institutional change in 60s and psychiatric nursing skills	5	18
Nursing practice Innovative	7	37
The roots of psychiatric nursing	8	41
confidentiality and sensitivity	4	6
Deinstitutionalisation & Rehabilitation	12	36
Emotional Resilience	6	8
Gender issues	12	34
Housekeeping	3	5
Influences	12	115
Influence of policy and legislation	11	46
The influence of doctors	12	32
The influence of drugs	5	8
The influence of nurses	17	100
Institutionalisation	15	53
Interpersonal relationships with patients	12	55
Leadership	13	52
Nurse training in Psychiatric Nursing in asylums in 40s & 50s	14	97
Nurses perception of the asylum	11	31
Nursing Values	17	109
Patients Activities during the day	11	24
Power	9	61
Professional Agency	13	53
Psychiatric Presentations in the mid-1900s in asylums	16	109
Gender issues	12	34
Housekeeping	3	5
Psychiatrization of life experiences and events	7	15
Reason for going into Psych Nursing	14	44
Recovery from illness	12	49
Searching for the Voice of Nursing	6	25
Social Admissions	13	26
Social community	11	30
Social Values	11	58
Society	7	16
Spirituality	2	7
Stigma	15	71
the medical model	12	43
The role of the nurse	17	168
Role in the community	7	35
Treatments available for patients	14	62
Treatments available in 50d	11	61
Treatments in the 60s	7	24
Under Utilisation/Devaluation of Nursing skills	10	26

Voice	6	25

Figure 3.10 Phase 4 of thematic analysis

Phase 4 – Developing a Thematic Framework (4 Major Themes with Sub-themes Developed in Phase 2	Interviews Coded	Units of Meaning Coded
T1 - The Asylum System	**17**	**908**
T1.1 - Physical Environment	14	60
T1.2 - Working Conditions	9	25
T1.3 - Institutionalisation	15	53
T1.4 - Asylum practices	14	152
T1.5 - Patriarchal System	14	94
T1.6 - Psychiatric Presentations	16	109
T1.7 - Psychiatrization of life experiences and events	7	15
T1.8 - Patients Activities	11	24
T1.9 - Medical Treatments	15	147
T2 - Influences on Psychiatric Nursing	**17**	**360**
T2.1 Reasons for going into Nursing	14	44
T2.2 Influences	12	115
T2.3 Legislation and Health Policy	11	46
T2.4 Unions	9	20
T2.5 Introduction of Anti-Psychotic Medications	5	8
T2.6 Nurse Training	14	97
T2.7 External Influences	11	30
T3 The Impact of Stigma on a Profession	**16**	**362**
T3.1 Stigma	15	71
T3.2 Societal Stigma	14	57
T3.3 Professional Stigma	12	74
T3.4 Shame	15	110
T4.5 Professional Voice	6	50
T4 Nurses Conceptualisation of their roles	**17**	**1529**
T4.01 Nursing in the Asylum	17	359
T4.02 Resocialisation	17	350
T4.03 Deinstitutionalisation	12	36
T4.04 Introducing the Community	6	50
T4.05 Caring	17	263
T4.06 Caring For	17	216

T4.07 Caring About	12	110
T4.08 Family Caring	6	50
T4.09 The Human Connection and Relationship Based Care	13	87
T4.10 Emotional Resilience	6	8

The final phase of the thematic analytical strategy involved the final analysis and write up of the report. This report presents a 'concise, coherent, logical, non-repetitive and interesting account of the story the data tell(s)', linking to the research question and cited literature (Braun & Clarke, 2006 pg. 93).

3.9.3.1 Verification of data

Triangulation of different data sources of information was required to build a coherent justification for themes contributes to validating the accuracy of findings (Creswell 2012). In ensuring internal validity, the researcher employed the following strategies:

- Triangulation of data: Data was collected through multiple sources to include interviews, field notes and critical friend.
- Member checking: Meadows and Morse (2001) support the notion of member checking as a means for ensuring truth value of research findings. I engaged in the process of member checking during and at the end of interviews in order to clarify any ambiguities that may have arisen in the process of the interview: Guba and Lincoln (1994) state that this is a major way of demonstrating truth-value of the findings. Participants were invited to check their written interview texts to clarify that the record represented their interpretations of their role and reality to ensure the truth value of the interview data. Participants were also invited to review a copy of my analysis of the study findings in order for them to '…provide an assessment of the overall adequacy in addition to confirming individual data points' (Guba and Lincoln (1994 pg. 314). Only three interviewees accepted this invitation.

Munhall (1994, pg. 189) also refers to assessing affirmation of participants as one of the criteria for establishing rigor in qualitative research. Affirmation is confirmed through observing ‘nods’ of agreement when participants hear your interpretation or read your interpretation. Member checking did not occur with a number of respondents as some participants had passed away before this process was possible.

- Clarification of researcher bias: At the outset of this study the researcher bias was articulated in writing

The primary strategy used in this study to ensure external validity is the provision of rich, thick, detailed description so that anyone interested in transferability will have a solid framework for comparison (Merriam, 1998). The researcher uses text embedded quotations using the wording of the participants. The following three techniques employed to ensure reliability are as follows:

- The researcher provided a detailed account of the focus of the study, the researcher’s role, the participant’s position and basis for selection, that the context from which data will be gathered.
- Triangulation of a number of sources of data collection and analysis is used.
- Data collection and analysis strategies are reported in detail in order to provide a clear and accurate picture of the methods used in this study.

All phases of this study were supervised by two academic supervisors who are experienced in qualitative research.

3.9.4 Reporting the findings

Although data collection and analysis strategies are similar across qualitative methods, the way findings are reported is diverse (Polkinghorne, 1997, Canagarajah, 1996). Miles & Huberman (2002) address the importance of creating a data display

and suggest that narrative text has been the most frequent form of display for qualitative data. As this study is a narrative inquiry, the results are presented in descriptive narrative form with intertwining quotations from participants with the author's interpretations. A description of the nurses' experiences of working within the asylum is presented. The report communicates a holistic picture of their experiences and the meanings attached to them. This provides the reader with a lens though which they can view the participant's world as a Nurse in the asylum system in Ireland and although the patient's voice is lost to us, nevertheless the Nurses shed some light on the context of asylum life and what life was like for them.

3.9.5 Limitations of the study

Hermann (1995, pg. 183), referring to the limits of narratives as a source of data, states '...it is always only 'the story of' that can be narrated, not a state or an always recurring routine'.

Probability sampling methods are considered to be the gold standard for recruiting participants who are most likely to be representative of the larger population from which they are drawn. The author used purposive sampling along with the non-probability method of snowball sampling in this study. Snowballing as a sampling method does not recruit a random sample. The participants in this study do not participate by chance alone, therefore the risk of bias may exist as the sample could have an over-representation of individuals with numerous social connections who share similar characteristics (Magnani et al., 2005). However, to reduce the likelihood of potential for bias, the author broadened the scope of the study to asylum staff nationally which incorporated urban and rural settings.

Reaching saturation point is also an additional limitation of snowball sampling in the research context as there is no statistically reliable way to estimate whether 'saturation' of the sample has been reached. In qualitative research "saturation" is defined as when no new information is forthcoming from the participants in the

sample that has been recruited already, therefore the author cannot know if additional information could be gleaned had a random sample been recruited. However, the author relied on the concept of 'information power' (Malterud, K., Siersma, V. D., & Guassora, A. D. 2016) to guide an adequate sample size for this qualitative study. Information power indicates that the more information the sample holds, relevant for the actual study, the lower amount of participants needed.
On the other hand, the sheer amount of textual data that unstructured texts can produce may present problems in interpreting them (particularly if stories steer away from the study topic).

Snowballing as a methodology also carries the inherent risk of disclosure of personal information to the researcher therefore sources might be reluctant to contact other individuals whom they believe to have a certain characteristic, as that might represent a disclosure of information about themselves or information that has been obtained in a personal and private context.

The need to find more effective and efficient recruitment strategies is paramount. Snowball sampling is a recruitment strategy that is particularly effective in reaching hard-to-reach groups. Variations on this technique have proven to be adaptable and appropriate in a wide variety of education and research applications. The benefits and limitations of these adaptations of snowball sampling, when used in the research context, must be carefully evaluated against the benefits and limitations of probability sampling in order to select the optimal strategy. The benefits of using these approaches to recruit participants for health intervention programs must be weighed against the privacy concerns that are inherent in any individual social situation or health condition.

In the face of these limitations, the researcher is still confident that a narrative inquiry using snowballing methodology was the most suitable approach for this research question and for the interviewees within this study.

3.10 Conclusions

As stories are a fundamental way in which meaning is expressed, embodying the cultural values and emerging understanding revealed by stories, this approach seems particularly applicable with the context of this study. The appeal of a narrative oral history approach for the researcher lies largely in its ability to explore and communicate internal and external experience: it has the capability of crossing the boundaries between research and practice. Therefore, capturing these nurse's stories and analysing them may lead to a better understanding and yield a greater/deeper insight into the origins and development of psychiatric nursing, the changes across time in mental health care and the evolution of the profession. Engaging in this research also gives these nurses a voice and an opportunity to testify on behalf of a vulnerable group of people who existed in our society.

3.11 Summary

This chapter has described the epistemological and ontological position of this research. It has detailed the theoretical and conceptual frameworks along with the methodological rigor applied to the research from the research design, ethical review, data collection, data analysis along with the potential limitations. Chapter 4 follows with an analysis of the data, a presentation of the research findings using a significant number of individual quotes. These quotes seek to provide a description of experience that is complex and multifaceted (Denzin, 2001).

Chapter Four

Findings

4 Introduction

As foregrounded in the review of the literature, a history of psychiatry which did not include the history of nursing was incomplete. In Ireland, the history of nursing is absent and the voice of nurses silent and isolated from this history in the mid-1900s. A significant portion of this history lies in the memory of those who were psychiatric nurses in asylums at that time. This study which aims to capture these nurse's voices, through fifteen oral histories and fifty four pages of field notes obtained, should contribute to providing some equilibrium to that history and contribute to making it more complete as unfortunately the voices of the patients who populated those asylums are now lost to us.

Considering the paucity of capturing the voice of these nurses in research conducted in an Irish context, the researcher wanted the voices of the nurses to be heard in the presentation of the data (Creswell, 2012). Therefore it is of utmost importance that I use copious amounts of quotes to allow for contextualisation and a deeper and more meaningful understanding of nurses' lived experience of working within the asylum system in the mid-1900s. I wanted to facilitate the construction of a collective narrative between the voices of these nurses: the research participants so that a thicker description and a deeper understanding of their experiences as nurses is achieved. Since it explores the experience of nurses whose contribution was marginalised within the history of the asylum system, it was essential that these voices were not 'silenced, disengaged or marginalised' (Creswell, 2012, pg.285). Direct quotes from female registered psychiatric nurses are indicated and abbreviated as FRPN and from male registered psychiatric nurses as MRPN.

The findings of this research indicate that the composite of the nurse's experiences is composed of four themes. The data was coded and analysed using Nvivo 12

(Appendices 4-8). The following themes and subordinate themes emerged as being the most significant in the investigation. These themes are captured in Table 4.1 below:

Table 4.1 Thematic Representation of Research Findings

Theme 1:	**The Asylum System**
Sub-theme	The physical environment
Sub-theme	Working Conditions
Sub theme	Institutionalisation
Sub theme	Asylum Practices
Sub theme	A Patriarchial System
Sub theme	Patient Presentations
Sub theme	Psychiatrisation of normal stressful life events
Sub theme	Patient Activities
Sub theme	Medical Treatments
Theme 2: Influences on Psychiatric Nursing	
Sub-theme	Reasons for going into Nursing
Sub theme	Influences
Sub theme	Legislation and Health Policy
Sub theme	Unions
Sub theme	Introduction of Anti Psychotic medication
Sub theme:	Nurse Training
Sub theme	External Influences
Sub theme	A Social Community
Theme 3: The impact of Stigma on a Profession	

Sub-theme	Stigma:
Sub theme	Societal Stigma
Sub theme	Professsional Stigma
Sub-theme	Shame
Sub-theme	Professional Voice
Theme 4: Nurses Conceptualisation of their roles	
Sub-theme	Nursing in the Asylum
Sub-theme	Resocialisation
Sub theme	Deinstitutionalisation
Sub theme	Introducing the Community
Sub-theme	Caring
	Caring For
	Caring about
Sub-theme	Family Caring
Sub theme	The Human Connection and Relationship based care
Sub-theme	Emotional Resilience

4.1 Theme One: The Asylum System

A significant finding of this research deals with the asylum system and the social context and culture in which nurses worked. This finding is particularly relevant as it describes how nurses experienced the environment and culture in which they learned their trade. These asylums represented in this study provided mental health services to twenty counties nationally and are located in both urban and rural settings. They were part of the national network of asylums that were built across the Republic of Ireland

It was a deliberate decision of the researcher to include descriptive quotes from nurse's narratives in order to have an appreciation of the context in which these nurses worked and the dominant culture which prevailed.

4.1.1 The Physical Environment

This section offers a description of the physical structure of the asylum. It attempts to shed some light on the impact of this asylum structure socially as well as culturally and how that system impacted on the experiences of psychiatric nurses.

The experience of this influenced and shaped nurses understanding of their roles and the role of patients in their care as follows:

MRPN6 *The asylum in 1948 was a frightening place, tin mugs, plates with CLA stamped on them, CLA, and you asked what did that mean and you were told what it meant Clonmel Lunatic Asylum, there was no knives of course because of possibility of injury to themselves, raggy clothes, little or no bed linen, no sheets it was appalling honestly.*

FRPN7 *Locked away behind high walls around the Hospital and grounds with a gate was kept closed and locked all the time… the gate Lodge was on the right of you, next to that was the laboratory and the Mortuary.*

FRPN5 *Two theatres (surgical theatres) going full whack, one in the male house and one in the female house which were totally separate… because… at that time psychiatric patients were not allowed into any general hospitals for any reason, under any circumstances, other than to the Richmond (hospital) for a leucotomy, numerous operations were carried out: appendectomies, caesarean sections… etc. Other facilities in the institutions was 'a delivery room and a Maternity Nurse on the staff too.*

While the nurses presented individual accounts of their experiences, in all of the narratives severe overcrowding and lack of resources were highlighted as a major challenge to them providing any semblance of care. In one asylum in the Grangegorman hospital the number of nurses and attendants in 1925 were 454, providing services on a 24 hour basis to a population of 3,413 patients (Weekly Irish Times, 29 Nov. 1930.)

MRPN4 *The overcrowding quite staggering. It had gotten to a stage where they just wouldn't be able to cope with it… everything was more or less pushed into the Psychiatric service, the elderly you know, the handicapped and the mentally ill'*

MRPN1 *I think the overcrowding was the worst thing, a big dining room would hold… I don't know how many patients, upwards of 300 or 400 patients in a huge dining hall. It wasn't very nice for them; it didn't help their progress you know, so many of them.*

FRPN6 *It was frightening and we were working with all of those patients, that was another thing, and we had very little antiseptics, you might get your hands washed and you might not, there was no place for you to go and wash your hands, have a bit of soap, nothing.*

FRPN7 *The 'Big Kitchen' was in that Block too. All the food for the patients and nurses who all worked together, the meal came from the Butchers shop on a horse and cart, as did all the other vegetables, etc. there were huge big ovens in the Range, where all the meat was cooked. Patients eat in big Dining Halls, 'what it was like, some big shed you'd see out in the country.*

MRPN1 *The dinner used to be on from twelve o'clock until one. And there'd be about two hundred and fifty odd, there could even be a bit more.*

MRPN1 *There was a bit communal bathroom with about 10 baths in it, there was big sheets you'd dry them in you know, there was no towels.*

The above excerpts highlight the demands of providing care in such a work setting for these nurses in a diverse range of areas. The asylum contained farms which were generally located away from the institution where cattle and cows were kept and milked, a piggery where pigs were kept as well, gardens where vegetables were grown and crops harvested, which supplied the institution

FRPN7 *The hospital had had their own abattoirs, its own Workroom, Bakery, Pharmacy, Shoe repair shop, Mattress shop, Butchers shop, Tailors shop, Carpenters shop, canteen, etc. They had their own Fire Service, Two churches, C of I and RC, they had 2 Masses every Sunday to facilitate all the patients. Then the laundry and the boiler house, patients and staff worked hard in the Laundry, all divisions would send in their linen and clothes, they were collected and delivered back again by horse and cart. All the vegetables were grown there and taken to the Hospital by horse and cart. Most of the patients were farmers or farmer's sons.*

FRPN7 *The grounds were very well kept, flower beds shrubs, etc., There was a football pitch, hockey, cricket grounds, a tennis court at the nurse's home, 2 Bowling Greens beautifully kept with seats around it,: one in the Female Hospital and one in the Male Hospital, all supervised by a gardener and a land Steward who lived on the grounds with his family.*

FRPN4 *They had their own cinema and dances, patients' entertainment, there was regular entertainment every week, films and dances*

Nurses described their impressions of the asylum when they first arrived there to start training as a nurse. Young male nurse's recount arriving in the asylum, being weighed, measured, taken to a small room off a large ward where he would live in and sleep and issued with his own traceable pass key. Females were accommodated in a nurse's home

MRPN1 *Was kind of… maybe not frightened but amazed at… I think I was kind of mesmerised really*.

MRPN6 *It was a very noisy place, you know it could be really dangerous place; it was frightening that's the only honest to God answer you can give!*

FRPN5 *The patients were extremely disturbed, when I arrived, I thought they were acting, their level of disturbance. It was like a drama. They were in their own little world and I didn't talk much to them. They marched up and down and I stayed out of their way. It was the most hopeless situation I ever came across. It was terrible, terrible.*

4.1.2 Working Conditions

Psychiatric nursing, unlike general nursing, constituted equal numbers of male and female nurses; males were not allowed train as general nurses in Ireland at that time. Genders were segregated within the profession of psychiatric nursing. Nurses described the diverse range of patient's presentations on the wards among a cacophony of noise and a diverse range of behaviours along with a heavy workload:

FRPN3 *It was terrible, I was a tough character myself, I could face anything like but I tell you, it was hard, hard work now. You could have 120 patients in one dayroom and in that dayroom you'd only have about what,*

maybe four or five Nurses. Then as well as that, they didn't have the medications and treatments that they have nowadays you know

Later in the early 1960s nurses recalled wards being divided, due to overcrowding, importantly staffing numbers were also divided, which did not facilitate increased therapeutic engagement:

MRPN2 *You could have 120 patients in one dayroom and you'd only have about what, maybe four or five nurses*

FRPN6 *Staff were very scarce so you were very, very busy. Then as well as that, they didn't have all the medications and treatments that they have nowadays you know.*

Nurses were rostered on day and night duty in a variety of wards and locations on 12 hours shifts: All nurses recalled the poor wages they received:

FRPN7 *You worked a 48 hour week and every week then, when you worked a day on, day off, for three days and then you had a half day work or a day until 5pm, it was a very long, it was very intense you know. Then you did night duty about every three months when you're turn came around and in those days it was very hard because you did a whole month of night duty, 28 nights running without one night off, not one night off and that was very hard and I can remember it so well, it was very tiring you know.*

MRPN4 *It was so variant you know. You could be actually working with patients in the gardens or cutting the lawns or if you got a load of onions from Portrane, you had to supervise them, putting them into storage and all of that type of thing and then in the Wards, you were looking after the patients, there was kind of more security and preventing*

them from escaping as you say and then there was the years of working in the Infirmary.

FRPN7 *We were badly paid too. We all worked very hard, our cheque given to each of us on the last day of every month was £4-6-4p (that was 1944). We had to do with that which meant we couldn't even buy our clothes; we had to go to the Hire Purchase scheme. I also had to pay 2/6p per month to buy my bicycle.*

MRPN4 *They had a Nurse in charge of the pigs which was a fairly senior position, a charge Nurse, I think he got x number of pounds more per year than the charge Nurse of the Infirmary which housed the sickest patients in the Asylum so that will show you how important the pigs were!.*

4.1.3 Institutionalisation

It is important to note the agreement between nurses' expressed experience of the patient's presentations when admitted to the mental institution and the subsequent impact of the institution on them. While this research is not examining patient experiences, all of the narratives provided by the nurses in this study refer to aspects of the institutionalisation factors: loss of contact with the outside world; the enforced idleness; browbeating and bossiness of staff; loss of choice, loss of family and friends, loss of possessions and personal events; drugs; ward atmosphere; and loss of prospects outside the institution (Barton, 1976) that patients experienced. This was patient's daily reality which nurses witnessed and applied in an extremely overcrowded patriarchal culture and which contributed to the institutionalisation of patients. One nurse reflected on the harsh orders which influenced patient's admission and how they came to being in the asylum:

MRPN2 *They were put in there for various reasons, troubled rows at home over something, some brothers are getting married and no place for*

them at home and dumped in there, …….family quarrels, well family quarrels usually ended up with a patient ended up in Hospital and not a case of been thrown there because he should have never have gone there.

MRPM6 *Once you went in, you were on your own really, weren't you? You had no one to support you!*

MRPN1 *There is no doubt in my mind those men could have gone home, you would ask yourself the question 'why are these men here?*

MRPN5 *Always that conversation arose whether they should be there or not. They were there so long they wouldn't manage at home and their families didn't want them to come home then'. Ah it was sad, the whole thing!*

MRPN6 *No… no… no, no…. no…. no…. a lot of those people after thirty years in our hospital or any other psychiatric hospital probably wouldn't fit in at home.*

FRPN1 *It is amazing how quickly institutionalisation happens, a lot of patients ended up institutionalised. If you put people who are psychotic, out of control, hearing voices, and feeling vulnerable and you provide them with a safe environment where they are cared for, warm, fed, they will want to stay. It is very hard to deinstitutionalise them then.*

MRPN6 *I (a community nurse) saw them go home after they'd been there for years, I'd help get them home by going to the parents and families and they went home and they would last forty eight hours, they were institutionalised, you know they were institutionalised so there was no way, a lot of them didn't fit in!*

Another nurse while recollecting the many patients whom he believed was impacted by this iatrogenic illness gazing sadly into the unknown, nodding his head from side to side and tutting stated ‘ and these are stories of people, real people’ (MRPN6).

4.1.4 Asylum practices

Nurses in this study reported their role in trying to control patients and managing disruptive behaviours in the absence of pharmacological interventions. They described the ‘abysmal’ overcrowding along with small numbers of demoralized staff were saddled with the thankless task of trying to contain it all while paying lip service to notions of care and treatment (Barker, 2009, pg26).

> MRPN1 *The patients would start to go to bed at six thirty. And that was my biggest shock of the evening, sun shining on the wall and everybody in bed and doors locked then when you left. Clothes were tied up; every Patient tied their clothes up in a bundle and left them outside the door they were all along the corridor.*

Considering everything, I mean considering overcrowding and all that, the patients were basically looked after well enough in that, we ensured that they were kept, they had their weekly bath, they had their weekly change of clothes, the beds were pretty well kept. Even though it was hard work like, they just had the basics you know.

The bathroom was in the old building and the whole one hundred sixty odd, seventy, or eighty patients, they marched down to bath, ….there were about twelve baths, I think but there’d be a Nurse or a Man taken from this Ward and that Ward to have extra Staff for bathing, bathing would last about an hour!!. Ohhh (tutting)!

> MRPN7 *Now I think the asylum in (name removed) was very, very rough, nothing for a Patient to get a belt of a brush to put him in his place.*

Patient supervision, maintaining social order along with managing patients and the daily rhythm and routine, was a major responsibility of nurses working in the midst of an often unpredictable and disruptive reality (Bochma, 2003). All of the nurses described the strict hierarchical system of asylum governance and how it held nurses responsible for the safe custody of patients. The escape or suicide of a patient was unacceptable and could result in nurses being dismissed from employment. This was a major concern for nurses privately as they could lose their jobs and socially this was also a matter of public concern and embarrassment for the RMS. Such events would get priority in local print media. One nurse recalled how some nurses on one asylum managed patients in the 1940s and responded in kind to outbursts of violence.

MRPN5 *Well a bit of kindness it never was wrong, that'll do no harm. That would be in short supply there in those days because you know the environment didn't lend itself to it and this fear thing you had, like you know, fear of basically doing anything (wrong), you were afraid of losing your job.*

MRPN7 *There was no medication, the charge nurse there if a patient misbehaved, they were beaten and clattered. And a charge Nurse there I saw him hitting patients with a sweeping brush. Marks from getting a belt of a brush or something and it was all covered up. But that was now that was must be the 40's.*

4.1.5 A patriarchal system.

All of the Resident Medical Superintendents (RMS) in Irish asylums were male and all of the nurses in this study recalled how they held primary power and predominance in governance roles, moral authority and administrative privilege and overall control. Nurses' narratives suggest that the RMS saw themselves as prestigious and intellectually superior to nurses. They recalled their uncompromising authority with which they ran the asylums; RMSs did not develop a rapport with

nurses. They recall the RMS's as being all males; they didn't recall a RMS showing particular interest in patients in the 1940s and 1950s. Nurses described how the RMSs often considered nurses as institutional property.

> MRPN2 *You had to get permission to get married, you know that? That's unbelievable, from the RMS!'*

> MRPN1 (The RMS) *used to think that they should inter marry the staff, because he says, they wouldn't just go talking about Patients or that in public if they did.*

> MRPN 7 *There was a Resident Medical Superintendent* (RMS) *was in charge of each institution. The so called RMS was the boss; you see the RMS was the General Manager of everything.*

Nurses were aware of their requirement to conform to the regimental patriarchal system within the institution if they wished to continue working there. Nurse's narratives described how this hierarchy of power manifested itself in countless visible and subconscious ways. While patriarchy can be a system of power that divides along ideas of gender, neither males nor females were privileged over one another, both sexes while strictly segregated and were equally powerless in the asylum system:

> MRPN3 *If you were found on the female side of the house you would be sacked!*

> FRPN7 *We had to be in the Nurse's Home at 11pm every night, except when we could get a 11.30pm pass once a week, and 12.30am pass once a month.*

There was no evidence provided in this study to indicate that nurses held power to influence their situation or that the needs of nurses were considered by asylum

authorities. The evidence would indicate that the consideration given to nursing staff within the asylum system was equivalent to if not less than the consideration given to the patients. The social control of patients and care of the physical aspect of the institution was the RMS's main priority, nurses' recall having no power or authority to influence any aspect of hospital policy.

> MRPN3 *You couldn't say anything to the RMS that was the way the place was run, that was the type of care. You know as far as the Nursing Staff were concerned it was all about a safe environment just providing the safe environment, not about the patients' themselves.*

The description of some of the nurse's experiences would indicate that distinctive social behaviours and norms along with management practices that existed within the asylum system, defined its culture. The ability of the institution to adapt to change was restricted and some nurses recalled how this impacted on them professionally. The system of seniority was one such practice and was notable as one which impacted negatively on incentivisation of initiative.

> MRPN1 *So I wasn't very long here when I said to myself I am not sitting around here for 20 years waiting from promotion, so what do I do?*

> MRPN3 *I had done the sums on it and it would take me 25 years to get a promotion with the seniority system and I'm going to get a promotion in the next month if I go to England*

It is important to note that the majority of nurses in this study acknowledged that unions supported the democratic needs of nurses in improving their working conditions and salaries. However all of the nurses agreed that such representation did not necessarily support or result in culture change and the professional development of the nurses' role to modernise mental health care provision in Ireland.

It was notable that all of the nurses who travelled to the UK to train as general nurses experienced prejudice and harassment and a devaluation of their role when they returned to work in the mental institutions in Ireland:

MRPN6 *When I came back and I was a lost soul I got a, instead of working the ordinary hours I was put on an eight to five time so I used to clean up the patients and dress them up. Now when you come out of a forty bedrooms surgical ward and patients coming going and coming to theatre and now I was in a big ward, washing faces and washing hands and tidying, lacing their shoes and so on.*

MRPN1 *In Ireland I heard terrible things being discussed, some at union meetings, how nurses should be treated when they return from doing general training. It frightened me. Instead of supporting nurses to get the best qualifications to develop and progress nursing to improve patient care!*

MRPN6 *I remember one morning a fella said to me: you so and so (name calling)… but like no, you weren't wanted…You had to be thick enough not to… let it bother you?*

It was notable that all of the nurses involved in this study were aware of and identified a failure to develop psychiatric services and implement mental health policy and change within institutions during that period. This failure to progress also applied to the profession of nursing along with governance systems and processes in asylums:

MRPN1 *Nurses were stifled by the lack of progress in mental health policy in Ireland in the 1950s.*

MRPN3 *There was a lack of opportunities in Ireland in mental health nursing compared to England. No opportunity for promotion on merit at all.*

MRPN6 *Opportunities: there was none here, none whatever. But I came back because well I was married and had children.*

MRPN1 *The Commission in 1966 made recommendations that patients should be discharged and that there should be community care, where patients could be visited in their own homes. It also suggested that rehabilitation should start.*

It was important to note that with the exception of isolated incidents of innovative leadership on behalf of one or two individual consultants, nurses noted the apathy and failure of psychiatry in general to implement the recommendations of the Report of the Commission on Mental Illness (1966) supporting the rehabilitation, deinstitutionalisation and community development. This did not occur for a further 20 years almost (Dept. of Health, 1984).

4.1.6 Patient Presentations

Nurses recalled how they were deprived of having access to patient's admission notes, clinical histories and biographical data. Patient's charts were either retained in a central office where only the psychiatrist or RMS had access to them or locked away in the ward. As a result, in attempting to classify patients admitted to asylums and their clinical presentations, such diagnostic processes were based on nurse's memories and experiences of having nursed these patients. Nurses recall with regret how they were not trusted with such clinical information.

Nurses narratives on patient presentations on admission to the asylum demonstrate a wide range of diagnosis with some vivid descriptions of patient's behaviours as

shouting, groaning, aggressive, extremely disturbed, troublesome, having nightmares, in stupors unable to speak, etc. Nurses recalled the most common presentations of patients admitted were: depression, schizophrenia and epilepsy. All of their narratives recalled large numbers of patients with epilepsy, wards full of 'epileptics'. The numbers were so great they had huge numbers in wards dedicated to that specific diagnostic group:

> FRPN5 *A lot of patients would have epilepsy – they would be falling at your feet. Other patients with physical illnesses included patients with venereal disease: syphilis and patients with TB.*

> MRPN4 *Other patients who were physically unwell and who had neurological involvement were also admitted to asylums: Patients with the late effect of venereal diseases treated by anti leutic treatment administered by injection. These patients were not allowed to be treated in the local general hospitals…The psychiatric hospital had to take many patients that could not get treatment in other facilities.*

While nurses recalled geriatric patients with dementia and presenile dementia, they also referred to individuals with physical, sensory and intellectual disabilities in asylums. Many patients were also admitted with alcohol addiction

> MRPN4 *There would have been patients with alcohol problems and a lot of very well-known people suffered from alcoholism, publicans, politicians and writers, some very well-known people. For the delirium tremens (DT's) they would probably have some sedation but beyond that there wasn't any great treatment.*

> MRPN5 *We had a lot of patients from Connemara, they maintain it was the Poitín was also a big problem.*

They recalled a majority of the women as presenting with bipolar depression, post-natal depression and suicidal ideation, they recalled a significant number of these women were unmarried mothers with some coming from Magdalene laundries and unmarried mothers homes.

Nurses also recalled patients diagnosed with schizophrenia presented with symptoms of delusions particularly delusions of persecution, grandeur and guilt; many delusions had a religious content. Sensory hallucinations, hearing voices being the most common, paranoid schizophrenia which was associated with morbid jealousy syndrome and assaultive behaviour as well as individuals with suicidal ideation

MRPN4 *There were two main categories of diagnosis really, people were either depressed or were schizophrenic or Dementia Praecox as it was formally known'.*

FRPN5 *The patients were extremely disturbed, when I arrived in (the asylum), I thought they were acting, their level of disturbance. It was like a drama. It was the most hopeless situation I ever came across. It was terrible, terrible!'*

MRPN3 *But there was a terrible lot of aggression you know, we discovered later on, the reason the aggression was, it was nothing got to do with their condition at all, it was space.*

It was notable that nurses who had trained and worked in the UK had a different perspective on how patients should have been managed. One nurse recalled how all of the patients were cared for in the same ward.

MRPN3 *There was a mixture of all sorts of patients, psychotic patients, neurotic patients and at that time, everybody had a different diagnosis. Impulsive Psychopaths, eating things, swallowing things, etc.*

Fellows had no insight into anything and they were hearing voices and talking to people and talking to themselves.

MRPN4 *Paranoid Schizophrenia, you know severe depressions, agitation, severe agitation particularly and they took a lot of minding really. People with alcohol addiction: publicans, politicians and writers came into the service with the DTs (Delirium tremens) probably have some sedation and people after the war, they came back with syphilis.*

It was notable that some nurses questioned the ethics of prescribing certain treatments along with the efficacy of those treatments, They also questioned the diagnosis and classification of mental illness in some patients and how aetiology was established or how such broad categories of diagnostic classifications was defined :

FRPN1 *Patients had defined categories, psychotic depression bipolar schizophrenia etc. They were broad categories which were clearly defined. I am not sure if that was appropriate or not maybe people should not have fitted so clearly into these categories, maybe it was just to put a label on them. It is more difficult to pin it down we were not aware of the many contributing factors that influence mental wellbeing. The social environmental factors addictions and the contributing factors in the 50s and 60s we did not know about. From a MH point of view a lot of illnesses were seen as genetic in those days.*

MRPN6 *If it was cured by insulin coma, you would have to ask yourself did they really suffer from it (Schizophrenia) in the first instance?*

MRPN3 *Well they were schizophrenic mostly and they were signed in because they caused some trouble at home or something. One fellow had set fire to a cock of hay for example.*

Many nurses recall how the causes or attribution of the cause of patient's distress was never discussed. They recall believing that poverty, neglect, trauma and abuse was misunderstood and not acknowledged within Irish culture or within the biomedical model of psychiatry at that time, many recalled:

MRPN2 *Poverty was a real problem. Maybe neglect too.*

FRPN1 *Who knows what trauma people carried with them that they couldn't speak about that led to psychotic symptoms. Such trauma may not have been a direct cause of schizophrenia but similar behaviour and distress acting out.*

FRPN1 *Like abuse which is coming to the fore now, physical and particularly sexual which was very prevalent and was never mentioned by any psychiatrist that I am aware of. I never heard a Psychiatrist refer to it, I never saw it in any patients file, nobody ever thought about it or talked about it but who knows how many people were in here as a result of it. Such trauma at a young age may have been a direct cause of schizophrenia or psychotic state.*

MRPN6 *Sexual abuse. All those things were all hidden you know they were all hidden in those years, God knows I never came across any relative who complained that any member of their family had been Sexually Assaulted or something like that, never, it was never discussed!*

It was notable that some of the nurses in this study questioned how aware people were of the role of societal culture and behaviours had on individuals' mental health and how societal values condoned such abusive behaviours and neglect.

FRPN1 *A lot of people were traumatised and made to feel worthless at a very young age particularly in schools, primary schools, People were regularly told they were useless. All of that contributed to*

individuals having low self-esteem, depression inability to form or keep relationships and all of that in later life and it would have been very easy to fit them into diagnosis of depressive, border line schizophrenia, without people knowing what was going on in their lives. I am not sure that there was an awareness of it in the 1950s and 60s.

It was never seen as contributing to their illness unless the individual was able to articulate what the trauma was they had experienced. Because they would hide it or be afraid to admit it as it would be seen as weakness.

It is notable that all nurses, with the exception of two nurses, recalled with sadness the social role asylums assumed in confining significant numbers of individuals whom they believed were inappropriately admitted and confined to these mental institutions for long periods of time, for some, their life time. They believed that the labelling of individuals with a mental illness diagnosis occurred surreptitiously for social or political convenience.

FRPN6 *Was never discussed you'd have to decide what had social issues.*

MRPN3 *There was a little boy of ten admitted as a patient. He was loved by all including myself, I'd say maybe 1949, no further on that 1950 you know and he was there in little short pants that little boys wear in those years, a lovely little fellow. He could have outbursts of anger and it appears that was what happened at home and as you probably know yourself from your own experiences, in those years, of '48, '49 and '50 all along it was easy for the Parents to put him there and close the door and forget all about him… when he was about fourteen the hospital gave him a Job as a messenger boy just delivering messages around the hospital you know. And he grew up in it.*

MRPN6 *Two brothers in a house, one maybe a bit contrary the other fella went to get married, he brings in the Wife the Brother is in the way, ends up in the asylum. Now that's true I saw that myself I did, saw*

that you know. And there was many, many reasons, that the asylum became a loading house for admissions where the young girl became pregnant, that was a typical one, you know. Shame of course in those years, in the 1940's into the hospital, Priest and all there all agreed they should be put out of the way. They just grew old there! You probably know all about those yourself it's just a common discussion, into the asylum and never come home. And those were the jobs that I and others had to do when we went on to Community I in particular because I started the Community in 1964.

Nurses remembered a significant number of patients who they believed were admitted for social control reasons, individuals presenting with behaviours that were perceived by society as not normal or unacceptable. Nurses believed that society was strongly influenced by the Catholic Church.

MRPN3 *Unmarried mothers, homosexuals, lesbians, alcohol, poverty was a real problem and neglect.*

FRPN7 *May came from a small town in Co Mayo, she got pregnant at a very young age: I think she was 16years old, the baby went up for adoption when it was born and May was sent to a Magdalene laundry, she was later sent in to the asylum and worked in the laundry in the hospital, she worked really hard. She was the same age as myself and we were great friends.*

In stark contrast however, one female and one male nurse recalled as follows:

FRPN5 *Contrary to what you'd hear there were nobody there by accident, definitely not.*

MRPN7 *They were pretty bad before they came in because nobody would want them to go into a Mental Hospital, the relatives wouldn't want the stigma of having a relative in the Psychiatric Hospital.*

4.1.7 The psychiatrisation of normal stressful life experiences

While the nurses recall in their respective narratives many individuals whom needed care and detention, as outlined in section 4.1.6, they also recalled caring for many individuals who they believed were inappropriately admitted and labelled as mentally ill for either social or political purposes. In this study nurses identified cultural issues, stigma and social difference as influencers of diagnoses of mental illness and admissions to mental institutions. Nurse's narratives indicated that a significant amount of admissions represented human experiences and behaviours that were 'psychiatrizatised' (Kelly, 2016) through admission to an asylum: family quarrels, entitlement issues, gender issues, domestic issues, greed. Many nurses recall individual being admitted for reasons of demonstrating distress to normal stressful life events which they may not have had the power or opportunity to talk about. Such symptoms of distress which the respondents deemed as an appropriate response, would not have lasted and would not have affected the individual's life, however the temporary nature of the event and distress was not considered.

FRPN1 *Patients were very often admitted for the safety of the public rather than themselves and generally at the behest of the family. There could be multiple reasons for that, I saw parents coming in with young lads who were causing problems and with younger children, begging us to take them and they would be admitted.*

MRPN1 *Another case was a man who became paranoid also around home, was taken to the local asylum, realising he was there, he got terrible upset, he was in a single room. When he was at Mass on a Sunday in the hospital he managed to get out. At the time it was a terrible crime for a patient to escape. He lay in a field of corn and they walked all*

around him and didn't find him. There was a regulation at the time that if you were gone for 30 days they couldn't take you back. He travelled by night and hid by day, he ended up in the north of Ireland. He returned home and lived a long fruitful life, he actually worked and lived beside people I know and I often ask the question if that man had not managed to escape from the asylum, would he have died there. I think he would, so…

4.1.8 Patient Activities in the Asylum

Mental asylums needed a large workforce and a great deal of work done to ensure its efficient functioning. Within the asylum nurses recall patients being engaged in a variety of occupations, many worked on the farms, in fields, in orchards, gardens, various trades, workshops, laundry, stores, and in both indoors and outdoors activities. While nurse's recollections of the collaborative involvement of patients with them in these activities were in the main positive, they were aware that the purpose of such activities was to ensure the effective and efficient upkeep of the institution.

This work in the 1940s to the late 1970s for patients went without pay. While no nurses in this study referred to the patients work as being exploitative labour, many nurses recalled how hard patients worked:

MRPN5 *The patients worked hard! They did. They never asked for anything you know, they gave them their food and tobacco and that was all they wanted. They used give them rat tail tobacco, it was about a half inch thickness.*

Nurses recollected a diverse and varied range of chores carried out externally in the asylum:

MRPN52 *The pines now was a farm ward, you would leave every day with about 30 to 40 patients. The patients worked on the farm, they*

did all the farming work… pulling turnips… digging potatoes, washing vegetables, some digging, some milking, some with the pigs, that was their living, they seemed to enjoy it, they were happy. None of them (patients) ever went home.

MRPN5 *I did 20 years in the garden. I was a charge nurse in the finish. I had so many patients every day with me. We supplied all the flowers to the hospital and to the wards and to the town. They (patients) did different jobs gather up the sheets, count them, bring them to the laundry, check them, you could depend your life on them. A lad worked in the boiler shop, the tailor shop, and the baker shop. They used bake their own bread, carry in the flour and put the cakes in the oven. Another lad used keep the grass cut, another lad did painting, he kept the place well painted, the charge nurse never had to worry about the place. One of my patients, he was a foreman, when I was missing he took charge. Some of the female patients worked inside in wards and kitchens, others worked in the laundry.*

FRPM5 *Patients enjoyed working in the laundry, they would be waiting in the morning to go, they felt valued and free there. We did the autoclaving in the laundry.*

It was notable that while the asylum had a large range of sporting facilities, no nurses recalled patients taking time out of their day to participate individually in leisure and sports activities other than the annual sports day for both staff and patients and some social activities.

FRPN7 *There was a dance once a week for the patients – the music was supplied by members of the staff that was held in the big dining room*

4.1.9 Medical Treatments

The nurses recalled working in overcrowded wards, in poor conditions, with periodic outbursts of violence. All of the nurses referred to the use of tobacco within the wards as a panacea for human distress either woodbines to smoke or rat tail tobacco, from a giant coil into which it was compressed, to chew, One nurse recalled some physical treatments which were carried out on patients in the 1940s, treatments such as cold water baths and the use of a swinging chair. One nurse recalled the administration of emetics and purgatives was also practiced; it was thought to remove toxic matter from the patient in an attempt to improve his well-being.

> MRPN7 *They did purges and in-enemas. Well I know when a new Patient came in they got camomile and in-enemas, and that was the kind of treatment, they felt that that it helped them. But it was no use. God it was mad, bizarre kind of thinking. Completely mad!*

Another nurse could recount a time when he was involved in the administration of ECT and Insulin therapy and inducing insulin coma's. This he recalls was a treatment option for patients with schizophrenic, particularly children and adolescents.

> MRPN4 *We carried out ECT, Electrical Convulsive Therapy and we'd have about 30 (males) three times a week and the female side was roughly the same, we had 60 three times a week for ECT and we had insulin coma therapy, we had about 30 patients every morning, they were at various stages into insulin coma.*

This nurse recalls the intensive nursing care provided to patients who were prescribed insulin therapy:

MRPN4 *It was quite intensive nursing. We minded them, there were no Doctors you know. There would be a Doctor in charge of the hospital but it was the general qualified nurses that carried out the treatments. It was discovered, by accident, it was thought that Epileptics didn't develop Schizophrenia and the idea of the insulin coma therapy was you induced seizures in the patient. So they might have, during the insulin coma therapy, they could have up to… they were allowed to have up to six seizures you know during the coma and once they had six seizures, they had to be taken off the treatment, they were only allowed six. It was something like the amount of ECT a patient would be allowed.*

How effective insulin therapy was also recalled by one nurse who stated:

MRPN 4 *I think it was discovered afterwards had to do with the amount of attention they (patients) got. It was that thought more that it was the Psychotherapy aspect of it more than anything else that had the good effect you know. Working with the group in close proximity had that good effect because of the attention they were given so that was it. Overall the amount of cures didn't warrant its continuation.*

Another nurse remembers patients being admitted with tertiary syphilis (General paralysis of insane: GPI). He recalled:

MRPN 7 *After the First World War there were an awful lot of patients in mental hospitals that had general paralysis of insane you know, they had been out in India and they got, they had venereal diseases. They were treated with an injection of malaria, they'd have to get so many high rise temperatures, their temperatures used to spike and you had to be very fussy about watching the temperature that it would spike at a certain date and a certain time and you'd have to keep a record of that. But that was the first (*medical*) treatment of patients that he (the RMS) introduced in St Brendan's. I was the first general trained Nurse to come to that hospital* (name removed).

Another nurse recalled subsequent treatments prescribed for patients with syphilis:

> MRPN4 *Leutic therapy I think they called it, one of the parts of the treatment was arsenic, you know it was a very severe treatment but unfortunately they weren't cured of it but it alleviated the symptoms you know. I remember we had a patient that I was giving the injections to and he hadn't completed the course but he wanted to go home and there was no reason why he should stay in the Hospital but they wanted to make arrangements for him to have the injections outside, now there was no community service at that time but we tried his local general hospital in Dublin (name removed) to see if they would give the injections to the patient and no way they wouldn't. The general hospital wouldn't give the injections because of what he had.*

Nurses recalled the administration of Electro Convulsive Therapy (ECT) as a treatment in the 1940s and later administered under general anaesthetic in the 1950s (Henry & Deady, 2001, p54). The nurse recalled their role in the administration of ECT as:

> FRPN5 *You had to bring them in and hold them down on the trolley while they put the thing on their head, and administered ECT. It worked for some for a while and then they would relapse again!*

Along with ECT, nurses recalled frontal lobotomy or leucotomy as a treatment option prescribed by psychiatrists. Leucotomy involved surgery on the frontal lobe of the brain. It was a controversial and contested treatment which entails the cutting of nerve connections to and from the prefrontal part of the brain (Kelly 2016, p176).

There were a diverse range of recollections in nurse's narratives on the professional ethics of leucotomy as a treatment:

FRPN5 *Patients who were extremely disturbed were referred for leucotomy, some patients came from the country hospitals and was nursed in the Dublin hospital. I thought leucotomy was barbaric; it quietened them down but did nothing for their mental illness.*

FRPN7 *But in those days, the poor patients didn't get any choice I suppose … well it did help, some of them and some of them it didn't*

In summary this first theme attempts to shed some light on the asylum structure and its system of administration. These findings demonstrate the experiences of psychiatric nurses who worked in asylums. It provides an insight into the social and cultural role of asylums in the mid-1900s, the patriarchal culture that existed and the role of nurses within that system. The findings provide an insight into how nurses were excluded professionally from having any authority to influence policy.

4.2 Theme Two: Influences on psychiatric nursing

Influences emerged as a theme from my data analysis. Data indicates that there were a significant number of influences on psychiatric nursing in the mid-1900s. What influenced individuals to choose psychiatric nursing as a career option, what were the social and cultural influences on the profession and on nursing practice at that time, along with the impact of contextual factors such as the introduction of new mental treatment legislation. The introduction of new pharmacological interventions in the mid-1950s and the impact of this on symptom management and on nursing practice is also considered along with the introduction of new healthcare policy specifically addressing mental illness and service development. These themes will be explored and relevant interview and research diary note excerpts presented to support my interpretation of data provided.

4.2.1 Reasons for going into Psychiatric Nursing

It is interesting to note that psychiatric nursing was a ‘word of mouth’ profession; the majority of nurses recall being influenced by either their parents or family members who were in the business and /or knowing psychiatric nurses which influenced their choice of career. Many nurses followed family members or colleagues into nursing in the asylum and others needed influence to get into such jobs:

> MRPN7 *When I went into (name of asylum) you were very lucky to get in because there was no such thing as a job in Ireland. My father spent or dished out buckets of whiskey to the committee of the Sligo Mental Hospital to get me into work in Sligo*

> FRPN8 *You know you had to know someone, they thought … caring was genetic.*

The lure of talent influenced recruitment policy within asylums; many at interview were asked what they could contribute to patients.

> MRPN3 *I knew a lot of the psychiatric nurses, they played hurling and I played hurling myself. At that time, I played minor county hurling for Galway and I got an all-Ireland with them boys, Jesus come on in, they wanted me to play with them.*

> MRPN5 *That was one of the conditions when I went in, the head nurses asked what can you do to help the patients and I said I could play the fiddle.*

Most nurses recalled the poor unemployment situation in Ireland at that time. Recruitment and retention of staff in asylums did not appear to be problematic, nurse’s recall waiting for vacancies to arise and waiting to be called for nursing:

MRPN5 *There wasn't a lot of work around at that time. I was two years waiting to get in.*

MRPN1 *My sister wrote to me and said there's a vacancy coming up and at that time you have only about ten vacancies every year.*

The guarantee of a steady salary and a public service pension was also identified as an incentive. Jobs were very scare and emigration high in Ireland in the 1940s and 1950s.The recruitment process entailed an interview and/or exam in all asylums along with achieving a certain physical height criteria.

FRPN7 *I came to Grangegorman Mental Hospital in Oct 1944 having had a medical and a written exam. Anyone wearing glasses were not taken on, we also had to be a certain height, we had to have a black dress, apron.*

MRPN3 *I applied for the interview. I went and when I got there, there was 94 people for interview… there was 10 places available.*

4.2.2 Influence of Psychiatrists

The data in this study highlights the role of the Resident Medical Superintendent (RMS) who was appointed by the Minster was both executive and administrative, and how influential he was within the asylum system. The RMSs were always male. . His role was 'to superintend and regulate the district mental hospital and to devote his best exertions to the efficient management thereof' (Section 13; http://www.irishstatutebook.ie/eli/1946/sro/203/made/en/print). The evidence in this research indicates that the asylum workplace and cultures were informed and governed by psychiatrists. The data demonstrates that the governance, culture, daily practices and routines evolved under their direction and influence. As psychiatry entrenched itself within the asylums the nurse's narratives describe how psychiatric

nursing did so also. The data highlights how psychiatric nursing emerged from this culture.

> FRPN7 *In the early years the whole idea was that nurses weren't to speak to the patients, stay as far apart from them. You can observe you know but not to talk, not to communicate with them and that and to be seen talking to a patient, you could be reprimanded for it.*

> MRPN4 *Doctors tried to prevent nurses from communicating and doing psychotherapy with patients you know, that's not their job, they (nurses) were restricted by the system from doing that and probably still are.*

It is important to note that throughout the period of time from the 1940's to the 1950s nurses in this study could not recall a RMS or medical presence on wards and they recalled minimal medical presence at ward level, in the 1960's and patients being generally brought to a central office to see a Consultant or the RMS. Nurses articulated in the data how they were prohibiting from accessing patient charts and how their roles were disrespected and devalued by their medical colleagues ignoring and excluding their professional opinions and contributions.

> MRPN7 *The RMS was seldom seen; he had a secretary in the annex. If a serious decision needed to be made the patient was brought to him.*

> FRPN1 *At that medical level we didn't know what went on, what was discussed, nothing was recorded and nothing shared with the team. You were a silent learner weren't asked for an opinion, you didn't offer an opinion and you didn't have an opinion.*

The above excerpts indicate how different professional groups held different beliefs about the importance of their contributions, the impact of interdisciplinary rivalry and the professional philosophical belief of supremacy within the medical profession.

The data however, provides a glimpse of the potential and opportunity for RMSs and Consultant Psychiatrists to influence policy, lead change, develop and modernise mental health services and influence nursing practice as was indicated by two nurses in two different areas in this study.

> MRPN6 *The Medical Superintendent was the kind of a man, the man who really started it all. He promoted Nurses going to England to do the General, he got rid of the tin cups and all that, tin mugs, different bed linen, different suits. If you went looking for something from them (hospital administration) for a Patient …the Hospital would provide money for that so they in fairness to them Dr Egan promoted it.*

> MRPN2 *I remember there were a Dr McDaid started in'57, he was a different stamp altogether to what we had. He did work that the rest of them didn't ……he started picking suitable clients he would have them ready for discharge, getting them out home for weekends, …he would have to write to the families and get them to accept them for a weekend and we would go out with them. So, he discharged quite a significant number!*

4.2.3 Influence of Catholic Church

While the Catholic Church had no involvement in the governance of asylums, the data in this study indicated that socially and culturally the Roman Catholic Church's values and views influenced the social and admission practices in asylums. Following the establishment of the Irish Free State, the Vatican was offered the power of veto over legislation contrary to faith and morals in return for papal recognition of the new Irish state (Cooney 1999). This power of veto was agreed

informally. This moral influence is also evident in the findings in Section 4.3.1 and 4.3.2 on stigma and section 4.1.6 on social admissions.

FRPN1 *The church shaped thinking in society – they preached ethics and ethical principles, it should have been situational ethics!*

MRPN3 *That was the rules I suppose, do you know, in the 50's male nurses weren't allowed into female wards that was the sort of the culture at the time. You remember the ladies had to wear long skirts; well it was the influence of the Catholic Church.*

FRPN1 *We took choice from family units. The more families have a say and they can make choices about themselves and their lives the better, we took choice from them.*

MRPN7 *As men could not apply for general nursing in Ireland in the 60s. The only way to do general nursing was to go to England to do it. A number of the lads went and did their general so there was always a RGN available to work in the acute units.*

The above excerpt suggests that nurses in this research believed that they defended these Catholic values and morals in practice within the institutions, particularly those relating to traditional family values and to sexual relationships. Some male nurses in positive ways took a critical stance and contested such moral views by travelling to the UK to train as registered general nurses. This new professional development in psychiatric nursing however, signified a major change and challenged the institution's informal customs and practices which created stressors likely to cause workplace discontent (Section 4.2.4).

4.2.4 Legislation and Health Policy

Within mental health services there were significant developments in mental health care in the 1940s. A number of nurses recalled the impact of the Mental Treatment Act of 1945 in providing safeguards against the arbitrary detention of patients. However despite this legislation, the numbers of individuals being detained in asylums continued to increase until, by 1959, there were over 20,000 patients in Irish mental hospitals. Nurses recall that it was not until the 1960s that Ireland began to give public consideration to its psychiatric services. When this happened the nurses believed that the introduction of involuntary admission status provided for in the 1945 Mental Treatment legislation had a major influence on the development of the nursing role.

> MRPN6 *You talk to them and then you were able to convince them and, I say, no need to get a Doctor it's a voluntary patient you come in with me now this evening, I'll take you in…*

The above excerpt suggests that the right of an individual to enter and leave a mental hospital voluntarily formalised nurses' role in clinical decision making and accountability for the assessment and monitoring of an individual's mental health function both within the institution and in the community.

In stark contrast however to these views, one nurse believed this legislation took away the right of the institution to compel patients to engage in work based activities while in the hospital, this he believed contributing to the deskilling of the patients and institutionalisation.

For many nurses the 1966 report of the Commission on Mental Illness was welcomed as an opportunity to develop their professional skills through the modernisation of the mental health services.

> MRPN1 *The commission on mental illness in 1966 was the biggest influence on nursing in asylums. The Commission made recommendations that patients should be discharged and that there should be community care, where patients could be visited in their own homes.*

The above excerpt suggested that nurses saw a glimmer of hope of change and progression of their roles and professional career prospects. However nurses identified a number of historical customs and practices which had been inherited from the early 1900s had become management policy and which retarded development and progression in mental health services

MRPN1 *The majority of nurses were in favour of making progress. A big hindrance or drawback to progress within psychiatric hospitals was the policy of seniority. When I started in the hospital you got promotion by seniority as opposed to merit. The only way around that was if you acquired another qualification: your general (nursing).*

MRPN1 *It took almost 30 years to become a deputy or charge nurse. There was no incentive to improve themselves. One thing you learn very quick was …the person that was in a week before you was senior to you, that's all you heard was seniority.*

The above excerpt highlights the structural and policy challenges nurses needed to overcome to develop professionally. Over 70% of the male nurses in this study, travelled to the UK and trained as general nurses and returned to work in Ireland.

MRPN1 *I arrived back to take up the job and all hell broke loose. The unions were very much against me taking up the post. I was adamant that I had trained in England worked my butt off, had two children and was going to take the job and I did.*

MRPN6 *No, no, no (accepted by staff when he returned) as a matter of fact I came back and I was a lost soul, Now you come out of a Surgical Ward you know with these tips and forty bedrooms in a Surgical Ward and patients coming going to Theatre and all this craic. Then I'm in a big Ward, washing faces and washing hands and tidying, lace their shoes*

and so on. I remember one morning a fella (nurse) said to me (respondent's name) you're a so and so (derogatory term)… but like no you weren't accepted no! They didn't want me there, no. They thought, I was different because I had an extra qualification.

The above excerpts indicate that for many nurses following general nurse training some nurse's experienced professional isolation. The perception of their role definition had changed and these nurses entered an internal struggle within their own professional group to articulate the contribution of this change. Some staff experienced horizontal workplace violence manifested in a range of behaviours that were often hidden, being ignored, name calling, put down and insulted. Some nurses saw the RGN coming back after doing general nursing as a threat.

4.2.5 Influence of Trade Unions

The data identified the increased dissatisfaction nurses experienced in the patriarchal system within the institution and how little power individual nurses wielded. In this void trade unions became established. In 1917, the Irish Asylum Workers Union (IAWU) of Ireland was established and led the first nurse's strike in Ireland in March 1918 (McCabe & Mulholland, 2017). This union became the Irish Mental Hospital Workers Union (IMHWU) from 1922 and due to falling membership, in1926 the union was amalgamated into the ITGWU Many nurses in this study recalled how the formation of unions provided nurses with a means to express their dissatisfaction to employers and improve their terms and conditions of work and that they had benefitted financially from them. The unions worked from the premise that;

MRPN7 *If they improved it for staff that would improve it for patients!*

MRPN5 *The unions that got extra money for the staff and they got in extra staff or staff, One of the biggest changes was the wages for*

nurses, was the improvement of wages, we were paid very poorly in the 40s and 50s and 60s. SIPTU were strong at the time it was very poor for a long time.

However from a professional perspective the vast majority of the nurses in this study stated that unions did not promote and support change and development within the service and within the profession of nursing.

MRPN1 *In Ireland I heard terrible things being discussed, some at union meetings, how nurses should be treated when they return from doing general training. It frightened me. Instead of supporting nurses to get the best qualifications to develop and progress nursing to improve patient care and to ensure nurses were more competent and confident in their practice.*

MRPN6 *I couldn't ever say that (the unions were helpful), no they, I wouldn't say so, no, no I wouldn't say that at all.*

FRPN6 *I'm not so sure if they (unions) would be the people that brought the standards up, no!*

These excerpts suggest that while nurses understood that unions represented the needs of the majority of nurses, however they strongly believed that these democratic needs to maintain the status quo did not necessarily harmonise or translate to service change, progression and the modernisation of mental health services.

4.2.6 Influence of introduction of Anti-Psychotic drugs

The most significant development in physical methods of intervention within psychiatry according to this group of nurses was the introduction of pharmacological

treatment in particular the anti-psychotic medication in mental institutions and how it impacted on the quality of the patients' lives. The nurses provided many examples of patients who improved dramatically and could go home.

MRPN7 *The turning point in psychiatry, patients' lives were totally different and nurse's lives were totally different, as well as their relative's lives were different.*

MRPN6 *Well some people today say, that medication is bad for some people it's of no advantage I can assure you I say that one hundred percent one thousand percent they are wrong it is and, it was then.*

MRPN6 *Now I saw people in the Ward in those years in 1949 in strait jackets. I went away for a few years to do my general, and came back. …….I said to somebody, tell me, where is Joe (I won't mention his name), ah he went home, and where is Mick, these two guys had been in Strait Jackets and I going away and now they were gone home. I was flabbergasted you see for these two in particular.*

This nurse subsequently described how he began working in the community:

MPRN6 *On my list of people was Joe. And I couldn't wait to knock on the door. Come in, he was the same Joe but now he was dressed up and talked away, how are you? You were in England he said, yeah talked away, normal talking…..And that was the effects of medication Joe was on medication as was Mike. …..hundreds of others you know who improved and went home too, but the medication was the turning point in my opinion, and it was my practical experience.*

FRPN5 *We had a titled lady one time; she was locked up day and night because of her level of disturbance, very aggressive. She was tortured. Two of us would take care for her physically. She was*

commenced on Serpazil drug and she was restrained each time she needed it. She became completely better.

The introduction of pharmacological interventions majorly influenced the atmosphere within the institutions for nurses. The environments became more conducive to therapeutic engagement for nurses and provided greater opportunities for interpersonal relationship development.

MRPN6 *The improvement was unbelievable. The patients became more calm, they were less aggressive and it changed the tone of the unit. More of them could go to work, it was very exciting for them. They came out of the darkness; they were rational enough to hold a conversation with you.*

MRPN5 *The tranquilisers helped you to talk to them. They helped you to communicate with the patients that were one major thing.*

Nurses recalled numerous pharmacological interventions prescribed for a variety of presentations, some for depression, psychosis and sedation purposes. However because of the positive effects of these drugs, the enthusiasm with which these drugs were prescribed caused some nurses concern. Nurses expressed concern regarding the occurrence of side effects and identified a correlation between the dosage of the drugs and the duration of treatment with these medications to some negative side effects

MRPN6 *Tranquillisers became the main treatment, administered in large doses.*

MRPN4 *Largactil and Melleril was given to everyone really, psychosis and depression. I always thought it was good for that type of depression. It was probably overused. There were terrible side effects to the drugs, Parkinson's, etc.*

MRPN1 *When drugs were introduced…the drugs were mostly beneficial but there were some not so nice side effects such as sedative, stuttering and parkinsonian side effects. Some charge nurses were very reluctant to give patients the doses they were prescribed as there were risks involved and side effects that were not reversible… This was double abuse!*

4.2.7 The influence of Nurse Training

For the majority of nurses who qualified as registered psychiatric nurses in the 1940s and 1950s,nursing care was informed by a training syllabus within the 'Red Handbook' which had been prepared by the Medico-Psychological Association in 1884 for the training of attendants. While some nursing instruction was provided by senior general nurses, the predominance of the medical profession's influence was evident in its content and at examination. Nurses recall attending lectures in their own time. The training involved first aid, surgical instruments, storage and sterilisation, heart failure and respiratory conditions. The 'Red Handbook' contained condensed and elementary information relating to the physical body and physiological functions, nursing the sick, the mind and its disorders and the care of the insane.

MRPN4 *The lecturing was different, at that time there was no full time lecturers when we started and wasn't for a long time. All through our training it was all hourly lecturers. The Doctors lectured you late at night and you got lectures from the Psychiatrist and you got lectures from senior nurses. In some places, it was the matron or the Head Nurse, in other places it would be a General Nurse, duly qualified nurses, that's who would be appointed to give the lectures. You had the prelim lectures and you had the final lecture but you could attend either.*

Nurses recall different standards of training around the country, one nurse recalls his experience of training as being of a practical nature:

MRPN2 *They would be supervising that they were bathed properly just, that's the way it was, that was in '56, '57 then, no there was no training no, just the bare essentials.*

FRPN2 *I would be put in charge of a Ward from time to time without any training so you would go up and be responsible for a certain ward of patients*

All of the nurses recall inadequate curriculum content, an inappropriate medical emphasis and its overall unfitness of purpose of the nurse training to inform practice. This concern was also expressed and highlighted in the report of the Commission on Mental Illness in 1966. The report identified that training schools were generally poorly organised and it recommended greater leadership from An Bord Altranais, requesting that a 'forceful' inspection approach was required to ensure that standards were improved. Some nurses also saw education as a way of bringing about change in the culture of the institutions while others believed it was a professional obligation to develop the profession of nursing. The data in this study outlines how Psychiatric Nurses designed a new education curriculum, with a more patient focused, philosophical and ethical approach to care. This initiative discarded the medical model and changed the language of nursing and nursing care. Nurses recalled how they intentionally pursued a career as teachers to influence development of the profession and professionally identity. By initiating the development of nursing schools with new specialist psychiatric nursing programmes and curriculums, nurses believed this would contribute to a collective sense of professional nursing agency for the wider profession of psychiatric nursing:

MRPN4 *Becoming an Educator in Nursing, I suppose it was a way to bring about change. I think that would be the biggest motivation that if you were to change something, you would be trying to be a teacher of change; I think that was probably one of the reasons!*

MRPN6 *When I came back from England there was no Nurse Tutor here because I asked to do it … to develop the nursing role and establish a nursing school'.*

FRPN2 *I brought something of a new perspective to it because I had been through the general Hospital but you see, all the time I knew it (psychiatric nursing curriculum) wasn't right. It was embedding a medical model and I was understanding and learning a lot about physical medicine and you know, expert of the brain and heart and the eye and the ear and teaching all of that very dramatically and you could see it all and you could work it on the Board. But when it would come to Psychiatry, I hadn't a clue you know really, apart from the fact that I would be able to talk about people with their delusions and hallucinations and I could understand what that was but I had no sense really of psychiatry. So I had to learn it from the book and every year that was 1960, anyhow so I kept muddling away like that.*

FRPN2 *A complete change was required, but at the same time, what the complete change was from custodial care to an attempt to become more therapeutic. This change would be noticed in Nursing, not in medicine. It started from the School of Nursing, the change. It didn't come from medicine and it didn't come from a Psychiatrist, it came from the programme that we had developed in the School of Nursing. It was a more experiential programme so we moved away from the old chalk and talk medical model of education and we began to do much more group work and interpersonal work and we thought students in that mode rather than chalk and talk!... involving greater self-reflection and self- engagement with their personal selves to be part of their work in order for them to understand and interact therapeutically with others …As a result of this change, at exam time a tutor colleague (in another area) examining our nurses, used say' 'Here they come - all head and no hands' (laughing)!*

Nurses were aware that psychiatric nursing was a specialist division of the registrar of nurses and recall the requirement for a practice orientated curriculum to inform this specialist practice that differentiated it from the other divisions of nursing. It was required to be based on theory, knowledge, and skills that are most often peculiar to that specialist discipline within the profession of nursing. The nurses in this study identified the need for specific tools and psychological approaches to use within their practice, different from those within the generic discipline of general nursing. However one nurse recollected that such theoretical approaches were beyond the understanding and/or capability of nurses at that time and needed to be constructed.

> FRPN2 *Very much into the therapeutic and interpersonal stuff, we were all ready, you know, to challenge the older way of doing things and to create a new perspective on Psychiatric Nurse Education because we always said there are no two people presenting the same so you must have an open mind when you go out there to care for people and you've got to be able to listen and to relate and to teach and to encourage people to develop their own coping mechanisms. ……we were getting people to stand back, patients to sit back and think, have I a skill that might help me to deal with this depression I have and what is that skill you know, maybe it is that I am able to read or write or cook or… but nobody has ever helped me and in that way, patient's began to take control of their own lives a bit better as well*

Nurses recall this active construction and generation of new knowledge and learning to inform the creation of a new curriculum. They ensured this learning was to take place not alone in the classroom but also in personal and professional practice, through clinical work but also through personal development of attitude and behaviour.

> FRPN2 *But they were wonderful tools of development and that's what they were, developmental tools and it did influence practice in the wards so the voluntary admission had come, students would take patients out, now I know that was happening elsewhere as well. Students would*

organise little groups in the Ward, in the same way as they were doing it in the classroom, so they might have a little stress management group or they might have a voices group or they would have some little group. We were trying to develop a spirituality group at the time and that was the hardest one, would you believe that, even for us we didn't know what spirituality really was!

With nursing experience the awareness of these nurses grew of the need for the integration of intrapersonal work in the curriculum to prepare the psychiatric nurse to develop more authentic interpersonal relationships. This relationship based care they believed would ensure greater fitness for purpose to ensure the profession was appropriately prepared and proficient to meet the diverse range of needs patients were presenting with.

4.2.8 External Influences

The issue of poverty which was a social phenomenon from the 1940s to 1970's in Ireland influenced the admission of individuals to mental institutions. The introduction of the Community Welfare Officers who had a statutory responsibility for the administration of community welfare services and payments to individuals with a mental illness to support themselves influenced the discharge of some patients to the community.

MRPN3 *Poverty (in rural area), poverty was the big bumbler and I think it was a good part of the reason of somebody was got rid of into the asylum, you know they weren't able to provide or they weren't an asset, they weren't wanted.*

MRPN2 *I know people who were coming and going from Hospital they may have been sent back and had no money but as true as God as*

my Judge, the day they got the DPMA (Disabled Persons Maintenance Allowance) they never came in again, that's true.

The establishment of Mental Health Associations in 1966 supported and funded the resocialization and subsequent deinstitutionalisation process in many areas. Nurses involvement in this initiative pioneered the beginning of introducing members of the public into the institutions with altruistic intent, bringing in the community.

MRPN4 *The mental health association, with the musical evenings bringing people into the hospital, that was very beneficial. Patients began to see that society is not as threatening as they thought, that they were not really as rejected as they thought and that to go outside (in public) wasn't as threatening, it wasn't as dangerous as they felt. The mental health association gave them a lot of interest and activity, moving out you know, then going to different things outside the hospital.*

MRPN4 *Patients would go out and away for a weekend, the minibus that they hired was a white minibus, I actually remember people running into their houses when they'd see the white minibus, that is a fact, stigma of course was an issue it was always an issue you know although the degree got less and less, as the time went on I suppose.*

4.2.9 A Social Community

Workplace structures and processes in the asylum were both formal and informal. While a formal patriarchal administrative system required certain practices from nurses, informal workplace structures and cultures developed within asylums. Nurses recalled in their narratives how their social lives existed within the institution and the development of internal social networks. The primary socialisation began when nurses all lived within the institution, off the wards in rooms and in the nurse's home, accommodation was strictly gender segregated: male or female, nurses were

subject to restrictions on their movements with continual supervision and discipline if rules were breached. Nurses recalled the security of the internal hospital community. This influenced how nurses socialised. It resulted in a high level of engagement and comradery between both the female and male nurses. This engagement provided opportunities for both sporting and leisure integration. The development of an internal social community provided significant social and professional supports for these nurses lasting throughout their lifetime. The nurse's professional and social life was bound to the asylum. However for some nurses, this socialised community presented some obstacles for nurses who did not accept the status quo and/or required change.

MRPN3 *There was a very large group of us started at the same time and we had a great hurling team, we won a few championships.*

MRPN5 *Nurses were a clannish crowd, all the nurses met up with the female nurses. I met my wife in the hospital. She was 10 years working when we got married; she had to leave work anyway.*

FRPN7 *We had a great social life in hospital, we had dances about four times a year, we had a social committee and music from our own staff, there was a great comradery among staff.*

FRPN6 *We used to have dances down in the big hall, many a romance blossomed down there'. I met my husband there. We went out for about two or three years, then we got engaged and we got married in 1959.*

MRPN5 *All the nurses built their own houses, we helped one another, we designed our own houses and built them.*

In summary this theme outlines the influences which impacted on nursing both positively and negatively. It highlights the influencers of the creation and

maintenance of the culture within asylums and the struggles within nursing to extricate itself from the medical model and strengthen the professional values and practices of the profession.

4.3 Theme Three: Professional Challenges

This theme offers a description of what professional challenges nurses encountered as psychiatric nurses. The data in this study presents significant challenges relating to the nurses identity and acknowledgement of their profession. For many of these nurses who shared their stories with me, being professional and being acknowledged as professionals was important to them. Many of the nurses narrated how society's opinions on mental patients and asylums and societal values were responsible for influencing their professional identity at that time. The challenges psychiatric nurses faced and their strive for acknowledgement of a professional role and identity within psychiatric nursing, within the profession of nursing and within society as a whole, is presented through these nurses' narratives in this study.

The sub themes in this section are as follows:

Sub-theme: Stigma:

Sub theme: Societal Stigma

Sub theme: Professional Stigma

Sub-theme: Shame

Sub-theme: Professional Voice.

4.3.1 Stigma

The word stigma is a Greek word, its origins referred to a type of marking or a tattoo that was cut or burned into the skin of criminals, slaves, or traitors in order to visibly identify them as blemished or morally polluted persons. These individuals were to be

avoided particularly in public places (Goffman, 1963). Nurses described a range of behaviours and experiences of individuals being admitted to the mental institutions which they believe occurred to eradicate or reduce family embarrassment, the stigmatising behaviour or outcome of behaviour.

FRPN2 *There was a stigma attached to having a family member with a mental illness so they (the family) would get them into a psych hospital they thought it was the best thing to do, the safest thing to do for them. But it wasn't always in the patient's interest. That wasn't considered as much as what people thought, and what might happen.*

MRPN6 *The asylum (name) was 'a loading house for admissions, young girls became pregnant, that was a typical one, you know. And, you, they got pregnant, shame of course in those years, in the 1940's into (name of) asylum, Priest and all there all agreed they should be put out of the way And those were the Jobs that I and others had to do when we went on to Community, when I started in 1964.*

FRPN1 *Society was not kind in the 40s 50s and 60s it was not a compassionate society, there was no compassion for individuals who found themselves in difficult situations. Society provided so little choice to individuals and families, in particular to women; women had no choice and no voice. The church shaped the thinking of society. They preached ethics and ethical principles … it should have been situational ethics.*

Nurses described how frequently, admissions came from homes for unmarried mothers or similar locations because those individuals did not conform to the mores of these institutions (Walsh and Daly, Mental Illness in Ireland, 1750-2002).

FRPN5 *Oh there were lots of them (unmarried mothers), if they were in a home the Magdalene as you know now, and if they gave any trouble at all… (Patients name) was one of those, she was sent in there, if*

she gave any trouble at all in these homes, they put them in there you see. And she was a lovely patient now.

FRPN7 *The nurses had a great relationship with Mary, this was frowned upon by the hospital management and the senior staff, and it wasn't acceptable that nurses would be friendly with patients. We tried on many occasions to help Mary make contact with her family in Mayo; they didn't want her home, it was so very sad as she was very homesick. Mary died in her mid-fifties, when she passed away RIP she would have to be buried in the Paupers Grave where patients with no relatives were buried. But all the senior (nursing) staff collected money and we got some from the office and we took her back to the country and buried her with her family. Such were the times in those years you were put out of your home and forgotten about because you were pregnant out of wedlock. , society was like that, there were many girls like May, who were in that predicament and ended up in asylums. .*

MRPN1 *The Psychiatric Hospital was looked down on and it wasn't good for patients or staff.*

The above excerpts demonstrate the spiritual pain which both patients and nurses experienced. This pain which nurses could not express and which was not acknowledged and they couldn't influence came from the hidden areas of their professional lives. This pain experience which was felt on a daily basis by both patients and nurses was very real and impacted on their emotional health and wellbeing. As society didn't empathise, this pain was dealt with on an individual basis. The power of stigmatization was recognized by all of the respondents in this study. The impact of an admission to an asylum for patients and their families created this painful experience.

A number of nurses recalled how individuals speaking of the institutions refused to say the 'word' the name of the asylum, the asylum's identity was often anonymised in their conversation and individuals practiced social distancing in case of contagion:

FRPN8 *He's gone down below', God help us' …and they would bless themselves.*

MRPN1 *It was said she was gone to the local big town. Now the only thing that this town had was a mental hospital.*

MRPN4 *The public would cross the road when walking past the asylum; they would look away and bless themselves as they passed.*

The data highlights the weight of such stigmatization on both patients who were detained and on nurses who worked within the asylum, on their professional identity and their profession. Nurses described the fear patients experienced of the public:

MRPN4 *They (*patients*) felt threatened; oh there was no doubt about it. There was a terrible fear about going out, yeah.*

4.3.2 Societal stigma

Goffman (1963 p 35) described stigma as a phenomenon whereby an individual with an attribute which is deeply discredited by their society is rejected as a result of the attribute. Goffman graphically refers to this process as the 'mortification of the self'. Nurses in this study recollect how they experienced admissions to the asylum and how admission impacted on the individual's interpersonal relationships and their sense of self-worth.

MRPN1 *It was a big slur to have anybody belonged to you in the mental hospital. That was the society we were in at the time you know and you kind of kept it to yourself if there was anyone belonging to you.*

FRPN5 *At that time psychiatric patients were not allowed into any general hospitals for any reason under any circumstances.*

MRPN3 *I would say, you have a society and you conformed… or well you were banished by the Catholic Church you see, what you had to do and certain behaviours and all that.*

4.3.3 Professional stigma

Many respondents recalled their struggle with the negative impact stigma had on them as professional nurses. Nurses described how they experienced stigma and how it impacted on their personal status as well as their professional prestige because of their association with patients with mental illness.

FRPN8 *My father didn't want me to training there, you see at that time, he said 'you know when you work with them you get like them'.*

MRPN4 *We would take Patients out for a weekend, the minibus that they hired was a white minibus I actually remember people running into their houses when they'd see the white minibus coming, that is a fact, that's how ignorant they (*society*) were.*

The psychiatric nurses who were interviewed in this study all believed there was a low approval rate of their profession within the asylum governance system, within the larger profession of nursing and within society. Within the profession of nursing psychiatric nurses witnessed being labelled as inferior by their peers. Psychiatric nurses were aware that their social identities did not meet the stereotypical expectations of nursing as healers within the society they lived in at that time.

FRPN1 *There was definitely professional snobbery between general nurses and psychiatric nurses. You just knew psych didn't have*

the glamour of general. I was doing my general when cardiology was just starting; a bypass took the whole day. I worked in intensive care and it was so exciting. Nothing like that was happening in psych. You were learning more, seeing more, maybe you were not interacting with the patients any more than in psychiatry but you seen patients outcomes quicker.

MRPN7 *The Matron of the Richmond, call the Nurses in Brendan's the mop and bucket crowd.*

FRPN2 *My poor mother when I told her I was going to do Psychiatric Nursing, she was very upset, she could only think of the local asylum and nobody at home ever spoke about it (name), because it was such a terrible place and she thought, oh my god this is terrible. Later, after I started, I was preparing a woman for ECT and wasn't she my neighbour from the village at home and they own the village and they were very wealthy and very nice and very… they were nice to us too but I nearly died. Then I never said a word to my mother but when she went home better after her depression and her ECT and all that, she met my mother and she told my mother that I was looking after her. Of course, my mother thought, this must be a lovely place, sure she changed her mind about mental nursing then, it was something a bit better. So I mean from there on, I never thought again that I shouldn't be a Nurse but isn't it funny! And sadly I don't think the perception of psychiatric nursing has changed much.*

On the other hand however, this professional attitude did not seem to influence some of the psychiatric nurse's sense of self-worth or self-confidence. They responded to this moral judgment by creating a collegial culture within their own professional group:

MRPN2 *I personally didn't feel inferior. There always was a sort of a feeling that maybe the General Nurse thought they were superior rather than we thought we were inferior.*

In stark contrast, two of the nurses in this study while expressing their experiences and condemnation of such attitudes and behaviours, were unaware of moral judgements of patients they articulated in their own narratives. One nurse stated with incredulity, that following the admission of a mother with postnatal depression in the 1960s, ‘and the husband accepted her home again’ (FRPN5). Another nurse recalled how his wife also a nurse had an idea of women (patients) who went in to (asylum) hospital who had children; she believed should stay at home with them and mind them (MRPN5).

4.3.4 Shame

The definition of shame is a discrete, basic emotion, described as a moral or social emotion that drives people to hide or deny their wrongdoings (Gilbert & Andrews, 1998) Many of the female nurses self-stigmatised in this study recalling how they claiming to be general nurses in public:

I had my uniform on, I asked the driver to stop at the Mater so the others on the bus would think I worked there. I didn’t want them to know I worked in Grangegorman, I walked the rest of the way’ (RD)

> FRPN7 *A few of us were at a dance one night one of the fellows asked one of ours where she was working, she said she was the theatre nurse in the Richmond Hospital.*

All of the nurses expressed experiencing a sense of reluctance or shame when recalling how their roles and careers were perceived within the profession of nursing and publically, such was the dilemma for these nurses. One nurse recalled:

> RD *It was almost as if you carried the stigma of mental illness around with you, you could never discuss your job or what you did for a living with any sense of pride or honour, even to this day!*

MRPN6 *It was a sad, sad time in our history.*

4.3.5 Professional Voice

Voice is defined by the Merriam Webster dictionary as a particular wish, choice, opinion or attitude openly or formally expressed .(https://www.merriam-webster.com/dictionary/voice 25032020).The nurses in their narratives experienced an awareness of not having an opinion or choice within the institution they worked in and experienced frustration by the deafening silence of their own professional voices in this system.

MRPN4 *In the early years the whole idea was that Nurses weren't to speak to the patients, stay as far apart from them. You can observe you know but not to talk, not to communicate with them and that and to be seen talking to a patient, you could be reprimanded for it, you could be told off for doing it you know except when you were telling the patient to do something, ordering them to go to a meal or to go and have a bath and that. There was a particular incident where a charge Nurse was reported to An Bord Altranais for communicating with the patients. The senior Psychiatrist in the hospital rang An Board Altranais, the psychiatrist reported the nurse. He said, 'I caught him sitting down reading the paper to a patient.*

FRPN1 *There was no opportunity to change anything in the 60s. Everything was kept calm and nice and peaceful. Whatever went on went on between the consultant and the patient; nurses weren't involved in those discussions. There were junior doctors who were there to do whatever the Consultant wanted. At that medical level we didn't know what went on, what was discussed, nothing was recorded and nothing shared*

with the team. You were a silent learner, you weren't asked for an opinion, you didn't offer an opinion and you didn't have an opinion.

In summary this theme highlights the social and cultural prejudice and discrimination of the mentally ill exercised by society through a variety of social structures, stigmatising attitudes and behaviours in the mid-1900s. This predominant discourse impacted negatively on the public perception of psychiatric nursing. This was related to the understanding and expectations society had of this professional group and the roles and functions they performed within society.

4.4 Theme Four: How nurses conceptualised their roles

Nursing is a profession within the health care sector focused on the care of individual's, their families and communities so that they may attain and maintain or recover optimal health and quality of life. Mental health refers to our cognitive, behavioural and emotional well-being – it is all about how we think, feel, and behave (Medical Times Today 1/2/2.) Psychiatric nursing therefore focuses on caring for and meeting the psychological and emotional health care needs of individuals and consequentially their physical and social health care needs. This will also involve the needs of their families, of their communities and of society's.

As the nurses in this study reflected on their experiences and their practice and recalled their memories, they described their nursing journey from the 1940s through to 1970, from when nurses first had to be registered as psychiatric nurses to work in asylums, when punitive rules applied, to when long stay patients were being discharged to their homes and nurses began working in the community. Telling their stories helped provide clarity on the evolution of psychiatric nursing as an occupation and a profession. Nurses reflected on their experiences. An overarching theme in this study was the role they provided in caring, they described caring for patients and caring about patients as well as caring for families when they had opportunities to meet with families in the community. The constraints of the medical dominance that

restricted their practice was removed and the scope for nursing to develop was enabled. As patients were being discharged to the community the role of nursing progressed resulting in the advancement of the development of mental health services. Their role, as well as direct patient care, involved education of other health care professionals working in the community, advocating on the patients behalf, educating families and promoting tolerance in society. In the community, nurses considered that family care, education of other professionals and families along with the promotion of tolerance in society for these individuals with mental illness required as much attention and time as direct patient care. In the mid-1900s the nurses acknowledged the multiple challenges this presented for them.

4.4.1 Nursing in the asylum

As highlighted in section 2.1 the nurses' narratives in this study indicate that nurses and attendants carried out care within the asylums in the 1940s at a time when no medical treatments were prescribed by psychiatrists other than physical interventions and moral management. The male nurses lived in wards with their patients and were constantly immersed in the practical activity of minding patients. Nurses controlled behaviour, some through punitive methods, they coerced, conversed with patients, risk assessed, fed, bathed, dressed, observed, worked alongside, nurtured, guided, directed, joked with, humoured, etc. with patients on an hourly and daily basis. The data in this study would indicate that practices changed through the decades and the following excerpts relate to the involvement of nursing roles in the 1950s.

> MRPN1 *I generally enjoyed nursing from the word go, I enjoyed the interaction with the patients, we had some great staff and I always admired some great brilliant charge nurses. They were meticulous about how they dealt with patients, how they managed their behaviour without getting aggressive. They really impressed me in the early stages and I learned a lot from them.*

MRPN5 *The patients were great very harmless. Paddy (nurse) would bring the patients home to his family for a day. He also knew some of the patient's families and he would bring them home to their families for a day. They loved to get news from home, when a patient came in from his area; Paddy was the first to meet him and get to know him.*

MRPN5 *Of course, you see we had a non-confrontational policy you know. You see we would agree with anything, there was no point in telling him he wasn't God if he said he was god. You would have to say well there was more than one God (laughing). We used to have a lot of fun with the patients.*

MRPN1 *I knew many staff that took patients home…bring them for entertainment purposes. Nurses did everything in the hospital. Nurses became parents to some patients, gave them money. One very good nurse drove a van delivering food around the place, he always brought patients. Many of these interactions were very therapeutic and a different type of therapy. Many of them may not be described as clinical nursing however patients enjoyed it, enjoyed the fun, and developed their skills. There were a lot of side-line therapeutic interactions that motivated patients and gave them a sense of purpose.*

The above excerpts indicate how nurses learned and developed their practice and nursing roles within a custodial environment. They related to patients at a human level and described how they provided conditions and interactions that enabled and facilitated patient engagement through the development of therapeutic relationships. Nurses described how they created opportunities to engage patients in purposeful and personally gratifying activities and began to introduce the community into the asylum and into patient's lives.

4.4.2 Resocialisation

I have chosen to use the term resocialisation in this study as it is defined as the process of learning new attitudes and norms required for a new social role (https://www.dictionary.com/browse/resocialization 180420). An important aspect of resocialisation is that what can be learned, can be unlearned. This re-engineered process described by nurses in in this study in their respective narratives, entailed cognitive and behaviour change and their work in the 1950s and 1960s formed the basis for the resocialisation process that prepared patients for discharge and the de institutionalisation process. They facilitated the patient to unlearn institutional behaviours and values and relearn those of the community. This process in the late 60s was deliberately carried out by nurses to prepare patients for discharge and to upskill patients to live as individuals in the community when they were discharged. The following excerpts demonstrate how nurses developed cohesive and collective approaches to organising normal social activities and learning opportunities for patients.

MRPN3 *Socialising was the major thing, we got shops for the patients, and we used to have sports for the patients and all that sort of thing. I remember bringing Big Tom into the Hospital and he entertained the patients and they were delighted to have him. When the RMS heard about Big Tom's visit called me to his office and chastised me for bringing him in, he told me I had put him (Big Tom) at risk and what we would do if something had happened to him! Did you ever hear the likes?*

MRPN3 *We brought in fellows and dressed them up properly; they used to have institutionalised clothes and everything. We put proper clothes on them, we would bring them into a restaurant we gave them nice food, gave them a menu and trained them. We set up a little place that patients could learn about currency!*

FRPN3 *No, we weren't asked to do it. You did it yourself out of the goodness of your heart; you know you just did it.*

MRPN6 *There was a Charge Nurse and there was a Deputy and there was a Staff Nurses because of medication improved them immensely to go home, we took them home for a weekend, took them home for a day, I often had four or five patients going home in the morning, collect them again in the evening, get home at all hours of the evening. That's what it took, now that's been honest, everybody not thinking of anybody but the patient!*

The above excerpts identify the commitment and endeavour of these nurses in their desire to resocialise patients. This resocialisation process began assisting patient's awareness of the psychological tasks of living in the community. These nursing interventions and the associated learning, nurses recall was important for the patient's personality development and coping mechanisms.

FRPN2 *You must have an open mind when you go out there to care for people and you've got to be able to listen and to relate and to teach and to encourage people to develop their own coping mechanisms. We were getting patients to sit back and think, have I a skill that might help me to deal with this depression? I have and what is that skill you know, maybe it is that I am able to read or write or cook or… but nobody has every helped me in that way, patient's began to take control of their own lives a bit better as well and that was good I suppose from the community point of view.*

Nurses demonstrated how they developed the human potential of each individual. They acknowledged the presence of patient's feelings and valued them as important. Their interactions served to influence the patient's thoughts and behaviours and their interpersonal intervention was focused and meaningful for the patient. Nurses recollected achieving better results for patients through their continuing resocialisation process than the many other forms of medical interventions/treatments patients had experienced in the institution, with the exception of the anti-psychotic drugs. The nurses expressed great pride in achieving improved outcomes for patients from nursing interventions. .

4.4.3 De-institutionisation

Nurses in this study appeared to be instrumental in facilitating the replacement of long stay institutional care for some patients with care in the community in less isolated accommodation. Deinstitutionalisation entails the process of releasing institutionalized individuals from institutional care to care in the community (https://www.merriam-webster.com/dictionary/deinstitutionalization) replacing long-stay psychiatric hospitals with less isolated community mental health services like community residences and other such accommodation. In this study the less isolated accommodation was the patent's home with their families, as the implementation of the deinstitutionalisation policy was not implemented nationally until the 1980s. While the implementation of deinstitutionalisation policy was in its infancy and implemented sporadically in the 1960s in Ireland, three nurses involved in this study have provided valuable insights into the practice of the psychiatric nurse in implementing this process and their contribution in leading reform outside the walls of the institution.

> RPN6 *I had a man who in his younger years he hit someone with a poker and he was put into the Hospital he was there for over 20 years, I saw a lovely man, talked to him. So, I went to his Brother and his Mother was also alive and his Father they said, no one, no one hits with a poker we're not happy. I said would you not take him for an hour I said, I'll stay with him even, they were lovely people offer you tea and so on which I had of course because I was wanted to know them and they agreed to take him for an hour and I would stay for the hour and then they would say look if you want to come back after a while you can he'll be alright. That man went home about a month later and, I would call regular the brother said to me you know, we wouldn't get on without him. He said it was a god send. What happened was occasionally we'd go to the Public Health and the Community Healthcare Officer he didn't' take much heed of us so I suggested one day to the Doctor that we'd call all the Community Welfare Officers (CWO) to a Meeting you know, explain to them that people who went home were so long away from working they'd no means of income,*

now these people were, while they were fit to go home they were still not fit to work. I used to go to the Doctor's before this came about and didn't get very far, but we sat down with the Consultant and these people (CWOs) from all over and explained what was required and from that day on we had no trouble.

MRPN1 *Nurses contributed hugely to the rehabilitation of patients back into the community.*

MRPN1 *The majority of nurses were in favour of making progress, the nurses that worked in the community in particular made a major contribution to deinstitutionalisation and change.*

These excerpts identify how some nurses acted on their ethical, clinical or social knowledge and made judgements to manage and cope with difficulties and transitions within the workplace that were absolute to the profession of nursing.

4.4.4 Introducing the Community

The publication of the Report of the commission of inquiry on mental illness (Department of Health 1966) outlined a re-orientation of psychiatric services away from an institutionally-based system to a community-based service. A community based service cover an extensive and diverse range of activities including in people's own homes, rehabilitation houses, community clinics, centres, day hospitals, etc. (https://www.kingsfund.org.uk/publications/community-health-services-explained 200420). An inherent aspect of the nurse's role was that of patient advocate. The extent of advocacy varied according to their individual circumstances of each patient. While previous excerpts highlight the advocacy role of nurses in securing financial allowances and community supports for patients on discharge, advocacy was also an innate role of the nurse between patient and their families. Nurses often experienced their advocacy role as one of mediator to achieve a sense of acceptance and harmony.

MRPN6 *I actually had an experience one time with one man in particular who come to me on a couple of occasions to go home and on one occasion my whole day went she threw me and her husband out the door, that's true, yeah. And he said I'll go over to my sister so I went with him to his sister, I was then told by his sister I should go to a certain Priest in the Parish and I went to him and he came with me to the house and he knocked on the door and walked in she walked out I was behind him he was a huge big man she ran past the Priest and caught me and threw me out the door again and I waited outside the Priest came out and said to me, it'll be alright you can go home.*

Creating an awareness of mental illness for families involves bringing into the consciousness of the family member that fact that mental illness exists within the family. It entails the creation of a consistent and cooperative milieu where a family's awareness of the reality of their situation becomes apparent to them. It involves a cohesive approach between the nurse and the family members to move forward in managing this family member

MRPN6 *So, I went to his Brother and his Mother was also alive and his Father they said, no one, no one hits with a poker we're not happy. I said would you not take him for an hour I said, I'll stay with him even, they were lovely people offer you tea and so on which I had of course because I was wanted to know them and they agreed to take him for an hour and I would stay for the hour.*

The nurses who worked in the community described communicating with and caring for family members as an integral component of their nursing practice. The focus on families only became evident at the time of discharge and this focus increased following discharge. This was an extension of the role that nurses needed to develop as they did not have access to families when these patients were in hospital. They considered that working with families required significant attention to support caring for the patient and achieve discharge and integration into the community. Nurses

acknowledged that it presented multiple challenges for them. For some it may have been the anticipation of social acceptance, the issue of stigma, the reality of mental illness or would the patient adjust to their changing situation.

Throughout this study the extent of family patient communication and interaction was non-existent within the institution. In the community nurses were involved in allying families concerns and fears. They nurtured both a sense of acceptance and hope as well as educating and supporting families on the individual's mental illness. It was an enabling process that helped families come to terms with mental illness and its impact on family.

MRPN1 *Nurses contributed hugely to the rehabilitation of patients back into the community.*

These excerpts highlight some of the challenges and the sedulous nature of nurses in identifying and breaking down barriers to allow patients return to live in their communities and society.

4.4.5 Caring

4.4.5.1 Caring "for"

One of the consistent findings in the nurse's narratives was the concept of caring in defining their role as psychiatric nurses. Both concepts of caring for patients and caring about patients. Jecker & Self (1991, p295) in differentiating between caring for and caring about stated 'a health professional who cares about a patient makes a cognitive or emotional decision that the welfare of the patient is of great importance. Caring about requires keeping the patient's best interest in the forefront of mind and heart. By contrast, a health professional who cares for a patient engages in a deliberate and ongoing activity of responding to the patient's needs.

While the nurses described how they provided care for the physical, psychological and social needs of the patients. Their outlined their daily involvement with them providing psychoeducation through the provision of teaching structured problem solving and communication skills, integrating emotional and motivational aspects to enable patients cope with their illness and to enhance their recovery. Nurses' demonstrated awareness of the patient's thoughts and feelings and demonstrated responsiveness to the patient's personal needs along with their social and emotional contentment.

MRPN6 *I made every honest effort to help people that was my, one thing I did things I wouldn't' do in a lifetime like I went into the Dispensary Clinics beyond I met Doctors I went into Priest homes and asked for things for Patients, I went anywhere if I thought it would help patients.*

FRPN6 *I often brought a patient out for the day, take them into town, they'd love to have the day out so you'd bring them out and give them a bit of lunch or something. They were quite good you see.*

MRPN6 *It was important to be aware of how you relate to someone; you had to be structured in your thinking and watch for how they were thinking and what was behind it.*

MRPN6 *You gave respect and got respect and you got trust, there was great comradeship in the whole thing so there was.*

FRPN2 *We related to our patients at a human level.*

The above excerpts highlight how nurses engaged with patients, talked with them, were involved with them and how nurses believed that treating the patient with dignity and respect had a measurable effect upon their emotional healing and health and their uniqueness as a person. This human approach and providing spiritual support facilitated the patient to understand and find social purpose in their lives.

4.4.5.2 Caring "About"

Jecker & Self (1991, p295) states that 'a health professional who cares about a patient makes a cognitive or emotional decision that the welfare of the patient is of great importance. Caring about requires keeping the patient's best interest in the forefront of mind and heart'. One of the main finding in this study relates to the extent to which nurse's cared about the welfare of patients even after death.

> FRPN7 *May died in her mid-fifties, when she passed away RIP she would have to be buried in the Paupers Grave in Glasnevin where patients with no relatives were buried. But she wound up not be going there as we all the senior staff collected money and got some from the office and we took her back to the country and buried her with her family.*

> MRPN4 *I went down to Limerick (institution) to give a talk one time and whilst I was waiting at the front entrance for somebody coming to meet me, there was a fellow sitting on the corridor with a lady, I presume she was a patient and I presume he was a Solicitor and he was trying to convince her that it would be in her own best interest that she signed over her farm to a relative, you know. There was a lot of that like you know that went on as well. But the nurses objected to that happening here and it ceased when you had to accompany the patient with the visitor you know, to protect them.*

The following excerpt highlights how other nurses expressed this care for patients welfare post their discharge to ensure patients had every opportunity to maintain their progress as well as providing them with social opportunities and preventing social isolation.

> MRPN5 *Some of the others are settled in the community, I meet them in the local community now; although I am gone myself (retired) I*

still play the fiddle for them, I go up every week, on Tuesday to play. We made sure they were cared for in the community as well.

4.4.6 Family Caring

The data in this study indicated that providing family care by supporting family members through the acceptance of having a family member with a mental illness, their discharge home and impact on family is complex. It posed significant challenges for families that required immediate and long term adaptations. Helping them to deal with mental illness and its impact on family constituted a large part of the nurse's activities when transitioning to the community. It requires nurses to possess a range of interpersonal skills and knowledge regarding family functioning in order to facilitate families to come to terms with this issue. Nurses considered that working with families required critical attention to support them in their roles. The role of the nurse in this study indicates that developing trust helped families to come to terms with their individual challenges. The nurse got to know the family and journeyed with them through the initial acceptance process of having a family member in a mental asylum discharged, during the deinstitutionalisation process to the family home, empowering them to cope, while offering them ongoing psychoeducation, support and advice.

MRPN6 *They were lovely people, offered me tea which I had of course because I was wanted to know them!*

FRPN2 *Good nurses were concerned about patients, they carried the best values of nursing from the hospital into the community, and they also provided organisation, structure and order.*

MRPN1 *The nurses provided that social supports and advocacy services were available to patients, re housing, welfare, employment, company.*

The nurse needed to take cognisance of the various factors that interplay in each family situation. The nurse needed to adapt interventions to encompass the different levels of family functioning, the state of family relationships prior to and following the discharge of their family member from a mental hospital. On occasions it presented nurses with ethical challenges, making difficult choices regarding what the appropriate course of action was. While nurses felt that families needed to know the reality of the situation; however, not all families were aware of it, or maybe in a position to accept or acknowledge this. The nurses in this study demonstrated how they acted ethically with tolerance and respect for the different responses to their approaches.

> MRPN6 *I'd be very careful, I'd be very careful that you went to a house and knocked on a door, this happened to me now, these are actual events which happened you know, I remember knocking one day at a door and I knew the patient had been in for many, many years so I'd expect when I knocked on the door that person for approximate age would open the door to me but instead a young woman opened the door to me so I asked was Mr So in So inside and they said no can I help you and I said no it's personal I'll come back again. Anyway came back a younger woman (answered) again so I knew I was on the wrong day so I said I'd call back. Can I help you? No, I'll be back next week. Met him, third time, he said are you the man who called last week, I am, I'm glad he said, I know what you're about, you're here about a certain person, I said I am yeah. Well he said, you saw what's going on here they don't even know that woman exists he said, they've no knowledge of her existence in any way. So, what could I do, a lovely man, thanked me and all that asked me did I appreciate his situation all I could do is go back and put in my report that was it? That's a true story now.*

A key aspect of providing family care is the nurses' ability to form an emotional connection and a relationship with both the patient and the family while continuing to push the patient's agenda. Making this emotional connection and developing a relationship based on trust meant that focused and appropriate support was provided

that was based on each patients unique presentation and family situation. It involved nurturing both a sense of acceptance and hope within families. It is a psychodynamic enabling process that helps families in coming to terms with mental illness and its impact on family.

4.4.7 The Human Connection and Relationship based care

Nurses explained how in professional isolation, in the absent of patients notes or history, they deciphered the individual patient's particular needs, through observing, listening, talking with and attending to and interpreting nonverbal cues: postures, facial grimacing, eye movements, etc. Nurse's narratives articulated how they cared for patients through engaging in deliberate and ongoing activity of responding to the individual's patient's personal and social needs. The knowledge of what their needs were was gleaned through the relationship and engagement the nurse developed with the patient as well as their abiding efforts to cultivate the profession.

MRPN6 *Oh yeah I learned my psychiatry myself and much more about psychiatry when I went onto the community, I really and truly studied it, I took a deep honest interest in it.*

Assessing the individual's mental and emotional distress as well as the individual patient's own awareness of the extent of their emotional and mental distress as an element of care provided several challenges to these nurses who were professionally isolated from their medical colleagues as staff nurses. It required an awareness of the overt and covert signs, anticipating behavioural changes and an understanding of whether the patient was cognitively and emotionally open to nursing interventions.

MRPN5 *I remember a lad coming in one time and I knew when I went in he wasn't well, he was tensed up, we knew these patients better*

than a doctor did. I was minding him and next thing he got up to go to the toilet, I went with him, next thing is he made a plunge to knock his head against the wall. He tried it a few times, I spoke with him and asked him what he was doing and why he needed to do it, he was married with five children. I talked with him and asked him would they or God like what he was doing and he settled and eventually went to bed and slept. The next morning he thanked me for talking to him. I spoke to him a few times about it you know, I wasn't a charge just a nurse. He went home after spending about two weeks there. Anyway the charge nurse called me and told me I was wanted abroad in the visiting room about two months later. I went out and there was me bold Tom and he having bars of chocolate for me for saving his life. He said he was in 20 years before that and he had busted his head off a wall. Little things like that was important to get to know and read the patients.

MRPN6 *When you treated them as an equal, you got respect and you got trust, there was great comradeship in the whole thing so there was.*

The above excerpt demonstrates the influence of an interpersonal engagement with the patient which the nurse purposefully planned, for therapeutic reasons. The initial engagement progressed to a mutually intimate relationship which entailed listening and understanding this individuals specific concerns and responding by reinforcing the patents unique values and spiritual needs through respecting his human dignity. This therapeutic interaction created an educational opportunity for the patient to be aware of his maladaptive behaviour. The respectful approach and preservation of the individual's dignity during this interaction by the nurse, involved enabling the patient's emotional affirmation and learning of other possible more adaptive approaches to manage his instinctive impulses. This contributed to emotional healing for that patient. Such emotional healing and resilience building is evidenced through the following excerpt from a nurse who stated nurses;

FRPN2 *They understood things very well, they had respect for patients, they brought a new sense of understanding and respect and what's the word… you know, enabled the development of people who were reduced as a result of mental illness or psychiatric patients and they tried to give them a sense of their own worth and their own dignity.*

4.4.8 Emotional Literacy & Resilience

This data from the nurse's experiences indicate the professional and socially complex range of problems that nurses were presented with and managed in both the institutional setting and community, some without prior knowledge and experience of. The challenges they highlighted indicated the personal and professional attributes that were required to survive, manage, negotiate, advocate, influence, communicate, break down barriers, create relationships, care for and care about patients, liaise with families, promote tolerance communities, etc. These nurses demonstrated an ability to understand patient's emotions, the ability to listen to patients and empathise with those emotions. The development of therapeutic relationships in this study entailed emotional engagement for therapeutic effectiveness. Nurses demonstrated emotional strength and resilience in facing many of these challenges, in sustaining their motivation the face of resistance and motivating others, to maintain a positive attitude when experiencing professional isolation and loss of professional integrity, the use of empathy, humour and optimism in a challenging and submissive environment. In this study there was a direct relationship between these attributes and the nurse's self-concept.

MRPN6 *If I didn't believe in these people I could not have done my job so well.*

Nurses articulated clear feelings about their emotions and situations which occurred and their capability of dealing with those emotions.

In summary the findings in this theme demonstrate how the development of interpersonal skills and establishing relationships was critical from a nursing perspective in getting to know the individual patient, making nursing assessments, establishing emotional engagement, providing therapeutic interventions, planning resocialisations processes, identifying the significant stakeholders in the patients care post discharge along with connecting with the patients family and involving them in their care, in creating awareness of mental distress and illness, in promoting tolerance in communities and breaking down societal stigma while all retaining a sense of professional conviction, self-assurance and resilience. .

4.4.9 Conclusion

As a result of hearing the narratives of the nurses in this study who worked in the asylum system in the mid-1900s, this study has assembled significant new information on nursing within this system at that time and the type of care patients received. The findings of this study also provide important considerations into the influence of society and public attitudes. The findings provide a glimpse into the presence and reach of stigma and prejudice when unchallenged. This burden was borne by both patients and psychiatric nurses and it impacted hugely on the quality of both parties' lives, both personal and professional.

The insights provided form these finding demonstrate the impact of a unidisciplinary governance structure and its negative impact on the health and development of integrated service delivery. The findings demonstrate how collaborative models of care became possible when nurses moved away from such a patriarchal system and could progress their practice. Finally these findings are relevant not only for the profession of nursing but to inform the broader profession of nursing as well as the external world of the discipline's role and development.

Chapter Five

Discussion

5 Introduction

My aim in this study as set out in chapter one was to explore the experiences of nurses who worked as psychiatric nurses in the asylum system in the mid-1900s in Ireland. I proposed to capture the individual narratives of nurses who worked within that setting to elicit knowledge and insight into the presentations of patients, the treatment modalities available, nursing practices at that time, their influence on care, and the changes over time in mental health care. In addition, I hoped to glean information relating to the role of nurses, their leadership within the profession of nursing and the social environment in which they worked. In this discussion chapter I now propose to meet this aim by providing a discussion of the findings outlined in chapter four, that emerged from this study, discuss these findings in light of the literature and set out what the nurses experiences contributed in theoretical terms. The findings from this study generate valuable insights into how psychiatric nursing evolved both as an occupation and a profession. In addition, it presents the ontogenetic development of psychiatric nursing from its birth in the asylums in Ireland in the 1940s through to the 1970s when nurses were appointed as Community Psychiatric Nurses, community care policy was starting to be implemented and psychiatric nursing diversified.

Analysis of the data from this study highlights the asylum system where psychiatric nursing was conceived, the dominant and developing processes and influences and what supports were available to them, what shaped their nursing practice and how the profession of psychiatric nursing was constructed. The data also identifies what constituted nursing practice and how nurses established agency as a profession. The last step of this evolutionary journey deals with the role of the nurse in both the asylum and in community, the influence of the psychiatric nurse on introducing community care and shaping it, along with the impact of nurse's practice on the

development and delivery of mental health services. The findings chapter also identifies the attributes and commitment of nurses throughout this ontogenesis. The discussion takes account that the findings are conceptually interrelated. There are a number of major areas for discussion that will be presented in this chapter and each will be reviewed in the context of both the findings and the literature explored earlier in the study.

5.1 Medical Dominance

Medical dominance was the organising principle in governance in psychiatry in this study. Implicit in this study is that the emergence of psychiatry as a medical specialism was facilitated by the existence of lunatic asylums; the development of professional authority and credibility was facilitated through these large institutions that wielded significant local social and economic power, and ultimately, political power. In addition, this development required a professional 'underclass', nurses and attendants became that underclass, over whom to wield said power within the institution, and do the bidding of the doctors.

This dominance of the discipline of medicine to dictate healthcare and clinical policy regarding asylum treatment was exclusive in asylums. Such dominance of one discipline, in this study, to dictate healthcare and clinical policy contributed to a devaluation of nursing and a limitation of patient outcomes. Within this model of medical dominance executive authority lay with the individual RMS resulting in the use of exclusive personal discretion regarding the implementation of policy. Such discretion was evidenced in the patchy implementation of the recommendations of the Report of the Commission of inquiry on mental illness in 1966, a policy that had far reaching implications for patients and for nursing practice, as demonstrated in this study. While some progress was achieved in some areas, the first acute admission unit attached to a general hospital was opened in Waterford in the 1960s, it was not until the late 70s and early 80s before further acute units were opened in other counties around the country, however in no instance did these initiatives lead to the concurrent closure of the parent mental hospital (Walsh 2012). Unfortunately

the majority of RMSs and Consultant Psychiatrists maintained an introspective approach to asylum care and the status quo was maintained in the majority of institutions until the 1980s when Planning for the Future (1984) was implemented.

This medical dominance prohibited opportunities for collaborative interdisciplinary working and discussion on the efficacy of some prescribed treatments as was evidenced in this study. Such exclusive authority contributed to the isolation of the profession of nursing along with a lack of representation for patients.

5.2 Struggle for Voice

Voice is defined by the Merriam Webster dictionary as a particular wish, choice, opinion or attitude openly or formally expressed .(https://www.merriam-webster.com/dictionary/voice 25032020). The nurses in this study were aware of not having an opinion or choice within the asylum system and were frustrated by this. There was silencing of nursing through unexamined acceptance of the governance structure and dominance of one profession within the asylums. The governance structure also supported clinical dominance where there was a refusal to share clinical information and lack of consultation by doctors with nurses into patient care, treatments and patient outcomes, and lack of input by nurses into health care decisions. The way nurses thought, acted and learned was constrained by their socio cultural context in which they worked. The governance structure which facilitated medical dominance created power inequities within the professions of medicine and nursing. Nurses were controlled largely by exclusion;

> FRPN1 *At that medical level we didn't know what went on, what was discussed, nothing was recorded and nothing shared with the team. You were a silent learner weren't asked for an opinion, you didn't offer an opinion and you didn't have an opinion.*

This governance structure also undervalued nursing practice. This undermining of the nurse's role contributed to the relegation of psychiatric nursing as a lower status and discipline. This study indicates that nurses displayed silencing at work.

This increased dissatisfaction with the exclusion of their voice in asylums created gaps in the representation of nurses. While individual nurses wielded very little power, in this void unions became established and were socially constructed as the professional voice of nursing. Buresh and Gordon (2000, p 35) state that 'agency involves being able to speak for oneself'. Crowley (1993, p. 95) asserts that a strong 'first person voice is the self that speaks from experience that knows from clinical observation'. She maintains the first person voice is authentic, 'the authentic self'. The nurses in this study strongly believed that this voice of the professional 'self', this ' authentic self' was not represented by trade unions or staff organisations at that time, they believed that such voicet can only come from the clinical professional promoting the agenda of the patient, not the agenda of the majority of nurse members. These agendas are not mutually exclusive

The important roles however, provided by unions in providing nurses with a means to express their dissatisfaction to employers and improve their salaries and terms and conditions of work was acknowledged in this study. This contribution of unions to the profession of nursing is also shared by Loughery (2019) whose work on the History of the Irish Nurses and Midwives Organisation (INMO) offers a comprehensive nurse based perspective of the Irish Nurses and Midwives Organisation's service between 1919 and 2019 for general nurses and midwives in Ireland. However while Loughery deems that the INMO provides a 'professional voice' for the profession, it is less clear if such a voice is representative of the clinical professional promoting the agenda of the patient.

Psychiatric nurses established their own staff organisation/trade union with an initial membership of 500 in 1970. This membership increased to over 2,000 a decade later (Robins, 2000). .

5.3 The Social Construction of the Profession of Psychiatric Nursing

Social constructionist's theorists commonly use the metaphor of narrative or conversation which provides a space for an individual's own narrative to emerge (White & Epsom, 1990). The respondents in this study recognised a conflict between their own internal professional world of caring for these patients and the lack of acknowledgement and appreciation by the asylum administrative governance system. Nurses were acutely aware of how social attitudes and beliefs undermined and undervalued the work that they did along with the individuals they cared for. The nurses recognised and acknowledged the patients experience of loss within the asylum system. Some nurses almost identified with this sense of loss. The profound sadness experienced and expressed by some respondents who declined to participate in this study (RD) along with those that did participate in this study was palpable. Their experience demonstrated a loss of professional legitimacy as a professional and as a profession within the larger profession of nursing. O'Sullivan & O'Donnell (2012) state that the silence of the staff who worked in the asylums and institutions in the mid-1900s and now is difficult to fathom. This section provides a number of reasons why nurses stayed silent; the evidence would indicate that primarily there was no audience to listen.

The emergence of the occupation of (general) nursing in Ireland came from the acceptance of physical illness and infirmity as unavoidable factors of human life and from society's anxiety to ameliorate these conditions (Robins, 2000). The perception of psychiatric nursing was socially constructed and tainted by society's ignorance and unacceptance of mental illness and the negativity directed towards asylums in which patients were housed, largely viewed as places of containment rather than cure. Because nursing was inextricably woven into the fabric of the asylum system, it was impossible to separate the profession from the system because of the persistence of institutional care for these patients until the second half of the 20th century. This may be why psychiatric nurses' have been reluctant to examine their history and their contribution to patient welfare during that era.

5.4 Stigma

Goffman (1963 p 35) described stigma as a phenomenon whereby an individual with an attribute which is deeply discredited by their society is rejected as a result of the attribute. Goffman graphically refers to this process as the ‘mortification of the self’. Stigma-related prejudice and discrimination experiences can have a profoundly damaging effect on a person's well-being and may result in minority stress (Frost & Meyer, 2009). The data in this study highlighted significant challenges relating to the nurses identity and acknowledgement of their profession. For many of these nurses being professional and being acknowledged as professionals was important to them. Many of the nurses through their narratives described how society’s opinions on mental patients and asylums and societal values influencing their professional identity at that time. These nurses professional self-esteem and professional identify were influenced by the cultural and social values of Irish society.

‘It was almost as if you carried the stigma of mental illness around with you, you could never discuss your job or what you did for a living with any sense of pride or honour, even to this day!’(RD).

Many nurses believed that their role as a nurse and a carer could not be acknowledged openly, discussed publically or supported socially. The psychiatric nurses in this study all believed there was a low approval rate of their profession within the asylum governance system, within the larger profession of nursing and within society. Within the profession of nursing, psychiatric nurses experienced being labelled as inferior by their peers in general nursing.

Psychiatric nurses were aware that their social identities did not meet the stereotypical expectations of nurses as healers within the society they lived in at that time. Some nurses self-stigmatised to achieve public approval. The nurses struggled with these memories, emotionally recalling the patient’s awareness of it along with the associated spiritual pain they both experienced as a result. Nurses expressed a

profound sadness of having been part of this aspect of this system. Their articulation of their experiences went beyond a lack of professional acknowledgement to a sense of social rejection or renunciation of their own profession ‘you are trained for nothing’ (RD). Individual nurses managed the sadness of this spiritual pain in different ways.

5.5 A Disenfranchised Profession

To disenfranchise is defined as to deprive someone of a position of power, rights and privileges in society (Doka, 1989a). Patients by virtue of their admission to an asylum were a disenfranchised population who had been rejected by society. The psychological impact of and consequences for nurses of caring for this disenfranchised group of patients in the asylum were reflected in the findings of this study.

Some nurses while acknowledging the need for this research study declined to be interviewed. Nurses who declined to share their narratives with the researcher apologised for not contributing and justified their decision stating: ‘I would prefer not to go there again’. ‘I don’t want to be sued’. These nurses were described as excellent carers by their peers who referred them to me as part of the snowballing recruitment process; however, they struggled with their memories. They expressed embarrassment and a sense of shame (Chapple et al, 2004) when reflecting on the custody and treatment of and personal losses that patients experienced as residents within the asylum system at that time. Some interviewees articulated the detention of some patients in the asylum system as ethically and morally wrong. The nurses who declined to tell their story along with those who did carry a self-perception that in some way through the work they did in ‘gatekeeping’ (RD) within the institution, they threatened the dignity or integrity of the patients they served. They experienced a sense of professional helplessness as they believed they could not influence the professional elitism of general nursing and society’s failure to appreciate the need to care for individuals who did not have physical illnesses but needed a different type of care

Shame is a painful feeling: a mix of regret and dishonour (Doka, pg.67), it grows when it exists in hidden places. Some nurses expressed experiencing a sense of shame as they believed patients residing in the asylum system were forgotten (RD). Niemeyer & Jordan (2002, pg. 96) cited in Doka (2002) refers to this as 'empathic failure' – the failure of one part of a system to understand the meaning and experience of another'

5.5.1 Impact of Stigma

The social power to sanction was intrapsychially experienced by nurses in their professional role as well as in the presentations of patients in their care within this study. The perception of the social role of the nurse contributed to their social standing and this was influenced by the prejudice and stigma attached to mental illness and asylums. This study into Psychiatric Nursing identifies common experiences of RPNs who developed their own sense of professional identity and professional agency. This development differentiated from other nurses who did not cultivate such a professional identity and responded to patients accordingly through the perceived judgements of society at that time; in a punitive way.

5.5.2 Abuse

It is notable that some of the other institutions which contained individuals during those decades in Ireland have since revealed a culture of abuse by Church and State, and Ireland is still coming to terms with that dark chapter of our history (Commission to Inquire into Child Abuse /Ryan Report, 2009, Report of the Inter-Departmental Committee to establish the facts of state involvement with the Magdalen Laundries, 2013), and the report of the Commission of Investigation into Mother and Baby Homes and certain related matters (ongoing). As the survivors of this abuse push for recognition and justice, it is notable that few victims have come forward from psychiatric institutions alleging abuse.

While abuse is defined as the improper usage or treatment of a thing, often to unfairly or improperly gain benefit, abuse can come in many forms, such as: physical or verbal maltreatment, injury, assault, violation, rape, unjust practices, crimes, or other types of aggression (Section 3, Commission to Inquire into Child Abuse (Amendment) Act 2005).

Within this study 'physical' abuse is referred to, there are two references by male nurses to witnessing staff members physically abusing patients in the 1940s in asylums in Ireland. The findings indicate that the physical abuse referred to was articulated by male respondents. One episode of verbal abuse was reported in Hannah Greelly's first-hand account of the twenty years she was incarcerated in an Irish asylum and also one of physical abuse made by a male patient in his autobiographical book of his experiences in an Irish asylum in the late 1930s in Ireland (Duffy, 1941).

However, within this study also, many nurses articulated how they struggled ethically with the unjust incarceration of some patients in asylums, along with the many treatment regimens administered to patients, particularly in the 1940s and 1950s. Nurses articulated the perceived lack of efficacy of these treatment interventions along with a perceived lack of benefit to the patient and the negative impact of some of these prescribed treatments on the quality of the patients' lives. These issues weighed heavily on their shoulders in their caring role. Their professional isolation and inability to contribute to any discussion on clinical efficacy of treatments or outcomes created major ethical issues for them as nurses

Hannah Greally, a patient confined for nearly twenty years in the asylum between 1943 and1962 made no reference to being abused in her book, other than by the harsh medical treatments that were prescribed for her. (Greally,2008). As no reference was made to physical abuse by females in either first-hand accounts by patients or by female respondents in this study, the evidence would indicate that care by female nurses to female patients was caring and compassionate,

The findings in this study would indicate that the treatment of patients in a punitive way was particular to male patients and male nurses in a particular decade. The evidence would indicate that it was an individual act carried out by individual nurses. There is no evidence in this study to indicate that such behavior was part of the culture of the institution or the practice of the profession within this study.

What differed psychiatric hospitals from the landscape of abuse of the other institutions at that time? The abuse reported in this study in male wards refers to the late 1930s and early 1940s, a period in the asylum when overcrowding was extreme, staffing levels were low and psychopharmacology had not been developed. Nurses were compromised by lack of resources within this system; the neglect of patients also meant the neglect of staff, particularly those on the lowest rung of the professional ladder in the hierarchy of the medical system and society in Ireland. This occupational environment threatened their professional identity and in so doing, it also impacted on the boundaries of some nurses' practice. The legislating for the training of all nurses caring for patients in mental institutions in the early 1940s meant that a greater emphasis was on professional regulation with greater numbers of staff being trained as nurses. Such regulation provided nurses with professional standards for the performance of their duties. Within the profession such standards are imposed and observed by peers within the profession,

The evidence in this study would indicate that physical abuse referred to was particular to an individual and not endemic in the culture of asylums as it was in the other reported institutions of the same era. The existence of a lay inspectorate who had lay and civil control over the employees was influential in deterring abuse and identifying abuse when it happened, ultimately imposing an acceptable standard of behavior for staff. The existence of such an inspectorate had the potential to safeguard patients and prevent abuse.

This study is limited in that its focus is on the science and profession of nursing and the development of the profession of nursing within the asylum years. As a result this study does not have the opportunity or the remit to research whether or not there was abuse and if so the type of abuse which occurred in these institutions. It would

also not be possible to address comparatively the reporting of abuse in this study to the reports of a culture of abuse as reported in the other institutions which contained individuals during those decades in Ireland. The reporting of abuse in those instances has been provided by users of the services, in this study the accounts are reported by the providers of a service. The perspectives from these different lenses are not congruent.

Within this study there is a potential disparity between what the nurses narrated on their caring role and the references to some male nurses abusing patients. As the nurses in this study self-selected in that they responded to an invitation to share their experiences. It is possible that nurses who had experienced greater work satisfaction in their careers, achieved a greater sense of professional agency in their roles and had developed professionally were more interested in sharing their experiences than those nurses who had not developed as great a sense of professional agency and professional identity within their nursing careers.

Another possible explanation for this disparity is that oral history facilitates the uncovering of information, which is not easily extracted by other methods. It allows the informants to record their experiences and lived realities in nursing in all their complexities. It acknowledges the multiple, overlapping and often complex realities (Kiely & Leane, 2004) and as such facilitates the compilation of a more nuanced account of nurse's experiences than that permitted by quantitative, historical documented data.

5.6 Gender

The role of women in Ireland at that time was also socially constructed. Societies' understanding was that a women's place was in the home with her children dedicated to domestic responsibilities. Unmarried women with children risked being locked up in institutions while married women were refused the right to work outside the home upon marriage.

The analysis of these narratives throws light on the discrepancy in the number of quotes from female respondents. There is an over-reliance on male participants in this study with 139 of the quotes being from males as opposed to only 63 from female nurses. The narratives in this study indicate that a gendered structure of nursing existed within the asylum. The gendered way in which the nursing leadership structure evolved revealed explicitly how the social respect of female nurse training was essentially connected to single woman hood. Within the narratives, the majority of the women interviewed had less years of experience of nursing and the developments in nursing over the years studied due to having to leave work when they got married. Their narratives were not only stories of personal experience but also they were deeply embedded within the various institutional structures that influenced their careers and women's lives; socialising in the institution, the importance of meeting a husband, getting married and having to resign from their nursing careers, having a family and their engagement in their domestic roles as wives and mothers.

The 'marriage bar' on women as permanent employees in the mid-1900s, meant that married women had to leave their positions in nursing and once married were excluded from taking up positions as nurses. There were higher levels of recruitment and turnover of female nurses, which deprived the healthcare system of a potential developed female nursing intelligence to inform nursing policy and practice. This discriminatory hiring practice was not lifted in Ireland until1973 (Galligan 1997) allowing some women to return to work at different stages of their married life which they all enjoyed.This significant reduction and longevity of female nursing intelligence at a senior level impacted on the potential for the collective female voice to inform policy development in psychiatric nursing and in healthcare during those years and in subsequent years. The significance of this reduction in the female nursing intelligence and the limited impact of their voice as nurses was demonstrated in a small scale in their contribution to this study. The potential significance of this at an organisational national level was much greater.

5.7 Nursing Practice

As this study is one of capturing nurse's narratives of their experiences, the author is aware of how the concept of care along with the patient's world is contextualised from a nursing perspective. The nurse's narratives demonstrate that while nurses had very limited training in psychiatry and did not have access to patient's charts or medical notes, they assessed the patient on the basis of the benefit of their experiential knowledge drawn from their interpersonal and emotional engagement as part of the relationship they had developed with the patients. Nurses indicated how they practiced from personal ways of knowing in the absent of theoretical knowledge (O'Neill 2005). While these nurses described the patriarchal system in which they worked was administratively and clinically governed by the RMS and Consultant Psychiatrists which were the dominant influences in the social cultural and disciplinary contexts of the asylums as well as the daily regimes and routines, there is also evidence that nurses did not restrict their practices to this narrow and exclusive approach. They observed and communicated with patients to elicit their cognitive psychological and emotional functioning and to interpret cues and relied on previous knowledge and understanding of patients as well as practice role models.

Nurses identified patient's talents, interests and skills in order to create opportunities to engage them in occupations that use personal resources, as part of the socialisation process they led within the asylum. In their day to day role caring and observing patient's socio emotional functioning and emotional adjustment to various situations as well as social behaviour awareness during resocialisation and latterly the transfer of patients to the community, psychiatric nurses were learning nursing. This study would indicate that this skills enrichment influenced the negative effects of incarceration on patients and supported greater potential for successful community re-entry of these patients.

Within the community, the creation and development of the nurse's role within the community called for a higher level of clinical decision making, risk assessment and therapeutic interventions from these nurses than they had previously experienced in the institution. According to Benner's (1984) analysis maximising the patient's participation in his or her own recovery requires skill and knowledge and action

(Benner 1984). The advancement of the nurse's practice developed from their own informed experiences. This mastery of journeying with the patient and later their family facilitated recovery.

There is a significant relevance of the sociology in this study to the practice of psychiatric nursing in particular. The social context in which this study was carried out can provide an understanding of social influences on the health and illness of individuals and groups. To provide quality care, nursing needs an understanding of individual socio cultural beliefs and practices to determine their decision making and person centred care. Within this study restrictions on nurses accessing patient's notes along with the omission and censorship of socio cultural information defending Catholic values, particularly those relating to traditional family values and to sexual relationships (Robins 2000) from patients charts were identified: '*Like abuse which is coming to the fore now, physical and particularly sexual which was very prevalent and was never mentioned by any psychiatrist that I am aware of. I never heard a Psychiatrist refer to it, I never saw it in any patients file, nobody ever thought about it or talked about it but who knows how many people were in here as a result of it'* FRPN1. Such practices militated against patients receiving appropriate nursing care.

The socio cultural and political factors that contributed to the existence of asylums may have prevented permission to admitting Psychiatrists to access and document such information. Alternatively it may also be that the biomedical approach did not allow for it. Alternatively it may also be due to the difference between the nurses' and doctors relationship to the patient. Psychiatrists may have viewed their ethical responsibility as being legally responsible for prescribing treatments for patients. On the other hand, the ethical responsibly of nurses is to care for the patient and to administer the treatments prescribed.

While the evidence in this study would indicate that mental institutions were used to address what was perceived as socially objectionable behavior in the mid-1900s, including the concealment of women who were pregnant as a result of sexual activity outside marriage (Luddy, 2011) and individuals who were victims of trauma and abuse, in particular sexual abuse. It is notable however, that the impact of such

trauma and abuses and what treatments available to patients including psychotherapies and psychotherapies went unacknowledged within psychiatry in Ireland (Kelly, 2016). While Shorter (1998) cited by Kelly (2016) acknowledges that the psychiatric practices and psychiatric diagnosis are subject to social, political and various other influences, within the history of psychiatry in Ireland the only reference to psychiatric diagnosis of a sexual nature at that time was to homosexuality, listed as a mental disorder (sexual deviation) in DSM 1(1952) & DSM 2 (1968).

Kelly's view of the general absence of the Roman Catholic Church from the history of the systematic provision of psychiatric services in Ireland (p109) is opposed within this study. His view that the field of mental health was not dominated by the church and for many decades their only role lay chiefly in the provision of chaplains to the state run asylums that emerged in the 1800s and early 1900s is totally divergent to the views of nurses practicing at that time. While evidence is provided within this study to highlight the imposition of the church in the ethical aspects of the nursing curriculum, no reference is made by Kelly on the influence of the church on medical ethics and medical practice.

5.8 A Nursing Philosophy of Care

In the absence of psychiatric theoretical knowledge their clinical judgement and decision-making relied almost exclusively on their own experiential working knowledge and intuition. Clinton (2010) refers to this routinized and intuitive judgment and decision making as to be expected when working in a demanding high pressured work environment with time limitations. This way of applying knowledge to problem solving is an essential feature of professional practice (Higgs et al 2001, Thompson 2002). Crowe et al (2008) have described this valuing the individual approach to assessment as formulation, as opposed to diagnosis. This practice of formulation was also described by nurses in their narratives as an organising principle in their day to day care of patients as well as in the context of the resocialisation process within the asylum. Such application of knowledge was evident in narrative representations of case formulations in the deinstitutionalisation

of patients and the nursing role in the disciplinary application of mental treatment legislation as well as the development of the community service. This was a very discrete nursing role finding in this study and exclusive and distinct from medicine and psychiatry.

> FRPN2 *The medical training inherited from psychiatry where patients were viewed as an interrelated sets of anatomical parts, physiological systems and biochemical processes contributed to the fragmentation of the individual patient.*

The integration of this formulation approach also underpinned nurse's discursive construction of the professional identity of psychiatric nursing from a training and education perspective, in this study. The active construction and generation of new knowledge and learning for curriculum development purposes, was based on experiential and intuitive nursing practice and knowledge. The narrative representation of the integration of intrapsychic work required to prepare the psychiatric nurse to develop more authentic interpersonal relationships incorporated into educational programmes was established. Considering the nurses' narratives it is clear that the design of a new psychiatric nursing curriculum, encompassing a new nursing language and grounded in a new nursing philosophical approach, provided the foundations of a specialist body of knowledge within nursing from which practice was drawn was developed. This body of knowledge, which is coherent with Peplau's (1952, 1989) theory, served to inform contemporary psychiatric nursing practice, emerged from within the institution.

The narratives in this study portray the reformist role nurses played in caring for patients within the asylum system and how they effected change from within. In some areas in Ireland in the 1960s, a small number of Consultant Psychiatrists demonstrated leadership by initiating the recommendations of the Report of the Commission (1966). Where this leadership was effective, nurses were empowered, patients were discharged and community psychiatry was established

This study, however, would indicate that the heavy lifting was done by nurses, originally based in the institutions and later in the community. Skilled nurses, who had gained their psychiatric nursing knowledge and intelligence in the asylums, demonstrated their practice in the community to achieve better results for patients. Some of these nurses had further developed their professional competence and confidence through advancing their professional development through further education by challenging restrictive state policies and practices. The nursing practices that evolved and developed particularly during the 1950s, following the introduction of anti-psychotic drugs, within institutions and later in the 1960s, nurses through a humanistic approach provided relationship based care and developed patient's personal and social competence. Through the resocialisation of patients they prepared patients for deinstitutionalisation and reintegration to community.

The *function* of a role is the part it plays in the maintenance or destruction of the system or pattern as a whole' (Goffman 1961; p. 78). Nurses were the first professional group assigned to the community. The evidence would indicate that their practice and role was reformist and instrumental in making the walls porous and influencing the transformation of a custodial psychiatric service to a community mental health model of care. Benner and Wrubel (1989, p. 382) stated that the expert caregiver learns "through repeated experience with patients...to perceive the particular rather than the typical, care becomes individualized rather than standardized and planning becomes anticipatory of change rather than simply responsive to change", these nurses became expert caregivers and pioneered the origin of the contemporary community mental health services.

The findings of this thesis demonstrate how nurses contributed to the deconstruction of the asylum system from the inside out, using a bottom up approach. The leadership of this deconstruction came from individual nurses as opposed to the profession of nursing. The nurses in this study have demonstrated how as disempowered nurses, they developed professional agency and how this professional agency influenced their professional leadership. In so doing they developed and modernised the profession of psychiatric nursing, with limited supports during the 1940s, 50s and 60s in Ireland. However, as King (1981, p2)

illustrates ‘if nurses are to continue to function in a professional role, that role must be defined by the profession’.

The involvement of these nurses in the administration of medically prescribed treatments in asylums in the mid-1900s led to nurses being associated almost exclusively with a medical model in the literature (McGabhann, 2014, p30, Nolan, 1993, Sheridan, 2006). While the data indicated nurses did administer medically prescribed treatments, it also indicated that nurses did not restrict their practices in this narrow and limited way. This research concurs with Clinton (2010), there is no evidence that medical psychiatry influenced the care these nurses provided, the care they provided was not based on the patient’s medical categorisation or diagnosis, as nurses were not privy to that information. No diagnostic labelling was used to explicitly borrow and wield power from medical psychiatry (Hamilton & Manias 2006). It is critical that the role of nurses and the profession of nursing is not conflated with that of psychiatry.

The data in this study however, demonstrates how the custodial, social and cultural realities of asylum care, portrayed in the nurse’s narratives, underpinned their discursive construction of the patient’s identity as one of vulnerability and a potential inability to take responsibility or make self-determined decisions. While this study does not assess the qualitative nature of these nurses’ assessments, it predisposed the patient to a paternalistic approach. This approach however in this study appears to be motivated by a beneficent concern for individuals’ best interests and having their best interests at heart.

5.9 A Nurse’s role

To describe the nurses role as being a ‘doctors handmaiden’ within the institution does not harmonize with this study’s findings and could be seen as a reductionist view and a diminution of the contribution of nursing, disregarding and overlooking the caring and psychotherapeutic aspect of the nursing role as evidenced in this study,

both in the asylum system and in community. This study finds that nurse's had a very discrete nursing approach distinct from medicine in the asylum system. Psychiatric nursing focused on caring for and meeting the physical, psychological and emotional health care needs of patients and consequentially their social health care needs. This also involved the needs of their families, of their communities and of society's. In their day to day role caring of patient's, their socio emotional functioning, emotional adjustment as well as social behaviour awareness was integral to their practice. Their psycho educational and psycho therapeutic interactions enabling the patient's emotional affirmation and learning of other possible more adaptive approaches to manage instinctive impulses. The findings indicate that while the patriarchal and cultural context in which they worked influenced their habitual patterns and daily regimes, a parallel nursing model existed and a distinct nursing role was being practiced, albeit in professional silence.

5.10 Professional Agency

The individual agency a psychiatric nurse had in the asylum system and the social context in which they practiced was separate but mutually constitutive and highly interdependent. This study highlights the way nurses thought, acted and learned was constrained by their socio cultural contexts. The nurses' demonstrated frustration and tried actively to gain control of their work lives and their professional careers both professionally and organisationally within the institution and in the community. This sense of agency was evident in this study over the period of time being studied and across the nurses' life course. Their sense of professional agency was borne out of concern for patients. Their nursing interpretations and sense of purpose in relation to their professional agentic actions were intertwined with their professional identity commitments. Because of the cultural context, the institutional system and lack of professional support systems, their struggle in the asylum would indicate a notion of 'bounded agency' (Ecclestone, 2007; Evans 2002).

Male nurses going to the UK to train in general nursing achieved for individual nurses an increased sense of their own professional agency and professional

credibility. The narratives of the psychiatric nurses who were general nurse trained portrayed a greater sense of professional confidence and competence. The contribution of this additional qualification contributed significantly to the nurse's professional and social identity and their sense of optimism in their clinical judgements and decision-making. It also influenced their career progression. In achieving this development of general nursing registration in Ireland, these male psychiatric nurses, contributed to the modernisation of the profession of nursing, they challenged the integrity of Irish healthcare policy and influenced and shaped services and the nursing profession.

The transition of the locus of care to the community required the reshaping and renegotiation of not only their roles but also their work identities and their sense of professionalism. This transition of care created enormous emotional and psychosocial relational problems for the patients involved, their families, the primary care professionals, society in general as well as for the nurse. A more deterministic account of professional agency and existential agency became evident with the development of community care by these nurses through their capacity to make clinical decisions. Their clinical judgements could be autonomous as well as their nursing interventions. Nurses had to make nursing decisions and clinical judgements, some of which were not necessarily socially acceptable or in agreement with family's wishes. This challenge to the habitual patterns of social attitudes and behaviours influenced the professional identity that the nurse had internalised. Their professional identify commitments motivated nurse's practice and they exercised agency in the very performance of their identities. These identity commitments served to guide the nurses in establishing a vision for their own nursing practice as well as that of the profession.

This struggle for professional agency, as evidenced in this study, was an individualistic internal, bottom up approach, as there were very limited professional or social supports for these psychiatric nurses or for the profession. Their struggle involved both individual and social aspects of agency. Psychiatric nurses constructed and actively negotiated their identity as a professional at work and as a profession within the greater nursing profession and in society. Fenwick & Somerville (2006)

cited by Etalapelto et al (2013) refer to such processes as ‘inhabiting their identities’. Recognition by the nurse of their agentic capacity brought greater capabilities and potential for them as caring, creative and relational nurses. The impact of such professional agency also influenced the development of the profession and served to shape the development of community mental health services.

What is interesting is that the more deterministic account of professional agency and existential agency became evident at the time that psychiatric nursing began to professionalise through improved educational opportunities, the introduction of a new nursing specific curriculum, and greater involvement in informal therapeutic nursing activities detailed by the participants in this study. This period also coincided with improved emphasis on resocialisation and the deinstitutionalisation process to patient’s homes and transition to community.

5.11 Caring

The dominant overarching discourse in this study was the human approach these nurses displayed in describing the service provided to patients and the emphasis on their role of caring, both caring for patients and caring about patients. The human depth of caring borne by these nurses within this research study and the intrapersonal sense of gratification and contentment these nurses experienced as a result of such caring was palpable from these nurses and provided professional fulfilment for them.

MRPN5 *It was a good life you know!*

MRPN6 *I felt very good afterwards so when I was finished I said to myself not to anybody to myself I did my very best honest. I had no apprehension but no, they can’t say I didn’t do my very best!*

The nature of caring described in this study involved the attributes described by nurses as those of knowing the patients, patience, honesty, trust, respect, empathy, compassion and courage. Through the knowing and development of intimate relationships and emotional engagement with patients these nurses enabled patients to develop skills and coping mechanisms to recover and actualise to their own individual potentials, enabling 'the other to grow in its own time and in its own way' (Mayeroff 1971, pg17). Nurses described the centrality of comradery in their relationship with patients, through their physical presence, assisting the patient to move onward, closeness of contact and companionship nurses demonstrated attributes of care that concurs with Campbell (1984) theory of caring. Nurses exhibited care in different ways. Many articulated protective qualities and talked about how they cared about what happened to the patients and promoting their welfare. This protective attitude of nurses caring directly and indirectly, followed patients into the community, into their families homes and into society. Their caring role entailed the promotion of a two way process as identified by Noddings (1984) as the 'reciprocity' of care:

> MRPN6 *I mean you became very good friends with these people, you became very close to some of them and I remember when my wife died I met so many patients at the funeral, you know patients reciprocated my care.*

The level of compassion evident in the communications and relationships nurse experienced with the patients contributed to a depth of caring that was emotive. All of the narratives related to these nurses desire to be good people and serve patients, this ethical caring along with a moral ideal of caring was central to their definition of nursing. This finding is at odds with Barker's international survey on what is psychiatric nursing and how do psychiatric nurses do nursing (Barker, 2009, p.4) where few of the respondents referred to 'caring or care' except in very general terms such as 'nurses give nursing care'. It is unclear why these contemporary definitions do not refer to caring as a central component of the psychiatric nurses' role and function. This may relate to the ideological differences which have emerged between vocationalism and professionalism. As the roots of nursing in Ireland

evolved from within the holy orders and dedication to duty and vocation was part of the nursing service, There is a clear view that the physical vocational work carried out by people with lesser or no formal qualifications is less demanding than professional work, (Birchenall & Birchenall, 2001 p.182).As professionalism is viewed as a knowledge based competence which is developed and held by experts (Rueschemeyer, 1983), it is likely that in the pursuit for professional status, caring associated with vocationalism was considered misrepresentative and discarded by our contemporary nurses.

Nurses through their narratives highlight the detrimental nature of those large-scale psychiatric institutions for nursing, for patients and for holistic person centred care. They also articulated their disbelief that the medical model adequately represented patient's presentations and behaviours or the capacity of this approach to meet patient's total treatment and care provision. Nursing was more than looking at isolated symptoms, it involved a more holistic approach and nursing responded in both autonomous and collaborative ways. The findings of this study concurs with Peplau's theory of interpersonal relations and psychodynamic nursing respectively (Peplau, 1988, pg.16 & 1991, pg.9), where psychiatric nursing is defined as a 'therapeutic, interpersonal process' that requires the need to get to know patients and know yourself, understand one's own behaviours in order to help others identify felt difficulties and applying principles of human relations to problem arising during an experience. During the narrative discourse, the majority of nurses articulated an awareness of their own emotions and values and portrayed a developed sense of empathy. This was reflected in their thoughts, actions and professional decision making. Their understanding of the relevance of personal self-awareness and self-reflection was central to enabling them to read emotions in other people' (Goldman, 2007) and informing their practice and educational nursing programmes. These nurses demonstrated a high ability to maintain emotional control in emotionally charged environments. Such mind sets curtailed negative emotional states and sustained them in experiencing more positive emotional states to achieve better outcomes for patients. This study would indicate that the nurses who developed such optimism, humour and emotional literacy (Goldman, 2007) fostered a greater psychodynamic engagement with patients, families and the public.

MRPN6 *I expect to be honest with people but above all what is it, to be honest with yourself and I was honest with myself when I did that job. I wanted to help the people and I can honestly say I did help a lot of people!*

The altruistic and unconditional positive regard for patients and their needs evidenced in this study contributed to the design and construction of a bridge between the institution and the community, strengthening social bonds and confronting social stigma and promoting tolerance in order to develop mental health services. The nurse's capacity to care for patients and about patients is inextricably interwoven within these activities and achievements

MRPN6 *If I didn't believe in these people, I could not have done my job so well!*

Psychiatric/mental health nursing therefore is defined within this study as the structured delivery of professional care for and care about individuals with mental health difficulties. This care requires the creation of an interpersonal relationship and specialist clinical knowledge to facilitate a therapeutic human connection with the individual and engage with them at an emotional level to identify their talents, their socio emotional functioning and motivational capacity to achieve growth, resilience and ultimate recovery.

Individual psychiatric nurses developed a collective voice for patient advocacy. Their strong sense of values and professional agency motivated and sustained this practice. While these nurses were energised and influential in relation to their patient advocacy role, they demonstrated a reluctance to advocate for their own profession, this critical work nurses did was accomplished in silence.

5.12 Contribution of this study

Having worked in Nursing in the Health Service Executive's Directorate for the Planning and Development of Nursing and Midwifery services for almost twenty years, I noted a yawning gap in relation to psychiatric nursing. The history of psychiatric nursing in the asylum system in Ireland has not been researched. While there are many publications on psychiatric nursing, education and its association with institutions in Ireland (Cowman, 1997, Sheridan, 2000, Nolan, 1993, Nolan & Sheridan 2001, Robins 2000), unlike the other divisions of nursing, there was no evidence available of the contribution of psychiatric nurses to the history of nursing or the profession of nursing in those formative years. This study aims to close that gap, it looks closely at the experience of nurses who worked in psychiatric institutions in the mid-1900s, the work they did and the impact of that work. This study highlights the importance of looking backwards to make sense of today, and how we as a profession arrived here if we are to progress and inform our own future and legitimise our profession. The study aims to integrate the history of the emergence of their profession, as narrated by these nurses into the story of the profession of nursing in Ireland with the institutional landscape it emerged from without losing sight of nursing as a separate and distinct profession in its own right.

The intention for this study is neither critical nor celebratory, only informative. The aim of this research is not to claim some territory for psychiatric nurses but to fill that gap and eradicate the ignorance relating to psychiatric nursing and its contribution to modern mental health care. The research described what analysis has revealed about the experiences of these nurses who worked in the asylum system between 1940 and 1970, it remains to discuss the implications of this work in relation to contemporary psychiatric nursing practice, the profession of nursing and the modernisation of mental health care. This study constructs a history, built by and around a profession, which widened the scope of historical enquiry to produce new evidence from the 'underside' and gave 'back to the people who made and experienced history, through their own words, a central place' (Perks &Thompson, 2006, p.2-26).

This study demonstrates that the structural governance arrangements and clinical primacy invested in the RMS and Consultant Psychiatrist negated interdisciplinary

team working. This governance system of service provision dictated largely nurses daily routine and habitual role and nurses subserviently responded. Such professional dominance strengthened the application of an exclusive medical model approach and diminished the role and contribution of nursing. This dominance diluted professional nursing accountability and professional agency and contributed to diminishing the development of nursing. Nursing and medicine are interdependent professions however they are different professions. This study evidences how nursing cannot develop within a medically dominated model of service delivery. This study would also indicate that in the absence of nursing, the patient is poorly represented or potentially misrepresented.

This dominance and total investment of authority in one professional discipline permitted discretion in the implementation of health policy. Such discretion resulted in inequivalent application and implementation of the recommendations of the report of the Commission of Inquiry into Mental Illness (1966) which would have influenced the modernisation of mental health services at an earlier time in Ireland. The exploration of professional imbalance in power at clinical governance level is required to avoid limiting the potential for more autonomous, therapeutic work (DoHC 2006). It is essential that the governance structures and processes are equitable and respectful of all disciplines to facilitate interdisciplinary working to promote person centred care.

Nurse's professional identities were socially constructed by society and the broader profession of nursing. Psychiatric nursing must become visible and have a professional voice. Nurse's stories also reveal how silence about the moral and professional implications of nurses' work and patients treatments in an overcrowded system did not serve patients, healthcare or the profession well. Finding a way to bringing difficult issues to light is one of the great challenges facing our profession. The need for a strong professional voice from nurses is critical if the profession is to progress and become influential in the healthcare arena. Nurses have a significant role with patients but leave no public evidence of their work behind them. This professional voice needs to come from professionals who are representing the patient's agenda as opposed to staff organisations who represent the staff's agenda.

This study would identify the need for strategies to develop a voice for the profession and not rely on other disciplines to do so. Silence is no longer an option.

The nurses in this study demonstrated leadership and professional entrepreneurship. With limited professional or administrative supports, they relied on their own professional innovation to create other models of professionalism to include a nursing education curriculum informed by a new nursing language and new nursing practices. The implication of these findings is significant for the profession of psychiatric nursing at a time of major societal change. Peplau (1994) observed that throughout history, the boundaries of psychiatric mental health nursing practice have expanded and evolved in response to changing circumstances in society. .As our society widens to encompass the global aspects of social groups and cultures, the nature of the individuals and presentations requiring psychiatric nursing care will change. This will challenge psychiatric nurses to innovate and extend their professional understandings of the impact of social and cultural influences along with their professional obligations to place the individual at the centre of that care and advocate on their behalf.

While historical asylum structures and processes as well as deinstitutionalisation and community care all influenced and impacted on shaping professional nursing practice. This study has demonstrated that the centrality of caring for and caring about patients is central to the nurse's role, and was not context based.

Kelly (2016) in his publication 'Hearing Voices-the History of Psychiatry in Ireland states it is premature to identify the leaders of modern psychiatry in Ireland. This study would indicate that it is now very timely to identify some of those leaders. While psychiatry was accountable for implementing national mental health policy, in the geographical areas where this policy was introduced and deinstitutionalisation to family homes was initiated, psychiatric nurses steered the mental health services and care out from the asylums and into the communities. Through developing their professional agency, they communicated, negotiated, networked, educated, cared for and about and designed and shaped the development of contemporary mental health services. This group of nurses nudged in change and commenced the

construction of a new model of mental health care by making the institutional one obsolete. They contributed to metamorphic change in psychiatric service provision, in psychiatric nursing and the maturation of the profession.

There were two findings in this study, which surprised me. The first I would have had some experience of in my practice as a psychiatric nurse, however, I was unprepared for the significance of it on these individuals. This finding related to social and professional stigma. Nurses expressed their inability to explicitly challenge either privately or publically the dominance of the asylum governance and the social order to influence patient care. This caused nurses significant professional regret and shame and strongly influenced the nurse's professional identity. The impact of this and the weight it bore on their person as well as their professional identity and professional integrity was profound. I was unprepared for the magnitude of this emotionally for nurses, the consequences of which I was not expecting.

The second finding of 'caring' I was expecting; however I was also surprised by the extraordinary degree of caring that the nurses articulated. The cogency of their caring underpinned their moral and philosophical approach to their professional practice in every aspect of their role including direct and indirect care of patients. The role these nurses performed fulfil the definitions of psychiatric/mental health nursing (Peplau, 1991) Barker (2009). However the finding of caring in this study, as a foundational cornerstone of psychiatric nursing, is not identified in the contemporary definitions in Barker's international survey (2009, p4) and in the American Nursing Association (1980) however the nurses in this study perceived caring to be the 'soul' of their nursing practice.

5.13 Conclusion

The profession of Psychiatric nursing in Ireland is less than 100 years old. The period of time this study relates to captures a significant part of the ontogenetic maturation of the profession from the early 1940s to 1970. Despite the historical

notion that nurses were ‘doctor’s handmaidens’ it would be misleading to accept this traditional stereotype of psychiatric nurses. This traditional psychiatric nurse in the asylum stereotype obscures the fact that there have been nurses who both cared for and cared about patients, some cared profoundly. These nurses’ narrated an unspoken gap in the narrative of healthcare in the Irish state. Michael D Higgins quoting from a book: Memory, Narrative and Forgiveness: Perspectives on the Unfinished Journeys (Gobodo-Madilizela & Der Merwe, 2009) stated that the burden of the past can be too heavy and that some people are not capable of providing adequate answers to the multitude of questions that can preoccupy individual’s minds. As many of the manifestation of mental illnesses were strongly determined by social, religious and cultural influences of the time, many nurses found it difficult to articulate their experiences of working within the asylum and what happened there. They found that burden too heavy and didn’t participate in this study. However the nurses who did participate ‘remembered ethically’ (Higgins, RTE Feb 9th 2020), patients vulnerability reached deep into nurses psyche. Ontogeny is defined as the process through which each of us embodies the history of our own making. As psychiatric nurses we must carefully consider the collective memories we propagate, they are vital in shaping future generations of nurses. How this profession based oral history will be reconciled within the future professional nursing curriculum and how it will affect the historical memory of the public remains to be evaluated?

5.14 Limitations of the study

The limitations of this research are defined in the research sample and size of the study. The researcher had 15 narratives of nurses who worked in the asylum system nationally, between 1940 and 1970. The researcher is confident that the study had sufficient ‘information power’ (Malterud, 2015) relevant to the particular study due to the consistency in language, memory and interpretation (Murphy, 2005) as well as the repetitious quality of the dialogue. The researcher is also confident of the trustworthiness of the narratives due to the level of emotion displayed (Munhall, 2012). However, it is important to note that the position of the researcher as “insider researcher” is not considered a limitation. On the contrary, the rich data that

emerged from this group was assisted by my knowledge of and familiarity with psychiatric nursing and the institutional context.

Another limitation of this research is the lack of patient's voice, which would have offered another perspective on experiences of nursing in the asylum system (Cusack, 1994). Despite these limitations, the research provides valuable insights that may have implications for both policy and practice.

5.15 Implications for further research

- Further research following on from this exploratory study should look at the experience of nurses from the 1970s when nurses were appointed as Community Psychiatric Nurses to work exclusively in the community services and the role of nurses following the implementation of the policy Planning for the Future (1984) which proposed a comprehensive model of community mental health service provision

- The experiences of patients during this period.

- There were so many examples of how nurse's practice made a difference to a patient's life however the professional self-abnegation of psychiatric nurse's work with patients requires further research. This aspect of agency and professional voice in psychiatric nursing needs further exploration.

- This research highlighted issues relating to stigma as having a socio cultural basis and the impact of stigma for the professional role of nurses and their professional identity, is stigma still an issue for psychiatric nurses and their professional identity?

- Within this study the professional voice of nursing was absent from healthcare and policy. Further research is required to:

- Explore how the systems and governance structures of mental health service provision facilitate professional voice and influence the development of nursing and interdisciplinary team working.
- Monitor the voice of nursing within healthcare, within the broader profession of nursing and society, to inform a greater understanding of nursing work and what nurses do (Buresh & Gordon, 2000).

- This research indicated that staff representative organisations were socially constructed as the professional voice of nurses; however this study also indicates that this professional voice for the profession presenting the patients agenda cannot be provided by such organisations, further research is required to elicit the contemporary views of nurses in this respect

5.16 Recommendations:

Based on the findings presented in Chapter 4, some recommendations are suggested to further develop the profession of psychiatric nursing and improve the quality of clinical input.

- Explore the medical model influences in contemporary psychiatric nurse training programme.

- Recommend that counselling and psychotherapy become a core skill of the psychiatric nurse.

- To develop this skill as a core component of psychiatric nursing, I recommend that counselling and psychotherapy be integrated into the under and post graduate nursing programmes.

5.17 The personal learning of the researcher throughout this study.

So many people are shut up tight inside themselves like boxes, yet they would open up, unfolding quite wonderfully, if only you were interested in them.

(Sylvia Plath, Johnny Panic and the Bible of dreams: short stories).

Any reflection on the personal learning for me as researcher would be incomplete without the acknowledgement of how privileged I feel to have had the experience of meeting with and listening to the nurses who told me their stories and informed this research: a collective narrative of psychiatric nursing in the 1940s, 50s and 60s in Ireland. I was required to intently and attentively listen to their stories and to step into their shoes and interpret their narratives from their perspective. This was by far the greatest influence on my learning as a researcher and my personal development more generally for this demanded that I use a critical reflexivity to confront my personal biases and prejudices in opening up the personal experiences, memories and emotions of nurses, most of them telling their story for the very first time. Using a narrative inquiry methodology I sought to hear the voices of the nurses which to date had never been heard before as the nurses believed no one wanted to listen to them. Unfortunately we cannot access the voice of the patients who resided there, however, through the nurses' narratives we achieve an insight into the context in which many of the patients lived out their lives.

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Appendices

Appendix 1 Ethical Approval Application

Consent Form for Interviews
Eithne Cusack
[redacted]

As you are aware the large psychiatric institutions have closed and mental health services are now delivered in an integrated model with a focus on community services. This study is focused on getting narrative (stories) accounts of the experiences of nurses who worked in the Mental Health services in the mid-1900s. I am interested in hearing about your experiences, especially, the changes you encountered in mental health service provision during that time and your role as a nurse over the years.

This history of nursing and the social history has not been captured and risks being lost to the profession and to society.

DECLARATION

- I have read the study information sheet and this consent form
- I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.
- I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential.
- I understand that the anonymised data from this study may be used in future studies without the need for additional consent
- I understand that a transcript of my interview will be provided to me upon my request
- I freely and voluntarily agree to be part of this study, though without prejudice to my legal an ethical rights
- I have received a copy of this agreement and I understand that the results of this research /work may be published
- I understand my participation is voluntary and that I may withdraw from the study at any time.

Participants Name (block capitals)

_____

Participants Signature

_____

Date _____ Contact Number _____

Information Leaflet

Study: Narrative history of Psychiatric Nursing in Ireland in the mid-20th Century.

Eithne Cusack

[redacted]

Rationale

As you are aware the large psychiatric institutions have closed and mental health services are now delivered in an integrated model with a focus on community services. This study is focused on getting oral narrative (stories) accounts of the experiences of nurses who worked in the Mental Health services in the mid-1900s. I am interested in hearing about your experiences, especially, the changes you encountered in mental health service provision during that time and your role as a nurse over the years.

This history of nursing and the social history has not been captured and risks being lost to the profession and to society.

What will participation involve?

You are under no obligation to participate. If you do agree to be involved, you will be asked to take part in an interview. This interview will involve your reflecting on your experience of working within the mental health services in the mid 1900s, the changes you encountered in mental health service provision during that time and the role of those employed in nursing roles over those years.

How long will I be interviewed for?

Each interview may take anything from thirty minutes to one hour, the researcher will give you whatever time you need to tell your story. In order to ensure that an accurate account of your experience is captured the interviews will be audio recorded. . If you wish to review the transcripts of the digital voice recordings of your interview, you may do so and I will provide them for you in print form.

Where and when will the interviews take place?

The interview will take place at a time and place convenient to you.

What will happen to the information once collected?

Once the interview is over the information will act as a reference point for an analysis of its content. The interviewer will be looking for common themes and any particular insights that you may have provided. All interviews will remain confidential. At no stage will your name appear on any written report or notes as pseudonyms will be used. So your confidentiality will be protected at all times.

Many thanks for taking time to read this leaflet

Study: Narrative accounts of life and your experiences of Nursing in Asylums in Ireland in the mid-20th Century.

Letter to Retirement & Professional Nursing Associations

[redacted]
Castleknock,
Dublin 15
Phone [redacted]
Email [redacted]

Study: Narrative history of Psychiatric Nursing in Ireland in the mid-20th Century.

Dear Chairperson,

I am a Psychiatric Nurse who is currently doing a Doctorate in Education in DCU and my area of research is capturing oral narrative (stories) accounts of the experiences of nurses who worked in the Mental Health services in Ireland in the mid-1900s. I am interested in hearing about those nurse's experiences, especially, the changes they encountered in mental health service provision during that time and the role of the nurse over those years. Ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee.

As you are aware the large psychiatric institutions have closed and mental health services are now delivered in an integrated model with a focus on community services. This history of psychiatric nursing and the social history has not been captured and it risks being lost to the profession of nursing and to society.

I would appreciate if I could have an opportunity to meet with the retired members of your association at either formal or informal events to inform them of this study to access nurses who would like to contribute to this research.

Members are under no obligation to participate, however, if a member agrees to be involved, they will be asked to take part in an interview. This interview will involve reflecting on their experience of working within the mental health services in the mid-1900s, the changes encountered in mental health service provision during that time and the role of those employed in nursing roles over those years. The interview will take place at a time and place convenient to them. All interviews will remain totally confidential; confidentiality will be protected at all times.

I would appreciate if you could forward this communication to your members and advise them to contact the undersigned at Ph.: [redacted] or [redacted] if they wish to contribute to this research.

I look forward to hearing from you.

Yours sincerely

Eithne Cusack

Eithne Cusack
[redacted]
Castleknock,
Dublin 15

Study: Narrative history of Psychiatric Nursing in Ireland in the mid-20th Century.

Dear Nursing Colleague,

I am a Psychiatric Nurse who working in the mental health services in the Dublin region for 39 years. During this period and over the last generation significant developments occurred and we witnessed many changes. The large psychiatric institutions have closed and mental health services are now delivered in an integrated model with a focus on community services.

However, while much has been written on nursing in General hospitals and the Intellectual Disability sector including Midwifery, nursing in the mental health system from a historical perspective has not been examined along with the contribution of nurses which has rarely been described. This history of nursing and the social history has not been captured and risks being lost to the profession and to society.

If you worked in nursing in the 1940s, 1950s or 1960s or know someone who did, I would appreciate if I could meet with you to hear your story. I am interested in hearing about your experiences, especially, the changes you encountered in mental health service provision during that time and your role as a nurse over those years.

I am doing this as part of a Doctorate and I am hoping to capture stories which are the storied experiences of nurses' your life as told by yourself and the environment in which you worked. No individual patient or patient's story will be used in this research. In the event of patient stories emerging, this information will be anonymised. As these asylums are all now closed there is no possibility of patients being identified? Ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee.

Each interview may take anything from thirty minutes to one hour, I will give you whatever time you need to tell your story. The interviews will be audio recorded as it would be impossible for me to remember or take accurate notes on everything that your say. If you wish to review the transcripts of the digital voice recordings of your interview, you may do so and I will provide them for you in print from. The interview will take place at a time and place convenient to you.

Once the interview is over the information will act as a reference point for an analysis of its content. The interviewer will be looking for common themes and any particular insights that you may have provided. All interviews will remain confidential. At no stage will your name appear on any written report or notes as pseudonyms will be used. So your confidentiality will be protected at all times.

Please feel free to contact me, my details are at the top of this letter. I look forward to hearing from you.

Yours sincerely

Eithne Cusack

Interview Schedule:

1. Can you tell me about when you started nursing in the mental health services?
2. What was your impressions of the service was at that time?
3. Can you describe for me what that life was like for you nurses
4. Can you describe for me what life was like for patients in the asylum system at that time?
5. Bearing in mind not to use patient names, can you give me examples / case examples of individuals who were admitted to the mental health services, why they were admitted and the treatments / interventions they received?
6. What changes in thinking or practice did you see during those years (examples)?
7. What helped or hindered bringing about change?
8. What influenced change in the provision of care for patients in the Mental Health services at that time?
9. Would you like to add anything else?

Appendix 2 Ethical Approval

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University

Ms Eithne Cusack
School of Policy and Practice

8th October 2018

REC Reference:	**DCUREC/2018/180**
Proposal Title	**Narrative History of Psychiatric Nursing in the mid-20th Century**
Applicant(s):	**Ms Eithne Cusack, Professor Joe O'Hara**

Dear Eithne,

Further to expedited review, the DCU Research Ethics Committee approves this research proposal.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee.

Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

Donal O Gorman

Dr Dónal O'Gorman
Chairperson
DCU Research Ethics Committee

DCU
Research & Innovation

Taighde & Nuálaíocht Tacaíocht
Ollscoil Chathair Bhaile Átha Cliath,
Baile Átha Cliath, Éire

Research & Innovation Support
Dublin City University
Dublin 9, Ireland

T +353 1 [redacted]
T +353 1 [redacted]
E [redacted]
www.dcu.ie

Appendix 3 Profile of Participants

Case Profiles	Decades nursed in	Gender	Location of Employment	Location of Origin	Location of practice	Participant Type	Years of Service
Interview 1	1950s x 1960s	Female	Urban	Rural	Asylum	RPN	35 to 40
Interview 2	1960s	Male	Rural	Rural	Both	RPN x RGN	35 to 40
Interview3	1960s	Female	Urban	Rural	Both	RPN x RGN	35 to 40
Interview 4	1950s x 1960s	Female	Urban	Rural	Asylum	RPN	5
Interview 5	1950s x 1960s	Male	Rural	Rural	Both	RPN x RGN	More than 40
Interview 6	1940s	Female	Urban	Rural	Asylum	RPN	
Interview 7	1950s x 1960s	Male	Urban	Rural	Asylum	RPN x RGN	More than 40
Interview 8	1940s x 1950s x 1960s	Male	Rural	Rural	Asylum/	RPN	More than 40
Interview 9	1940s x 1950s	Female	Urban	Rural	Asylum	RPN	10 to 15
Interview 10	1950s x 1960s	Female	Urban	Rural	Asylum/	RPN	
Interview 11	1950s x 1960s	Male	Rural	Rural	Asylum	RPN	More than 40
Interview 12	1940s x 1950s x 1960s	Male	Rural	Rural	Both	RPN x RGN	More than 40
Interview 13	1940s x 1950s x 1960s	Male	Urban& Rural	Rural	Both	RPN x RGN	35 to 40
Interview 14	1960s	Female	Urban	Rural	Both	RPN x RGN	35 to 40
Interview 15	1950s x 1960s	Female	Urban	Rural	Both	RPN x RGN	25 to 30

(Both refers to participants who had experienced working in both the asylum/institution and the community)

Appendix 4 - Codebook\\Phase 1 - Generating Initial Codes (Open Coding)

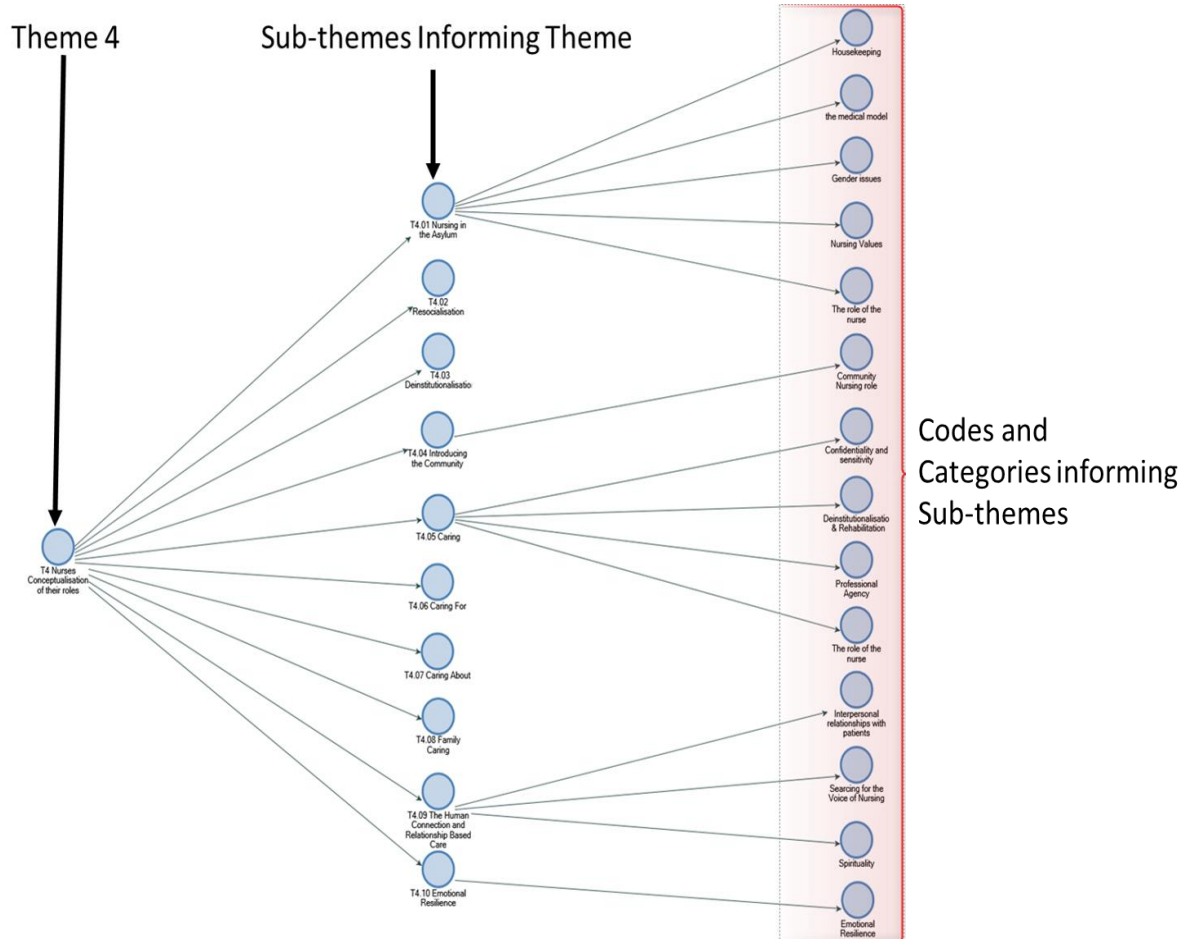
Phase 1 - Generating Initial Codes (50 initial codes were developed at this phase of the project)	Interviews Coded	Units of Meaning Coded
Asylum Environment	17	202
Asylum culture	12	85
Nurses Reflections	18	140
physical environment	14	60
Working conditions	9	25
Community Nursing role	6	50
Institutional change in 60s and psychiatric nursing skills	5	18
Nursing practice Innovative	7	37
The roots of psychiatric nursing	8	41
confidentiality and sensitivity	4	6
Deinstitutionalisation & Rehabilitation	12	36
Emotional Resilience	6	8
Gender issues	12	34
Housekeeping	3	5
Influences	12	115
Influence of policy and legislation	11	46
The influence of doctors	12	32
The influence of drugs	5	8
The influence of nurses	17	100
Institutionalisation	15	53
Interpersonal relationships with patients	12	55
Leadership	13	52
Nurse training in Psychiatric Nursing in asylums in 40s & 50s	14	97
Nurses perception of the asylum	11	31
Nursing Values	17	109
Patients Activities during the day	11	24
Power	9	61
Professional Agency	13	53
Psychiatric Presentations in the mid-1900s in asylums	16	109
Gender issues	12	34
Housekeeping	3	5
Psychiatrization of life experiences and events	7	15
Reason for going into Psych Nursing	14	44
Recovery from illness	12	49
Searching for the Voice of Nursing	6	25
Social Admissions	13	26
Social community	11	30
Social Values	11	58
Society	7	16
Spirituality	2	7

stigma	15	71
the medical model	12	43
The role of the nurse	17	168
Role in the community	7	35
Treatments available for patients	14	62
Treatments available in 50d	11	61
Treatments in the 60s	7	24
Under Utilisation/Devaluation of Nursing skills	10	26
Voice	6	25

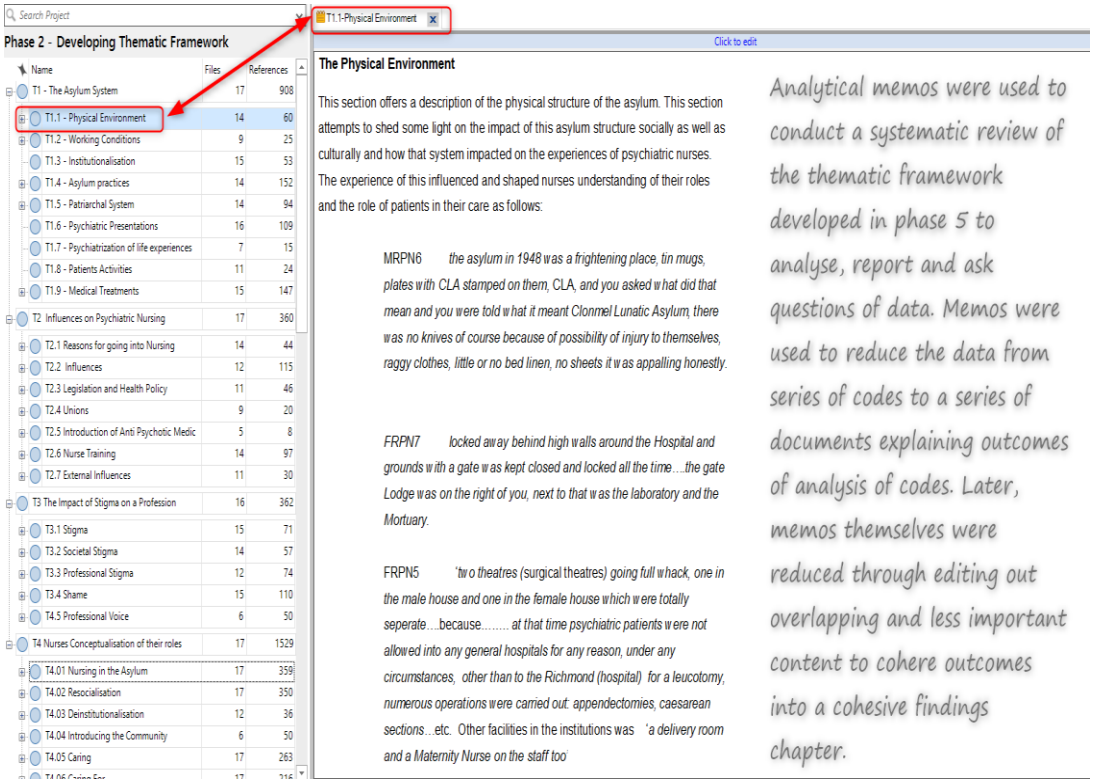
Appendix 5 Codebook\\Phase 2 – Developing a Thematic Framework

Phase 2 – Developing a Thematic Framework (4 Major Themes with Sub-themes Developed in Phase 2	Interviews Coded	Units of Meaning Coded
T1 - The Asylum System	**17**	**908**
T1.1 - Physical Environment	14	60
T1.2 - Working Conditions	9	25
T1.3 - Institutionalisation	15	53
T1.4 - Asylum practices	14	152
T1.5 - Patriarchal System	14	94
T1.6 - Psychiatric Presentations	16	109
T1.7 - Psychiatrization of life experiences and events	7	15
T1.8 - Patients Activities	11	24
T1.9 - Medical Treatments	15	147
T2 - Influences on Psychiatric Nursing	**17**	**360**
T2.1 Reasons for going into Nursing	14	44
T2.2 Influences	12	115
T2.3 Legislation and Health Policy	11	46
T2.4 Unions	9	20
T2.5 Introduction of Anti-Psychotic Medications	5	8
T2.6 Nurse Training	14	97
T2.7 External Influences	11	30
T3 The Impact of Stigma on a Profession	**16**	**362**
T3.1 Stigma	15	71
T3.2 Societal Stigma	14	57
T3.3 Professional Stigma	12	74
T3.4 Shame	15	110
T4.5 Professional Voice	6	50
T4 Nurses Conceptualisation of their roles	**17**	**1529**
T4.01 Nursing in the Asylum	17	359
T4.02 Resocialisation	17	350
T4.03 Deinstitutionalisation	12	36
T4.04 Introducing the Community	6	50
T4.05 Caring	17	263
T4.06 Caring For	17	216
T4.07 Caring About	12	110
T4.08 Family Caring	6	50
T4.09 The Human Connection and Relationship Based Care	13	87
T4.10 Emotional Resilience	6	8

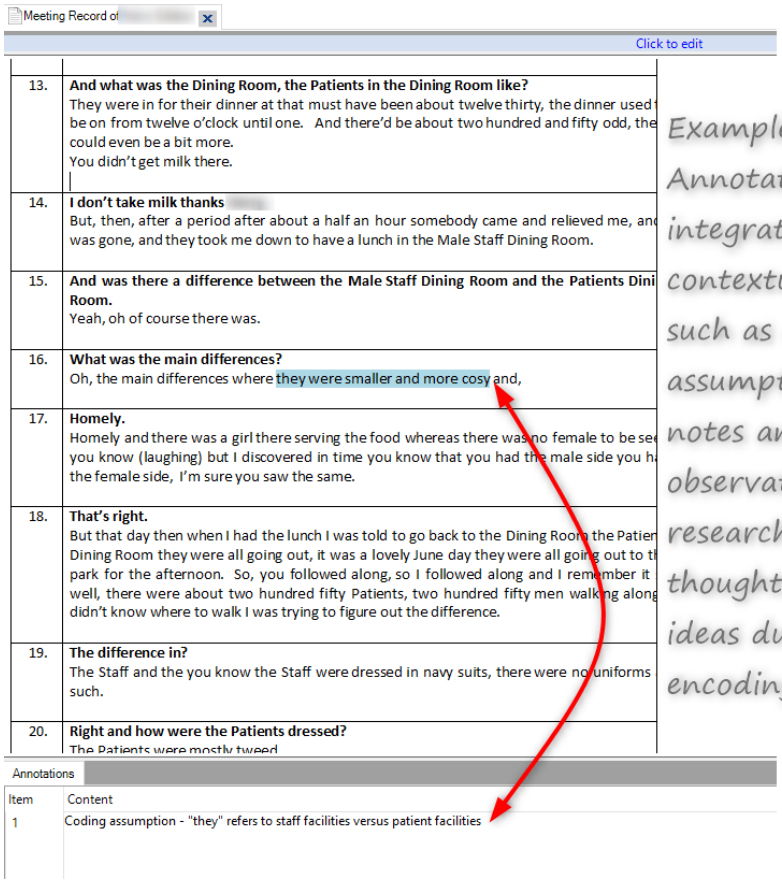
Appendix 6 - Example of flow from codes to categories to themes



Appendix 7 Example of the role Analytical Memo



Appendix 8 Example of the role of Integrated Annotations



Example of Annotations to integrate contextual factors such as coding assumptions, field notes and observations and researcher's thoughts and ideas during the encoding process