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THE CIRCUMSTANCES AND IMPACT OF POWERLESSNESS IN PSYCHIATRIC NURSING

by

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Abstract

Nurses comprise the largest professional group in healthcare; yet, they do not possess a degree of power compatible with their numbers. Nursing, being a predominantly female profession, suffers many of the same oppressive forces imposed on women in a patriarchal society. In addition, nurses suffer the oppression inherent in the hierarchical healthcare structure. A sense of powerlessness may compromise nurses' competency, and this is of particular importance in the mental health field where nurses' ability to advocate for patients can significantly impact the care given. The aim of this study was to explore the situations in which acute care psychiatric nurses feel most powerless, and the impact this has on them, both personally and professionally. A qualitative research design was used, and data were collected through four focus groups with four to five nurses in each group. Three groups were conducted in lower mainland hospitals, and one group took place in an interior British Columbia hospital. Four common situations in which psychiatric nurses feel powerless, emerged from the data. These include (a) those related to medicine's dominance and control; (b) when nurses feel they are in a no-win situation; (c) when there is a lack of communication and support; and (d) when there are system problems. The personal and professional impact of feeling powerless is explored. Implications for both nursing and counselling are discussed.

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CHAPTER ONE

Introduction

In spite of feminist advances, Canada's dominant culture remains patriarchal. The structure of the healthcare system mirrors that of society, with a well sanctioned hierarchy reinforcing gender-based power differentials (Hugman, 1991). The dominant force positioned at the top of the hierarchy is the medical model, a philosophy of healthcare that tends to objectify and pathologize the human experience, incorporating power differences between helper and patient as integral to the cure (Hall, 1996; Liburd & Rothblum, 1995). The dictates of this philosophy attribute physicians, who are predominantly male and the most powerful professional group in healthcare, a tremendous amount of responsibility for meeting the health needs of society. Adherence to the medical model has traditionally been perpetuated through the education of healthcare professionals; however, society has come to embrace this ideology with a great deal of tenacity. Though the public may, at times, question this dominant approach to healthcare, there is a continued widespread expectation that physicians be omniscient and capable of miracles. In the face of such expectations, physicians do, at times, experience a sense of powerlessness, or inability to know and effect change.

Although the word *powerlessness* may seem to suggest a complete lack of power, it is used in this study to suggest a sense of impotence or "inability to accomplish an effect" (Funk & Wagnalls, 1989, p.1058), with an accompanying lack of authority. In order to minimize their sense of powerlessness, doctors have traditionally dominated those groups lower in the hierarchy, most notably nursing (Dykema, 1985). Power plays over nurses are manifested in the devaluation of nursing care, and in the disrespect of nursing decisions and viewpoints. Medicine, being the dominant group, has had the privelege of establishing its ideas as the *right* ones. "One of the basic elements of power is that those who have positions of power are able to manufacture ideas" (Kirby & McKenna, 1989, p.23). Nurses, who are

predominantly female, can be conceptualized as an oppressed group that has integrated the dominant group beliefs, in spite of the incompatibility of some of these beliefs with the nurturant, holistic nature of nursing. Many of the collective behaviours of nurses reflect typical oppressed group behaviours (Ford & Walsh, 1994; Roberts, 1983).

Like those above them, nurses may try to gain a sense of power through exerting control over those below them in the system (Hewison, 1995; Huston & Marquis, 1988; Kavanagh, 1991; Lanza, 1997a). For example, nurses may unnecessarily control the routine and agenda of care, limiting the choices available to patients. Ultimately, it is the healthcare consumer who suffers at the bottom of the hierarchy. This phenomenon is often most profound in the mental health field, as many patients are particularly vulnerable to external control when mentally ill. For this reason, the need for patient advocacy is extraordinarily important within psychiatry. Perhaps, with a greater sense of personal and collective empowerment, psychiatric nurses will be more able to empower and advocate for mental health consumers.

Change within a system can begin at any level. No one person or group of persons can exist without affecting others and being affected by others. A change at one level of a social system necessarily creates change within the entire system (Becvar & Becvar, 1996). A shift in nursing attitudes and behaviours, therefore, has the potential for creating a cascade of changes throughout the healthcare system. An understanding of nurses' experiences of powerlessness within the workplace is essential if change is to be activated at the level of nursing practice. This study explores the circumstances of powerlessness for psychiatric nurses, and the impact on them. The focus is on nurses working in acute care institutional settings, as power relationships are often most integrated and oppressive in such settings (Hugman, 1991; Yarling & McElmurry, 1986).

Background to the problem

My interest in this problem stems from personal experience working as a psychiatric nurse. As a nurse, I often felt I lacked significant influence regarding patient care decisions;

the essence of my role seemed to be to carry out actions dictated by others, often physicians. As a result, I frequently found myself carrying out procedures to which I was personally opposed. With horror, I would observe myself actively limiting patients' autonomy under the guise of beneficence. Any autonomous interventions I made seemed to be considered 'extras' and were not given much validation. Without fully understanding how the dynamics of the healthcare hierarchy were affecting me, I found myself feeling increasingly hostile and uneasy at work. I have come to understand this as my reaction to being oppressed by my position in the healthcare system. When I began to acknowledge and react to this oppression, I was confronted with tremendous resistance to change on behalf of all members of the healthcare team, including nurses. As a result, I experienced a sense of isolation and a lack of collegial support, which added further to my dis-ease at work. Eventually, my distress manifested physically, and I was forced to acknowledge the toll it was taking on me. Ultimately, I left my job. Since this time, a number of psychiatric nursing colleagues have spoken to me about similar experiences of feeling oppressed at work, and all described a sense of isolation.

I began to wonder what kept psychiatric nurses working under these conditions, and a number of questions emerged for me. Why do some nurses seem more comfortable in their nursing role than others? Why is the subordinate position acceptable for some nurses? Why do nurses experience a sense of isolation when they challenge the oppressive structure in which healthcare is delivered? Why was there such resistance to the changes I was proposing? If change could make things better, why wouldn't people want it? Clearly, I have my own ideas about what "better" is, and they do not seem to coincide with how some of my co-workers felt. I seemed to represent a significant threat for some reason. I observed myself begin to separate from my identity as a nurse. For me, 'nurse' began to mean someone who accepts a subservient role; someone who either does not think critically or finds it acceptable to act incongruently with how one feels. How could I identify myself with such an image?

I began to notice that psychiatric nurses seem to play an integral role in perpetuating their own oppression. For example, the choice to work twelve hour shifts, as opposed to 8 hour shifts, leaves psychiatric nurses in a very disempowered position regarding patient care decisions. How can one truly make an impact if one is absent from work more often than one is present? With twelve hour shift scheduling, nurses are essentially on the ward for only two days out of a week. I recall returning to work each week, after night shifts and days off, feeling very out of touch with what was happening with my so-called "primary patients," those patients whose care I was supposed to be directing. I really had very little impact on major patient care decisions. I also noticed that many nurses are very reluctant to challenge physicians' decisions, in spite of acknowledging their disagreement with them. Although nurses are educated to believe that patient advocacy is central to the nursing role, very few nurses take advocacy beyond voicing the patient's concerns.

I began to wonder how things could be different if each health care discipline was valued equally. If the unique expertise of each professional group was understood and valued, then medicine would not sit in such a dominant position, and the experience of being a nurse could potentially be very different.

Research Purpose

Drawing from Freire's (1987) model which suggests that both insight and action are necessary for the liberation from oppression, this study contributes to the first phase, that of insight, for psychiatric nursing. "By beginning with the experience and research needs of those who have been silenced, the process of knowledge production is transformed and the ideological power base is challenged" (Kirby & McKenna, 1989, p. 28). Nurses tend to internalize their workplace frustrations (Attridge & Callahan, 1987) which feeds into a further sense of isolation and powerlessness. I intend to add to the growing body of literature that aims to expose the forces impacting the psychiatric nursing experience. The purpose of this study is to explore the circumstances in which hospital psychiatric nurses' most often feel powerless, and the impact this has on them, both personally and professionally. Through

this, I hope to increase the visibility of psychiatric nursing work and its undervalued position in the healthcare hierarchy. An understanding of the psychiatric nursing experience can facilitate the development of new structures and strategies with which to minimize powerlessness. As well, increased discourse among psychiatric nurses may result, leading to greater unity within the profession. Kirby and McKenna (1989) emphasize the importance of this kind of research for subordinate groups: "Without reflection on our actions and experience, we will continue to re-invent the wheel, and will remain divided and powerless" (p. 168). This study may also increase awareness of the power relationships between psychiatric nurses and other groups within the healthcare system. A shift in these relationships may ultimately advance the empowerment of mental health patients.

Research questions

The research questions driving this study are:

1. What are the situations in which acute care psychiatric nurses feel powerless?
2. How does feeling powerless affect the personal and professional experiences of psychiatric nurses?

Research design

In order to access the complexity of psychiatric nurses' experiences, while taking into account the variation between nurses, a qualitative research design was used. A feminist theoretical framework guided the research, in terms of viewing all experiences as context-driven, and recognizing multiple realities, rather than striving for generalizations (Kirby & McKenna, 1989; Reinharz, 1992). Data were collected through focus groups. Focus groups combine elements of both individual interviews and participant observation in groups, providing kinds of data that cannot be accessed easily through only one of the other two methods (Morgan, 1988). That is, the interaction among members in the group stimulates discussion and the development of ideas. Thus, more information can be obtained than in individual interviews alone. "The participants' interaction among themselves replaces their interaction with the interviewer, leading to a greater emphasis on participants' point of view"

(Morgan, 1988, p. 18). As well, the group format allows the researcher to observe the interaction among group members, noting areas of contention and agreement. The group interaction also allows for more spontaneous responses than the individual interview. The focus group data were analyzed for situations of powerlessness and themes within these situations. As well, the personal and professional impact of powerlessness on psychiatric nurses was examined.

CHAPTER TWO

Literature Review

Issues of power and oppression pervade the psychiatric nursing profession. As a result, an understanding of these concepts is necessary in order to understand the experience of the psychiatric nurse. The literature offers a variety of perspectives on both concepts. A number of these perspectives are presented here. Applications of these concepts to the healthcare system, specifically the hierarchical structure and the nature of relationships between physicians, nurses, and healthcare consumers, are included. Specific emphasis is on the mental health care system and the unique demands it places on these relationships.

Traditional model of power.

Power plays an integral role in the human experience; yet the nature of this role eludes universal understanding. Traditionally, one paradigm of power has dominated in western societies. It involves the influence and control of others, necessitating an imbalance of power in one's relationships (Dahl, 1957; Erlen & Frost, 1991; Yoder & Kahn, 1992). In this model, power is viewed in terms of dichotomies; that is, one is either 'powerful,' 'independent' and 'active,' *or* 'powerless,' 'dependent' and 'passive' (Surrey, 1991). Action directed toward particular outcomes or goals is considered a requisite part of power (Seeman, 1959), and it has been suggested that this action necessarily involves some degree of conflict (Hugman, 1991). As well, a detached intellectualism is considered essential for the successful attainment and maintenance of power, while emotionality is considered weak (Hugman, 1991; Surrey, 1991). Although this conception of power continues to dominate the western mindset, alternate models are emerging in reaction to the limited and exclusive nature of this model.

New understandings of power.

More current thought challenges the idea of power as an absolute state that manifests in certain actions. Rather, *empowerment*, or the attainment of power is a very individual

process, under constant revision and negotiation. It is a personally defined phenomenon; a sense of power is attained differently by different people. Feminist theorists have suggested that the traditional view of power reflects only the western male perspective, neglecting the experience of other groups (Gilligan, 1982; Miller, 1991; Surrey, 1991). Thus, many critiques of the traditional model emphasize its exclusivity and its obvious neglect of the characteristically female experience (Gilligan, 1982; Miller, 1991; Surrey, 1991).

Gilligan (1982) discusses the differences between masculine and feminine approaches to empowerment in terms of gender-related developmental issues. She suggests that boys tend toward and are encouraged to make an early emotional disconnection in order to move toward independence and self-sufficiency, whereas girls tend to have a greater focus on relationships and on maintaining interdependencies. These different orientations are not valued equally in western culture, where maturity and adulthood tend to be defined in terms of separation and individuation (Gilligan, 1982; Surrey, 1991). A focus on relationships, in turn, is devalued. Surrey (1991) criticizes society for de-emphasizing the importance of ongoing interpersonal connection, and for not offering enough support to the development of interpersonal skills. She claims that as a result of this, women's "relational pathway of development is obscured; its potential remains unacknowledged and undeveloped" (Surrey, 1991, p. 169), and she suggests that this undermines women's efforts to develop and maintain adult forms of connection in which mutual strengths can be experienced. Gilligan (1982) asserts that woman's role has traditionally been to nurture ongoing relational attachment throughout the life span, "while the developmental litany intones the celebration of separation, autonomy, individuation and natural rights" (p. 191).

Surrey (1991) suggests the need to shift away from the perception of feminine characteristics as lacking in power. Rather, "one of women's particular sources of strength (is) the power to empower others, that is, to participate in interaction in such a way that one simultaneously enhances the power of the other *and* one's own power" (p. 164). This process is what has traditionally been called *nurturing*, and Miller (1991) has suggested that because

it has occurred primarily in women's domain, it has been undervalued and misunderstood. Gilligan (1982) asserts that women fulfill the necessary roles of "nurturer, caretaker, and helpmate, the weaver of those networks of relationships on which she in turn relies. But while women have thus taken care of men, men have, in their theories of psychological development, as in their economic arrangements, tended to assume or devalue that care" (p. 17).

Surrey (1991) offers a conception of power that is more inclusive than the traditional model, and "might be termed a 'power *with*' or 'power *together*' or 'power emerging from *interaction*' model" (p. 165). Such a framework "overrides the active/passive dichotomy by suggesting that all participants in the relationship interact in ways that build connection and enhance everyone's personal power" (Surrey, 1991, p.165). Surrey prefers the term "empowerment" to "power," as she believes it lacks the connotation of *power over*. Yoder and Kahn (1992) agree, suggesting that personal empowerment embraces a "power to" approach, as opposed to a "power over" approach. They define empowerment similarly to Bandura (1989) who describes it as a sense of personal control over one's thoughts, feelings and behaviours, rather than control over others. Surrey (1991) defines "psychological empowerment" as "the motivation, freedom, and capacity to act purposefully, with the mobilization of the energies, resources, strengths, or powers of each person through a mutual, relational process" (p. 164). She suggests that a potent source of power exists in the fostering of relationships. In this relational model, one person is not in control; rather, "each is enlarged and feels empowered, energized, and more real" (Surrey, 1991, p. 168).

Although gender appears to account for many of the variances in expression of power, it is too simplistic to cite gender alone as the source of power differences. Sagrestano (1992) suggests that status and organizational power play a more significant role than gender in one's approach to power attainment. However, because "gender is inextricably linked to power and status" (Sagrestano, 1992, p. 439), separating the influences is difficult. Those with greater power and status tend to use the *power over* approach more, regardless of their

gender (Sagrestano, 1992). Because men tend to have more power and higher status in society, this approach belongs predominantly to men. "When power is considered, people with power choose strategies typically associated with men and those without power choose strategies typically associated with women" (Sagrestano, 1992, p. 445).

In spite of the increasing recognition of human diversity, particularly of women's unique sources of strength, western culture continues to embrace the individualistic, 'power over' approach as the superior model of power. The patriarchal healthcare system exemplifies this ideology, with its hierarchical structure dictating differing degrees of power for different occupational groups. Physicians, who are predominantly male, tend to value independence, intellect, decisiveness, and control, all of which are consistent with the traditional, detached and dominating approach to power (Hugman, 1991; Roberts, 1983; Will, 1995). Hugman (1991) asserts that "medicine's status as a profession is based predominantly on its claims to be regarded as a set of practices derived from rigorously tested knowledge about and skills in treating disease and illness" (p.17). The opposite qualities that often characterize the predominantly female profession of nursing, such as warmth, nurturance, and sensitivity, in turn, are devalued (Roberts, 1983). In order to maintain its status, medicine, operating from within the traditional paradigm of power, must necessarily undermine less objective approaches, such as the more intuitive and personal nurturance provided by nurses.

Not only is the individualistic, 'power over' model exclusive, but it can actually disable women if they perceive their 'powerful' action to be disempowering of others, or leading away from connection (Surrey, 1991). This conflict has led to the perpetuation of male dominance in many relationships, as women will often choose to focus on the needs of the other person allowing the other to feel powerful (Surrey, 1991). When viewed in terms of the dichotomies ("powerful-powerless;" "active-passive") that accompany the traditional model of power then, "women's behavior often looks 'passive' or 'inactive' or 'depressed'" (Surrey, 1991, p. 165).

Oppression

Various theorists (Dykema, 1985; Freire,1987; Podgorecki, 1993; Roberts, 1983) link such power dynamics to the phenomenon of oppression. Freire (1987) describes oppression in terms of the dehumanization of people. Podgorecki (1993) concurs, explaining oppression as "an external or internal man-made [sic] limitation of the available options of human behavior of an individual or a group" (p.6). Similarly, McLaren and Lankshear (1994) state "oppression has been experienced as a constraint to living more fully, more humanly: constraint born of social contingencies of power; of discursive regulation through interested and contrived social practices carried out so as to privilege some at the expense of others" (p. 1). Although this definition hints that oppression involves the benefit of one group at the expense of another, McLaren and Lankshear argue that oppression does not necessarily involve a specific oppressor group; rather, it can result from more subtle oppressive social forces. Young (1992) agrees that oppression is more complex than simple domination of one group over another. She suggests that rather than being the result of evil perpetrated by a single ruling power, oppression often involves "the everyday practices of a well-intentioned liberal society" (Young, 1992, pp. 175-176) Oppression is systematically reproduced in all areas of our lives; it permeates major economic, political, and cultural institutions (Young, 1992). It involves the "unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchy and market mechanisms, the normal ongoing processes of every day life" (Young, 1992, p. 177). For example, oppression is so integrated into the nursing role that nurses willingly *take orders* from physicians without even questioning the use of language that clearly requires a dominant and a submissive party.

Because oppression is integral to so many of our social structures, its existence is often unacknowledged or minimized. Podgorecki (1993) differentiates between totalitarian and post-totalitarian systems in order to create a framework with which to understand the more subtle forms of oppression occurring in modern societies:

> The *totalitarian system* is understood as a social system dominated by a homogeneous ideology imposed on society by a mono-party (one-party) and its oppressive apparatus. A *post-totalitarian system* emerges when the dominance of a monoparty has formally ceased, but while its deeply entrenched bureaucratic structure remains in place and the values, mores, and basic mechanisms generated under the totalitarian system still predominate (p. 15).

Thus, oppression may originate within a totalitarian system, but it does not end with the downfall of such a regime. Over time, "social control enters into the psyche of an individual" (Podgorecki, 1993, p. 8), and it becomes internalized as normal. This insidious, internalized oppression "can be more powerful than all the spectacularly oppressive or covert and seductive institutions that constantly impose social conformity" (Podgorecki, 1993, p.18). Once internalized, oppression is self-perpetuating. Those who are oppressed often begin to behave as oppressors of those perceived to be less powerful (Freire, 1987).

Dominant groups have the privilege of establishing their norms and values as the 'best ones' in society; as a result, the characteristics of subordinate groups are devalued (Freire,1987; Kirby & McKenna, 1989). The belief system of the dominant groups eventually becomes internalized by those in subordinate groups, leading to a rejection of self and the erosion of self-esteem (Freire, 1987; Roberts, 1983). This self-depreciation derives from the internalization of the negative opinions that oppressors hold of them (Freire, 1987). The subordinate groups' rejection of self manifests in their acceptance of the belief that to be like the dominant groups is to be superior and powerful (Freire, 1987; Roberts, 1983). This adopted belief system is dangerous, as the members of an oppressed group will never truly be 'like' those in the dominant group, and it simply adds to the rejection of self (Roberts, 1983). Roberts posits that if those in the oppressed group are "unable to avoid the presence of their devalued characteristics...self-hatred and a resultant low self-esteem develop, which perpetuate the cycle of domination and subordination" (Roberts, 1983, p. 23).

Because oppression is an *imposed* inhibition on the human experience, the struggle against oppressive forces will always exist, either consciously or unconsciously (Freire, 1987). "No one can accept complete impotence short of death. If he [sic] cannot assert himself [sic] overtly, he [sic] will do it covertly" (May, 1972, p.94). Poor self-esteem and a fear of further oppression often inhibits the oppressed person from directing aggression directly at the offending forces (Freire, 1987; Roberts, 1983). Roberts writes,

> . . .fear of aggression against the dominant group originally develops as a result of the realization that the subordinate groups could be destroyed if they were to attempt revolt. This fear is the basis of submission to authority. A secondary fear develops as the process of oppression continues, that is, the fear of change itself and of alteration of the status quo, no matter how oppressive (p. 23).

Caught in this duality of desiring freedom yet fearing it, oppressed people will often exhibit passive-aggressive behaviour and misdirected aggression toward one's own group members (Freire, 1987; Roberts, 1983). This intergroup conflict weakens the unity of the oppressed group, adding to the perpetuation of powerlessness.

Nursing, being a predominantly female profession, suffers many of the same oppressive forces imposed on women in a patriarchal society. In addition, nurses suffer the oppression inherent in the hierarchical healthcare structure by virtue of being 'under' the powerful medical profession (Ford & Walsh, 1994). Like other oppressed groups, nurses have tended to internalize the dominant group beliefs, that is those of medicine, as superior. This is apparent in nurses' struggle to gain increased credibility through attempts to establish medical-like 'scientific' theory based on the principles of objectivity. Keddy (1996) states "this objectification of knowledge. . .has exercised power over nurses' thoughts and behaviors" (p.383), and she asserts, "the nursing profession has suffered by buying into science that is ethnocentric, racist, classist, heterosexist, and positivistic in nature" (p.383). In her analysis of psychiatric nursing discourse, Keddy (1996) writes, "social control through language and knowledge generation is a primary mechanism by which nurses remain

oppressed by the patriarchal structures within which they are educated and work" (p.390). As a result of attributing greater value to beliefs and practices that belong to the dominant group, nursing is suffering an identity crisis and a rejection of what makes nursing unique from medicine. The less precise, more intuitive and holistic approach to care that nurses can offer has been forsaken in this misguided pursuit of respect and power.

This rejection of the unique nature of nursing reflects the rejection of self that typically occurs within oppressed groups. It is in fact disempowering nurses, rather than gaining them the increased credibility they seek. Roberts (1983) has observed nurses exhibiting "self-hatred and dislike for other nurses" (p. 27), which is apparent in the lack of unity within the nursing profession. "It is as if to align with other nurses is to align with other powerless persons - something that has been shown to be unwise" (Roberts, 1983, p.27). There is also a general reticence within the nursing profession to challenge authority, although there tends to be a significant amount of complaining about physicians and administration within nursing groups. This reflects the passive-aggressive behaviour that often typifies oppressed groups, stemming from a fear of change and freedom (Freire, 1987; Roberts, 1983). As previously described, it is a double-edged sword. Autonomy is necessary to live authentically, but the internalized oppression maintains one's fear of it (Freire, 1987).) Evidence of the depth of nursing's oppression lies in the lack of autonomy, power and control that nurses possess (Roberts, 1983), in spite of the fact that they comprise the largest professional group within healthcare.

Once oppression is internalized, freedom from its clutches is dependent upon a shift in attitudes and actions within the oppressed group (Freire, 1987). Relying upon the oppressing forces to grant autonomy is simply another manifestation of deference to authority. Roberts (1983) submits, "the oppressor is not able or willing to grant autonomy, but rather it must be acquired" (p. 25). Freire (1987) identifies two phases which he considers essential to the liberation from oppression: The first involves exposing and acknowledging the oppression. The oppressed person needs to become conscious of his/her

own perception of reality and critically examine the contradictions in it, rejecting those that belong to the oppressor (Freire, 1987). As Foucault (1980) purports, knowledge equals power; therefore, increasing awareness of one's plight is the first step toward emancipation. Freire's second phase involves taking action to challenge and eliminate the institutionalized belief systems that are perpetuating oppression. "To surmount the situation of oppression, men (and women) must first critically recognize its causes, so that through transforming action they can create a new situation, one which makes possible the pursuit of a fuller humanity" (Freire, 1987, pp. 31-32).

It has been hypothesized that nursing leadership has been a powerful force in the perpetuation of oppression in nursing (Huston & Marquis, 1988; Roberts, 1983; Sinda, 1984). "Nursing leaders have represented an elite and marginal group who have been promoted because of their allegiance to the maintenance of the status quo" (Roberts, 1983, p.28). This allegiance contributes to the further negation of nursing characteristics, through identification with the oppressor groups rather than one's own group. "This kind of leadership leads to divisiveness and competition among nurses and does not foster united efforts to change the system" (Roberts, 1983, p.29). Acknowledging the existence of oppression and rejecting the status quo are essential at all levels of nursing in order to move toward greater autonomy and power.

Power in healthcare

The western healthcare model is structured around hierarchical divisions of power based on professional status. The healthcare consumer, given his/her lack of professional status, usually has the least amount of power in the system. The professional is considered the expert and the patient the passive recipient of care. A Funk and Wagnalls (1989) definition of patient is "anything passively affected by external actions or impressions" (p.988). The medical model that underlies this approach to healthcare reinforces the supremacy of the objective over the subjective. This places a tremendous amount of responsibility onto the healthcare team to diagnose the patient's problem and find a cure for

it. Physicians, being the most dominant professional group in healthcare, possess the greatest responsibility for the patient. When they do not have the answers for a patient, doctors will often experience a sense of powerlessness. This will manifest in attempts to bolster personal power, often through the domination of subordinate groups, such as nursing (Dykema, 1985). Nursing will, in turn, dominate its subordinates, the patients (Hewison, 1995; Huston & Marquis, 1988; Kavanagh, 1991; Lanza, 1997a). It is the patients at the bottom of the hierarchy who experience the greatest powerlessness.

Hierarchy

The institution of healthcare is a microcosm of society. Within it, lie sanctioned power differentials, human inequities, and complex reinforcing structures that maintain the status quo. This structure is perpetuated by the hierarchical nature of healthcare which mirrors the patriarchal social hierarchies that have existed in every area of public life for centuries. Hierarchy is a vertical structuring of power that relies on the traditional model of power to maintain itself. That is, the level of power experienced by one group depends on its ability to exercise power over a 'lower' group in the hierarchy. Hierarchy, then, forms a central aspect of power within and between healthcare professions.

Hugman (1991) suggests that hierarchy is power embedded in organizational language and structures, and he warns, "the overt exercise of power is only one of its forms in hierarchical organisations...the structure may operate through the mobilisation of bias, for example, in the day-to-day work of caring professions" (p. 40). He states further, "hierarchical power is exercised through routinised sets of expectations about work, about objectives, methods, scope, and so on, in a context in which some professionals are defined as having the right and the capacity to influence and at times direct how that work should be undertaken" (Hugman, 1991, p. 66). Unless social hierarchies are made visible, power relationships cannot be honestly examined and altered.

If hierarchies are based on descending degrees of power, who or what is at the top of the healthcare hierarchy? Hugman (1991) suggests that the state is at the top, controlling

healthcare to meet the needs of dominant social groups. The state's needs then are inextricable from those of the dominant groups within it. The real clients for whom health care is engineered are the dominant groups in society. The majority of actual service recipients do not exist in these upper levels of the hierarchy, and are therefore subject to a model of care that is dictated by and for the more powerful groups (Hugman, 1991). Hugman (1991) suggests that the concept of patient, as a distinct social group, has been constructed by healthcare professionals, creating "a pattern of exclusion, and the beginnings of usurpation" (Hugman, 1991, p.42). He argues that patients are more often objects rather than subjects within the healthcare system. "They may be researched, but they are not consulted or involved in the definition of needs which caring professionals address, either generally or specifically" (Hugman, p. 43). Diagnoses, then, reflect the biases of the healthcare provider (Hall, 1996). From this perspective, health care can be seen as an expression of patriarchy delivered under the guise of beneficence.

Hugman (1991) contends that ongoing maintenance of the existing power structure in healthcare is leading to a conflict between economics and ideology. The government gives senior healthcare professionals the authority to define needs and allocate resources and, as a result, many of the structures and processes in healthcare reflect the needs of the professional rather than the community at large (Hugman, 1991). This suggests the need to examine the philosophy underlying healthcare in the western world - the medical model. It is actually the major controlling force residing at the top of the healthcare hierarchy, influencing all levels of healthcare provision. Physicians fall under this dominant ideology as the next major influential layer in the stratified health system. Below this group are nurses. At the bottom of the hierarchy are the healthcare consumers or patients.

Medicine and the western medical model.

As a culture we ascribe to the western medical model, a philosophy of healthcare in which health is defined by the absence of disease and success is defined by the avoidance of death. This model involves "the assumption that human behavior, like physical illness, can be diagnosed and classified as a disease. This view produces an overreliance on objectifying behavior through diagnosis and focuses decision making almost exclusively on problems identified by the professional" (Hall, 1996, p. 17-18). This, in turn, leaves the healthcare professional responsible for creating change and improving the patient's situation through prescription. Freire (1987) claims that "one of the basic elements of the relationship between oppressor and oppressed is *prescription.* Every prescription represents the imposition of one man's [sic] choice upon another, transforming the consciousness of the man [sic] prescribed to into one that conforms with the prescriber's consciousness" (p. 31).

Central to the western medical model is a focus on pathology and on objectifiable biological causes of human difficulty. In the past century, very little acknowledgement of sociocultural, emotional, spiritual, or political influences on health has existed. The absence of a holistic perspective of the human experience limits the scope of the medical model; however, this reality is rarely acknowledged. Instead, healthcare delivery has come to rely on inherent power relationships (Liburd & Rothblum, 1995). The act of diagnosing can be considered a powerful act in itself, as it "separates the knower from the known, because it invites the health professional to focus on the diagnosis rather than the person with the diagnosis. Diagnosed people then lose control of their own destiny, since the most powerful judgments of them as people are controlled by experts" (Hall, 1996, p. 18). Hugman (1991) asserts that a central component of the professional/patient relationship is "the structural capacity of the professional to have 'the final word' on what constitutes cooperation" (Hugman, 1991, p. 37). He suggests that 'cooperation' means that patients behave in accordance with the expectations of the professional. Such a dynamic automatically elevates the power of the professional while diminishing that of the patient.

The medical model has become so entrenched in our approach to healthcare delivery that its power often goes unacknowledged, and its perpetuation is ensured through the education of healthcare professionals who are indoctrinated with its ideology. As well, healthcare consumers have come to embrace and perpetuate its tenets through their expectations of modern medicine. The general public tends to deify physicians, attributing to them an inordinate amount of power and demanding that they be omniscient and able to cure all ails. Physicians, being mere mortal beings, cannot fulfill all of the expectations that society has come to demand from them. Reality suggests that people do die in spite of modern medicine, and there will always be problems that do not fit neatly into diagnostic categories. Because such a denial of the complexity of humanity is inherent in the medical model, its dictates will, at times, create a sense of powerlessness for physicians.

The strategies often used to counter this powerlessness are paternalism and objectification. "Attempts to become masters of knowledge about people come from a patriarchal way of thinking of them as objects to be described, explained, predicted, and controlled and are more often informed by issues of power and economics than by positive regard for patients as unique persons" (Hall, 1996, p. 26). In spite of this negation of the subjective human experience, and the unrealistic expectations placed on healthcare providers, the medical model continues to survive in western societies. This is a result of the power and authority embedded within it, such that the authority of the physician is seen as an integral part of the patient's healing (Liburd & Rothblum, 1995). With this model guiding the delivery of healthcare, the platform is set for a sequential cascading of powerlessness down through the layers of the healthcare system (Mgoduso & Butchart, 1992).

Family systems theorists would describe such a cascade of powerlessness in terms of deflected or misdirected expressions of emotion or experience (Walters, Carter, Papp, & Silverstein, 1988). An example of this is a family who experiences violence: A husband feels powerless at work but does not feel able to address this directly with the source; rather, he attempts to gain a sense of power at home by dominating those he perceives to be less

powerful than himself, his wife and children. Often, children from violent families then pursue a sense of power themselves by becoming aggressive with other children (Walters, Carter, Papp,& Silverstein, 1988). An analogy can be drawn to power-driven behaviours in healthcare. The doctor can be viewed similarly to the father in the example, feeling controlled by the dictates of the medical model; the position of the nurse parallels that of the mother; and the healthcare consumer has the least power, like the child in the family. Much of the anger and litigation that is levelled against the healthcare system by patients, stems from a lack of personal and professional empowerment and responsibility that is fostered by the system.

Nursing and power

Hugman (1991) articulates the essence of the difference between prescribed nursing and medical roles: "the doctor may care about the well-being of the patient, through skills and knowledge devoted to the diagnosis and treatment of disease and illness, whereas the nurse both cares about and cares for the patient in skills and knowledge devoted to the tending of the person" (p. 15). A key difference is that the caring work of the nurse involves a greater degree of intimacy with the patient, requiring that the nurse acknowledge, at least to some degree, the individuality of the person receiving the service (Hugman, 1991). Medicine, on the other hand, strives for distance and objectivity. As a result, physicians often see things in more general, categorical terms (Hugman, 1991). Will (1995) views nursing and medicine as very different cultures, and she asserts that "the basic assumptions made by nurses and physicians, those which underlie their practice decisions, can produce cross-cultural conflict. This results in an inability to collaborate" (p. 30), which negatively impacts patient care. It is in this difference in orientation to patient care that nurses and doctors experience the greatest conflict, and it is here that a sense of powerlessness is most salient for nurses.

In an effort to increase their sense of power, nurses, like those above them, will often try to control those below them, namely their patients (Hewison, 1995; Huston & Marquis,

1988; Kavanagh, 1991; Lanza, 1997; Mgoduso & Butchart, 1992). Keddy (1996) writes, "patients' lives are ruled, ordered, and organized by nurses, who are themselves subject to the relations of ruling" (p. 388). In a study on the use of language between nurses and patients, Hewison (1995) found that nurses exert power over patients by controlling the frequency of nurse/patient interactions and the content of those interactions. Nurses will often use inaccessible language to relate to patients, playing on the fear and helplessness that frequently accompanies illness. As well, nurses seem to exert power through unnecessarily controlling the routine and agenda of patient care (Hewison, 1995). Hugman (1991) suggests that the general acceptance by patients of treatments administered by nurses is evidence of nursing power.

> Not only is power socially structured, but because it is socially and culturally located it may have the appearance of consensus. That patients may be in full agreement with nurses' administration of drugs may in itself be considered as part of the exercise of power by nurses collectively, for example; it may be a 'normal' part of everyday life (pp. 32-33).

Thus, nurses exercise power by influencing and even determining their patients' desires in a given situation (Hugman, 1991). This coerced agreement between patient and nurse often leads to a distortion in the perception of power differentials (Hugman, 1991). A more collaborative nurse/patient relationship, which is promoted by some nurse theorists as an alternative to paternalism is, in reality, "constrained by this pre-existing power relationship" (Hewison, 1995, p. 81). Although nurses may appear to be involving patients in decision-making, Hewison found that "the sub-text of the interactions reveals them to be performing a controlling role" (p. 81). Kavanagh (1991) claims that having control does not necessarily increase one's power; rather "control allows an illusion of power" (pp.256-257). Handy (1995) suggests that psychiatric nurses are actually perpetuating their own powerlessness by adhering to the dominant mandate of control in hospitals, as opposed to adhering to a patient-centered mandate espoused by nurses. She observed a great deal of stress in psychiatric

nurses based in the contradictions between the ideology of nursing which suggests promotion of patient autonomy, and the control-oriented environment of hospitals.

Mgoduso and Butchart (1992) suggest that "a redefinition of health and illness... would create the conceptual and political ground in which a less authoritarian and more preventively oriented system of health care could flourish" (p. 200). What they are implying is that our current model of health is handicapping our healthcare system. With the medical model sitting powerfully at the top of the healthcare hierarchy dictating our approach to care, all healthcare providers and consumers are affected by and, to some degree crippled by, its essentially unchallenged doctrine. However, because oppression is multi-layered in the system, it is unlikely that change will occur at the highest level of the hierarchy until the professional groups below it reject the social roles imposed on them by their titles.

As suggested by Freire (1987), freedom from oppression must come from within the oppressed group. A shift in nursing attitudes and behaviours has the potential for creating a cascade of changes throughout the healthcare system. Holden (1991) purports that if nurses truly desire more power and autonomy, they must undergo "rapid shifts in attitude" (p. 398). If nurses are to advocate for patients by helping them to assert their needs, they must find their own voice. Huston and Marquis (1988) assert that "patient advocates must have a power base in order to meet their patient's needs" (p.40).

Nurses need to begin modeling effective use of personal power if change is to occur in the healthcare system. Keddy (1996) cites psychiatric nurses as having particular potential to create significant change in mental health care, as "nurses are responsible for the everyday social ordering of the psychiatric milieu" (p.385). "Psychologists, psychiatrists, and social workers are all professionals whose work depends on the nurses mediating their work for them" (p. 385). She urges nurses to challenge established knowledge and social constructions, emphasizing that they are humanly produced, and as such, can be humanly altered. "New paradigms and discourses can create psychosocial, political and economic change" (Keddy, 1996, p. 383). It is important to note, however, that real and lasting change

is a complex, multi-level process, that must be nurtured and prodded against multiple resistant forces. Keddy warns that "old theory and knowledge can be modified and dressed up to give the semblance of change while maintaining the status quo" (Keddy, 1996, p. 383). Actual change at the level of psychiatric nursing, leading to more effective patient advocacy, can have profound effects on the experience of the mental health patient.

Patient advocacy

Patient advocacy is central to the role of the professional nurse. Gadow (1980) suggests that "the philosophical foundation and ideal of nursing is that of advocacy" (p. 80). A universal definition of advocacy is lacking however. Gadow (1980) views advocacy as the opposite of paternalism, contending that "paternalistic acts and attitudes are those that limit the liberty or rights of individuals for their own interest" (p. 82). She asserts that self-determination is a fundamental human right and this belief underlies the concept of advocacy. Gadow states, "the right of self-determination ought not to be infringed upon even in the interest of health" (p. 84), and she perceives the nurse's role as that of intervenor when the patient's rights are violated by the system. Barton (1987) states simply: "Advocacy involves assisting the patient in choosing among treatment options and supporting the patient regardless of what his or her decision may be" (p.87). Murphy (1979, in Millette, 1993, p. 607) suggests that advocacy entails supporting and defending the autonomy of the patient. She identifies three types of advocacy; bureaucratic advocacy, in which the needs of the institution are the priority; physician advocacy, in which the needs of all others, including nurses and patients, are secondary; and client advocacy, in which the needs of the client or patient are the ultimate priority. In current nursing discourse, patient advocacy is the promoted ideal; however, in practice, bureaucratic and physician advocacy prevail (Yarling & McElmurry, 1986).

The barriers to the actualization of patient advocacy by nurses are multidimensional, and are perpetuated by factors both internal to nurses, such as beliefs, feelings and values, as well as external, such as those of the social and bureaucratic structures in which nurses work.

Murphy (1979, in Millette, 1993) observed that nurses are less likely to advocate for their patients when they are feeling vulnerable and powerless. Gadow (1980) found that most nurses' desired loyalty is to their patients; however, they are caught working within a paternalistic model. She states "the conflict between advocacy and paternalism is felt most acutely by the nurse, since it is the nurse who must reconcile nursing's traditional alliance with the patient and the modern allegiance to medicine" (Gadow, 1980, p.81). Nurses who may truly wish to place patient needs at the forefront of their practice often experience conflicts of loyalty with colleagues, physicians, administration, and themselves (Millette, 1993; Sines, 1993; Yarling & McElmurry, 1986). Millette (1993) captures the essence of this conflict: "As long as there is no disagreement on what the patient wants and what is best for the patient, there is no problem. When there is disagreement, however, nurses are in the least powerful position and are the least likely to prevail" (p.661). Millette (1993) found that a more patient-centered approach is desired by most nurses, yet the practise of client advocacy remains limited. For those nurses who function from a primarily caring orientation as opposed to adhering strongly to external rules and regulations (a justice orientation), a sense of frustration and impotence predominates in their practice, and it is this group of nurses who is most likely to leave nursing altogether (Millette, 1993).

Psychiatric nursing

This study is concerned specifically with the experience of psychiatric nurses. The field of psychiatry is unique within healthcare as it defies formulaic approaches to medicine more than any other area. In spite of tireless efforts, science has been unsuccessful in its attempts to conclusively establish cause and effect relationships in mental illness. Human thought and behaviour is simply too variable and complex to be confined to a single conceptual paradigm in which it can be objectively understood. Yet, in spite of this, formulae exist and attempted applications have been made in almost all cases of mental illness. Hall (1996) observes that diagnoses of mental illness are too often "arrived at from a simple and narrow understanding of patients' lives" (p. 17), resulting in limited treatment

approaches. Kennedy (1981) confers, stating it is a "shaky intellectual basis on which the concept of mental illness rests" (p.109).

An imbalance of control and power is particularly evident in the psychiatric setting. The elusive nature of mental illness lends itself to moral and ethical judgement by the dominant social order (Szasz, 1991). Szasz suggests that the foundations of psychiatric diagnoses are value judgements, based on the belief systems of healthcare professionals. Keddy (1996) confers, describing the purported progression to cure for mentally ill patients:

> Individuals who need psychiatric treatment are expected to change their behavior until a transformation has occurred and they are able to fit into society. These patient behavioral changes must meet with the approval of the psychiatric nurses who, in turn, notify the psychiatrists of the transformation. It can then be said that a patient is cured (p. 385).

Because this power structure is integral to mental health care, psychiatric nurses are presented with unique challenges and opportunities. Psychiatric nurses possess significant power to coerce their patients into the dominant constructs of health and normalcy. Alternately, nurses can interrupt the power imbalance by genuinely including patients in care decisions and advocating for them throughout their hospital stay. Glenister and Hopton (1995) state that psychiatric nurses need to play an active role in addressing the oppression of mental health patients. They suggest that "to talk of empowerment without recognising the reality of oppression is simply hot air" (Glenister & Hopton, 1995, p. 63). They assert further, "nurses could strive to end the social exclusion of people who act, think and feel in a different way to others, rather than accepting legal coercion and back-door eugenics" (Glenister and Hopton, 1995, p. 63).

Research in nursing

Because there is no universal conceptualization of power or powerlessness, there is a significant lack of clarity regarding its use in research studies. There have been a number of studies claiming to look at power and powerlessness in nursing; however very few provide clear definitions of these concepts. In spite of this, most of the studies utilize a deductive method of inquiry, and many neglect the subjective experiences of nurses. In a review of cross-disciplinary literature on power and powerlessness, Pieranunzi (1997) made four observations:

> The first is the relative lack of research studies which examine these concepts. The second observation is the overwhelming focus on a reductionistic and narrow perpective of power and powerlessnes. The third is the predominance of an intrapsychic view of power and powerlessness, even though much of the literature itself agrees that the concepts are relational. And last, there is an almost complete absence of any phenomenological or hermeneutical studies of power (p.156).

The lack of inductive research on power and powerlessness in nursing may reflect the widespread adherence to the dominant conception of power. The lack of understanding about nurses' subjective experiences may be contributing to the perpetuation of nursing subordination. Pieranunzi (1997) observed that most of the literature on power in nursing views power from the perspective of administration, and it treats power as a commodity that is finite. He asserts that this view may act to limit the study of powerlessness in staff nurses' because it is driven by the belief that in order to empower another, one must relinquish some of one's own power (Pieranunzi, 1997). Thus, giving voice to subordinate groups such as staff nurses may be perceived as threatening.

Studies focusing specifically on power and powerlessness in psychiatric nursing are scant. Most of the research in nursing focuses on medical, surgical or intensive care nurses. It is of value to consider these studies, as psychiatric nurses are a part of the larger nursing culture; however, the unique experiences of psychiatric nurses warrant more attention. This

section describes four research studies on power and powerlessness in the general nursing population (Attridge, 1996; Chandler, 1992; Erlen & Frost, 1991; Groves, 1992), and one study on the experience of power and powerlessness in psychiatric nursing (Pieranunzi, 1997).

Perceptions of power and powerlessness in general nursing

Erlen and Frost (1991) explored the relationship between nurses' perceptions of powerlessness and ethical decision-making. They examined how nurses perceive their role in the resolution of ethical dilemmas, hypothesizing that nurses may be limited in their ability to affect healthcare decisions because of perceptions of powerlessness. Data were collected through in-depth interviews with 25 (22 female, 3male) acute care nurses, ages 20 to 49 years. The interview tool used was the "Perceptions of Nursing Ethics interview schedule," which asks participants to describe a specific situation involving an ethical dilemma. Participants were asked why the situation was difficult, what nursing action was taken, and what factors influenced that action. Data were categorized according to both the nurses' words and the context of the situations described. Content analysis revealed that 84% of the nurses interviewed described perceived powerlessness in relation to ethical decisions involving patient care. The specific themes related to a perception of powerlessness were: (1) physician control or dominance; (2) lack of knowledge or information regarding alternatives in a given situation; and (3) ineffectiveness regarding influencing the outcome of an ethical dilemma.

Erlen and Frost (1991) found that nurses' sense of powerlessness may relate to a difference between doctors' and nurses' perceptions of, and approaches to, ethical dilemmas, and to a very real lack of influential power next to physicians. They found that when physicians "exerted power and dominance, nurses perceived themselves to be powerless" (Erlen & Frost, 1991, p. 404). "Without power, nurses may be unable to influence patient care decisions" (Erlen & Frost, 1991, pp. 404-405). Further studies aimed at uncovering and challenging the forces inhibiting a sense of empowerment in nurses are essential, in order to

move toward more effective patient advocacy in healthcare, and the personal and professional empowerment of nurses.

My study extends Erlen and Frost's research, broadening the scope from which participants were able to relate their stories of powerlessness. That is, although many powerless situations involve ethical dilemmas, my study is not limited to this domain. Thus, a further understanding of the varying types of situations affecting nursing power are exposed. Erlen and Frost accessed nurses' perceptions of power and powerlessness, but the actual impact of feeling powerless was not addressed. My study explores the personal and professional impact of powerlessness on nurses, specifically those working in psychiatry.

Erlen and Frost (1991) mention a limitation of time in their study. However, they do not specify the time lapse between conducted interviews and the actual occurrence of the reported events. This lapse in time may have led to memory distortions in the nurses' reports. For this reason, I have limited my participants to the identification of situations that have occurred in the past six months to one year.

Groves (1992) explored the attitudes of general hospital nurses toward the meaning of power, speculating that nurses' perceptions of power or powerlessness impact their nursing practice. The Power Orientation Scale (Goldberg, Cavanaugh & Larson, 1983 as cited in Groves, 1992) which quantitatively measures attitudes toward power using six different power orientations, was administered to randomly selected, acute care hospital nurses in British Columbia. Of 200 mailed questionnaires, 112 were returned. Contrary to her expectations, Groves found that the participants' attitudes toward power were moderate to high on all six scales, reflecting a positive view of power overall. However, she notes a continued reluctance by nurses to exercise power in the workplace. She suggests that this may "reflect the absence of a clear conceptualization of power in the context of nursing today" (Groves, 1992, p.52). Nurses may view power positively, but they may not be clear on what power means to them in terms of action, nor how its use or lack thereof manifests in the workplace. Groves suggests "the need for nurses to re-examine their understanding of

power in order to recognize and affirm power as an inner strength" (p. 26), adding that increasing the discourse on nursing attitudes toward power has the potential to "inspire a unification of nurses to mobilize the potential and strength of professional nursing" (p. 27). My research adds to an understanding of what inhibits nurses from utilizing greater power in the workplace.

Groves also assessed demographics in relation to power orientation, and found that there were no significant differences in attitudes toward power between demographic groups, based on nursing education level, age, marital status, primary area of practice, and status of employment. This is consistent with Erlen and Frost's (1991) findings regarding demographics.

This study obtained its data through mail-out questionnaires. The response rate was very high, suggesting a good representative sample. However, ths method limits the depth and breadth of data that can be obtained, and it precludes the opportunity for participants to ask questions and receive clarification. Thus, the accuracy of some responses may have been affected. Groves concedes that her study did not "capture the concept of power within the context of the complexities of clinical nursing practice" (p. 62). A qualitative research approach can provide the richness that cannot be obtained in such a quantitative study.

Circumstances of empowerment and powerlessness in general nursing

Chandler (1992) explored the nature of staff nurse empowerment and powerlessness, using an exploratory, descriptive design. She based her study on a definition of empowerment that involves enabling individuals to feel effective so that they can act successfully. She differentiates this from traditional understandings of empowerment, in which "managers have assumed that to empower subordinates is to delegate power by parcelling out some control, authority, and influence" (p.65). A convenience sample of 56 staff nurses from a variety of acute care areas, was used. Individual interviews were conducted, and the data was then content analyzed to identify key terms and themes related to situations of empowerment and powerlessness.

Of the participants, 57% experienced empowerment through their interactions with the patient and family. They described feeling effective when they felt as though they made a difference for the patient. The next largest group of nurses (23%) felt empowered by positive nurse-physician interactions, in which they felt trusted and respected. "When physicians asked for the nurses' opinions, considered their input, collaborated in making patient care decisions, and verbally acknowledged the nurses' input, the nurses experienced empowerment" (p.68). In the remainder of empowering accounts, 7% described working well as a nursing team, 7% referred to recognition and compliments from their head nurses, and 6% felt empowered when they felt good about themselves.

In descriptions of powerlessness, 52% related to negative nurse-physician interactions. "The negative interactions ranged from the physicians' ignoring the nurses when there should have been nurse-physician collaboration for the benefit of patient care, to the physicians' listening to nurses and either not responding to, or verbally abusing, the nurses" (p.68). The remainder of powerless experiences include; "when a patient dies unexpectedly (12%)...when the patient or family is not appreciative of the nursing care (11%)...shortstaffing (10%), floating (7%), dictums from administration (5%), and an ineffective supervisor (2%)" (p.68).

This study suggests that empowerment for nurses is derived from interpersonal interactions, rather than from receiving power from another, or having power over another. "Staff nurses are closer to the relationally oriented, feminist model of empowerment'" (p.71). Chandler speculates on the cascade of powerlessness from physicians to nurses: "One can only surmise that the harsh situations described in the negative nurse-physician interactions may have been a result of the physicians' perceiving the nurses as threatening to their autonomy and control; therefore, the physicians cut off the relationship by ignoring or attacking the nurses" (p.70). The impact on the nurses, when the relationship was obstructed, was an inhibition of nursing action and a feeling of powerlessness. Chandler also notes that a sense of isolation characterized most of the nurses' descriptions of powerlessness. She

suggests "if the nurse had garnered support from colleagues the effect of powerlessness might have been dissipated" (p.70).

Chandler's study addresses circumstances in which nurses feel powerless and unable to act. My study extends this understanding by asking not only what are the circumstances, but also what specifically happens for nurses which fuels an inability to act.

Similarly, Attridge (1996) explored the circumstances of powerlessness in general hospital nursing. She drew her data from two previous studies in which the notion of power in relation to nursing was explored (Attridge & Callahan, 1987, 1989). The original purpose of these studies was to explore nurses' view of a quality workplace and how it could be achieved, taking into account that female-dominated professions have traditionally endured stark inequalities in the workplace. The data were originally collected within workshop settings in which two primary methods of data generation were used, nominal group technique and critical incident technique. The first study (1987) involved 19 research 'subject' participants, including representatives from nursing education, administration, British Columbia Nurses Union, Registered Nurses Association of British Columbia, staff nurses, and middle management. The second study (1989) was designed to replicate the first, using a larger sample size (N=45), drawn from general staff nurses in three acute care hospitals in British Columbia. In the present study (1996), Attridge analysed the data specifically obtained in the critical incident technique portion of both prior studies (Attridge & Callahan, 1987, 1989) to identify common themes in nurses' experiences of powerlessness. The decision criteria and method used for delineating these themes has not been included in the research report. Seven interrelated themes emerged that characterized the circumstances in which nurses experienced powerlessness. Nurses felt powerless in the following situations: (a) in incidents that involved "very basic, almost primal, fundamental human situations" (Attridge, 1996, p. 44), that is, in situations that stimulate strong emotion in all those involved. When nurses perceived that such a situation did not go favourably due to factors outside of their control, they described a sense of powerlessness; (b) in incidents

characterized by nurses' sense of being in an unsafe or potentially unsafe situation, regarding patients or others; (c) when the nurses felt out of control of the work situation, including situations in which others have control or situations which are uncontrollable; (d) when "competing, very serious demands" occurred, such that there seemed to be a no-win solution; (e) when the nurses felt alone or abandoned; (f) during incidents that required the nurse to make a choice or act resulting in visible negative consequences; and (g) when a lack of resources was evident.

Attridge (1996) addressed nurses' definitions of power, observing that a sense of power for nurses seems to include control over one's work situation such that one can successfully do one's job and achieve effective patient care. She notes that this conception of power differs considerably from that found in the traditional power literature, as it does not suggest control over others, but rather, control over one's situation in order to achieve success. As well, "nurses sought to be powerful rarely for themselves, but instead almost always for patient or group advancement" (Attridge, 1996, p. 50).

In her suggestions for change, Attridge (1996) suggests that the necessary components to nurses' sense of power are respect and value, collegial support, and autonomy. She found that if nurses' judgements are seriously considered and they feel successful in influencing quality patient care, they are much less likely to describe feeling powerless. Thus, Attridge emphasizes the necessity of "*respect* and *value* for the nurse herself, the importance of her work and the quality of her clinical judgment in the performance of that work" (p. 52). She also found that collegial support "by peers, administrators, physicians and others" (p. 53) is a critical variable for nurses in reducing a sense of powerlessness. Thirdly, Attridge stresses the necessity of "support for the *autonomy* of the nurse in her definition of the nursing work situation" (p.53). She urges nurses to make the absence of these elements visible "to our managers, to our employers, to our profession, to the union, to the public, and to the government" (Attridge, 1996, p. 55). My study will contribute to increasing the visibility and value of psychiatric nursing work. Again, Attridge did not distinguish between

nurses working in different specialty areas, and given the uniqueness of psychiatry from most acute care areas, it is of value to look specifically at nurses working in this field.

Experiences of power and powerlessness in psychiatric nursing

Using a Heideggerian hermeneutical approach, Pieranunzi (1997) explored the meanings of power and powerlessness in the lived experience of psychiatric nurses. He was particularly concerned with the role power plays in the psychiatric nurse-patient relationship. The basis of this method of inquiry is described as follows: "Heideggerian philosophical perspective sees the essence of being, or Dasein, as embedded in day-to-day experience and thus needing hermeneutical extraction, hermeneutics being the process of interpretation (Heidegger, 1927/62)." The intent of Heideggerian hermeneutical phenomenology, then, is "to uncover meanings embedded in descriptions of everyday lived experiences" (p.158). In this approach, emphasis is placed on the language used by participants to create personal narratives. Pieranunzi interviewed ten psychiatric registered nurses from diverse backgrounds, using semi-structured interviews which were taped and later transcribed. A team of people were involved in the preliminary analysis of the transcripts, followed by further analysis by the author's dissertation chair and committee. In the third phase of analysis, participants were given the study outcomes and they were encouraged to offer feedback regarding the accuracy of the results. Pieranunzi claims that the involvement of various individuals in the analysis process ensured "truthful interpretation" (p.158). The process of data analysis involved using hermeneutic methods based on Heideggerian phenomenological philosophy.

Pieranunzi (1997) presented the findings in terms of a dominant "constitutive pattern" which permeated all data, capturing the relationships among themes and subthemes. The constitutive pattern is "the power of knowing." Pieranunzi found that for his participants, power did not have much to do with control and influence; rather nurses "related power to an ontological ability to understand and respond to clients based on an intuitive and personal mode of knowing" (p.158). Participants talked about different ways of knowing, and of

struggling with trying to justify their intuitive ways of knowing with linear, observable means. The main theme within this constitutive pattern is "power as connectedness in relationships." The nurses experienced power between themselves and others, not over others. Pieranunzi writes "power is centered in knowing - not knowing 'how,' but knowing 'to'. . .it was the knowing which connected them (nurses) with people in deep, mutual, and profound ways" (p.159). He found that the nurses wished to know their patients in mutually empowering ways, and he describes this as "an intuitive and esthetic knowing and connecting which transcended mere intervention" (p.160).

Three subthemes of "power as connectedness in relationships" were identified: "the personal versus the professional," "the power of mutuality," and "the contextualized nature of relationships." In the personal versus the professional subtheme, emphasis is on the personal connectedness between nurse and patient that enhances healing. The relationship is mutually beneficial and moves beyond the ideal of objectivity as essential to professional practice. Pieranunzi suggests that this way of knowing

> calls us to reach out to the humanness in other persons and open ourselves to the meaningfulness in their lived experience and share the meaningfulness of our lived experience with them. . .Powerful knowing involves the whole nurse and the whole patient and ulitmately empowers them both (p.160).

The power of mutuality extends from this, emphasizing that the nurse-patient relationship is one in which both parties grow and learn equally from one another. The final subtheme - contextualized nature of relationships - challenges traditional role theory which suggests that people can move easily in and out of different roles. Pieranunzi found that "to exist mutually and connectedly with another implies an honesty and authenticity that contradict the notion of operating within a certain role" (p.160). He concluded that nursing is more than "just a job" for participants, it is a way of being.

This study sheds light on psychiatric nurses' conceptions of power as inextricably relational and associated with intuitive knowledge. It suggests that nurses seek greater power

in order to enhance therapeutic relationships with patients, which they perceive as foundational to healing and mutually beneficial. Pieranunzi concludes that the nurses' "caring created a link, a bridge that allowed one human being to cross over and experience another human being. Power (is) part of human creativity, rooted in intuitive and esthetic knowing, and focused on enabling one to 'be' and 'be with'" (p.161). This study suggests that nurses may be inhibited by inappropriate conceptions of power that do not really fit their lived experience of power, and that embracing misfit ideas of power is perpetuating nurses' view of themselves as powerless.

Summary

The research literature contributes to an understanding of nurses' perceptions of power and powerlessness, generally and in relation to specific, personal experiences (Erlen & Frost, 1991; Groves, 1992). As well, the situations in which nurses feel most powerless have been described (Attridge, 1996; Chandler, 1992; Erlen & Frost, 1991). Pieranunzi's (1997) study offers an understanding of how psychiatric nurses experience power and powerlessness in the context of the nurse-patient relationship. Chandler (1992) addresses how a sense of powerlessness creates an inability to act. What is of interest in the current study is what is going on for psychiatric nurses in powerless situations that fuels this inability to act, and what is the impact of powerlessness on them. Notably absent from the literature are studies on the personal and professional impact of feeling powerless on psychiatric nurses.

Research purpose

The purpose of this study is to explore the circumstances in which hospital psychiatric nurses' most often feel powerless, and the impact this has on them, both personally and professionally. An understanding of the psychiatric nursing experience can facilitate the development of new structures and strategies with which to minimize powerlessness. As well, this may lead to increasing discourse among psychiatric nurses, potentially creating greater unity within the profession. My hope is that the visibility of psychiatric nursing work will be increased and the devaluation of nursing care will be exposed. This study may

enhance awareness of the power relationships between psychiatric nurses and other groups within the healthcare system. An ultimate shift in these relationships may advance the empowerment of mental health patients.

Research questions

The research questions driving this study are:

1. What are the situations in which acute care psychiatric nurses feel powerless?
2. How does feeling powerless affect the personal and professional experiences of psychiatric nurses?

CHAPTER THREE

Methodology

The current study employs an exploratory, focus group design to examine the circumstances in which acute care psychiatric nurses experience powerlessness, and the impact of this powerlessness on them. A feminist theoretical framework guided the research, in terms of viewing all experiences as context-driven and subjective. The descriptive data were analyzed for situational and experiential themes of powerlessness.

Research design

A qualitative research design was used for this study in order to access the complexity of psychiatric nurses' experiences, while taking into account the diversity within nursing. As nurses have both a collective voice as well as many individual voices, it is important to investigate both the common themes and the variations in their experiences of powerlessness. As I believe that nurses' sense of powerlessness stems, in large part, from their having to work within a positivist framework that impinges on their right to challenge existing knowledge and create alternative knowledges, a research methodology that allows multiple realities is appropriate. Thus, understanding the experience of powerlessness from the participants' perspective is paramount (Carey, 1994; Kirby & McKenna, 1989; Palys, 1992; Reinharz, 1992).

Feminist framework

Feminist research challenges taken-for-granted realities imposed by the dominant orders in society, and it attempts to offer new paradigms with which to understand phenomena (Kirby & McKenna, 1989; MacPherson, 1983; Reinharz, 1992). This is based on the belief that the human experience is very subjective; there is not one objective truth or reality, but many. While feminist research encompasses both quantitative and qualitative approaches, qualitative methods are frequently used to allow room for the voices and actual experiences of the research participants to be known. This contrasts with the more traditional positivistic approach to research, which attempts to fit participants' experiences into pre-

existing constructs. Positivism is the position that there is one reality that can be discovered and observed through objective means (Stevenson, 1996).

A feminist approach questions the power base that researchers have traditionally enjoyed as the creators of knowledge. It attempts to interrupt the perpetuation of dominant ideologies that can occur through traditional research. MacPherson (1983) asserts that although the positivistic method of research can offer useful information "it can simultaneously function to provide rationalizations for existing power distributions, since the paradigm is devoid of any analysis of the inferior status and oppression of women" (p.18). Kirby and McKenna (1989) confer with this, asserting that "subordinate groups have been structurally blocked from the process of selecting, naming, disseminating and evaluating knowledge" (p.28). As a result, feminists feel a responsibility to make research findings meaningful and accessible to those groups who are being studied (Kirby & McKenna, 1989; MacPherson, 1983; Reinharz, 1992).

It is important to note that although most research based on the concept of "experience" intends to dislodge accepted knowledge constructs, it runs the risk of perpetuating existing ideological systems. This is because it often treats experience itself as the foundation for new knowledge, neglecting the multiple contexts influencing the experience (Oleson, 1994; Scott, 1992). Scott (1992) speaks to the importance of contextualizing experience, "it's categories of representation...its premises about what these categories mean and how they operate, its notions of subjects, origin, and cause" (Scott, 1992, p. 25). She asserts

> we need to attend to the historical processes that, through discourse, position subjects and produce their experiences. It is not individuals who have experience, but subjects who are are constituted through experience. Experience in this definition then becomes not the origin of our explanation . . . but rather that which we seek to explain, that about which knowledge is produced (Scott, 1992, p.25-26).

Historical and social influences on nursing practice have been identified in this study in an attempt to contextualize the participants' experiences.

Integral to feminist theory is the idea that the personal is political. Feminist research is personal in that it accesses the actual experiences of individual people; it is political in that it offers new perspectives on the experience of oppressed groups, and it challenges the status quo.

Focus groups

Focus group research is increasingly utilized in the social sciences as it provides a unique combination of the elements of both individual interviews and participant observation, thus providing kinds of data that cannot be accessed easily through one of the other two methods alone (Morgan, 1988). Focus groups are interviews in the sense that a researcher asks a few key questions (see Appendix A); however, the direction of the discussion is essentially left up to the participants. What differentiates focus groups from other group interviews is "the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group" (Morgan, 1988, p. 12). Focus groups provide rich data by tapping into genuine interactions between people, which allows the researcher to access perceptions, attitudes, and beliefs that underlie behaviour (Carey, 1994; Krueger, 1994). This method of inquiry is particularly useful for studying issues that involve complex feelings, beliefs and experiences (Carey, 1994). Focus groups provide a forum for participants to "describe the rich details of complex experiences and the reasoning behind their actions, beliefs, perceptions, and attitudes" (Carey, 1994,p.226).

As the intent of this study was to access nurses' *subjective* experiences of powerlessness, an approach encouraging participants to describe situations in their own words is most appropriate. "In the history of the feminist movement, the primary means of empowerment has been women's telling of their own stories" (Ristock & Pennell, 1996, p.3). The group format is particularly useful as "the participants' interaction among themselves

replaces their interaction with the interviewer, leading to a greater emphasis on participants' point of view" (Morgan, 1988, p.18). Because individuals do not form opinions and reactions in isolation, the interaction found in a group can facilitate clarification and expression of thoughts and feelings. Kingry, Tiedje and Friedman (1990) suggest "the synergy of the group has the potential to uncover important constructs which may be lost with individually generated data" (p.125). As well, the group setting allows the researcher to observe the interaction among group members, noting areas of contention and agreement. Moreover, this method of inquiry is meant to stimulate discourse amongst participants, something that is sorely lacking and very necessary for psychiatric nurses. Such a goal is concordant with the goal of feminism "to transform the competitive and exploitative relations among women into bonds of solidarity and mutuality" (Reinharz, 1992, p.264-265). As well, public access to the knowledge gained in focus group research tends to be greater than in traditional research, as both the method and results are fairly easily understood. Finally, this approach enables the researcher to interview a relatively large number of people in a short period of time.

Interview questions

Although participants determine the content of discussion in focus groups, the group facilitator needs to create a framework for the discussion. This is done through the use of key interview questions. The questions used in this study were arrived at in response to prior studies on powerlessness in nursing. A number of studies have identified situations of powerlessness for the general nursing population (Attridge, 1996; Chandler, 1992; Erlen & Frost, 1991), but there is a lack of information regarding situations of powerlessness specifically in psychiatric nursing. Thus, it was important to access this information. In addition to identifying the circumstances of powerlessness, I am interested in what inhibits nurses from acting more powerfully and how they are affected by feelings of powerlessness. This interest underlies the remainder of the questions. In all of the groups, the key questions were answered, whether they were asked by the researcher or not. In some groups,

participants provided the sought information spontaneously in their discussions. See Appendix A for key interview questions.

Researcher's assumptions

In qualitative research, it is important to account for the impact of the researcher on the construction of understanding about the investigated phenomena (Lincoln & Guba, 1985; Morse & Field, 1996; Stevenson, 1996). Self-reflection enables the researcher to gain clarity about his/her preconceptions and biases, and to make these explicit to the reader of the research. Thus, I have included a list of assumptions which I bring to this study, in appendix B.

Leader and co-leader

The focus groups were facilitated by the principal researcher, and three of the groups were co-led by an assistant graduate student in counselling. She was not a nurse, and had experience in both individual and group counselling.

Participants

Seventeen female nurses were interviewed in four different focus groups. Three groups had four participants and one had five. All of the nurses were currently working in inpatient psychiatry, and they were interviewed in focus groups with only those nurses from their same workplace. As the majority of nurses continue to be women, and in order to attain some consistency of information as well as increasing the participants' comfort with expressing themselves, participation was limited to women only. Krueger (1994) states that focus groups are best with people who are similar to each other in order to increase comfort with speaking up. "The focus group is characterized by homogeneity but with sufficient variation among participants to allow for contrasting opinions" (p.77). Participants were recruited from three acute care psychiatric inpatient units in three different hospitals in British Columbia. Two hospitals are in the lower mainland of British Columbia, and one is outside of the lower mainland. Krueger suggests that "multiple groups with similar participants are needed to detect patterns and trends across groups" (p.17), as a single group

may be influenced by very specific factors unique to it such as those related to the institution of employment. Recruitment occurred through posters that were displayed on each psychiatric unit. As well, the managers spoke to their staff, encouraging their participation. Participants volunteered by contacting either their manager, who then contacted me, or by phoning me directly.

Demographics

Participant ages ranged from 30 to 59 years, with a mean age of 48 and a median of 41. Of the seventeen participants, ten were married, two divorced, two single and three were unmarried but living with a partner. All were Caucasian. Educational background varied considerably; nine nurses had RN diplomas, five had RPN diplomas, two had both RN and RPN diplomas, and one had a bachelor's degree in nursing. In addition, two of the participants had post-graduate diplomas in nursing, one had a diploma in a non-nursing field, three had non-nursing bachelor's degrees, and one had a non-nursing master's degree. The majority of nurses (65%) had ten or more years experience in psychiatric nursing, one nurse had 5-10 years, three had 2-5 years, and two nurses had under 2 years experience. Thirteen nurses worked full-time, two worked part-time, and two were casual. Within each focus group, there was approximately equal variation on all demographic variables. See Appendix C for more demographic details.

Procedure

The focus groups were held in meeting rooms within each individual hospital setting, in order to increase participants' ease of participation in the study. Each group interview was 60 to 90 minutes in length.

All of the focus groups were facilitated by myself, the principal researcher, and in the first three groups, a graduate student in counselling. All groups were video and audio taped. As well, a few informal written notes were taken during each group. My role as group leader was to facilitate the group discussion as non-directively as possible, while still guiding the discussion so that key questions were addressed. The role of the student assistant was to take

care of logistical concerns, such as operating the video camera and tape recorder. As well, she took notes during the group and offered her observations at the end of each session. Occasionally, the student assistant also asked some clarifying questions during the group discussion. Each group began with an explanation of the procedures and purpose of the group, along with a discussion of the researcher and assistant roles. As well, informed consent was reviewed and obtained (see Appendix D). Participants were encouraged to speak openly, and the value of diversity of ideas and experiences was emphasized. A few key questions (see Appendix A) were used to guide the discussion, but for the most part, the participants determined the direction of the discussion and the areas of emphasis. All questions were asked in an open-ended way in order to encourage rather than limit the sharing of a wide range of ideas. "Open-ended interview research produces nonstandardized information that allows researchers to make full use of differences among people" (Reinharz, 1992, pp. 18-19).

At the beginning of each group, the participants were asked to take a moment to think about and write down at least one specific situation in the past six months in which they felt they lacked power. Each participant was then given an opportunity to share her experience with the group, and group discussion followed. At the end of the group session, key points from the discussion were summarized, and participants were encouraged to validate, clarify, or challenge the content of the summary. They were also given an opportunity to add any other thoughts at this time. Upon completion of the group interview, a questionnaire was distributed, primarily eliciting demographic information but also including questions about how nurses feel supported or unsupported by their colleagues when they attempt to act more powerfully in their specific workplace (see Appendix E).

Ethical considerations

Before initiating recruitment of participants and data collection, ethical approval was obtained from the University of Northern British Columbia's graduate research ethics

committee. Ethical approval was also obtained from the hospitals in which the focus groups were conducted.

The rights and privacy of research participants were assured by providing information on the purpose and use of the study, encouraging any questions, and ensuring strict confidentiality. Informed consent was obtained to ensure participants were informed and willing to participate in the focus groups. All of the audio and videotapes have been securely stored. Two of the audio tapes were transcribed by university secretaries who did not have access to the names or places of employment of the participants. The remainder of the tapes were transcribed by the principal researcher. Only the principal researcher had access to the videotapes. Participants have been identified solely by code, on the tape transcriptions. In the results and discussion chapter, pseudonyms have been used to identify the participants.

Data Analysis

The audio tapes of the focus groups were transcribed verbatim. The transcripts were then reviewed in conjunction with the videotapes, to confirm the content and to identify significant non-verbal communications. Data from all four groups were considered together. The data were originally approached using content analysis. However, there was an incompatibility between the data and preconceived categories of powerlessness, which inhibited this process. Thus, a more inductive approach to data analysis was required. A theme analysis was conducted, in which four categories of powerless situations emerged from the data. The specific impact of these situations on the nurses was then identified. As well, significant differences between the groups were identified.

Seven factors identified by Krueger (1994), were incorporated in the analysis of the data. They include: (a) Consider the words. The words used by participants were analyzed from the transcripts, in terms of apparent meanings. The videotapes were then reviewed in conjunction with the transcripts to incorporate non-verbal and speech pattern clues regarding intended meaning. (b) Consider the context. All the data were kept intact in the original transcript form throughout the analysis, in order to maintain an understanding of the context

in which comments were made. (c) Consider the internal consistency. The transcripts were reviewed to determine whether individuals alter their positions on an issue after interaction with others, or whether they remain consistent in their comments. Where participants seemed to alter their opinions, clues suggesting the reason for the change were sought. In many cases, participants views did not alter radically; rather, they evolved after being influenced by the ideas of others. This is suggestive of the need for professional discourse among nurses in order to clarify and advance nursing ideas. (d) Consider the frequency or extensiveness of comments. Both the topics which were discussed by more participants, as well as the comments which were made more often than others, were noted. This was done within individual focus group data, and across all groups. Those topics addressed by many participants across all groups were identified as shared themes. Those topics which were addressed most frequently were considered to be of most pressing concern to the participants at the time the groups were conducted. Individual differences between the groups were acknowledged, and may be reflective of varied staff cultures, institutional differences, regional differences, or simply differences in the individual nurses who volunteered at each site. (e) Consider the intensity of the comments. The videotapes and the notes taken in the focus groups were used to pick up variances in speaking patterns and non-verbal displays, which were suggestive of strong feelings. For example, voice tone, rate of speech, volume of speech and emphasis on specific words were all noted, and were considered in conjunction with the actual words used. (f) Consider the specificity of responses. Specific comments, based on personal experiences were given more weight than more general, vague comments. (g) Consider the big ideas, or trends that cut across all of the data. Although individual voices have been acknowledged, emphasis has been placed on the shared ideas that emerged from the data as a whole.

Krueger's seven analytic factors were incorporated into a series of steps in the process of data analysis. Initially, immersion in the data as a whole was necessary, to gain a general sense of the overall content of the data within context (Morse & Field, 1996). Following this,

individual pieces of data, consisting of 1-2 sentences of participant comments, were highlighted if they were considered to be central to the nurses' experience of powerlessness. These included descriptions of situations, as well as feelings and thoughts about them. Following this, commonalties between the participants were identified. Morse and Field (1996) state "it is these inter-participant themes that constitute the 'essence' of the phenomena" (p. 173). In order to better manage the data, I dealt with the specifics of the situations of powerlessness separately from the nurses thoughts and feelings about them. First, I developed the situational categories of powerlessness. Following this, I identified the nurses cognitive and emotional experiences in relation to these situations. As well, I explored the interrelationships between categories. The specific process of data analysis is outlined below in more detail.

Stage One

Data analysis began with a review of all of the transcripts to acquire a general feeling for them. This involved reading the entire transcripts through twice, noting key areas of emphasis in the participants' comments. The transcripts were then reviewed again, and individual pieces of data were identified with a highlighter. The pieces of data consisted of participant quotations that related to experiences of powerlessness. These included descriptions of powerless situations, as well as feelings and thoughts about them. After multiple readings of the transcripts, the key situations of powerlessness were identified. Initially, an attempt was made to fit the identified situations into categories of powerlessness that had been previously observed in studies of the general nursing population (Attridge, 1996; Chandler, 1992; Erlen & Frost, 1991). This was unsuccessful, as the experiences of the participants were similar but not identical to those previously described in the literature. Thus, the transcripts were re-examined for situations of powerlessness emerging solely from the data. This was done by reviewing the pieces of data for suggested themes. From this, I identified six categories of powerless situations, with seven subcategories. These were: (a) When feeling out of control of the work situation (i) related to physicians' dominance and

control, (ii) related to bureaucratic structure and hierarchical organization, and (iii) related to the patient situation; (b) when there is a lack of effective communication and teamwork; (c) when there is a lack of support and a sense of isolation; (d) when there is a lack of respect and trust; (e) when there is a lack of resources such as (i) physical on-site resources, (ii) funding, (iii) staff and time, and (iv) community support services; and (f) when there is a lack of consistency in care. There were 272 pieces of data at this point in the analysis. Next, the pieces of data were cross-referenced across all categories, and commonalties and repetitions between the categories were identified. The categories and subcategories were then collapsed into four broader categories: (a) Physicians' dominance and control, (b) caught between meeting the needs of the patient and the needs of colleagues or the system, (c) structural or organizational problems, including a lack of resources, and (d) lack of communication, teamwork, support, trust, and respect. All of the data were then reviewed again in terms of the new categories, and pieces of data were eliminated once saturation of each category was reached. "Saturation occurs when added information does not reveal new understanding about relations or abstractions" (Kirby & McKenna, 1989, p. 138). At this point, 114 pieces of data were being used. A graduate student in counselling who had not attended the focus groups sorted identified data pieces from one focus group transcript into the four categories. She was provided with a description of the categories and was asked to sort each of the provided data pieces into one of the four categories. This was then compared to the organization of the data done by the principal researcher. Interrater agreement was 56% at this stage. Thus, the categories were refined once more through a further review of the data for descriptive themes. Four revised categories which seemed to more effectively capture the essence of the data, were created: (a) Medicine's dominance and control, (b) no-win situations, (c) system problems, and (d) lack of communication and support. These categories were then surveyed for saturation, and the data were reduced further to 95 pieces.

Interrater reliability

A graduate student in counselling who had been previously uninvolved in the study in any way, sorted the 95 pieces of data from all four focus group transcripts into the four identified categories. This coding was then compared to that done by the primary researcher and 89% agreement was reached. Where there was disagreement, the two coders discussed their differences and came to a mutual decision on how to code the data, thereby creating 100% interrater agreement.

Stage Two

In this stage of analysis, the transcripts were reviewed specifically for expressions indicating attitudes, feelings, and experiences, in relation to the four situational categories. Each piece of data that was assigned to a situational category was scanned for key words, phrases or nonverbal behaviours that indicated some personal or professional impact on the nurses. All pieces of data were reviewed in their original context. Specific words and phrases that described feelings and thoughts relating to each situation of powerlessness were identified as new pieces of data. Twenty-one to twenty-six data pieces suggesting experience were identified within each situational category. These data pieces were also cross-referenced across all of the categories of powerless situations, and experiences common to all categories were identified. The data pieces were then grouped with others that were similar, and eight themes on the experience of powerlessness for psychiatric nurses were identified. These include (a) frustration and anger, (b) helplessness, impotence, and feeling out of control, (c) apathy and hopelessness, (d) feeling pressured and stressed, (e) compromising personal values, (f) feeling isolated and lacking trust, (g) feeling undermined, demoralized, and invalidated, and (h) concern for the patient.

CHAPTER FOUR

Results

In this section, the types of situations in which participants most often felt powerless are described. This includes a discussion of the impact of these situations on the participants, both personally and professionally. Descriptions and direct participant quotations are used to illustrate the categories and experiences of powerlessness.

Situations of powerlessness

Participants identified four types of situations in which they experience the greatest sense of powerlessness (impotence or inability to act with effect, related to a lack of authority). Although these categories of powerlessness are addressed individually, this is not meant to suggest their mutual exclusivity; rather, they overlap and interact with one another in a variety of ways. The division between categories was created to provide a structure for understanding and communicating the research findings.

The four situations of powerlessness involve circumstances related to:

(a) Medicine's dominance and control. This includes negative interactions between nurses and physicians, as well as issues related to the more global professional dominance of medicine in healthcare.

(b) Feeling caught in a no-win position. These situations involve the nurse feeling torn between her allegiance to the patient and her allegiance to physicians and the system in which she works.

(c) System problems. This includes issues related to the Canadian healthcare system, as well as to organizational or institutional concerns.

(d) Lack of communication and support. These situations are characterized by nurses feeling isolated and alienated from colleagues.

Although each type of situation created different feelings and responses in the nurses, there were shared experiences across all categories. For example, feelings of frustration and anger permeate the nurses' accounts in all situations. Many of the stories shared by

participants reflect a feeling of lack of control, most often related to decisions made by more powerful groups. As well, a predominating concern for the patient was expressed consistently. One nurse explained,

> I think sometimes the patients, when whatever stress it is in the system, whether it's getting somebody in here inappropriately and slapping certifications on them just to get them in here, or trying to find a place for them to go when they leave here, or whether it's a miscommunication between staff members, it is the patients who feel the effects of all of that mostly anyways, most directly.

Generally, the nurses expressed decreasing satisfaction with their work, and increasing burn-out, exhaustion, and almost a sense of defeat against the system in which they work. Comments like "I've allowed myself to let my spirit break" and "you'll never win" are not uncommon. Many nurses cite support from their nursing colleagues as the major positive influence on their experience at work.

Medicine's dominance and control

Many of the situations described by participants relate to feeling powerless against the control and authority of the medical profession. These accounts can be understood in terms of two categories of situations, which are each characterized by two themes. The first involves nurses' individual interactions with physicians, in which they feel (a) unheard, and (b) belittled or undermined. The second type of situation involves reactions to the more global professional dominance of medicine in healthcare, and is characterized by nurses either (a) feeling forced to participate in care they do not agree with, or (b) feeling limited in their practice and decision-making power. In situations involving nurses interactions with individual physicians, the impact seems to be of a very personal nature and one in which the nurses' sense of self is most often threatened. Nurses used such words as "demoralized," "humiliated," "shamed," and "stamped down." Situations relating to the general dominance of the medical profession seem to create more feelings of frustration and hopelessness.

Feeling unheard

Participants described feeling not heard by physicians, and as a result, they felt they lacked significant influence on patient care decisions. There seems to be a general sense of helplessness when the physician involved is unwilling to listen to the nurses' ideas. One participant described such a situation: "I suggested (a certain treatment for a patient), and well she did end up getting (the treatment) and she did get better, she's not here any longer. But it took forever from the time I thought of suggesting it 'til the doctor decided to give it a try." In this case, the description of powerlessness is based around a concern for the patient. The participant stated her biggest frustration with the situation was having to sit by and watch the patient suffer. This is consistent with many of the nurses' accounts of powerless events; the focus of concern is usually the patient. However, this concern does not always seem to be enough to motivate the nurse to intervene on behalf of the patient. One nurse shared an experience in which she felt unable to stop a treatment from being administered, even though she felt it was damaging to the patient:

> I did say to the doctor I thought that this procedure wasn't necessary, but he thought that it was, and I thought that he used an approach that didn't leave room for negotiation . . . I felt powerless and very disappointed in the therapeutic process and not having that trust neither which I think is necessary.

These situations suggest that participants consider the power to alter the extent of nurse/physician collaboration, as residing with the physician. It seems as if the nurses feel they have input only if the physician involved is willing to collaborate. If the physician is not willing to collaborate, then the nurses seem to feel impotent. The nurses are aware of being discontent and undervalued, yet they are reluctant to challenge the authority of the doctor because of a belief that they lack power. Instead, the nurses complain about the doctors to each other, and at times give up, feeling hopeless. Further evidence that nurses perceive doctors to be considerably more powerful, lies in the following kind of comments. Liz explained that she finds it difficult to provide consistent nursing care because of

> so many inconsistencies between the psychiatrists and how they treat their patients . . we as a team can't be consistent because we have no consistency here (using hands to indicate a higher level for medicine and a lower level for nursing) . . . The rules are always different with every doctor, there are very few that you go well this is so-and-so's patient, so in this situation I'll do this, but if it was so-and-so's patient in that same situation, I would do this. So you spend years trying to figure out their little idiosyncrasies.

Nora agreed that the degree of input nurses have into patient care decisions, "depends on which psychiatrist you work with". Petra added "it depends on the psychiatrist that's involved; if you know you're going to be listened to, you're much more likely to speak up."

A number of nurses suggest that challenging medical authority can make life very uncomfortable and may even jeopardize one's job. One participant commented on the risks that may result from expressing one's differences:

> I've seen people actually quite damaged or have consequences, when trying to (make change). It's a lot of work, takes a lot of emotional stress to really work on making changes happen when you're still trying to keep your house going and your income in and it's like another job.

Other nurses offered their experiences of what keeps them from being more vocal and active in their relationships with physicians. Iris suggested that challenging a doctor can make life difficult: ". . .it is the doctors who make the final decision and they resent any challenge to their power. . .from time to time, if you've challenged them and they don't like it, they won't talk to you for days or weeks." She stated this inhibits her from acting because "you know you could have to put up with this childish behaviour as a consequence." Liz has experienced something she called "the passive-aggressive revenge factor," wherein physicians will unreasonably refuse to cooperate with a nurse's request, "so you have a patient getting sicker and sicker and sicker for no other reason than revenge."

Another participant, Jane, offered her understanding of why nurses don't speak up more, by likening their situation to "the abused wife syndrome; you get into a rut." This suggests an understanding of the dynamic of oppression that occurs in the nurse-physician relationship. With this understanding, Jane acknowledged that every participant in the relationship has a responsibility to create desired changes, and that nurses cannot depend upon physicians to create the changes they seek. She asserted ". . .it's not all the fault of doctors. I think we've all got our story as to why we shut ourselves down." Liz offered, "we've learned to shut ourselves down, because we go okay why bother. . .It's safer to just keep your head low." Iris conferred with this sense of hopelessness regarding change: "Well, you'll never win . . . So how are you going to feel, trying and trying and trying and then being stamped down." When repeatedly dismissed, one's tendency is to stop speaking up, which exacerbates the feeling of powerlessness.

Such examples suggest that physicians are determining the nature of nurses' experiences in caring for their patients. Clearly, the nurses' ability to effectively advocate for their patients is impaired when they feel blocked by the authority of the physician. Nora articulated the impact of this power imbalance on the nurse and the patient:

> you know you want to act. . .you can say what you want to say, but it's like you don't get heard despite saying what you say. . .it's like you know what you want to do, but you don't act upon it because there's not going to be a result of that. And so it's like an apathy or an ambivalence, or the advocacy that you ought to have to empower your patients, to be supportive, is not there as it should be. And that's scary that you don't follow it through, when you know that an injustice is being done.

Feeling undermined and belittled

In addition to not feeling heard by physicians, many nurses feel their decisions and input are sometimes undermined and belittled. Even when policies are in place, a number of nurses expressed distrust that physicians will adhere to them. One nurse explained, "you

know running a ward like this, we set up procedure manuals so that there is some consistency in following a plan. And what I find really undermining is that we (nurses) do follow it, and yet a doctor will come in and say well I'm going to bypass that." Another participant expressed her frustration at physicians' inconsistency in following an agreed upon plan: "I find that really, really hard because you're supposed to be part of a team, you're supposed to be working with the patient, for the good of the patient, with the physician and the rest of the planning team, and then they (doctors) change the rules, and I get really frustrated." So, even when units have overt standards and policies, there seems to be a double standard in terms of adhering to them because some physicians feel their authority can override policies. This creates a sense of helplessness in the nurses, as their approach to care, even if it is following an established protocol, may be subverted at any time. As well, some participants suggested that nursing sometimes has to deal with any problems resulting from the physician's decision. One participant referred to this as "secondary wounding," in which the nurse is blamed for poor patient outcomes that result from medical supersession of protocols or nursing decisions. Nurses are asked questions like "well what did you do to set that off?...Or why didn't you medicate him, or why didn't you prevent it?" Participants expressed frustration at the expanding and contracting roles they are expected to fulfill when it suits the physician or the system. In some circumstances, they are not considered capable of certain decisions and responsibilities; however, when things are not going well, nurses are often considered responsible for the problems.

Some participants feel that doctors minimize what nursing work entails. One nurse recalled talking to a physician about being assaulted, and his reply was "well, you went into nursing" as though getting hit is an expected part of the job. Another participant described a situation in which she felt invalidated by a physician. She was assaulted by a patient, and the psychiatrist involved minimized the impact the assault had on her, and he did not support her in challenging the patient about his abusive behaviour. She recalled, "I asked him (the psychiatrist) if there would be consequences, he walked away from me, and I walked down

the hall after him and he just sort of waved me off. . .So then the patient went outside and bragged about what he did. So, it was demoralizing." She described a process of "invalidating" and "shaming" that she has experienced as a result of trying to communicate observations or patient assessments to certain doctors. She viewed this as a tact by physicians to keep nurses in a subordinate position: "let's embarrass you so you won't challenge me again". She stated "your tendency is not to speak up if you're going to be belittled or shut down." Helen recalled a situation in which she mentioned her concerns to a physician regarding a potentially violent patient, and his response to her was, "you're being histrionic, you just exaggerate." When the patient did act violently, the same physician said to the nurse "I thought this would give you some satisfaction (to be right)". Helen bemoaned, he was treating it "like I've got some personal investment in it rather than the care of the patient, when consideration of patient care is the most on our minds. It becomes like a power struggle, that's what it does." Participants agreed that too much energy is spent on this power struggle, which detracts from patient care.

Feeling forced to participate in care

Another way in which medicine's assertion of power manifests is in pressure on nurses to participate in treatment they may not agree with. Georgia described an experience in which she refused to participate in a certain procedure, and the physician used his authority to pressure her:

> About a year ago, one of the doctors, one of the psychiatrists called late in the evening and asked if I'd do a phone consent for a patient to have (a certain treatment). . .The patient was quite elderly and I didn't know if she had. . .cardiac problems or respiratory. . .and I refused. I just felt that she that she was too frail to have (this treatment) in the morning, basically because she hadn't had a physical work up. And so, needless to say, putting it mildly the doctor wasn't very pleased and I called my supervisor and she agreed with me. But the doctor called the supervisor and the director of nursing and several other people related to nursing, to complain

> that I had refused. And it was a very traumatic experience. On the other hand I felt that I did the right thing because I didn't feel the patient was well enough to have this. And since then, now we have a protocol where our patients have physical work ups, which is great. But on the other hand, I certainly felt disempowered to say the least . . .and it was a very negative experience for me.

As Georgia told this story, it was clear that this was very upsetting for her. Her voice quavered and she looked anxious. Some of her nursing colleagues who were familiar with the example, validated how difficult this situation had been. She described the experience as "demoralizing" and "demeaning", stating "I wouldn't wish it on any of my colleagues." Though Georgia held her ground in spite of the pressure, numerous examples suggest that nurses more often succumb to the pressure than resist it.

Feeling inhibited from providing the best care

In addition to feeling pressured to participate in care they do not agree with, many participants stated that they often feel inhibited from providing the kind of care they believe would be most helpful, due to their lack of authority and decision-making power. One participant gave an example in which a patient was inappropriately admitted to her unit, and she felt the patient was not receiving adequate care. However, she felt her hands were tied, as she did not have the authority to transfer or discharge the patient. She expressed anger at having to put in a lot of work into admitting the patient, caring for her, and planning her discharge, when she felt it was inappropriate: "It is frustrating because I don't have the power to admit and I don't have the power to discharge. None of that is mine, but somehow it's become my responsibility to see that both of those things get done."

A sense of defeat about their lack of authority was present in a number of the nurses' stories. One participant stated,

> Well, ultimately the doctor has the power and control. So you'll just get your hands rapped or whatever (for making autonomous decisions); the more you do the more negatives you get. It's sort of a reversal as to how you get brownie points here. You

> get a lot less hassle for custodial care than you do for voicing your opinion and doing what you think is right.

Another nurse expressed the view that it is often not even worth trying to assert one's opinion because "in the final analysis on this ward, it is the doctors who make the final decision and they resent any challenge to their power." This sense of defeat reflects a belief that it is easier to maintain the status quo than to assert what one believes is right. In spite of injustices in patient care, nurses will still, at times, opt to be more passive than active in advocating for patients. A sense of impotence and hopelessness around change cut across all the powerless situations, but it is particularly prevalent in situations characterized by medicine's control and dominance.

When asked what would need to be different for you to feel more able to act in the best way for the patient, a number of participants suggested changes in the physicians' behaviours. For example, one nurse stated "I think for the doctor to respect nursing opinion or to listen, and not to feel like they have sole responsibility over the decision-making process."

No-win position

For participants, being in a no-win position entails feeling caught between competing demands. Often, succumbing to the demands of one person or group means neglecting the needs of another. These situations fall into two categories: (a) Feeling caught between patients' needs and the demands of the healthcare and administrative systems in which nurses work, and (b) feeling caught between meeting the needs of the patient versus meeting the needs of the physician. It is important to note that when participants talked about physicians' decisions, they often referred to them as though they were one and the same as those of the institution or the larger healthcare system. Thus, the separation between medical dictates and systemic or institutional does not always appear to be clear to nurses. What is clear to them is that they are experiencing a conflict with a more powerful group. This creates a tremendous amount of stress for nurses. In no-win situations, nurses most often describe

feeling out of control, uncomfortable, and morally conflicted. A great deal of their stress stems from trying to balance the need to maintain collegial relationships while advocating for patients' perceived and/or expressed needs. In all no-win situations, concern for the patients' needs was paramount in the participants' experience.

Patient needs vs. physician needs

Intertwined with the issue of medical dominance and control is the nurses' experience of feeling caught in a no-win position. Nurses describe feeling torn between providing the best possible care to the patient, while avoiding excessive conflict and maintaining collegial relationships. In situations in which medical demands conflicted with patient demands, participants often felt helpless and hopeless. They described feeling in a position of 'damned if you do; damned if you don't.' Participants tend to believe they do not have a choice in whether they participate in care decided upon by the physician. They feel they can offer their opinion; beyond this however, they feel they must carry out the physician's plan even if it might not seem in the best interest of the patient. For many, the perceived costs of challenging a physician outweigh the benefits of adhering to one's own principles. Participants recognized that a lot of the conflict regarding patient care decisions stems from the indefinable nature of mental illness and wellness. "I think there's a lot of people coming from a lot of different places about what makes people healthy." What frustrated participants about this, is the fact that the physician's ideas about treatment always supersede the nurses ideas. This created a sense of hopelessness in participants; comments like "why bother" and "what's the point" permeate their stories of no-win situations.

As a result of this hopelessness and helplessness, many participants have found themselves participating in care that they do not believe is in the best interest of the patient. Consequently, some nurses have experienced a great deal of guilt for contributing to the potential harm of a patient. In one example, a nurse described:

> I see this patient's physical and mental condition just deteriorating and I think that it's a bit because of the amount of damage that we've done giving these pills over the

> years. . .I've a very upset conscience that I'm contributing to this, that I'm being forced to contribute towards this.

Clearly, this participant felt she lacked power in this situation, as evidenced by her statement "I'm being forced". Many participants shared this feeling of being forced to act in a way that conflicted with what they felt was best. However, legally and ethically, nurses are *not* required to carry out physicians' orders they disagree with (RNABC, 1992)

One area in which participants frequently expressed conflicted feelings and a sense of powerlessness was in the care of patients with DSM IV axis-II diagnoses, particularly those with borderline personality disorder. This seems to be an area in which there is a great deal of room for divergent ideas in terms of approaches to treatment. Edith expressed her perspective:

> We all know that the best way to treat these patients is crisis intervention. . .It has been proven over time that it is far more therapeutic than enabling them and keeping them here until they decompensate and actually do get to the point that they're so ill that they do need to be hospitalized. And I find that the doctors do not respond to this because they put, in my opinion, put their own needs first. It is much easier to treat an axis-II in hospital than being at home. . .And I can't help but think probably there's a financial aspect to why they do it. Certainly it's much easier - they're very difficult patients - but also financially they're probably in a better position, for the time expended to have them in hospital than out. And I find this very frustrating, because I'm here for the patient. I have taken many courses throughout my career in psychiatry and. . .I have done a lot of work with it. And yet it's frustrating, because you learn it. . .and yet you can't apply it.

In this statement, a great deal of frustration is expressed in relation to feeling inhibited from acting in the best way for the patient. As well, a distrust in physicians' motives regarding treatment decisions is evident. Edith identified the patient as her priority, and she indicates skepticism about the priorities of physicians.

In spite of considering the patients' needs a priority, however, many nurses find themselves acting in such a way that the physician's perspective and decisions actually take priority. This is exemplified by the multiple situations the participants recounted in which they administered medications against their better judgment. Liz shared, "we know there are psychiatrists who have not kept track of their medications, don't know how to medicate, and we're forced to give out medications that we know better." Another participant's example reflects her distress in feeling she has to subvert her nursing practice decisions to those of a physician:

> We had a situation not too long ago where we had a patient who came down off of a medical ward on a large amount of medication; it had been increased on a daily basis, and the orders that came down with the patient were for me to give this large amount of med every four hours, and it was not a situation where I felt particularly in control because it was outside the normal range for the medication in the CPS manual, and it was not something we would normally do. And I felt that not only giving them that much but also the fact that the plan was to keep increasing it, was going to detract from the focus on the unit which would be to develop coping skills, therapeutic alliance. . .I thought they were stoned on the medication and they were getting more stoned on an hourly basis. And there was a whole bunch of orders from a whole bunch of different people and I felt really uncomfortable about that. So I called the specific doctor, who is responsible for the unit, and I clarified 'was this exactly what you meant to do?' and he said 'yes'. . .I said I didn't feel very comfortable with it and he said 'well, it's a safe range.' But I didn't feel we had a proper discussion about what was the care plan for the patient, and then so I had to give the meds even though I thought it was detracting from doing any kind of therapeutic work.

This participant expressed how difficult it was for her to administer the medication against her best judgment:

> It felt completely wrong. I felt I was being manipulated by the patient . . . they kept saying 'well the doctor said this was OK, and this is what I want. No, I don't want to talk, and I don't want to work on any of these issues. I just want medication.' I felt quite angry at the doctor but not able to . . . I was trying to keep that from interfering with my relationship with the patient. At the same time, I felt like I'm not helping this patient to work on anything, just letting them be completely sedated for the whole weekend . . . It was very frustrating.

Because psychiatry is less precise and formulaic than other areas of medicine, there is a great deal more room for subjectivity in treatment decisions. The above example illustrates this, with nursing and medicine disagreeing about the goals of treatment. Rather than functioning in a complementary way, physicians and nurses often spend a fair amount of energy in power struggles, both claiming righteousness. One participant talked about the impact of this power struggle:

> It hits the patients. That's where it's always going to be played out because if you're angry at a physician, a physician is angry at you, you guys are not communicating. So vital information about that patient and what that patient needs is not being communicated.

Some participants described feeling trapped by the power of physicians, wherein they feel they not only have to participate in care they disagree with, but they may also have to take responsibility for it. Liz offered:

> We're being held hostage because some psychiatrists are afraid of the para-suicidal patients who say, 'hey, we might kill ourselves.' And so, we keep them. And they know that, and it feeds into their dependency and we watch them regress and get worse and worse the longer they stay here. So, by the time we discharge them they're twenty times sicker than they were when they first came in the door . . . and the nurses get blamed for it.

Anna expressed her frustration in having to defend treatment approaches that she may not even feel are justified. She gave an example in which patients are questionably committed under the Mental Health Act: "Often patients will wake up in a seclusion room and say 'why am I here. . .because the doctor didn't say I was going to be'. . . You know, they (doctors) basically commit them to get them admitted which is very unfair, if they're not committable." As a member of the professional team, she feels she needs to present a cohesive front to the patient, but she is uncomfortable and angry with having to justify certain doctors' decisions to the patient.

In some situations where participants were not required to be actively involved in treatments they disagreed with, they still experienced guilt around their passivity in advocating for patients.

> I didn't think the approach was right for this particular patient. She had been certified and de-certified and certified and de-certified over and over, and it seemed more like a power play between the doctor and the patient, rather than what was really addressing the patient's needs. And I guess I just felt really uncomfortable with the whole situation . . . I felt really uncomfortable witnessing this and because I saw her come in and out, she was here for a long period of time, I thought this woman's deteriorating, and it was hard to watch.

When asked if she took any action on the patient's behalf, she stated that she did not because she found the doctor intimidating and because she only works occasionally, she did not feel comfortable asserting herself.

Patient needs vs. system needs

The nurses described feeling caught in a no-win position between meeting their patients' needs versus satisfying the demands of the healthcare and institutional systems in which they work. A number of participants made reference to a "cover your ass" mentality which is eroding patient care. They felt that this drives a lot of medical decisions in psychiatry, and that this really is a broad system problem. Jane explained:

> I was working with someone who was talking about giving up of control and I was trying to work with him on that, and put the responsibility on him to let me know what was going on with him . . . I was trying to put the responsibility on the patient rather than just keep neigling and protecting him . . . and I would work with him on signing a sheet on his expectations, this was what he was committed to do, with his family there. So about an hour later I got a phone call from the director questioning what happened because his family had reported me, that I was not taking control of this patient . . . and that I'd made them sign something . . . So the story got totally turned around. So I just thought what's the point here, because I end up getting in trouble . . . Now this patient's been on constant medications since because if there's any kind of hassle from the family or whatever- they don't want to take responsibility- then the doctor gets hear of it . . . and he'll always do what's safe, or what covers his ass, politically. So you get caught in the middle of it and unsupported.

Jane's distress here is related to the unwillingness of the patient and his family to take more responsibility for his health care. What seems to be most frustrating for her, however, is the lack of support she received from medicine when trying to empower this patient. Many participants claimed to be motivated by an intent to empower rather than disempower patients and they often view physicians as operating oppositely.

Jane's efforts to empower her patient backfired because she was unsupported by the physician. She felt caught in the middle, trying to provide what she believed to be the best possible care for the patient while the physician seemed to be taking a "cover your ass" approach, regardless of whether it was helpful for the patient. She described the personal impact of this kind of situation: "I feel like I'm giving myself up all the time...as to who I am and what I believe." She also indicated an impact on her professionally, when she expressed her hopelessness - "why bother" - about practicing autonomously. Clearly, this impact on her nursing practice has significant repercussions for the patient. She suggested that it seems easier to give up trying to make any autonomous practice decisions and go along with the

dominant mentality - "just cover your ass." Without an advocate for their concerns, patients are in a very vulnerable position.

Nurses often experience conflicts between what they wish to do for the patient and what the system demands of them. Influenced by a litigious mentality, along with shrinking resources, the system is moving in the direction of validating only tangible, measurable actions. This is quite incompatible with the intangible nature of psychiatric nursing, and it is pressuring nurses to be more task oriented, and to spend an increasing amount of time away from direct patient care. One participant stated, "we're so busy worrying about the politics and the paperwork and getting things, arranging, changing, getting beds y'know, you forget that there's a patient involved." Another participant gave an example of how the changing emphasis creates pressure to take action regardless of whether this is what is most appropriate:

> I feel like (giving lots of medications) is part of the way our system operates and so as part of the system, I enable it and keep that happening . . . I have to justify why I didn't give a medication as opposed to why I did, so for me it's ass backwards in what I'm doing here and this is where it goes against . . . who I am and what I believe.

Liz characterized the system as having "a lack of caring." Jane suggested that this has a preservative function for healthcare professionals: "Ultimately the system works because it provides us with our income of patients. I mean what would happen if they all got well? The system works."

System issues

In many of the described situations, participants attributed their sense of powerlessness to problems with the health care system, and with the institutional systems in which they work. The term, system, was used to include organizational structure, at both the ideological and practical levels. With the recent massive changes in the healthcare system, participants' sense of powerlessness has been heightened. Particular emphasis was placed on resource availability and allocation within the system, and the impact of this on psychiatric

nursing. Many of their descriptions of powerlessness relate closely to (a) inadequate resources, and (b) the driving values underlying current health care delivery, which many participants consider incompatible with good patient care. Participants acknowledge long-standing system problems, but emphasize that recent healthcare cuts and organizational changes have exacerbated these problems. Liz explained:

> I think the key is system, and what's driving the system right now. A lot of what we talked about here was what we used to have - used to, used to, used to. And that's system driven because the system is underfunded as far as I'm concerned . . . It's health care money, it's do more with less . . . We're doing a lot less . . . So when you talk about system it's not just--the system has been a problem since the system became a system, and communication has been a problem since there has been the need to communicate . . . This has made all those issues so much more difficult to deal with because you don't have the energy. You're fatigued, you're tired, you're burnt out. And if you don't have an optimum sort of workplace...when you have a system that's putting this much pressure on you, you aren't going to have healthy employees and you aren't going to have healthy patients, and you aren't going to have healthy psychiatrists. Nobody's ahead of the game.

Inadequate resources

The emphasis in many participant comments on system problems focused on diminishing resources and the resultant pressures of working within such a strained environment. Participants typically described high levels of stress, burn-out, and depression in relation to system issues. As well, there was a perceived decrease in the standard of care that is now possible, and an accompanying decrease in nursing job satisfaction. One participant described this:

> I've been really frustrated by the downsizing of healthcare and the fact that we can't provide the kind of care we should be providing because the dollars aren't there. We've been forced to move to heavier workloads, more unsafe work

> situations and less time for patients. Our level of care has changed, we're putting out fires. We aren't counselling people anymore, we're trying to stop them from exploding, that's it. We're fireworkers . . . So your quality of work has gone down, your workload has gone up, and the safety of where you work has been compromised a great deal. So you add those things together and you know it's all because the money isn't coming into healthcare. So from that point of view that's where I get the most frustration. Because I can see the evolution and we're just going down. It's kind of like going down the sink, you know. Like where's it going?

This sense of doom was very common in the nurses' accounts, regarding both the direction of the health care system and the potential for positive change. Liz referred to the speed of changes which have made adjustment very difficult, and she articulated what a decreased standard of care means for her in terms of altered expectations. Referring to recent changes on her unit, she stated

> there was no time for adjustment, it was just frantic, a whole change and your expectations . . . it takes a long time before you can go 'okay, I'm going to work today, and if I know my patients' names and where they are by the end of the shift and they haven't run away, that's my standard of care'...That really is sometimes all you can get out of the day . . . I've not just lowered my expectations of what I'm going to do on the ward, but also lowered my expectations of how much of my needs my job meets. So I look for my needs to get met outside of work. And basically I'm probably a lot more distant with people, my colleagues; I tend to sort of do my thing and get out of here. I find it much more harder to get connected with my colleagues anyways because of the size of the ward we so seldom have any chance to work with anybody.

Participants talked about the impact on them of the increasing barriers to good patient care: "It can keep you feeling down quite a lot;" "it's quite depressing...you feel helpless, you feel hopeless. . .Like why bother or why try."

Along with heavier workloads and increasing pressures, participants have experienced decreasing support at all levels of healthcare. Some participants talked about having to take on more responsibility in terms of patient care and administrative decisions; however, they continue to lack the official authority for such decisions. This puts nurses in a very difficult position, as they feel forced to make decisions when those with higher authority are unavailable, but they do not trust that they will be supported in their decisions. One participant described this:

> We've had to take a lot of responsibility or the appearance of having to, like in the last what, two years we've lost our head nurses, our supervisors. I can remember the first time I worked nights after that. There's nobody to phone, there's nobody, I'm it you know. There's no supervisors, there's no head nurse. . .Oh my gosh, you know you have this awful feeling what if something dreadful happens tonight like there's nobody. . .And it was just like. . .sink or swim. So you had to kind of look at your knowledge, like you had to take more responsibility for what you were doing. It's quite a scary feeling after you've had years of. . .'Oh I'll phone the supervisor and ask her what we should do here'. You know, you can't do that now. She ain't there.

She went on to talk about how nurses have been dumped with responsibility as it suits the system, but they have not been truly empowered and endowed with greater authority. She laughingly recounted how management tried to convince them they were empowered.

> I don't know if you remember when we lost the head nurses and the supervisors. Remember, they were coming around speaking to us about empowerment, we were all going to be empowered?. . .The catchword, the empowerment, to make our own decisions and. . .basically I think what frustrated most people was you weren't empowered. You had to make lots more decisions but you didn't really have the power to. Like, you had a lot more responsibility because there's nobody to ask

> But you didn't have the power to make the decisions. . .so that was a very, very frustrating time.

Another nurse added:

> And what kind of back-up would you get if something did happen and you were forced to make a decision then and you'd just have to make a decision, there's no supervisor, there's no head nurse, there's nobody, so then if you made the wrong decision well then what. You know, is the hospital going to back you up, is administration? I don't know. And you know that's kind of scary, because if you make a mistake . . .

Concerns were also expressed regarding the societal value placed on psychiatric care and the impact of this on the competition for healthcare resources. Betty stated:

> I don't think there's enough money spent on the over all health budget, but I think that our patients are pretty low priority. Psychiatric patients are nobody's favourites in the system. In fact, they just wish they'd go away . . . (they are) marginalized. None of them are very wealthy. That's what I think anyway.

For most participants, when they talked about the need for increased funding, concern for the availability of patient resources was paramount. Dorothy offered a typical comment:

> There isn't enough here for any of our patients; there's not enough halfway houses, there's not enough places to discharge them to, there's not enough mental health workers, there's not enough psych outpatients workers, there's no day hospital here, there's none of those programs.

<u>Values driving healthcare</u>

A number of participants expressed concern that some changes in the healthcare system are affecting psychiatry more negatively than other fields. As described earlier, there is a growing emphasis on creating hard evidence to validate one's productivity in the workplace. One participant used the label "outcome measurement" to describe the approach being used in her workplace to measure work efficiency. She argued that because mental

health care requires a more subjective approach involving less tangible interventions than other areas of health care, psychiatric nursing work is often difficult to measure. She articulated the problem:

> You've this program thing (outcome measurement) that sounds really good. And the idea was really good, but all it's done is, it's cost driven. It's totally cost driven and time utilization, and if you look at health care workers, and you say okay so much of our time is spent . . . You can't measure what we're doing because it might be . . . you're talking to somebody, a family member on the phone for 45 minutes because their kid that they've raised that they thought was fine, has his first psychotic break. And you're busy, there's things we can't measure, so we look really unproductive statistically.

Other participants agree that nursing, especially the field of psychiatric nursing, is really unpredictable, and the emphasis on tangible, objective measures of productivity is invalidating nursing work. Liz asserted, "we don't know what's going to happen, 'cause we're dealing with people, not things. We're not building cars; we're dealing with people. And with people, you never know." Nurses feel like they are running around, with barely time to think, yet statistics would suggest that psychiatric nurses are not doing enough. One nurse described the impact on her: "that is really disheartening. . .You aren't making any more money, you're working harder and you're achieving less. And it's exceedingly frustrating, and you're going home exceedingly tired, exhausted. Like the burnout is happening a lot faster."

Participants suggested the need for greater flexibility in the system, and expressed concern about the growing rigidity that is occurring with the tightening of budgets and the emphasis on outcome measurement. With shrinking resources, comes increasing competition for territory, and increasing pressure to justify the validity of one's work. Betty expressed her frustration at the multi-level bureaucracy that impacts nursing work:

> . . .there's an inflexibility about the bureaucracy. . .that's particularly annoying. . . because it's like a maze of trying to get to the appropriate place you want to be, when different powers and people have different territories and you can't just say this patient needs to go there.

A number of participants talked about the political dance they feel they must participate in in order to provide the best possible patient care. Many talked about the inefficiency of the current multi-level hierarchy. Here's one conversation between Anna and Dorothy, as they reflect on the time spent by those in power:

> A - Those meetings in that little room. There's a big frustration. What are they all about? I'm looking in this window and I figure that they're sitting in there planning discharges for what, two hours? And I'm looking at all the people - five psychiatrists, so many psychologists, and I think that is a $5000 meeting and when they walk out of that door, who is discharged? Nothing has happened!
>
> D - Well they have a $5000 meeting and whose shoulders does it fall back onto but the charge nurse? Then the lowest paid person in the room. . .who has the least amount of power. . .is set to do the most amount of work!

Anna talks about the incompatibility of some of the restructuring decisions with patient care. She states, ". . .one night I had a crisis, and who did I have to call? The accountant, because she was the administrator on-call. She was in charge that night. That was frustrating, let me tell you." Dorothy inserts ". . .and you call the accountant and her comment is 'so what do you think I can do about it?'" Because of the lack of administrative support, nurses are forced to make decisions outside of their authority, and they are often then challenged on their decisions. Dorothy stated:

> . . .so then you sit and you write all this stuff out at the end of a 12 hour shift so that the administrator who's coming on can know all the decisions that you've made. . through the night and some of them, they call you in the middle of your sleep and say

'what do ya mean you did this?' 'Well I'm sorry but it's all I had to go with at the time.'

Many nurses expressed frustration at the inconsistencies in patient care related to an inefficient system. Roberta described a situation in which she felt a patient's care was "chaotic and out of control." She recognized that a contributing factor was the acuity of the patient's illness, but she believed that the main problem was "too many people were involved but not managing the care, and there wasn't sort of a designated team." She stated "I felt very powerless, first against the severity of her illness, but also I think, as my role as a nurse and trying to interact with a team of physicians and a whole bunch of other teams, and it was like so many people were involved and so many people were doing other things." She stated it was not clear who ultimately had responsibility for this patient's care and she felt she lacked the professional power to take control. She stated "I felt a certain responsibility, but if you looked in the chart and who was charting and who was writing orders and who was making decisions, my name was rarely there (laughing)." When asked what kept her from trying to advocate for the patient more strongly, she responded "well, if I had been less burned out, if I had been less tired..." Other participants agreed that they are just so stressed at work that they often lack the energy required to really make a difference for patients. Feeling so pressured and spread so thin at work, has contributed to feelings of powerlessness for the nurses. Francine explained:

> We're more stressed than we used to be. . .I find that when I'm stressed I forget, you know, I had an issue over here but now I'm preoccupied with something here and over there, also something there. And I'm forgetting, I forget. . .And I don't follow up on it. . .You know, so it hangs on whatever doctor is involved.

Another source of frustration was the ideological changes that the decrease in resources is driving. For example, Jane talked about how nursing has changed over the past 15 years, and how her job satisfaction has deteriorated: "I think if I keep comparing what I do now to what I did when I first started in nursing, I'd be very angry. I'm angry now but I'd

be enraged." She described the primary difference being a sense of connectedness and cohesion with other nursing and medical staff, as well as a different philosophy of health care that seemed to value the person more.

> I find the focus has changed. The human factor used to be a real big deal, the heart factor used to be a real big deal. . .where now I find it very clinical, stats . . .document your process or whatever that you've done, so that you show that you've covered otherwise you're going to get sued, or reprimanded for something or other. . .We're always on the paperwork.

Numerous participants gave examples of the erosion and fragmentation of collegial relationships that is happening as a result of increasing workloads and decreasing time. Jane talked about cost-saving restructuring changes that have occurred in her workplace recently: "we have seen what doesn't work. And we have seen how impersonal it is and how that's lost us connection." Karen concurred, "we're all spread too thin that of course your relationship isn't so intimate when you're. . .you know, quick, write that or do that. There's no time for the niceties." Liz added,

> you know when we talk about these things like how things used to be different, it almost sounds like there were different psychiatrists at that point. There weren't. Not for the most part. . .The difference was they had more time, less patients. That was the biggest difference. We worked with these same people who had these same inconsistencies and idiosyncrasies, and all the things that we've identified.

Francine attributed some of the inconsistencies in care to the structure nursing has developed for itself, which in conjunction with the frenzied pace of hospitals today, is perpetuating nursing powerlessness. She stated, "everybody has more patients. . .everybody seems to be more busy. So it's difficult to get involved in the work. You're on a stretch of days and then there are nights and we are totally away from what happens everyday." With

the increased stress on the system, nurses are feeling spread so thin, that they do not have the energy to challenge problems. In addition, Francine's comment touched on the impact of shift work on nursing disempowerment. Of course, shift work is an inevitable part of hospital nursing; however, nursing schedules often contribute to this disempowerment. With twelve hour shifts, nurses are often at work only two days in a week. It is very difficult to provide consistent care and have significant input to treatment when one is away more often than one is present. Petra described how her work schedule impacts the degree to which she gets involved in patient care decisions: "I tend not to be as assertive as I might if I were here all the time."

Nora suggested that having a more flexible work rotation that allowed greater access to education would improve nurses' sense of power and autonomy. "It would be better if we had more freedom in our rotation because I think it would be better if we could job share to allow nurses to pursue education better. I mean more flexibility in our rotation would be more autonomy and more able to get the education you want to get." A number of nurses referred to education as a significant component contributing to feelings of power. Most nurses agreed that having more information and knowledge makes a significant difference in how much power they feel they have in terms of patient care input. Dorothy asserted "the more education there is, the better the system works."

Lack of communication and support

As mentioned in previous sections, problems regarding communication and support are closely linked to system issues and to the subordination of nursing to medicine. In situations in which participants felt powerless due to a lack of communication and support, a sense of isolation and disconnection from colleagues occurred. A lack of trust and respect amongst colleagues characterized this disconnection, and the nurses described an absence of genuine collaboration and teamwork. Again, the patient suffers in these kinds of situations, as inconsistent care is provided. Participants described feeling manipulated, fragmented, and

unhappy at work. Edith captured the importance of communication to quality patient care; "the success or lack of (patient care) is based on communication, effective communication. . . We can give all the reasons, too many doctors, big area, shifts, whatever, it's still a breakdown of honest, clear, direct communication."

Trust and respect

Participants suggested that greater communication, trust, and respect between medicine and nursing would be necessary, in order for them to feel more empowered. Nora explained what she means by trust; ". . .trust that what I said was appreciated and validated, and that it made sense and that it would influence the situation, and that it would benefit the patient. . .It's just communication and having someone respecting what you say, your suggestions." She asserted that the issue is not who is right or wrong; it is about feeling heard and having her input considered valid. She stated "we may agree to disagree, but then we can understand where we are coming from."

Many participants related blocks in communication to issues of medical dominance. The nurses identified situations of powerlessness in which they felt unheard, unappreciated and disrespected by their medical colleagues. One participant explained the problem:

> Sometimes there's a blockage, like you know, you deal effectively with a patient to listen to them, to hear their needs, and then when the major link is coming to speak to the doctor to keep the flow going, but then when you can't get across that bridge to that next person who is so vital in the communication process and decision-making process, it just cuts you off in half. And it's like you run back to the patient in a way, but you're going around in circles between you and the patient, but nothing is changing there. Because the person that you need to talk to is not there to hear you. I don't know, it's like going around in circles. You just don't get anywhere.

This description reflects a perception that nurses fulfill a liaison role between patients and doctors, and emphasizes the importance of communication between all three. For this participant, a feeling of powerless results when she feels unheard by physicians. Another

participant described how she feels when she is blocked by medicine, from providing the best care to patients:

> It kind of makes being a nurse a drag, y'know. It's one of the worst things about being a nurse, is that feeling...impotence, powerlessness, inability to act; I think that role of advocacy, not being able to speak up for what you see as potentially being the best thing for your patient.

Nora discussed the importance of trust between the disciplines, in terms of providing safe and effective patient care:

> It's like the trust that they put in you, the doctors, it's like we have the intimacy of 24 hour care with patients, so we have such insight and levels of maybe depth of their personality or what's important to that person, that we are the key, we are the key to what, how a treatment plan could go. Because it's the way we communicate and how we observe the patient to the doctor, that builds that trust in our ability to assess. So the doctors have to rely on our abilities to assess, so we can keep the treatment process going in a safe manner to get the person eventually discharged.

Although many participants maintained that medicine simply needs to trust nursing more, some recognized that the issue of trust is reciprocal. A mutual distrust exists between medicine and nursing. Roberta spoke about the importance of trusting the competency of all professionals:

> If you have a team member of any discipline who is incompetent or not performing to their professional standards and all of that, that causes difficulties. . .That can make it really difficult, and stuff that you try and advocate for, then can get sort of- - obstacles are thrown in the way or whatever

She felt it is equally disruptive to the team to have a nurse practicing incompetently, as it is to have a physician practicing incompetently. She acknowledged that the two professions have distinct roles, so the specific effects of their incompetence may be different; however, any weak link in the health care team is problematic. Most participants agreed that in order to

function effectively as a team, all disciplines must communicate and have faith in the ability of others on the team.

Teamwork and consistency of care

The structure of acute healthcare requires an interdisciplinary team approach. Teamwork concerns were littered throughout the participants' comments about communication issues. Primarily, the concerns were around inconsistencies in care that result from a lack of cohesion in the team. Many expressed that there is inadequate time and energy spent on team building. Olive commented on the impact that a lack of cohesion in the care team can have :

> If you have that discrepancy in the whole team where you feel like half of the team is doing one thing for a certain. . .and you're doing something else, and it's not quite together, it makes me just want to cut everything short and go back to doing what you have to do, and it makes you not want to come in the next day and go through it all again

She stated it makes her just want to provide minimal care; "get it done but no extras, and not put any special little touches." Petra added, "you have to change the tone quite a bit, to OK this is just a job, let's get through the shift, I'll do what I have to do and I'm going home."

When team members don't communicate effectively, there is more room for misinterpretation of treatment plans, leading to inconsistencies in care. Participants described feeling frustrated and undermined when this happens, and some felt this puts them in a position to be manipulated by patients. Anna expressed her frustration when she sets limits with patients, adhering to the care plan, and another team member decides to expand the limits. She gave an example:

> I'll say (to a patient) 'no you can't have a smoke because there's no smoking here and you're not allowed out right now,' but some other nurse will come along, like on the next shift and take them out for a smoke and they'll say 'well, she did, why can't you?' You know, we get that. . .Well it kind of blows your credibility and it's

> frustrating. . .I feel like a big tit if I don't (take them out for a smoke) sort of thing, but it's. . .it's hard especially when it's something you don't believe in, like smoking or something.

Anna stated she feels really unsupported when her approach to care is undermined by other team members in this way, and she asserts, it "is definitely not good for patients!".

Most participants agreed that their experience at work is strongly influenced by the quality of their professional relationships, particularly with physicians. Jane suggested that the rift between medicine and nursing is self-perpetuating, and that a commitment to relating to one another as individual people rather than groups of professionals is important:

> I just see so many doctors and nurses bumping heads with each other all the time. . . I think sometimes that's what happens is there's a split going on and we're so angry that we vent on them and they get so pissed off with us being angry with them all the time that they just avoid us, and, 'we'll get you back'. So nobody connects. And I think when you get the human factor, and people start respecting each other, and you have a personal contact, and you actually talk to each other more then you can sort of break through that. It's like, you know, you can't really go and kill somebody in a war if you know them, if you can put a face on them. So if you make it personal, somehow that helps break down a lot of barriers.

The importance of developing and maintaining interdisciplinary communication was acknowledged by most participants, and a number of people identified that the system lacks structures to support team-building. When asked what would need to be different in order for you to feel empowered, Nora responded:

> We need to have more forums for nurse/physician dialogue, and maybe more team building. For this ward, I think it's gone down over the years, deteriorated, and team building isn't there lately. So I think nurses need to strengthen their power amongst themselves somehow again. . .as a group.

Petra added:

> I think the onus, or not the onus but the trust for (nurse-physician dialogue). . .has to come from nurses because a lot of it seems contingent on which particular doctor is interacting with the nurse, and that really is giving away the power to the doctor involved. as opposed to, y'know if I want to be an advocate or autonomous or competent. it has to be regardless of my feelings. and that's part of being assertive. I'm not saying you don't monitor your approach depending on who you're with, but if that's the kind of nursing care that we want to give. we need to develop a forum to facilitate that.

Isolation

The changes occurring in the health care system seem to be exacerbating communication problems. Many participants commented on how shrinking resources and the increasing pace of acute psychiatric care, has led to the elimination of any team-building activities. within nursing and between disciplines. There was a general feeling that working on collegial relationships is considered a luxury that the system no longer supports. The result of this is has been a sense of isolation for participants. Nora explained this:

> It's a sense of isolation because if you don't talk to your peers. . .then you don't know if they're feeling the same way. Then if you do, that really makes a big difference...it validates your experiences. You need to talk to your peers; otherwise you do get isolated. I mean the nurses are the main support for myself here.

Most of the nurses described feeling very supported by other nursing staff, which they considered critical to their continuing function at work. It was interesting that each group of nurses considered themselves unusual in the degree of support they share. The following is a typical comment; "we're a unique group of nurses and we really, not everybody but the majority of us can really talk and share and be honest...we're very supportive."

A number of participants felt that along with supportive colleagues, it is really important to have a supportive leader. Olive talked about her experience of this:

> It's true that having a powerful peer network and a powerful charge nurse, maybe power is the wrong word, uh confident. . .assertive, non-judgmental charge nurse behind you. . .certainly makes me feel more empowered to have someone I can bounce ideas off and who supports you. . .I have a strong voice, but part of the reason I think my voice is so strong is because I can grab a couple people and say 'these are my ideas', and you know, let's talk about the pros and cons.

Unfortunately, even this support among nurses is being eroded. Nurses are feeling so stretched and splintered as a group, that any kind of united power base they may have had is being undermined by the restructuring of health care. Participants stated they are spread so thin that they don't always have time to support one another.

Numerous participants recognized the importance of pulling together in these stressed times. Nora gave an example of something that her unit is doing that has made a difference for her:

> One thing we did do differently this week. . .all the floor nurses are going to go into. . .the doctors' rounds, not only to share information but also to support each other as nurses, because if there's an issue you want to bring up, it's better when you have your other peers there so you can bring it there, you feel very supported, they help you voice it, so we did that for the first time this week. . .Every nurse that was on that day went to this particular doctor's rounds that day, for support and to hear what was going on, so that was good. I felt good about that. . .We used to do that years ago. I don't know why we got out of the habit. I think it's really important to do that. To have that support there. . .I think it's important that everyone goes at once. All the nurses go. You're more courageous to say what you want to say. . .

A few participants identified the importance of creating situations in which collegial support can occur. Roberta emphasized the responsibility of nurses to ensure that structures are in place to ensure greater connectedness between staff.

> I think structure is really important, and forums. Like you have to kind of have those things built in. And I think that that's what I'm hearing a lot from staff, is that the forum that we used to have, which was 'rounds,' the goal of that forum has shifted to medical teaching. And that's really silenced nurses because the role of that forum is not what it used to be. And I think that's part of our responsibility is participating and making sure that those kinds of forums and places are there.

When participants were asked to describe how their group of colleagues supports individual nurses in acting more powerfully, effective communication and gestures of support were cited most frequently. Nurses feel empowered when they receive verbal and physical expressions of support from colleagues. They value forums for regular exchange of information including sharing positive and constructive feedback. Consistent communication with regard to patients was considered helpful, and participants felt empowered when their input was expected, respected, and incorporated into patient care decisions. Participants also described a sense of support when colleagues are flexible with regard to providing coverage to enable nurses to pursue educational opportunities.

When asked how their colleagues undermine their attempts to act more powerfully, again participants identified mainly communication issues. Participants felt undermined when their input was not considered or was belittled. They expressed the necessity of open, direct communication. Some described feeling undermined by their colleagues' gossiping and indirect attempts to sabotage change efforts. Feeling an integral part of an effective team contributed to the participants' feelings of power. Conversely, they described feeling disempowered when colleagues do not pull their weight or do not comply with agreed upon plans of care. The nurses stated their sense of power is jeopardized by the increased

workload and accompanying burn-out that they are experiencing, as they are simply to busy to work on collegial relationships or address emerging issues.

Summary

The circumstances in which participants typically experience the greatest powerlessness can be understood in terms of four categories of situations; (a) situations characterized by medicine's dominance and control, (b) no-win situations, (c) when there are system problems, and (d) when there is a lack of communication and support. These categories exist across all four focus groups. The differences between groups lie in the areas of emphasis. For example, in the group of participants who work in a hospital outside of the lower mainland, system and resource issues predominated in their stories of powerlessness. In the most urban hospital, issues of communication and support were of prime concern. In the other two groups, participants cited medical dominance and control as the most problematic issue underlying their feelings of powerlessness. Differences between the groups may be reflective of varied staff cultures, institutional differences, regional differences, or simply differences in the individual nurses who volunteered at each site.

Across all situations of powerlessness, a number of themes characterizing the nurses' experiences of powerlessness became evident. Frustration and anger were the most frequently expressed emotions. Behind these feelings was often a sense of feeling blocked in terms of providing effective nursing care. Participants also described feeling helpless, impotent, and out of control. They most often described these feelings in relation to medical dominance and control. A sense of impotence regarding taking alternative action was expressed. This negatively affected the nurses' ability to advocate for their patients. As well, a sense of apathy and hopelessness permeated many of the participants comments. They described feeling disheartened, with little faith in anything changing. They talked about providing minimal care to patients, as extra efforts don't make any difference anyway. Most of the nurses felt pressured and stressed. Although they experienced this in all types of powerless situations, this was most often described in relation to system problems. Nurses

described feeling on edge, scattered, burned out, tired and depressed, with a decreased sense of work satisfaction. In addition, they described having little energy left for their personal lives. In many of the situations, participants felt they were compromising their personal values. Many recounted incidents in which they participated in patient care activities that felt wrong to them. They spoke of having upset conscience, and a sense that they are giving themselves up. The personal toll of acting incongruently with one's beliefs was perceived as high; however, the toll from challenging authority was often perceived as higher.

A sense of isolation and a lack of trust was also common among participants. They described feeling disconnected from colleagues, unsupported, and somewhat wary. The distrust of colleagues included both nurses and doctors, and resulted from a lack of cohesion and respect in the health care team. Participants felt that patient care suffers when team members are isolated from one another, as there is a lack of consistency. Nurses' recognized that their stress levels increase when they feel isolated and distrustful of colleagues. Participants felt undermined, demoralized, and invalidated in some situations, particularly in relation to medical dominance. They described feeling stamped down, belittled, demeaned, minimized and shamed. A sense of vulnerability and personal defeat often characterized the theme of medical dominance. Nurses described feeling depressed, and reluctant to continue asserting their beliefs regarding patient care. Overall, participants' experiences of powerlessness centered around a concern for the patient. Rarely did participants express wanting to be more powerful for themselves; their concern about their lack of power was usually focused on the patient.

CHAPTER FIVE

Discussion

This final chapter will discuss the meaning of the results, linking this research with other literature. It will be organized in terms of the interview questions used in the focus groups (see Appendix A). The purpose of this study was to explore the circumstances and impact of powerlessness for acute care psychiatric nurses, in order to offer an understanding of the nature of psychiatric nursing powerlessness. It is my hope that the findings may facilitate increasing awareness by nurses of their work behaviours, while making the constrained realities of psychiatric nursing work more visible. Implications for both counselling and nursing are discussed, and recommendations are offered.

Review of situational categories of powerlessness

As mentioned in chapter three, the nurses' experiences in this study did not coincide directly with those identified in previous studies of the general nursing population (Attridge, 1996; Chandler, 1992; Erlen & Frost, 1991). My attempts to fit the data into predetermined categories were unsuccessful. This is attributable to a variety of factors. The population in this study differed from that in other studies, as this research focused specifically on psychiatric nurses rather than on general staff nurses. As well, the methods of data collection and analysis varied in the different studies, accessing different types of information. The results do share some similarities to prior studies, however, and these will be discussed.

The issue of medical dominance and control has been cited in reference to nursing powerlessness in a number of studies (Attridge, 1997; Chandler, 1992; Erlen & Frost, 1991). Chandler (1992) found that the majority of her participants' descriptions of powerlessness related to negative-nurse physician interactions. Similarly, Erlen and Frost (1991) identified physician control and dominance as a theme that related to nurses' perceptions of powerlessness. They found that nurses perceived themselves to be powerless in ethical dilemmas when physicians acted with authority and control, and they suggest that nurses may be inhibited by such perceptions of powerlessness, in their ability to influence patient care

decisions. Groves (1992) study on nurses' perceptions of power also supports this idea. The results of my study are congruent with these findings; participants felt limited in their ability to influence patient care decisions if they did not feel heard and respected by physicians. In addition, the category of medical dominance and control in my study is broader than that offered in previous studies. It not only involves individual nurse-physician dynamics, but also identifies the wider issue of power imbalances between health care professions. Many of the nurses' descriptions of powerlessness relate to general medical dominance in health care. as well as to personal interactions with doctors.

A number of authors have identified the difficult position in which nurses find themselves, caught between their allegiance to the patient and their allegiance to medicine and administration (Attridge, 1996; Gadow, 1980; Yarling & McElmurry, 1986). Attridge (1996) found that nurses felt powerless when they were "exposed to competing, very serious demands" (p.46), in which there was necessarily going to be a loser regardless of the nurse's decision. Attridge asserts that the nurse is always one of the losers in these kinds of situations. She also identified that some powerless situations "demanded some choice or action on the part of the nurse which resulted in very visible and negative consequences" (Attridge, 1996, p.48). This theme aligns closely with the no-win category in my study. It involves nurses either participating in care they disagree with, or not participating in something they believe in, and feeling torn between loyalties. Attridge (1997) observed that nurses often experience doubt and self-blame in such situations. The participants in my study more frequently expressed guilt and hopelessness.

System issues were identified by participants as significant in determining their experiences of powerlessness. Concerns about system issues seem to have less emphasis in studies on the general nursing population (Attridge, 1996; Chandler, 1992). This may reflect an ever worsening health care climate in British Columbia. As well, it may reflect the unique concerns of nurses working in psychiatry. As suggested by some of the participants, the allocation of resources may be influenced by the marginalization of mentally ill patients. In

Chandler's (1992) study of staff nurses from a variety of acute care areas, only 10% of the described powerless experiences involved a system issue, that of shortstaffing. Attridge (1996) found that nurses often experienced a sense of powerlessness in relation to a lack of resources, primarily human resources. She found that the impact of inadequate resources was "often superficial, even dangerous and unethical patient care and unquestionably more complicated and harassing work" (Attridge, 1996, p.49). This is consistent with my findings. In addition, the results of my study suggest that system issues encompass not only human resources , but also material resources and structural and organizational barriers to good patient care.

Experiences of powerlessness that tie into a lack of communication and support have been identified in a number of research studies (Attridge, 1996; Erlen & Frost, 1991; Groves, 1992). This reflects the relational experience of power for nurses. Nursing collegial support was cited by most participants as the key element in helping them cope with feelings of powerlessness. Chandler (1992) also found that nurses felt empowered when they felt the nursing team was working well together. Along with positive collegial relationships, Chandler (1992) and Pieranunzi (1997) found that nurses feel empowered by positive communications and interactions with patients. Pieranunzi (1997) suggests that psychiatric nurses' sense of empowerment is based in knowing and connecting with their patients as people. Thus, current health care restructuring, in which many psychiatric nurses feel they have been forced to reduce their relationships with patients to simply ensuring patient safety, may contribute to nursing powerlessness.

Participants also identified lack of knowledge sharing and education as disempowering. Erlen and Frost (1991) had compatible findings. This is understandable in light of Foucault's (1980) theory that knowledge equals power, and it suggests the necessity of communication and information sharing between nursing colleagues in order to enhance feelings of power. Participants described feeling increasingly isolated from their colleagues, which feeds feelings of powerlessness. Both Chandler (1992) and Attridge (1996) found that

a sense of isolation permeated nurses' accounts of powerlessness. Groves (1992) asserts there needs to be greater communication between nurses regarding attitudes and perceptions of power in order to "inspire a unification of nurses to mobilize the potential and strength of professional nursing" (p.27). Attridge's (1996) findings support those of my study in suggesting that collegial support is critical for reducing a sense of powerlessness.

Because psychiatric nurses' experiences of powerlessness involve complex interactions between many personal, social, and structural factors, the divisions between the four identified categories of powerless situations do not really reflect the interactive nature of the categories. Many of the participants' experiences of powerlessness do not fall neatly into one category to the exclusion of all others. It is for this reason that I had difficulty delineating categories of powerless situations in my analysis, and I was forced to acknowledge the fluidity of the boundaries between categories, accepting that they are not mutually exclusive. Because of the interactive nature of the categories, participants' experiences of powerlessness will be discussed generally here, rather than in terms of the specific categories.

What inhibited the nurses from acting more powerfully?

A variety of factors inhibited the psychiatric nurses from practicing in a more empowered and autonomous way. Oppression underlies many of these factors, and it is perpetuated by the oppressive hospital structure in which health care is delivered, as well as nurses' internalized beliefs regarding their powerlessness. The participants' comments suggest an external locus of control with regard to affecting change in their work experience. Their narratives reflect a belief that the power to alter their situation lies outside of nursing. Although nurses are educated to believe they can practise autonomously and the patient is their priority, they have been socialized by the health care system to subvert their practice decisions to those of more powerful groups, even if it means jeopardizing patient care (Sinda, 1984; Yarling & McElmurry, 1986). Nurses may claim a priority focus on the patient; in practice, however, they will often place medical and administrative needs before patient

needs. The diminishing resources and increasing stress in the health care system are functioning to perpetuate nursing powerlessness.

Participants revealed incongruities between their ideals of nursing practice and their daily work realities. The nurses asserted that their primary allegiance is to the patient, and they shared the understanding that patient advocacy is a nursing responsibility. However, the extent to which the nurses were actually willing to advocate for their patients was limited. The general feeling was that nurses can offer their opinions, but if their voice is not heard, they have no choice but to participate in care that others dictate. This belief system is contradictory to ideological and legal standards for nursing practice (RNABC, 1991; Yarling & McElmurry, 1986). In nursing doctrine and official policies, nurses are considered autonomous professionals and they are expected to accept the responsibility inherent in autonomous practice. In reality, nurses are not free to practice autonomously because of social and organizational constraints (Rodney, 1997; Yarling & McElmurry, 1986). Yarling and McElmurry (1986) elucidate the dilemma for nurses:

> It is an indubitable fact for those who know the subculture of the health care professions and the power structures of hospitals that nurses who openly challenge established authority structures or powerful physicians in a hospital bureaucracy most often put their jobs, their economic welfare, and their professional careers on the line, even if they are acting on behalf of the patient and have strong justification for doing so (p.70).

This reflects the oppression that continues to be an integral part of acute care nursing. A number of participants acknowledged feeling as though they are putting their jobs and collegial relationships at risk by challenging the decisions of authority, whether that be physicians or hospital administration. Although many participants did not seem to be fully aware of their participation in perpetuating power imbalances through continuing to advocate for physicians and administration over patients, some did acknowledge their participation in

maintaining the status quo, and they explained their behaviour in terms of "playing it safe," in order to ensure their continued survival at work.

A sense of power and autonomy is necessary in order for nurses to fully advocate for their patients (Huston & Marquis, 1988; Millette, 1993). Because the hospital structure is based on hierarchical divisions of power that restrict nursing autonomy, this creates a dilemma for nurses. The more nurses feel disempowered and excluded from patient care decisions, the more they feel unable to act autonomously. It is a self-perpetuating cycle. Although participants vocalized their dissatisfaction with medical dominance and control over patient care, there was a general reluctance to challenge medical decisions. Many of the stories shared by participants reflect feelings of lack of control related to decisions made by medicine or administration. This finding is congruent with what Attridge (1996) found in her study; nurses frequently feel out of control of the work situation and this is often related to "the imposition of control by usually more powerful others" (p.45).

Feeling they lack power and control, nurses tend to place responsibility for change outside of themselves. When asked what would need to be different in order for them to act in a more empowered way, a number of participants suggested changes in the doctors or in structures outside of the nursing domain. Very few offered ideas for changes within nursing. Thus, it seems nurses are essentially letting medicine and administration determine the nature of their experience as nurses. Nurses are uncomfortable in their position of subordination, but many comments suggest that the degree of nurse-physician collaboration in patient care can only be determined by the doctor involved. By allowing physicians to determine the degree of nursing input into patient care, nurses attribute a tremendous amount of control to medicine. This internalized powerlessness by nurses and the apparent belief that the dominant group's ideas supersede those of one's own group is suggestive of oppressed group behaviour (Dykema, 1985; Freire, 1987; Roberts, 1983). This oppressed behaviour negatively impacts patient care, as nurses are not fully advocating for patients and patients are not benefiting from a true interdisciplinary approach.

The participants' accounts suggest that power is experienced interpersonally by psychiatric nurses. The nurses described feeling empowered when they have positive interactions with colleagues, such as receiving support. They cited forums for regular exchange of information such as sharing positive and constructive feedback, as essential for increasing nursing power. Chandler (1992) found that nurses feel empowered when they work in a well coordinated way with other nurses. Feeling an integral part of an effective interdisciplinary team contributed to my study participants' feelings of power. Participants felt powerless when their input was not expected, respected, and incorporated into patient care decisions. Participants did not express wanting greater power over others, and none of the nurses seemed to be seeking power for their own gains. Rather, the nurses' frustration with their lack of power was based in their sense of helplessness regarding providing effective patient care. Pieranunzi's (1997) study supports these findings; he found that psychiatric nurses are empowered by positive nurse-patient interactions in which the nurse feels connected to the patient and effective in helping them. In addition, Chandler (1992) found that nurses feel most empowered by positive interactions with patients, physicians and other nurses, and most disempowered by negative interactions with physicians.

The current economic realities impacting health care delivery in Canada, are having a profound effect on the experience of psychiatric nurses. Nurses are feeling too busy and exhausted to address emerging issues or work on collegial relationships. They are feeling so stressed that they are finding it difficult to support one another or engage in team-building activities. The collegial support that was described by so many participants as critical to their ongoing survival at work is being eroded. Changes in health care are splintering nurses and undermining any kind of united base of power they may have. Jobs are no longer plentiful, nurses are increasingly stressed, and the value of psychiatric nursing work is being diminished. During the nursing shortage of the last decade, nurses were in a position to assert themselves more forcefully, as the power of institutions to threaten job loss had less clout. Institutions were employing resources to retain nurses, and nurses knew that jobs were

plentiful. Now, with shrinking resources and health care restructuring, nursing has lost ground. The position of the institution has regained its power, and nurses' willingness to abide by its rules and those of the established social hierarchy has increased once more. Nurses are becoming increasingly reluctant to challenge authority for fear of losing their jobs.

Along with decreasing health care resources, have come changes in the values driving health care delivery. With the growing emphasis on objective measurement of nursing care, the essence of psychiatric nursing is becoming increasingly invisible. Participants feel frustrated and undermined by current strategies to measure nursing care, which neglect the intangible, interpersonal nature of psychiatric nursing. We have become a very litigious society, in which the fear of legal repercussions is ever present and seems to motivate the decisions made by many professional groups. The medical model has fed into this mentality with the creation of the 'expert' and the 'patient' as mutually exclusive entities. Generally, the public resists responsibility for its own health; it is not uncommon for people to place this responsibility entirely onto the health care system. Professionals working within the system tend to accept this position of power, thereby perpetuating the problem. Although many nurses contribute to maintaining such power relationships, there seemed to be a general perception by participants, that physicians are the most integral force maintaining this power imbalance. This may reflect the lack of power that nurses perceive themselves to have.

Participants feel their sense of power is further jeopardized by the strain in the health care system, with increasing workloads and accompanying burn-out. Participants feel they are providing fragmented care to patients, and are fragmented in their connections with colleagues. They are spread so thin that they do not have the time or energy to fully advocate for patients. The nurses stated they do not always follow up on things because they are spread so thin, they lose track of what they were doing. One participant illustrates: "when I'm stressed I forget; I had an issue over here but now I'm preoccupied with something here and over there, also something there. And I'm forgetting, I forget it, and I don't follow up on it." Generally, nurses feel they must adhere to the priorities dictated by the system, then if

they have any time or energy left after this, they can then provide the kind of nursing care they feel is best. Many participants stated that they rarely provide that extra care anymore because they are too exhausted and their efforts are often undermined or invalidated anyway. They feel it is easier to maintain the status quo than to assert what they believe to be right or in the best interest of the patient, in spite of the moral distress this creates for them. There was a sense of hopelessness regarding positive change and helplessness regarding providing the kind of nursing care they felt was best. This is typical of the sense of powerlessness that exists for oppressed groups (Freire, 1987; Roberts, 1983).

The impact of powerlessness

Participants identified numerous effects of feeling powerless. The greatest impact is on professional practice, and the implications for patient care. Collegial relationships are affected, and participants also identified the impact on their personal lives.

Nursing practice and collegial relationships

When participants talked about the impact of powerlessness on their nursing practice, they usually did so in reference to quality of patient care. Many expressed frustration and anger in relation to feeling inhibited from providing the kind of care they desire. One participant expressed the impact of feeling blocked by dominant groups: "It kind of makes being a nurse a drag. It's one of the worst things about being a nurse, is that feeling . . . impotence, powerlessness, inability to act. I think that role of advocacy, not being able to speak up for what you see as being the best thing for your patient." This comment captures the essence of the nurses' experiences of powerlessness, in which they are impaired in their ability to advocate for patients. This creates moral distress for nurses, as they feel their loyalty should be primarily to the patient. Yarling and McElmurry (1986) comment on the confusion that happens for nurses due to the multiple allegiances inherent in the nursing role.

> The moral situation of nurses is most poignantly revealed when they perceive that the right to freedom and well-being of patients in their care and treatment is threatened or violated by a physician, another nurse, or some other health care provider for whom

> the hospital is responsible. In such instances, nurses experience conflict, with respect to their choice of action, between the prima facie right of the patient and the prima facie right of the hospital . . . This produces conflict for nurses because their role embodies obligations to both patients and the hospital (Yarling & McElmurry, 1986, pp.64-65)

Feeling excluded from patient care decisions is particularly profound for psychiatric nurses because it undermines their role in patient assessments and negates the therapeutic relationship which is critical in psychiatric care. Patient assessments are not based on numerical lab values and other objective means in psychiatry; one participant describes, "it's like we have the intimacy of 24 hour care with patients, so we have such insight and levels of maybe depth of their personality or what's important to that person, that we are the key, we are the key to what, how a treatment plan could go." As stated previously, psychiatric nurses feel their role is being invalidated further and further by the move toward objective measurement of nursing practice.

The many references to the decreasing standards of care that nurses are feeling forced into, involve a sense of defeat, with comments such as "why bother." This reflects the powerlessness and internalized oppression experienced by nurses that creates passivity. Rather than directing their aggression directly at the oppressor, they have turned inward and express their anger and frustration indirectly. The focus of their aggression is most often doctors and "the system", as nurses attribute responsibility for many of their workplace frustrations to these groups. Congruent with oppressed behaviour, this aggression manifests in a significant amount of complaining about physicians and administration, but there is a general reticence to actually challenge authority or try implement change in any kind of united way (Roberts, 1983).

Decreased job satisfaction was a common complaint of participants. Many referred to how nursing "used to be," when caring was a central aspect of the nursing role. This reflects the confusion nurses are experiencing, wherein nursing values and ideals are becoming

increasingly dissonant with the practicalities of the streamlined health care system. Nurses talked about how they have had to come to expect less from their jobs in order to survive. As one participant described "you have to change the tone quite a bit to OK this is just a job, let's get through the shift, I'll do what I have to do and. . .I'm goin' home." Patient care is deteriorating as a result, and it is no longer clear who the system serves.

Participants described feeling disconnected from colleagues, unsupported, and somewhat wary. A sense of isolation and a lack of trust was also common among participants. The distrust of colleagues includes both nurses and doctors, and results from a lack of cohesion and respect in the health care team. Participants felt that patient care suffers when team members are isolated from one another, as there is a lack of consistency. One nurse described how her nursing care is affected when the team lacks cohesion:

> If you have that discrepancy in the whole team where you feel like half the team is doing one thing for a certain. . .and you're doing something else, and it's not quite together, it makes me just want to cut everything short and go back to doing what you have to do and it makes you not want to come in the next day and go through it all again.

Nurses recognized that their stress levels increase when they feel isolated and distrustful of colleagues, so it is a vicious circle perpetuating nursing powerlessness.

Participants asserted that collegial support is the key factor enabling their continued survival in the workplace. The support they described appears to exist on an individual level rather than on a broader professional level. The nurses support one another by listening and offering words of encouragement during difficult times. This is critical for nurses, in terms of coping on a daily basis. However, there also needs to be ongoing support for one another as nursing professionals. Rather than succumbing to the power of dominant groups, nurses need to pull together and encourage one another to be assertive and proactive in their responses to oppression. The lack of power that nurses feel they have in spite of their numbers indicates a lack of professional unity. Each group of participants described their

colleagues as unique because they are supportive. This suggests that nurses perceive collegial support to be very inconsistent within nursing. With the current stresses and changes occurring in the health care system, nurses are feeling increasingly isolated and disconnected from colleagues, and this is exacerbating feelings of powerlessness.

Personal life

A number of participants identified effects of work powerlessness on their personal lives, while others initially denied any impact. When stimulated by the focus group discussions, however, most of the nurses acknowledged some personal impact on them. This may reflect a reluctance on the part of some participants to acknowledge the significance of their work powerlessness. Lanza (1997a) comments on the dangers of nurses' acceptance of powerlessness. "Nurses, failing to recognize the oppression process, do not often unite to change the view of reality imposed by. . .more powerful groups. Further, nurses fail to appreciate that an important source of power is their numbers" (p.7).

In many of the situations described, participants felt they were compromising their personal values. In incidents in which they recounted their involvement in patient care activities that felt wrong to them, they spoke of having "upset conscience," and a sense that they are giving themselves up. What seemed to be most distressing to the nurses was that they felt they lacked the power to act congruently with their own beliefs.

Participants talked about feeling stressed, exhausted and burned out. For some, this manifested in very little energy left for their personal lives. One participant coined this "the post-work fatigue." Another described the effect of this: "Y'know it's your day off and you have your challenges of your normal life and you don't have any resources left for those things." Others admitted that their frustrations get transported home: "I feel terribly bad that my partner has to listen to me rant and rave. . .I'm obviously in a bad mood." A number of participants commented on how their mood is negatively affected by feelings of powerlessness. This is captured by the comment of one nurse: "It's quite depressing. . .you

feel helpless, you feel hopeless." This sense of vulnerability and personal defeat permeated many of the nurses' experiences.

The nurses recognized the importance of maintaining balance in their lives, by involving themselves in relationships and activities outside of work. Some explained that they have had to create a bigger division between their professional relationships and their personal relationships in order to cope. Most identified the necessity of separating their work and personal lives, in order to function in each. As one nurse explained, "I feel you have to be very careful of keeping your own emotional house clean and healthy. . .The patients deserve to have healthy caregivers." For many, though, this is difficult. One nurse stated she was only able to really regain balance in her life once she cut her work hours in half.

Needed changes

Psychiatric nursing in the hospital setting can only be viewed in light of the multidisciplinary team context in which it is practiced. Participants agreed that the degree to which care is most effectively provided depends, in large part, upon the coordination of the health care team. Some might argue that 'team' does not accurately describe the collection of professionals who provide health care, given the power and status inequities inherent in the health care hierarchy. However, the majority of participants used this term when describing the social context of their nursing practice, so it will be used here. It is interesting to note that most of the participants' comments involved concerns about a *lack* of team work. Glenister and Hopton (1995) assert the importance of teamwork in psychiatry: "shared decision-making is the hallmark of all good mental health services" (p.62). As previously mentioned, the problem of fragmented team care is compounded by recent stresses and changes within the health care system.

When asked to reflect on a time when they felt they were able to act effectively on behalf of the patient, the nurses most frequently cited communication, support and teamwork as the critical factors. One participant's comment typified the nurses' accounts of how things are different when they feel empowered.

> Things click...It helps I think when you start to get to know the people. . . that you're working with. . .you develop some sort of relationship with them, then you can work together and things work properly and everybody sort of tries to cooperate, then it can go really smoothly and work really well. And sometimes it's just all of a sudden, it's like uh somebody, I don't know, removed some kind of jam to the way things do work and it's just maybe one person changes, an attitude or somebody comes up with one different little idea and then everything will all of a sudden just fit into place.

This sense of coordination involves staff cohesion, and the nurses said they feel empowered when they feel they are an integral part of the team. In turn, they function more proactively than reactively in their nursing practice. A number of participants also commented on the importance of supportive nursing leadership, in terms of their sense of effectiveness and satisfaction at work. As one nurse stated, "having a powerful. . .assertive, non-judgmental charge nurse behind you. . .certainly makes me feel more empowered, to have someone I can bounce ideas off and who supports you"

Participants emphasized the need for greater communication, respect and support both within nursing and between disciplines. One nurse stated that what is needed is

> better communication, everybody listening a little more and giving . . . I'm saying interdisciplinary communication, like doctors, nurses, OT's, everyone communicating honestly to each other...The nurses are doing well, but we can still improve and there has to be an open communication for the whole team to give quality nursing care.

A possible key for enhancing interdisciplinary respect and collaboration lies in changing the patterns of inter professional communication. One nurse suggested that health care professionals need to begin to relate to one another as people rather than as casted professionals. By maintaining distance on the grounds of professional divisions, each individual profession is able to maintain its righteousness while avoiding personal

accountability for his/her behaviours toward a member of another profession. The following comment captures the problem with this system of relating, and offers a solution.

> I just see so many . . . doctors and the nurses bumping heads with each other all the time . . . I don't want to be against the doctors . . . I don't really think they're bad people and we're good people . . . I think sometimes that's what happens is there's a split going on and we're so angry that we vent on them and they get so pissed off with us being angry with them all the time that they just avoid us . . . So nobody connects. And I think when you get the human factor, and people start respecting each other, and you have personal contact and you actually talk to each other more, then you can sort of break through that. It's like, you can't really go and kill somebody in a war if you know them, if you can put a face on them . . . So, if you make it personal, somehow that helps break down a lot of barriers.

Rodney (1997) describes the need for "authentic presence" in communications between members of the health care team. "Individuals who are authentically present develop a sense of trust in each other, which enables them to create a relational matrix that is mutually supportive and that facilitates nurses' (and others') abilities to enact their moral agency" (p.154).

A shared sense of responsibility, and increased accountability at all professional levels, is necessary in order for effective team functioning. As one participant stated "everybody (needs to) come together instead of this pass the buck thing all the time." Participants expressed their frustration at the lack of collaboration in the health care team. particularly at the inconsistency in physicians' inclusion of nursing input. The physicians' behaviour may be driven by the "cover your ass" mentality identified by participants, in which doctors may make decisions based more on ensuring their own professional survival than what may be most helpful for the patient. So, similarly to nursing, medicine is bound by legal and institutional constraints limiting autonomous practice. More significantly though, the lack of doctor/nurse collaboration may reflect medical behaviours meant to maintain the

power imbalance between medicine and nursing, and nursing passivity related to an internalized sense of powerlessness to actualize change.

In some ways, the position of nurses parallels that of the opposition party in government. They are in a comfortable position to challenge the decisions of those in power because they do not share the same responsibility for the outcomes of their proposed decisions. Lanza (1997a) states "that by attributing all of one's problems to a lack of power, one does not have to feel accountable for finding a solution" (p.6). Nurses need to commit to active change in order to move toward equalizing responsibilities between all professional groups and the patient. Although physicians are in the coveted position of greatest power, I suspect that many doctors experience discomfort in the excessive degree of control and responsibility inherent in their title. If nurses truly desire increased power and control in their nursing practice, they must be willing to assume greater accountability and responsibility for patient care decisions. Lanza comments on nurses' tormented relationship with power: "Nurses are challenged and obsessed with defining what it is and how to use it. However, in the work place and political arena, they often recoil from applying it to advance the nursing profession" (Lanza, 1997a, p.6).

As stated previously, many of the nurses' suggestions for improving their work experience involve changes outside of nursing. In one hospital in which nurses had specialized knowledge for a very specific patient population, participants seemed to possess a greater internal locus of control, as evidenced by their suggestions for change. It is interesting to note that this group also had the highest percentage of university educated nurses. Their suggestions involved creating structures to facilitate staff communication and nursing unity. As well, they suggested that ongoing education and professional development are critical for enhancing nursing empowerment. One participant acknowledged that nurses need to act more consistently assertive because in not doing so, they are relinquishing their power.

Limitations

The value derived from the content of the descriptive data is the expansion of general theoretical possibilities, rather than generalization to other populations. The findings of this study add to a growing understanding of powerlessness in psychiatric nursing. Lincoln and Guba (1985) assert "that full information about a whole is stored in its parts" (p.127); therefore, there is value in exploring the particular. Although broad generalization cannot occur, the presentation of thorough descriptive accounts of the participants' experiences, allows the reader to form inferences that may be applicable to his/her own situation (Lincoln & Guba, 1985). Reinharz (1992) suggests that "the very act of obtaining knowledge creates the potential for change because the paucity of research about certain groups accentuates and perpetuates their powerlessness" (p.191).

Another limitation inherent in this type of research is the subjective nature of data collection and analysis. The researcher's own ideas and values will shape the treatment of the data and the appearance of the findings. In order to counteract this effect, I identified my personal assumptions (see Appendix B) before beginning the research. In addition, I provided the reader with personal background information that may influence the research. This allows the reader to discern the impact of the researcher's biases on collection and analysis of the data. In addition, 89% interrater reliability was established in the analysis phase of categorizing situations of powerlessness.

The study may have also been limited by my personal proximity to the issue at hand. It is sometimes recommended that the focus group leader be someone other than the researcher, in order to enhance neutrality in data collection (Carey, 1994). In order to offset this potential effect, I involved a non-nurse, graduate student co-leader, who had experience in group and individual counselling. I instructed her to observe for any apparent biases in my questioning, and we met at the end of each session to discuss this. She participated in the first three groups in which she offered useful feedback regarding areas in which I tended to ask leading questions or paraphrased in suggestive ways. After receiving feedback, I

incorporated this into my approach in subsequent groups by consciously monitoring my comments. By the third group, the effect had been minimized significantly. Thus, the co-leader did not participate in the final group.

Implications and recommendations for nursing

Nurses play a critical and indispensable role in health care, providing twenty-four hour care and nurturance to patients. Because their unique position allows them the privilege of knowing patients more intimately than other professional groups, they possess potential for tremendous influence on patient care planning and decision-making. As well, nursing is the largest professional group in health care, and if its influence reflected its numbers, nurses would have a far greater impact on patient care delivery. Therefore, it is important for nurses to expose and acknowledge their experiences of oppression, in order to create foundations for change. This is consistent with Freire's (1987) theory, in which the first phase in the liberation from oppression requires insight into its sources and impact. Increasing dialogue on oppression and powerlessness within nursing through regular forums, workshops and literature is important. Until nurses acknowledge the existence of oppression and begin to reject the status quo on a broader level, they will be inhibited from possessing greater autonomy and power.

It is important for nursing leaders to understand that empowerment for psychiatric nurses is derived from interpersonal interactions, and cannot be received as a gift simply through delegation of increased responsibilities. Rather, as suggested by the participants in this study, respect, validation, support and open communication are empowering to nurses. Nursing leaders must build and maintain a strong power base rooted in nursing values and knowledge rather than those of dominant groups. Nurses must begin to recognize and truly value their unique characteristics and practices. Lanza (1997b) stresses the importance for nurses to "applaud the knowledge and expertise of their own members and gain power, not by association with those in the dominant group, but by forming liaisons and increasing visibility in their own" (pp. 6-7).

Regular acknowledgment and exploration of the oppressive forces that impact nurses need to be included in nursing education. Students would benefit from exposure to the idea that the realities of nursing practice are not always compatible with the academic notion of nursing autonomy and equality. By promoting a model of nursing that is incompatible with the realities of nursing work, educators are blinding students to the issues of oppression and powerlessness in nursing, which ultimately disables nurses. Creating new, more empowering models of nursing are very important; however, it is essential that there is discussion around the difficulties of implementing them, so that new nurses do not feel disillusioned and disheartened upon entering the workforce. Along with discussions of oppression in nursing, information regarding ways in which nurses can unite to increase their power, including avenues of political activism, are essential to move toward greater empowerment. Yarling and McElmurry (1986) comment on the apolitical stance typical of nurses, in which nurses are "more concerned with serving individuals than with reforming institutions" (p.72). They state further "this propensity is natural to a caring profession, but it is inadequate as a professional style when social and political forces increasingly determine the context and conditions of practice" (Yarling & McElmurry, 1986, p.72).

For practicing nurses, ongoing discourse around nurses' limited capacity to act as autonomous moral agents due to social and institutional constraints, is critical. Educational opportunities, such as workshops, can provide forums for nurses to learn about and discuss nursing ethics and the conflicts between nursing ideals and nursing practice. This may set the stage for action toward reform of institutional policies and nursing practice structures.

More research exposing the subjective experiences of nurses is needed. Giving voice to those who lack power challenges pre-existing paradigms through which phenomena are typically presented and understood (Kirby & McKenna, 1989; Reinharz, 1992). Future researchers might benefit from using a feminist approach in order to challenge taken-for-granted 'knowledge' that reflects the values of the dominant order. Gilbert (1995) asserts that if they are "to empower others, nurses have to develop an understanding of the way in which

the hegemony of the present form of rationality is produced" (p.870). Unless subordinate groups expose and reflect on their own unique experiences, incorporating them into their 'knowledge' base, they "will continue to re-invent the wheel, and will remain divided and powerless" (Kirby & McKenna, 1989, p. 168). This kind of nursing research can pave the way for the validation of nursing knowledge as uniquely separate and equally as important as medical knowledge. There needs to be increasing dialogue on the different expertise of nursing and medicine so they can function in a more complementary rather than competitive way. University curricula involving courses that bring together medical and nursing students may help to bridge the gap between disciplines. If each group began to trust the expertise of the other, true collaborative team care may be possible. It is critical that research findings be made meaningful and accessible to nurses outside of academia. To not do so, would make researchers guilty of perpetuating nursing oppression through making new knowledge property of the elite (Kirby & McKenna, 1989; MacPherson, 1983; Reinharz, 1992).

Implications and recommendations for counselling

Counsellors need to develop expanded conceptions of oppression, acknowledging that oppression is alive and well in many workplace settings. This research provides insight into the dynamics of power within an oppressive work environment such as a hospital. It is essential for counsellors to have an understanding of the impact of power distributions within hierarchical structures, particularly when working with nurses. Counsellors must recognize that work attitudes and behaviours are impacted by multiple social and institutional constraints. In counselling oppressed clients, it is important to create the conditions for empowerment, and incorporate strategies to support and facilitate the maintenance of empowered behaviours.

A feminist therapeutic approach involves acknowledging and managing the inherent power differences in the client/counsellor relationship. It is critical that the counsellor model effective use of personal power, avoiding any replication of power inequities that the client may experience in his/her life (Rave & Larsen, 1995). A feminist approach is also useful in

terms of contextualizing and validating the experiences of nurses or other oppressed clients. To view the experience of an oppressed individual outside of the context in which the oppression occurs, may simply reinforce the client's powerlessness. Feminist theory suggests that the personal is the political; thus, in therapy, movement from the personal to the political in terms of action, is ultimately encouraged. Therefore it is very important for the counsellor to act as an advocate for clients, which may, at times, involve addressing the broader issues underlying the client's experience of oppression. Freire (1987) contends that a necessary step in the liberation from oppression involves taking action to challenge and eliminate the institutionalized belief systems that are perpetuating the oppression.

Counsellors can help to facilitate clients' understanding and development of assertive behaviours by using a cognitive-behavioural approach. Clients can be assisted to challenge and alter behaviours and belief systems which are sustaining their oppression. The oppressed person needs to become conscious of his/her own perception of reality and critically examine the contradictions in it, rejecting those that belong to the oppressor (Freire, 1987).

Incorporation of stress management activities is recommended for counsellors who are working with nurses. In order to prevent or minimize the burn-out that so many participants referred to, the development of self-care strategies is essential. Working with nurses in groups may help to facilitate empowerment through creating a shared experience rather than one of isolation. "Groups generate a sense of community, belonging, support, acceptance, and assistance" (Johnson & Johnson, 1994, p.481). This can function to offset the internalized frustration that is typical in nursing (Attridge & Callahan, 1987). In addition, group work can be useful in facilitating the creation of new group norms in nursing. Rather than accepting the status quo and succumbing to social and organizational constraints on nursing practice, nurses can use the group forum to explore alternate conceptions of nursing practice and strategies for change. Cash (1997) argues that the boundaries and status given to nursing knowledge are defined by other disciplines, mainly medicine, and he asserts "to

change the status of that knowledge is to redefine nursing" (p.143). Finally, positive group experiences can counteract the divisiveness in nursing and function to increase nursing unity.

Conclusions

There are four types of situations in which the psychiatric nurses in this study typically experienced powerlessness. These include (a) situations characterized by medicine's dominance and control, (b) no-win situations, (c) when there are system problems, and (d) when there is a lack of communication and support. The categories are interactive with one another, and the nurses' behaviour within the situations often reflects oppressed group behaviour. Nursing oppression parallels the oppression of women in patriarchal society. It is so widespread and insidious that it often goes unacknowledged. The oppression of nurses is perpetuated by both the hierarchical structure of health care, and by nurses' internalized oppression. Consistent with oppressed group behaviour, nurses are not united (Roberts, 1983). Thus, they are not capitalizing on the power inherent in their numbers. Huston and Marquis (1988) assert: "To the extent that nurses abrogate their responsibility for professional decision making and fail to collaborate with other nurses in exercising power, they fail their patients, themselves, and the profession" (p.43). Shrinking resources in health care and the increased pace of acute care psychiatry are exacerbating the disunity of psychiatric nurses.

Oppression in the study participants was exemplified by their sense of helplessness to create change against the power of medicine, administration, and the larger health care system. Many of the nurses' comments suggest an external locus of control, in terms of creating change. They expressed significant anger and frustration about feeling controlled by authoritative bodies, but rarely did they describe situations in which they expressed themselves directly to authority. A sense of fear regarding repercussions often keeps the nurses from speaking up. They are in a very difficult position, caught between their allegiance to the patient and their allegiance to medicine and administration. Although nurses are educated under the philosophy of autonomous professional practice and patient

advocacy, and legally nurses are bound to make autonomous practice decisions, the health care system does not support this kind of practice. It is structured such that nurses are still expected to act under the authority of medicine. Yarling and McElmurry (1986) comment on the conflict between nursing ideology and the realities of nursing practice.

> Student nurses today are taught that nursing requires patient advocacy, that patient care comes first. Yes, that is what they are taught verbally and overtly; but in a thousand nonverbal and covert ways, they are taught by clinical example the limits of that advocacy. . .They learn that their commitment to patients must be carefully contained (p.67).

The participants' accounts suggest that nurses are less likely to advocate for patients when they are feeling powerless and blocked by the authority of medicine or administration. This creates a great deal of distress for nurses because they feel inhibited from practicing congruently with their ideals of nursing. Many nurses seem to deal with this distress by attributing the problem entirely to those in more powerful positions than themselves, and by complaining amongst themselves. In this way, nurses can maintain idealistic and virtuous views on their nursing practice, blaming other groups for their inability to provide the kind of care they believe would be best. However, they are perpetuating their own powerlessness by relinquishing control over their practice to dominant groups. Nursing oppression has a long history that continues into the present; nevertheless, it is time for nurses to begin to understand their participation in the perpetuation of this oppression and to take greater responsibility for challenging the status quo.

Power is experienced by the psychiatric nurses through their interactions with others. They identified negative interactions with colleagues as disempowering, and they felt empowered when there was respect and cohesion both within nursing and between disciplines. Open communication and support were identified as critical to effective functioning of the health care team. Often, there seems to be a mutual distrust between medicine and nursing. Each discipline is maintaining separation from the other by asserting

their righteousness and negating the approaches of the other discipline. A great deal of nursing energy seems to be spent on what participants called the "power struggle." Perhaps, if nurses truly acknowledge and value their own unique skills and strengths, they will not subvert them to those of medicine, and the two disciplines may be able to function in a more complementary way.

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Appendix A

Key Interview Questions

1. Think about a situation in the last 6 months in which you felt you lacked the necessary power to act in the way which would be best (in your opinion) for the patient or situation. An example might be one in which you administered a medication to a patient in spite of the fact that you felt it was not necessary or may even be detrimental.

If you wish to take a moment to write down the situation, if that helps you clarify the details, then please do so. And include how you *felt* in the situation. I will then ask you to share this with the group.

2. What specifically inhibited you from acting in the above situation?

3. What would have needed to be different for you to feel more able to act in the 'best way'?

4. How are you affected when your actions are restricted or your voice is not heard?

a) How is your nursing practice affected?

b) How are your relationships with colleagues affected?

c) How do you think other aspects of your life might be affected by your feelings of impotence (or powerlessness) at work?

5. Reflect on a situation in which you felt you *were* able to act in what you considered to be the best way for the patient or situation. What was different about this situation? How did you feel differently, in this situation?

6. If there was one thing you could change about your workplace, what would it be and why?

Appendix B

Personal assumptions

The following list is a set of personal assumptions that the researcher brings to the study.

1. Psychiatric nurses feel powerless at times.

2. Feeling powerless is an undesirable experience, as all people desire a sense of personal empowerment and control in their lives.

3. Feeling powerless has both a personal and professional impact on psychiatric nurses.

4. The quality of patient care is diminished when psychiatric nurses feel powerless because nurses (a) are less likely to advocate for patients, (b) are less likely to encourage patients to activate their own power, and (c) may make power plays over patients to increase their own sense of power.

5. Psychiatric nurses desire the following changes: (a) they want to feel they are a more integral part of patient care decisions, and (b) they want their nursing work to be valued and validated.

6. Psychiatric nurses have ideas for change, but something inhibits them from acting on this.

7. Responsibility for creating change within the nursing profession lies with nurses.

8. Nurses possess a unique body of knowledge and skills that differs from medicine.

9. The expertise of nursing and medicine can complement one another rather than compete with one another.

Appendix C

Demographic Details

Age (years)
30 - 59

Ethnicity
All Caucasian

Marital status
10 Married
2 Divorced
2 Single
3 Unmarried but living with partner

Education
9 RN Diplomas
5 RPN Diplomas
2 Both RN and RPN Diplomas
1 RN Bachelor's Degree

Additionally:
2 Post-graduate Diplomas in Nursing field
1 Post-graduate Diploma in non-Nursing field
3 Bachelor's Degrees in non-Nursing fields
1 Master's Degree in non-Nursing field

Experience (years)
11 Ten or more
1 Five to ten
3 Two to five
2 Under two

Employment status
13 Full-time
2 Part-time
2 Casual

Appendix D

Informed consent

Title of study: The experience of powerlessness for acute care psychiatric nurses.

Purpose of the study: To explore the meaning and impact of a sense of powerlessness on acute care psychiatric nurses.

This is to certify that I, _____, agree to voluntarily participate in this study. I have been informed that this study is being conducted by Janice Cathcart as part of her thesis requirements for the Degree of Master of Education in Counselling at the University of Northern British Columbia. This study is being supervised by Dr. Colleen Haney in the Education Programme, Faculty of Health and Human Sciences, University of Northern British Columbia.

I agree to participate in one 2-hour focus group with three to six other psychiatric nurses who work in the same hospital as I do. I agree to allow the interviews to be audiotaped and videotaped. I agree to allow the tapes to be transcribed for the purposes of data analysis. I am aware that the information I provide will be analyzed for the purpose of identifying themes. I am aware that I may be quoted directly in the write-up of this study, but that my anonymity will be ensured. I understand that all data collected will remain confidential with regard to my identity. Participants will be identified by code on the transcription. I understand that only the investigator, her supervisor, and a transcription clerk will have access to the tapes. The tapes will be securely stored.

I understand that I do not have to participate and that I am free to withdraw my consent and may terminate my participation at any time. I may ask any questions I want about this research project. Questions I ask will be answered to my satisfaction. I will receive a copy of this consent form.

Date:_____ _____

Participant Signature

Faculty Supervisor:
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Investigator's Signature
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Appendix E

Demographic Information

For the sole purpose of understanding the similarity or diversity of participants, please answer the following questions about yourself. Your answers will remain anonymous and strictly confidential.
Please answer the following questions by CHECKING the most appropriate response(s) unless otherwise indicated.

1. What is your age? _____

2. What is your marital status?

Single	( )
Unmarried but living with a partner	( )
Married	( )
Divorced	( )
Widowed	( )

3. To which ethnic group do you belong?

Western European	( )	
Eastern European	( )	
First Nations	( )	
Caucasian	( )	
Hispanic	( )	
East Indian	( )	
Asian	( )	
Middle Easterner	( )	
African		( )
Other	( )	specify_____

4. What kind of education do you have?

RN diploma	( )	
RPN diploma	( )	
Bachelor's degree in Nursing	( )	
Post-graduate degree in Nursing	( )	
Post-graduate diploma in Nursing	( )	
Diploma in non-Nursing field	( )	specify_____
Degree in non-Nursing field	( )	specify_____

5. How many years have you worked in psychiatric nursing?

0 to 2	( )
More than 2 but less than 5	( )
More than 5 but less than 10	( )
10 or more	( )

6. In which job category are you?

Full-time, regular	( )	
Full-time, temporary	( )	
Part-time, regular	( )	
Part-time, temporary	( )	
Casual	( )	
Other	( )	specify_____

7. How does your group of colleagues support individual nurses in acting more powerfully?

_____

_____

_____

_____

_____

8. How does your group of colleagues undermine nurses who attempt to act more powerfully?

_____

_____

_____

_____

_____