

**University of Alberta**

**The Good, The Bad and The Therapeutic:  
Psychiatric Nursing Care in Film**

by

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Nursing

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## Abstract

The media is an important information source regarding psychiatric nursing care. There has been limited English language research that has specifically explored the nurse-patient relationships that were depicted in film between psychiatric nurses and the people for whom they cared. Using an interpretive visual inquiry method, fifteen films were selected and analyzed using a relational ethics framework. The films were: *Cosi* (Joffe, 1996), *Frances* (Clifford, 1982), *Girl, Interrupted* (Mangold, 1999), *Gothika* (Kassovitz, 2003), *Harvey* (Koster, 1950), *High Anxiety* (Brooks, 1977), *One Flew Over the Cuckoo's Nest* (Forman, 1975), *Persona* (Bergman, 1966), *Snake Pit* (Litvak, 1948), *Terminator 2: Judgement Day* (Cameron, 1991), *The Caretakers* (Bartlett, 1963), *The Cobweb* (Minnelli, 1955), *The Jacket* (Maybury, 2005), *The Sleep Room* (Wheeler, 1998), and *Titicut Follies* (Wiseman, 1967). The roles of the nurses were described using Peplau's (1952/1988) role descriptions. These included the roles of stranger, resource person, teacher, leader, surrogate, counsellor, consultant, tutor, safety agent, mediator, administrator, recorder, observer, and researcher. Exemplars were drawn from the films to discuss each of the following relational ethics themes: mutual respect, engagement, embodied knowledge, environment, and uncertainty. Two primary discourses were found embedded within the relational ethic themes: otherness and power/control. Within these discourses, sub-discourses relating to stigmatization, prejudice, domination, and marginalization were also found. Nursing must be attentive to the messages contained within the depictions of psychiatric nursing care. Nurses can no

longer afford to be silent; as these images have consequences for the patients, their families, and the nurses working in this complex specialty area.

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## Chapter 1

### Introduction

When I was a psychiatric nursing student, in one of my classes, I watched *One Flew Over the Cuckoo's Nest* (Forman, 1975). After watching the film, the class discussed the medical and nursing treatments used. These treatments included: electroconvulsive shock therapy, group therapy, and pharmacological therapies. We did not discuss the relationships between the patients and the nurses; nor did we discuss the effect of the environment. More specifically, we did not discuss the impact of the therapeutic milieu on the patients and the staff; nor did we discuss the ethical issues shown. Almost twenty years after first seeing this film, I still find myself reflecting on what we did not discuss.

At a societal level, too, dialogue concerning media depictions of psychiatric nurses and psychiatric nursing care have been limited (de Carlo, 2007). Additionally, many psychiatric nurses continue to avoid discussing the impact of the depictions of the psychiatric nurse and psychiatric nursing care. Unfortunately, a consequence of this avoidant behaviour is that the fallacies about psychiatric nurses and psychiatric nursing care go unchallenged. This leads to the public potentially believing what they see on the screen (Anderson, 2003; Bloomfield, 1999; Clare, 1992; Hall, 2003a; Wahl, 2003). For example, the unchallenged image of Nurse Ratched, a prototypical figure of the psychiatric nurse, has made it more difficult for people to ask for help and seek psychiatric care. Her image has influenced nursing students decisions related to choosing psychiatric nursing as their career. Would you want to be cared for by Nurse Ratched? Would you want to have a career in which you are

associated with doing the same thing as Nurse Ratched? Hereford (2005) demonstrated that fictional images of nursing are harmful to those who may consider nursing as a career. For example, “nursing students spoke to the issues concerning the inaccurate portrayal of nursing depicted in the media, which may interfere with individuals seeking a career in nursing (Hereford, 2005, p. 187). Psychiatric nurses and psychiatric nursing care are in a marginalized position (Gouthro, 2009). Gouthro (2009) presents a rationale for this marginalization - stigma by association. As psychiatric nurses associate with people with mental illness; therefore, they are attributed with the traits of mental illness. The psychiatric/mental health nurse also becomes the Other. Because of these consequences, it is essential that nurses look at the image of the psychiatric nurse and the depiction of psychiatric nursing care.

Nurse Ratched, the iconic psychiatric nurse, depicts the characteristics commonly displayed by psychiatric/mental health nurses in film. Researchers (Kalisch, Kalisch, & McHugh, 1980; Kalisch & Kalisch, 1981b, 1982a) identify several characteristics related to personality, primary values, and professional competence commonly depicted in the media. Personality characteristics repeatedly demonstrated by the cinematic psychiatric nurses include intelligence, confidence, ambitiousness, and critical thinking skills. Unfortunately, these personality attributes are used to control their patients and colleagues. The nurses demonstrate little regard for individual rights, ensuring a therapeutic relationship, or nurturing an ethical environment. As a result, psychiatric nurses are seen as unempathetic, callous, and whose actions are often viewed as malicious. The primary values of the psychiatric nurse relate to power, control and obedience. The psychiatric nurses are depicted as being

very competent in ensuring the rules of the unit/hospital/organization were followed by the patients and the other staff. They demonstrate their ability to control and have power over others.

Nursing research which focuses on the image of the nurse is interesting and important work, but I wondered about the depiction of the relationships psychiatric nurses had with others. This is critical as it is the relationship that forms the basis for psychiatric nursing care (Canadian Federation of Mental Health Nurses, 2006). Nurse Ratched has a relationship with each of the patients and staff on the unit. When beginning this research, I wondered about the basis of this relationship. Are her decisions and actions guided by a nursing theory or an ethical framework? It is only after the development of an ethical relationship that safe and competent nursing care can be delivered (Canadian Nurses Association, 2008). The central tenet of psychiatric nursing care, according to the Canadian Federation of Mental Health Nurses (2006), is the therapeutic use of self. This requires purposeful nurse-patient interactions. These interactions occur within the context of a relationship. But how is this relationship developed? How can we better understand the components of an ethical relationship? How does the media depict the relationships between psychiatric nurses and people with mental illness and the psychiatric nursing care that people with mental illness receive?

Watching a movie is not an uncommon occurrence in our Western industrialized society. Almost everyone in our society has engaged in this activity at one time or another. As we consume the media, we open ourselves to the influence of the directors', producers', and writers' priorities and their interpretation of the depicted phenomena (Monaco, 2000; Neale & Smith,

2005). The exposure to the images produced results in the interpretation, or decoding, of the messages and portrayals contained within the films (Hall, 1999). The influence of these messages is not merely limited to being entertained, or to finding out what has happened in the world, it also includes exposure to encoded values and ethics.<sup>1</sup> This exposure is particularly significant if the viewer does not have personal experience with the phenomena. For example, if the viewer watches a movie about mental illness yet has no personal experience with mental illness or the treatment of mental illness, they may believe what he/she sees is an accurate depiction. Portrayals of what is right and wrong, what is normal, and what issues are important are shared within the context of the film. For the naive viewer they do not have an alternate frame of reference with which to compare the depicted messages. They do not have a frame of reference to determine if what is depicted is out of the norm. As visual forms of knowledge and visual forms of communication become more common, the need to have the skills and abilities to deconstruct the portrayals and understand the messages contained within these vectors are increasingly important. It is critical to have nurses conducting research in the field of visual inquiry, as visual forms of communication provide a rich source of socially relevant data. Keller et al. (1990) suggest that the media has an enormous impact on the accuracy of public knowledge, general public attitudes, and the development of public policies. This includes public knowledge, attitudes, and the development of policies that impact nursing

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<sup>1</sup> For Hall (1999) it is the product of encoding and decoding that provides the audience with the meaning of sent or displayed messages; this will be discussed in detail within the methods section.



(Buresh & Gordon, 2000; Clarke, 2004; Honor Society of Nursing Sigma Theta Tau International, 1997; Kalisch, Kalisch, & Young, 1983).

The media has become a formidable factor in the formation of attitudes, opinions and beliefs (Hall, 2003a; Iedema, 2001; Jewitt & Oyama, 2001; Matas, el-Guebaly, Peterkin, Green, & Harper, 1985; Monaco, 2000). This extends to how we understand others (Gabbard & Gabbard, 1987; Hall, 2003b; Sieff, 2003; Wahl, 2003). Examples of “others” may be persons with mental illness disability and/or psychiatric nurses. Unfortunately, many depictions of people with a mental illness or psychiatric disability contribute to the continued stigmatization, oppression, and prejudice toward this group (Clarke, 2004).

The negative social attitudes toward people with mental illness compound the negative effects of the depictions of psychiatric nurses (Kalisch, et al., 1980) and have resulted in a skewed understanding of psychiatric nursing care. As a result, a person’s understanding of psychiatric nursing care, our expectations and assumptions regarding that care, and potentially, how care is experienced, are all influenced by the images within film. Therefore, it is essential for nurses to become aware of the messages contained within this visual medium. Unfortunately, nurse researchers have not devoted much attention to the subject of the portrayal of psychiatric nursing care in film. While academic examination of nurses in the media has occurred, it has focused on the characteristics of the nurse (Aroskar, 1980; Barley, 1990; Bloomfield, 1999; de Carlo, 2007; Donelan, Buerhaus, DesRoches, Dittus & Dutwin, 2008; Jinks & Bradley, 2004; Kalisch, et al., 1980; Kalisch & Kalisch,

1987; Payne, 2000; Stanley, 2008). There has been little emphasis placed on studying or discussing the portrayal of the nursing care delivered.

A substantial amount of research has been conducted to determine the effects of contemporary media on public belief systems (Boswell, 2001; Couser, 1997; Denzin, 1991; Farnall & Smith, 1999; Ganahl & Arbuckle, no date; Hall, 2003b; Keller, et al., 1990; Kriegel, 1988; Levers, 2001; Norden, 1994; Rose, 1998; Watson, 2004; Yuan, 1996). These researchers conclude that the media's power to influence public perception and the degree to which people are exposed to media representations combine to make the media one of the most significant influences in developed societies. The visual has become central to the cultural construction of meaning in contemporary Western societies (Guillemin, 2004; Hall, 2003a; Harper, 2000; Harrison, 2002; Prosser, 1998; Rose, 2005). The ocularcentrism of the west perpetuates the notion that images offer direct views of the world. Unfortunately, the images may or may not represent an accurate view of the world. This influence extends to how people view nurses, psychiatric nurses, psychiatric care, mental illness, and disability (Gabbard & Gabbard, 1987; Kalisch, et al., 1980; Kalisch & Kalisch, 1981b, 1982a; Welch, 1997). Therefore, it is critical that these representations be investigated. With this dissertation I attempt to reduce this gap by illuminating how psychiatric nursing care is portrayed in film. The relationship between the psychiatric nurse and the person for whom they care is a key factor in the delivery of competent psychiatric/mental health nursing care. Therefore, I will focus on the depictions of the relationships between the nurse and patient.

Nursing care is complex. There are several theories that nurses may use to help guide their practice (Cutcliffe, McKenna, & Hyrkas, 2010; Fawcett, Newman, & McAllister, 2004; Laurent, 2000; McCarthy & Aquino-Russell, 2009; Reed, Shearer, & Nicoll, 2004; Snowden, Donnell, & Duffy, 2010). One nursing theory that has been found to be appropriate for guiding psychiatric nursing practice is Peplau's Theory of Interpersonal Relations (1952/1988). This theory outlines the various roles a nurse may perform when providing care to others. These roles have been used as a guide to think about the provision of nursing care.

Nursing care, particularly psychiatric nursing care, cannot be performed competently without establishing an ethically based therapeutic nurse-patient relationship. Therefore, nurses also need a framework to help understand the components of an ethical relationship. Relational ethics is a framework that has been used previously within healthcare settings for this purpose (Bergum & Dossetor, 2005).

There is a plethora of films depicting psychiatric patients, psychiatrists and psychiatric care. My focus is on films that portray psychiatric nursing care. I explore how psychiatric nursing care is portrayed in English speaking films through the use of an interpretive visual inquiry research method to answer the following research question. How does cinema portray the relationship between psychiatric nurses and persons with mental illness?

To answer this question a background literature review has been completed. It focused on the depictions of nurses in the media. This background and literature review is contained within the second chapter of this dissertation.

The third chapter is used to explore cinematic depictions of psychiatric nurses and people with mental illness. Six films are used to explore the prominence of psychiatric nursing in the plot, personality characteristics, primary values of the psychiatric nurse, and professional competence. The films used are: *The Snake Pit* (Litvak, 1948), *High Anxiety* (Brooks, 1977), *One Flew Over the Cuckoo's Nest* (Forman, 1975), *Girl, Interrupted* (Mangold, 1999), *Strait Jacket* (Jones, 1998), and *Gothika* (Kassovitz, 2003). The chapter concludes with an exploration of the depictions of mental illness/disability and people with mental illness in film. The films used for this exploration are: *Silence of the Lambs* (Demme, 1991), *Hannibal* (Scott, 2001), *Kiss the Girls* (Fleder, 1997), *Hand that Rocks the Cradle* (Hanson, 1992), *Nightmare on Elm Street* (Craven, 1984), *Anger Management* (Segal, 2003), *Psycho* (Hitchcock, 1960), *Simon Birch* (Johnson, 1998), *Nell* (Apted, 1995), and *What about Bob?* (Oz, 1991).

Chapter four reviews Peplau's Theory of Interpersonal Relations (1952/1988, 1992; 1997). The importance of the nurse-patient relationship is discussed. The chapter concludes with a review of the potential roles of the nurse. The roles of the nurse, as outlined by Peplau (1952/1988) provide a means of thinking about the nursing care delivered within the films.

Chapter five provides an overview of Relational Ethics. A relational ethic framework is used as a guide when thinking about the nurse-patient relationships depicted. Many health care providers use a relational ethic framework to help guide their decision-making (Austin, Bergum, & Dossetor, 2003; Austin, Goble, & Kelecevic, 2009; Bergum, 2004; Bergum & Dossetor, 2005). The elements of mutual respect, engagement, embodied knowledge,

interdependent environment, and uncertainty are discussed. The chapter concludes with a discussion of the criticisms of relational ethics.

The next chapter, chapter six, focuses on the research method. The research question is specifically stated, the significance of the study is highlighted, the method of interpretive visual inquiry is explained, the film selection criteria is clarified, and the means of data analysis are described. This chapter concludes with a reflection on the study's limitations and ethical considerations.

Chapter seven provides an overview of the fifteen films used within this research project. The films used are: *The Sleep Room* (Wheeler, 1998), *Girl, Interrupted* (Mangold, 1999), *Cosi* (Joffe, 1996), *High Anxiety* (Brooks, 1977), *Titicut Follies* (Wiseman, 1967), *Frances* (Clifford, 1982), *Harvey* (Koster, 1950), *The Caretakers* (Bartlett, 1963), *One Flew Over the Cuckoo's Nest* (Forman, 1975), *Persona* (Bergman, 1966), *The Snake Pit* (Litvak, 1948), *Gothika* (Kassovitz, 2003), *The Jacket* (Maybury, 2005), *The Cobweb* (Minnelli, 1955) and *Terminator 2: Judgement Day* (Cameron, 1991). The location and setting, and plot are described. Nurses' roles/actions depicted within the film are outlined based on Hildegard Peplau's (1952/1988) delineation of nurses' roles in *Interpersonal Relations in Nursing*. The roles represented in the films include: stranger, resource person, teacher, leader, surrogate, counsellor, consultant, tutor, safety agent, mediator, administrator, recorder, observer, and researcher.

Chapter eight uses a relational ethic framework to review the films and the portrayals of the relationships between psychiatric nurses and persons with mental illness. Depictions of psychiatric nursing care, and the relationship in

which it is provided, are then discussed using the themes of mutual respect, engagement, embodied knowledge, environment, and uncertainty.

The ninth chapter highlights the primary themes of this research that emerged during the analysis of the depicted relationships. There are embedded themes within the depictions of the relationships. These themes are otherness, stigmatization, prejudice, maintaining power and control, domination, and marginalization. The chapter concludes with a discussion of implications this research has for nursing and further research suggestions.

The last chapter concludes with a summary of my thoughts on potential future academic activities in this area. The purpose of this chapter is to inspire further dialogue that may, facilitate the exploration of the impact of the media on our perceptions of the Other. It is hoped that such dialogue within nursing will stimulate further interest and research in how media has impacted the development of relationships in psychiatric nursing care.

## **Chapter 2**

### **Literature Review**

This review is an exploration of the available literature relating to the depictions of nurses in the media. The review is continued in Chapter 3 with my analysis of cinematic representations of psychiatric nurses, based on six selected films, using an established tool for monitoring media images of nurses and nursing. A description of the cinematic depictions of mental illness is also included in the next chapter. A review of media depictions of nurses, of psychiatric nurses in particular, and of persons with mental illness are necessary to provide the background to an examination of cinematic portrayal of the relationship between people with mental illness and the nurses who care for them.

#### **Nurses in the Media**

Each day, scores of images of nurses and nursing speed past readers and viewers, leaving only a diffuse awareness of their impact. These fleeting images rarely elicit prolonged contemplation or critical analysis. What symbolic worlds of nursing have these images produced? (Kalisch & Kalisch, 1987, p. ix)

The media has constructed thousands of portrayals of nurses. Within each of these portrayals are messages about the political, social, and economic value of nursing. Unfortunately, media consumers rarely consider the impact and consequences of these portrayals. Even more rarely, do nurse researchers study the visual. Traditional nursing scholars have prioritized the written word over visual forms of communication.

The image of nursing is socially and culturally determined. This image changes as people interact, with the passage of time, and with a change of place (Aroskar, 1980). For example, nursing images have evolved from men providing nursing care during the Crusades (Aroskar, 1980), to female unprofessional drunkards unable to find any other work, to female heroines, to female sex objects, to militant groups of women, and most recently, to careerists. According to Kalisch and Kalisch (1987), there are five dominant nursing image types depicted by the media between 1854 and 1982. These dominant images are: “1) the Angel of Mercy, 1854-1919; 2) the Girl Friday, 1920-1929; 3) the Heroine, 1930-1945; 4) the Mother, 1946-1965; and 5) the Sex Object, 1966-1982” (Kalisch & Kalisch, 1987, p. 8). These five image types parallel the four main images of nursing as described by Bridges (1990). Bridges (1990) main images are: 1) the ministering angel; 2) the battleaxe; 3) the naughty nurse; and 4) the doctor’s handmaiden. Bridges and the Kalischs also recognize that a new image has emerged – that of the militant nurse (Bridges, 1990; Kalisch & Kalisch, 1987). Since 1982, researchers have also identified the development of the careerist image being depicted in the media (Kalisch & Kalisch, 1987). A timeline is used to discuss each of these images, and an example of each of these images is provided in Appendix A.

The images of the nurse are “derived mostly from the historical roots of nursing and sometimes as a reaction to the increasing influence of the feminist movement” (Bridges, 1990, p. 850). However, it is important to note that all of these images are still present in contemporary media and influence public opinion about the profession of nursing. As other images of nursing emerge, the preceding images are not eliminated, the new image just adds another



dimension for public consideration and public consumption (Bloomfield, 1999).

#### **Pre 1854.**

Two predominant images emerged during this period of history. One is of women motivated by self-sacrifice and altruism, who are called to live a religious life caring for the less fortunate. This portrayal is the forerunner to the “Angel of Mercy” images that were predominate in the 1900’s (Bridges, 1990). The other is an image of a nurse at the polar opposite of the pious religious figure (see Appendix A), most notably Sairey Gamp (Dickens, 1843/1994) who is a drunken midwife and epitomizes all things unprofessional. Although these images are very different, they both represent women who were not in main stream society. They both occupied societal margins; albeit different margins. At this time, caring for the sick, dealing with bodily fluids and excrement, and the physical touching/intimacy that are required to provide physical care was seen as repugnant. In addition, nurses required little or no education. For example, during this time period, in Australia, convicts who could do no useful work were assigned nursing duties (Bloomfield, 1999). The work of nurses is portrayed in the literature of the time in a demeaning and trivial manner (Salvage, 1983). Florence Nightingale subsequently challenged this image of nursing. As a consequence, a new image of the nurse emerged – the angel of mercy.

### **The angel of mercy 1854-1919.**

In the English speaking world, Florence Nightingale, through her work in the Crimean War, began to challenge the notion that nursing was not an appropriate vocation for “proper women” (Simnett, 1986). She advocated that intelligent women, with the proper social connections, were needed to help improve the care for the injured soldiers. Nightingale recognized that when nurses were disciplined and well organized, they provided more effective care to the soldiers. In her role as Superintendent of the Female Nurses in the Hospitals in the East, or as she was generally referred to as Lady-in-Chief, she implemented measures for infection control and established kitchens to feed the soldiers and their families (Bloy, 2010). The nurses, through their dedicated and tireless efforts, made an impact on the image of nursing. For example, the poet Longfellow (1857), in *Santa Filomena*, writes of a lady with a lamp (Florence Nightingale), working heroically with the injured soldiers.

Lo! in that house of misery

A lady with a lamp I see

Pass through the glimmering gloom,

And flit from room to room.

(Longfellow, 1857, lines 21-24)

A lady with a lamp shall stand

In the great history of the land,

A noble type of good,

Heroic womanhood.

(Longfellow, 1857, lines 37-40)

Subsequently, the “Angel of Mercy” image arose (see Appendix A) through the images in newspapers, poems, drawings, and paintings. This image is a great improvement over the previous unprofessional image typified by Sairey Gamp. Florence Nightingale’s campaigns to educate the nurses helped to raise the image of the nurse from a repugnant, loathsome and demeaning occupation to one that required education, training, and strength of character (Kalisch & Kalisch, 1987). At this time novels and other media began to portray nurses as altruistic, noble, and self-sacrificing. Nurses are described as being trained versus untrained and unprofessional. For example, Kalisch and Kalisch (1987) quote the 1891 novel by Southam and Southam – *Three Weeks in Hospital*.

Surgeon Matthews stresses the difference between “born” and trained nurses. “no, my dear fellow”, interrupting a remark of mine, “you are wrong there, it is quite an old fashioned idea that a nurse, like a poet, must be ‘born and not made.’ In these enlightened days, one of these born nurses, whom you are so fond of talking about, would be quite useless in our infirmaries, unless she had undergone a thorough training.” (p. 22)

This depiction parallels the struggle nurses were experiencing, at this time, as they lobbied for more a formal nursing education system (Woodham-Smith, 1951). With this change in the image of nursing, the question can be raised whether nurses were becoming respectable because of their training, or because of the social status of many of the women entering nursing, now that nursing was seen as an occupation for “proper women.”

### **Girl Friday 1920-1929.**

The "Girl Friday" of the 1920s gave way to yet another historical image (see Appendix A). Despite the growing acceptance of women working outside the home, the roles women fulfilled were often seen as an interim activity before marriage. This notion that a relationship with a male was core to a woman's life extended to include a pervasive attitude that nurses were to be subservient to men (Bloomfield, 1999).

Nurses were seen as subordinate to physicians, more importantly, placed larger emphasis on love than their work, willingly abandoning nursing to pursue romance, marriage, or both. Their love affairs usually involved men met on the job – either doctors or patients – and the nurses stood faithfully by their lovers, helping them through thick and thin. (Kalisch & Kalisch, 1987, p.62)

As most nurses were female, this stereotype persisted until the onset of war when another image emerged – the heroine.

### **Heroine 1930-1945.**

It was not until the economy plunged and World War II broke out that the image of the nurse evolves beyond something to do, that could "keep a girl busy" until she got on with her life. Nursing is once again seen as a noble profession. Nurses are portrayed as patriotic, dedicated, and brave (see Appendix A). Kalisch and Kalisch (1982a) suggest that this is the most positive image of the nurse that has ever been portrayed by the media. Nurses are caring for men, making a contribution to their country, and as a result nurses are valued. Nursing during this time is seen as a worthwhile career. The "Heroine" image portrays nurses as "womanly, attractive, brave, and morally

pure” (Kalisch & Kalisch, 1982a, p. 606). But when the war was over, the heroic image of the nurse dissolved.

### **Mother 1946-1965.**

When World War II was over the number of women in the work force declined (Kalisch & Kalisch, 1987). There was a trend toward larger families and women left jobs outside of the home to embrace the role of wife and mother (Bloomfield, 1999). Women experienced societal pressures to return to a stable family based society. This meant that the mother stayed at home to take care of her family. The mass media disseminated these types of social messages effectively through television, newspapers, and radio (Hall, 1984; Jewitt & Oyama, 2001; McLuhan, 1964/2003; Monaco, 2000; Park, 1999).

The trend for women to stay at home and focus on a domestic life impacted the number of people interested in nursing as a career. If women wanted a family, nursing was typically no longer seen as an option. This belief is depicted in films and other media portraying nurses as leaving the profession once they married (see Appendix A). This perpetuates the idea and public opinion that there is no real personal fulfillment in nursing. As the feminist movement gains momentum, the wife/mother image of the post-war years loses favour. The “mother” image of the nurse collapses to become the stigmatized image of the nurse as a sex object.

### **Sex object 1966-1982.**

The sex object image of the nurse may have appeared in reaction to the increase in the popularity of the feminist movement (Bridges, 1990). Nursing was seen as a female profession; whose members knew about sexuality, frequently experienced the nudity of others, and often shared others intimate

personal experiences. The actions a nurse used to be empathetic and caring were metamorphosized into actions that suggested sexual yearning and promiscuity. The sexualization of nursing action resulted in the degrading of women, and the professional of nursing (Salvage, 1983), as they became the “focus of sexual titillation” (Kalisch & Kalisch, 1982a, p. 610) (see Appendix A).

During this time, portrayals of nurses demonstrating personal achievement, integrity, virtues, and intelligence in motion pictures are limited (Kalisch & Kalisch, 1982a); the focus is on their sexuality. During the years from 1960 – 1989, Stanley (2008) in his research found 183 movie story lines related to nurses. The largest proportion of the storylines relate to either romance/love (n=35) or sex kitten/object of desire (n=28). The other major story lines are related to a nurse’s care (n=24) or to a murder/mystery (n=24). As the image of the nurse evolves, Payne (2000) suggests that female gender role of a nurse becomes less stereotyped. However, the impact of the sexualization of nurses as being females continues to exist. For example, Spear (2005) describes anecdotal experiences that contradict Payne’s findings, as fifth grade school children still wonder if boys can be nurses.

### **Militant 1980-1995.**

Since the 1980’s, the sensationalism in the media related to nurses, has increased. Stories about nurses compete with other news stories and headlines, therefore, they are written to attract the most attention. The most predominant image in the media since the 1980’s is that of nurses on strike (Bloomfield, 1999). These images are frequently accompanied by an article that describes nurses as unhappy with working conditions and with the pay they receive.

Little is written about the positive role of nursing unions. An example is “Nurses' strike threat triggers new talks in N.B.; Vow to walk out Sept. 13 if no deal Province asks union back to table” (Canadian Press, 2004). Headlines such as this one influence how the reader interprets the information in the text of the article (Caulfield & Bubela, 2004). Therefore, this headline already suggests to the reader that nurses are expected to be uncooperative if their demands are not met.

As the power and control of women increased, so did the derogatory images. Images metamorphosed into the nurse as a self-serving labourer (see Appendix A). As a result, the projected image became one of an uncaring narcissistic group of women (Bloomfield, 1999; Kalisch & Kalisch, 1985a; Salvage, 1983).

#### **Careerist 1980 to present.**

Nursing advocacy groups now recognize the power of the media and are actively challenging nurses to display a professional image (Berry, 2004; Buresh & Gordon, 2000; Honor Society of Nursing Sigma Theta Tau International, 1997) (see Appendix A). They are attempting to ensure that a nurse is depicted in the media as a knowledgeable expert. This portrayal suggests that a woman's choice to be a nurse “may not be so much to support and advance her family as it is to realize herself as an individual” (Kalisch & Kalisch, 1987, p. 185). This depiction exposes the public to a nursing profession that is valuable, honourable, and worthy of respect. Unfortunately, there appears to be a lack of interest in the expert knowledge of nurses, or the portrayal of nursing as a career. This lack of interest continues from the 1960's and 1970's (Kalisch & Kalisch, 1982b). The College & Association of

Registered Nurses of Alberta (2010) are trying to impact public perception through their recent public awareness campaign *Expert Caring Makes a Difference*. The two primary objectives of this campaign are: 1) to impact public awareness regarding the importance of registered nurses in the provision of safe, competent, and ethical care, and 2) to provide Albertans with the facts on the vital role that registered nurses have within the healthcare system. This campaign uses advertisements on television and in newspapers.

### **The Nurse**

The image of the nurse has gone through many historical changes that have paralleled societal views of women. At times the nurse has been idealized, trivialized, and/or degraded. Nurses were idealized during the war – nurses were seen as heroes. After the war, the contributions of women were negated, as their contributions outside of the home were no longer needed. Nurses were working as a means of “filling time” until they married, raised a family, and experienced domestic bliss. The feminist movement then bore the sexualization of nurses – nurses were objects of sexual desire and titillation.

None of the above portrayals represent who a nurse really is. All are interpretations of reality (Park, 1999). Suggesting that nursing can be captured in a stereotype undermines the complexity of the profession of nursing. Depictions of nurses in the media is a compilation of facts, fiction, history, and myth. “The archetypal nursing figures are not merely a travesty of what real nurses are and what they do. They are closely related to the male defined images of women which we find where ever we look” (Salvage, 1983, p. 13). The above issues also plague the cinematic depictions of the psychiatric nurse.



## Chapter 3

### Cinematic Depictions of Psychiatric Nurses and Mental Illness

As I began the journey of this research, my first step was to look at the image of the psychiatric nurse and mental illness in film. Although this initial work was not about the nurse-patient relationship, and does not follow the same method using a relational ethic framework to guide the analysis, it was my starting point in examining cinematic depictions of psychiatric nurses and psychiatric nursing care. The method used is based on the work of Kalisch, Kalisch, and McHugh (1980). These researchers conducted a content analysis on film stereotypes of nurses using over 200 feature length films released between 1930 and 1980 that related to nursing or the image of nursing. They provided their *Nurse Character Analysis: Fiction Tool* and a *Checklist for Monitoring the Media* to me, and gave me permission to use these tools to conduct a small pilot study (personal communication, February 18, 2005). In the pilot study, I examined whether or not there had been any significant changes to the depiction of psychiatric nurses in film. The Checklist includes items such as: prominence in the plot, demographics, personality traits, primary values, sex objects, career orientation, professional competence, education, administration, and overall assessment. Understanding the nurse's personality characteristics, primary values, and the depictions of the nurse's professional competence were important. These attributes were thought to impact the relationship between the nurse and the patient. Just as nurses come to the nurse-patient relationship with their own characteristics, so do patients. I also wondered about how mental illness and how people with mental illness

were depicted. Therefore, I also conducted a review to determine the typical presentation of mental illness and of the people with mental illness.

In addition to the brief review I conducted there has been one ethnographic study that examined 19 American films made between the years of 1942 and 2005 concludes that these films “sketch mental health nurses and their patients as perverse curiosities” (de Carlo, 2007, p. 346) and fostered “the notion that mental health nursing occupies an aberrant, secret, and dangerous world and that its role remains one of custodial companionship” (de Carlo, 2007, p. 338). This study, however, does not investigate the relationship between the psychiatric/mental health nurse and the person for whom they care.

The results of the study by de Carlo (2007) conflict with the results of a mixed method research study by Stanley (2008). Stanley’s research purpose was to examine the “influence on how nursing and nurses are portrayed in feature films made between 1900 and 2007, with a nurse as their main character or a principle character and a story-line related specifically to nursing” (p. 85). There is no distinction made when selecting the films to focus on any specialty area of nursing. Although this study does include *The Caretakers* (Bartlett, 1963), *One Flew Over the Cuckoo’s Nest* (Forman, 1975), *High Anxiety* (Brooks, 1977), and *Persona* (Bergman, 1966) the total sample size is 827 films. Fifteen films are identified as having a plot line related to mental health nursing. This plot line was not discussed by Stanley within the article. However, Stanley (2008) did discuss the most common plot line ( $n=101$ ) as being nurses who fell in love or who engaged in romantic liaisons. He also discusses other minor plot lines that include missionary

nurses ( $n=9$ ) and nurse detectives ( $n=9$ ). Stanley (2008) describes seeing the “trend for films with strong professional, assertive, self confident nurses continuing and growing” (p. 93). This conclusion is not supported by research that focuses specifically on the specialized area of psychiatric/mental health nursing (de Carlo, 2007; Gouthro, 2009).

### **Cinematic Depictions of the Psychiatric Nurse**

Kalisch and Kalisch (1981b) have identified that psychiatric nurses have been depicted as physically less attractive than other nurses, typically given a spinsterish image. “Rigidly arranged coiffures; glasses; prim and starchy uniforms; and props associated with power – keys, clipboards – frequently marked these nurses” (Kalisch & Kalisch, 1981b, p. 117). This description varies slightly from de Carlo (2007). The psychiatric nurse in the films de Carlo studied embodied “every ghastly Dickensonian stereotype of both the inhumane nurse and the Victorian lunatic asylum: a peevish sex-starved spinster, overbearing, controlling, cruel, and custodial” (p. 344). However, he has also noted that psychiatric male nurses “were seen as hardened, middle-aged men and women were either tough, butch women, or young, nubile sex kittens (de Carlo, 2007, p. 343).

The following section begins with an overview of six movies that are analyzed to determine the image of the psychiatric nurse. The prominence of psychiatric nursing in the plot, personality characteristics, primary values of the psychiatric nurse, and professional competence are presented. These films were released between 1948 and 2003. Changes to the image of the psychiatric nurse during this time period are discussed. However, it is important to note

that every history is an act of interpretation laden with biases, and the history of psychiatric nurses in films is no exception.

### **The movies**

Five mainstream motion pictures and one alternative “B” film are identified as having a strong focus on psychiatric nursing. Although there are many other films that portray psychiatric nursing, the main stream films were chosen due to being of high quality, as evidenced by at least one Academy Award nomination. These films are *The Snake Pit* (Litvak, 1948), *High Anxiety* (Brooks, 1977), *One Flew Over the Cuckoo’s Nest* (Forman, 1975), and *Girl, Interrupted* (Mangold, 1999). In order to include a representation of a typical “B” genre film *Strait Jacket* (Jones, 1998) is also used. To include a more recent representation of Hollywood cinematography *Gothika* (Kassovitz, 2003) is also reviewed.

The first film chosen is *The Snake Pit* (Litvak, 1948), which was released in 1948. This film is based on Mary Jane Ward’s best selling autobiographical novel. It was filmed from the perspective of Virginia Cunningham, a young newlywed who is admitted to Juniper Hill State Hospital with amnesia. While there she receives electroconvulsive therapy, pharmacotherapy, didactic therapy, and hydrotherapy in an attempt to facilitate the recovery of her memory. There are several nurses in this film. Two psychiatric nurses figure predominantly - Nurse Davis and ex-nurse Summerville.

The second film, *High Anxiety: A Psycho-comedy* (Brooks, 1977), is an example of a satirical comedy. All of the characters work in a mental

institution. There are two psychiatrists and one nurse, Nurse Diesel, that figure prominently in the film.

*One Flew Over the Cuckoo's Nest* (Forman, 1975) is the next film reviewed. In this film a patient is admitted to a forensic psychiatric institution for evaluation. There is a power struggle between one of the patients and the head nurse – Nurse Ratched.

The fourth film, a typical “B” film, is *Strait Jacket* (Jones, 1998). The fictional Magnolia Mental Hospital serves as the backdrop for the character Percy Scavenger, a janitor, who investigates the mysterious disappearances/deaths of patients and visitors. The psychiatrist in this film is engaged in unethical experimentation with patients. Concern over this behaviour is further compounded, as one of the patients is the doctor’s sister. The lack of realism is further exaggerated when a patient uses his telekinetic abilities to levitate objects as he kills other patients. There is only one psychiatric nurse portrayed in this film. She is unnamed.

*Girl, Interrupted* (Mangold, 1999) is based on the experiences of writer Susanna Kaysen's 18-month stay at a mental hospital beginning in 1967. At the age of 17, Susanna voluntarily admits herself to McLean Hospital, a psychiatric facility in Belmont, Massachusetts. (In the film the institution is called Claymoore.) While there she confronts her illness, experiences profound unhappiness, and the treachery and kindness of peers and authority figures (nurses and psychiatrists). There are several nurses and orderlies characterized in this film. Nurse Valerie Owens is the most predominant psychiatric nurse.

*Gothika* (Kassovitz, 2003) is a more recent example of how Hollywood filmmakers portray people with mental illness, psychiatric nurses, and

psychiatric care. The film depicts a psychiatrist, who works at a large forensic psychiatric hospital, who is admitted for assessment after she is charged with the murder of her husband. There are several nurses depicted in this film.

### **Changes to the image of the psychiatric nurse**

The above films are used to generate data on the representational trends of the image of the psychiatric nurse in contemporary films. The Checklist for Monitoring Media Images of Nurses and Nursing (Kalisch & Kalisch, 1987) is used as a guide to complete this analysis. Kalisch and Kalisch (1987) developed this checklist as part of a large research project that looked at the overall image of nurses in the media. This tool does have relevance to psychiatric nurses. The tool aided in the collection of data in the following areas: plot prominence, demographics, personality traits, primary values, sex objects, role, career orientation, professional competence, education, and administration. These factors are pertinent regardless of what specialty area of nursing is being assessed. This tool does not facilitate the collection of data on the portrayal of ethical relationships. However, there has been no English language research publications analyzing the depictions of nursing care, which focuses on the nurse-patient relationship in the media (Kalisch & Kalisch, 1981a, 1983a, 1983b, 1983c, 1985a, 1985b; Kalisch, Kalisch, & Belcher, 1985; Kalisch, et al., 1980; Kalisch, Kalisch, & McHugh, 1982; Kalisch, et al., 1983; Kalisch & Kalisch, 1981b, 1982a, 1982b, 1987; Kalisch, Kalisch, & Clinton, 1982; Kalisch, Kalisch, & Petrescu, 1985).

When beginning this review, I had hoped that there would be evidence to suggest that the image of the psychiatric nurse had evolved over the 60 years represented by the selected films. Unfortunately, there is little difference in

how the psychiatric nurses, or the care they delivered has been portrayed. The depiction of psychiatric nurses in film continues to be very negative. This is in direct contrast to the trend that sees nurses, in general, depicted more often as strong competent professionals (Stanley, 2008). It is particularly interesting that the images of the psychiatric treatment facilities did not change either. Treatment is still associated with aging buildings, barred windows, rodents, massive locks on the doors, and located in an area that is geographically isolated. Therefore, what had originally been planned as an overview of the transition of the image of psychiatric nursing, had to become a description of prominence in the plot, personality characteristics, primary values, and professional competence of the psychiatric nurse as depicted in these films.

***Prominence in the plot.***

Nurses in all films hold positions with some administrative functions. For example, they are portrayed as Head Nurses, Administrators, or at the very least, having control over the orderlies. The depiction of nurses having these types of functions is consistent with the reality of nursing at the time the films were made. For example, nurses are in such short supply that as soon as they would pass their registration, or board exams, they are promoted to head nurse. It is interesting to note that amount of screen time could not generally be attributed to the importance in the plot. For example, Nurse Ratched in *One Flew Over the Cuckoo's Nest* (Forman, 1975) has a significant amount of screen time when compared to Nurse Diesel in *High Anxiety* (Brooks, 1977). However, despite this difference both characters serve as important and powerful antagonists.

The one extreme exception to this statement is *Strait Jacket* (Jones, 1998). Although this movie took place in a mental institution, there is only one scene that involves a nurse. The nurse is attempting to move a patient from one area to another. The entire scene lasts approximately 10 seconds. A nurse is not even listed in the credits.

In this movie the janitor is the main character and has the most screen time. It is of interest that the actor (Moon Jones), who plays the janitor, is also the writer, producer, and director of the film. One could speculate that if Mr. Jones had written himself to be a nurse, this nurse may have had a significant number of scenes and may have been portrayed positively. It is likely that the stereotype of nurses being female and subservient influenced Mr. Jones' choice to be a janitor rather than a nurse. Many of the actions carried out by Mr. Jones' character could have been demonstrated by a nurse. For example, engaging in therapeutic dialogue with patients, advocating for patient rights, and addressing unethical practices with the psychiatrist.

The nurse in *Gothika* (Kassovitz, 2003) also had minimal screen time, to the extent that we do not even learn her name. However, her images leave the audience believing that she will maintain control over the patients by whatever means is necessary.

### ***Personality characteristics.***

The personalities of psychiatric nurses are consistently portrayed as intelligent, rational, confident, ambitious, assertive problem solvers, and very powerful. However, these traits are used to the detriment of their patients and colleagues. For example, Nurse Ratched succeeds in getting McMurphy lobotomized when he would not conform to the rules of the unit. Nurse Diesel



succeeds in keeping wealthy patients hospitalized to ensure income for the institution. Any potentially positive personality trait is shown as transient and fleeting. Most of the nurses are seen as barren, unempathetic, rigid, and brutal. The facial expressions and uniforms add visual emphasis to the psychiatric nurses' repressed personalities. These visual metaphors include high-buttoned uniforms that are rigid and inflexible, tightly coiffured hairstyles, and large sets of dangling keys. Nurse Ratched's hairstyle even reflects the horns of a devil to further identify this character as a villain.

Most of the psychiatric nurses in film have a pervasive pattern of behaviour that demonstrates a disregard for human rights, for either the people in their care or their colleagues. This is evidenced by deceitfulness, such as using lies and manipulation to ensure that patients or colleagues comply with the nurse's wishes. The cinematic nurses also have a low tolerance for any type of behaviour that may be interpreted as a challenge to their authority. There is a consistent failure to practice in a manner that ensures non-malevolent, beneficent, and just behaviour. None of the nurses demonstrate any type of remorse, or insight, when they mistreat or hurt another person.

Several of the psychiatric nurses use their assertiveness to advocate with the physicians. However, the nurses advocate against the physician treating the patient as an individual and giving them "special treatment." This "special treatment" may include the physician writing an order allowing the patient to go outside, encouraging the patient to time to spend with family, or when the physician uses didactic group therapy and encourages the patient to talk about their emotions. This finding is consistent to that of Kalisch and Kalisch (1981b, 1982a). These researchers report that it is only the nurses

working in psychiatry that are depicted arguing with a physician. These behaviours also are also a reflection of their primary values.

***Primary values.***

Regardless of the year the movies were made, all the nurses are portrayed as guards and controllers of order. Very little time, if any, is spent doing nursing activities. For example, Nurse Ratched is portrayed with prototypical cinematic psychiatric nursing values. She values control, obedience and power – specifically power-over. All of these values are demonstrated with brutal consistency in a way that is detrimental to the patients. An image with Nurse Ratched and Billy typifies this portrayal. Billy is restrained into a submissive posture as Nurse Ratched towers over him, holding her keys as she condescendingly reprimands him for violating the unit rules. This scene represents the power and obedience that the cinematic prototypical psychiatric nurse craves. The moviemakers repeatedly conjure an image of the psychiatric nurse in this manner, despite the reality of nursing in this speciality area.

There is a scene in *Gothika* (Kassovitz, 2003) in which the nurse attempts to touch the principal character's (the patient's) knee. The principal character is demonstrating behaviour that indicates she is frightened and vulnerable. This touch could have been supportive and nurturing. However, the touch that has the potential to be reassuring is actually a means of manipulating the patient to take her prescribed medication. The filmmaker ensures that the audience understands that this medication will be given, with or without the patient's cooperation or consent. There is no empathy demonstrated.

Regardless of when the movies were produced power is the psychiatric nurse's principal value in relationships with patients. These images continue to perpetuate a general disdain for psychiatric nurses.

***Professional competence.***

The psychiatric nurse characters are not sincerely acknowledged for any professional competence that they may display. Those who are commended for their work are either sleeping with the physician that praised them (Nurse Diesel), or are praised for ensuring that the ward ran smoothly (Nurse Ratched). The "smooth running" ward is one that results in repeated violations of patient rights. If there is a suggestion that the nurse is genuinely competent, as Nurse Summerville in *The Snake Pit* (Litvak, 1948), it is at the expense of the nurse's sanity. Nurse Summerville leaves nursing when she is involuntarily admitted into Unit 33 (a locked maximum security unit – for those people with severe mental illness) at the Juniper State Hospital. The message communicated to the audience is that caring individuals cannot survive working as a psychiatric nurse.

Remarkably, over the last 60 years, the image of the psychiatric nurse in the films reviewed has not changed. Audiences consistently are encouraged to see psychiatric nurses as having considerable power. Unfortunately, all the nurses in the films are shown as misusing this power, frequently being obsessed with preserving their authority, and having personalities that are rigid and domineering. Hollywood filmmakers create a potent negative stereotype in the figure of the successful psychiatric nurse. These nurses achieve power and influence in their work, but sacrifice their ability to connect with others. For example, in the hands of the psychiatric nurse, power and influence are used

ruthlessly for personal advancement, revenge, sadism, or greed. Attitudes and behaviours toward the mentally ill by these powerful nurses demonstrate a deep sense of distrust, intense dislike to revulsion, and the use of extremely harsh methods of discipline.

In none of the selected films does a psychiatric nurse consistently demonstrate professional concern for her patients. This characteristic portrayal of the psychiatric nurse has shaped public opinion about this speciality area (Buresh & Gordon, 2000; Clarke, 2004; de Carlo, 2007; Edney, 2004a). This warped imagery of psychiatric nurses, embracing an insensitive philosophy of patient care, does a great disservice to the thousands of psychiatric/mental health nurses, and to the nursing profession as a whole. Consequently, I wonder to what extent these depictions have impacted the recruitment of nurses into the area of psychiatry and mental health that value relationships based on a power-with schema and those with an increased tolerance to deviance. These problems are compounded by comparatively little research money being spent in the area of psychiatric/mental health nursing which could further develop evidence-based practice in this area of nursing. Not only do these types of films impact public perception of psychiatric nurses, they affect the way the public views people with mental illness disabilities.

### **Cinematic Depictions of Mental Illness**

The media can easily perpetuate stereotypes and stigma. It is not unusual for people with a mental illness to be portrayed as violent and dangerous. Edney (2004a) has identified several negative thematic stereotypes portrayed in the mass media related to people with mental illness. These stereotypes include: dangerousness, objects of violence, pitiable and pathetic,

asexual or sexually deviant, incapable, comic figure, and burdensome. These stereotypes can be observed in several films: *Silence of the Lambs* (Demme, 1991), *Hannibal* (Scott, 2001), *Kiss the Girls* (Fleder, 1997), *Hand that Rocks the Cradle* (Hanson, 1992), *Nightmare on Elm Street* (Craven, 1984), *Anger Management* (Segal, 2003) and *Psycho* (Hitchcock, 1960); and in several newspaper stories (Barrett & Sadava, 2004; Brooymans, 2004a, 2004b; Cormier, 2004; LaJeunesse, 2004; Patrick, 2004a, 2004b; Ruttan & Mah, 2004).

For example, *Silence of the Lambs* (Demme, 1991) depicts people with mental illness as being dangerous, sexually deviant and burdensome. The negative impact of these types of movies and newspaper articles fuels public opinion that people with a mental illness are dangerous and violent; therefore, they should be controlled for the “good” of the rest of society. Despite this common theme in contemporary literature, only 3-5% of violent crimes are committed by people with a mental illness (Monahan, 1996). Individuals with mental illness are consistently among the most devalued and stereotyped of all persons with disabilities (Hinshaw & Cicchetti, 2000; Lyons & Ziviani, 1995). This societal devaluation is a contributing factor to the lack of treatment and research resources dedicated to this demographic (Bryne, 1999). Consequently, it is difficult to attract and retain talented people to work in this specialty area of nursing.

Mental illness, alcoholism, drug abuse, poverty, and homelessness are often portrayed as culpable (Beeber, 1998; Canvin, Bartlett, & Pinfold, 2002; Corker, 2001; Corley & Goren, 1998; Crawford & Brown, 2002; Gray, 2002; Hall, Stevens, & Meleis, 1994). Such beliefs are expressed in statements such

as “they are non-compliant” or “they have made poor choices.” Several authors identify non-compliance as a common stigma faced by people with mental illness (Canvin, et al., 2002; Cunningham, 2000; Marland, 1999; Moyle, 2003). In his article, “Officer's Death May Reopen Debate Over Compulsory Mental Health Treatment,” Barrett (2004) perpetuates the assumption that people with mental illness are non-compliant and dangerous. Several researchers and clinicians have documented that these opinions and stereotypes result in under funding of mental health services, delays in establishing standards of psychiatric care, and under funding for basic and applied mental health research efforts (Holley, Jeffers, & Hodges, 1997; Playle & Keeley, 1998).

The stigma and stereotypes formed by the portrayal of people with disabilities is a result of the lack of a relationship between the self and the Other. This consequence maybe a result of movies that do not portray people with disabilities or the treatment of impairments in a realistic manner. For example, depictions of people with a mental illness as extremely dangerous, and the psychiatric care they receive as either incompetent or/and controlling. Therefore, the inaccurate depiction of people with disabilities, including mental illness, and the treatment of impairments in the media is an ethical concern. The next section reviews how disability is portrayed in contemporary cinema.

## **Disability Portrayed in Contemporary Cinema**

### **Defining disability**

Disability has been defined in a number of ways. The *Oxford Dictionary of English* defines disability as “a physical or mental condition that

limits a person's movements, senses, or activities” (Oxford University Press, 2003, on line reference). The *Concise Medical Dictionary* defines disability as “a loss or restriction of functional ability or activity as a result of impairment of the body or mind” (Oxford University Press, 2002, online reference). In both of the definitions, mental illness can be a cause of disability. These two definitions are consistent with the traditional medical model of disability.

In contrast, the social model of disability defines disability as the barriers of prejudice, discrimination, and social exclusion. More precisely, disability is the disadvantage or restriction of activity caused by a society which takes little or no account of people who have impairments and thus excludes them from mainstream activity. (Therefore, disability, like racism or sexism, is discrimination and social oppression). (Morris, 2001, p. 2)

Within the social model of disability, it is the stigma associated with having a mental illness that produces the disability. The symptoms associated with the mental illness produce an impairment. In this model impairment is differentiated from disability. As an

impairment is a characteristic, feature or attitude within an individual which is long term and may or may not be the result of disease or injury and may 1. affect that individual's appearance in a way which is not acceptable to society, and/or 2. affect the functioning of that individual's mind or body, either because of, or regardless of society, and/or 3. cause pain, fatigue, affect communication, and/or reduced consciousness. (Morris, 2001, p. 2)

Disabled people, according to this model, then, are those with impairments who are disabled by society. This does not preclude that they may have functional limitations because of their impairments. When disability is socially defined it is closely related to the meaning of stigma. The meaning of the word stigma has evolved over time to be used when referring to a deeply discrediting attribute or trait (Goffman, 1963). Strangers are determined to have these attributes or traits based on weaknesses, perceived disability, handicap, impairment, or shortcomings. Expectations are then developed for “this kind of person.” This kind of person is “reduced in our minds from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p.3). This leads to discrimination, prejudice, and oppression. In other words, stigma leads to disability.

As a consequence of stigma and disability, we know little of “those” strangers, which are often referred to as the Other, and we engage in only shallow interactions with them (Bauman, 1993; Norden, 1994). Within the shallow interactions, “rational” attempts are made to group the Others (basically unknown to us) by using calculable and impersonal rules. These rules could also be referred to as prejudice. These prejudices may include ideas such as physical disability equals burden and suffering, or mental illness equates to unpredictability and dangerousness. The process of assigning people into groups of aggregates based on specific traits or attributes (discrimination) destroys the potential to see them as fully human and worthy of moral action (oppression). This is an ethical concern. Bauman (1993) writes that once the object [the Other] has been dissembled into traits; the totality of the moral subject has been reduced to the collection of parts or attributes of



which no one can conceivably be ascribed moral subjectivity. Actions are then targeted on specific traits of persons rather than persons themselves, by-passing or avoiding altogether the moment of encounter with morally significant effect. (p. 127)

Disability need not only be thought of in the dualistic manner advocated by the Social Model of Disability. It can be looked at in a postmodern way as both “personal trouble” and as a “political issue” (Williams, 2001). Williams (2001) argues that the:

trick is to see the thing [disability] nondualistically, to recognize impairment/disability not as something that is either-or but as simultaneously and ontologically both personal and public – to see it, therefore, as something that requires methodological lenses to help us change focus easily, without feeling that talking about one excludes or even betrays the other. (p. 123)

Therefore, from this perspective, the relational aspect of disability is of primary concern. It is both the individual and the collective experiences that give meaning to the term disability. When this connection/relationship is not acknowledged and honoured, it is an ethical concern. This is of particular concern in psychiatric/mental health nursing as the relationship is the foundation upon which ethical nursing care is provided (Canadian Federation of Mental Health Nurses, 2006). I will now turn my attention to how disability is portrayed in contemporary media and then, in chapter five, reflect on the framework of relational ethics as a means of navigating the ethical competent of safe health care relationship.

### **Portrayals of disability**

The depictions of disability in cinema reveal that disability has no consistent or no easily recognizable form. For example, in the movie *Simon Birch* (Johnson, 1998), Simon is portrayed as being very, very small for his age. We also notice abnormal movement of his wrists and ankles. Simon is called a “freak,” “a granite mouse,” and a “mishap.” We understand that Simon is disabled. Concomitantly, Simon’s father is portrayed as being emotionally unavailable, a neglectful father, and a pagan. Could he be considered emotionally disabled? Or, is he just a bad father? Another example is provided in the movie *Nell* (Apted, 1995), which depicts a woman found after her mother dies who is unable to communicate with the doctors that want to provide care for her. Yet, she was able to communicate with her mother prior to her death. Is Nell disabled? Has this woman always been disabled? Or, is she only now disabled because the doctors can’t communicate with her? Who actually has the disability?

The movie *What about Bob?* (Oz, 1991) provides yet another example of the complexity of the portrayal of disability. This movie portrays a man, Bob (Oz, 1991), with extreme phobias, obsessions, and compulsions who seeks treatment from a very learned and successful psychiatrist, Dr. Martin. It becomes evident that Bob’s phobias restrict what he is able to do, and how he is able to act. Bob is portrayed as a social outcast. Despite Dr. Martin’s usual clinical treatments, Bob continues to experience impaired cognitive, emotional, and social functioning due to his severe anxiety and phobias. Bob decides to take a vacation. Ironically, he decides to vacation at the same place and at the same time as Dr. Martin and his family are vacationing. However, it is Dr.

Martin who is not welcomed in to this vacation community. This is because he successfully purchased a summer home by out bidding a local couple, who had saved for years to buy this house, their dream home. The local community members, due to Dr. Martin's pompous attitudes and bourgeois demeanour, further ostracize him. In comparison, Bob is welcomed into this community and develops a number of friendships despite his emotional limitations and his strange behaviour.

Norden (1994) argues that when people with disabilities are portrayed in movies as the Other, it increases the objectification of people with disabilities. All of the main characters in the three movies cited above are objectified; 1) Simon Birch is not taken seriously and was an object of parental scorn; 2) Nell is objectified as she is viewed by one of the doctors as an object of pity and something that needs to be cared for; and 3) Bob is an object of Dr. Martin's scorn as he does not get better with the course of usual psychiatric treatments. The objectification of each of these characters is a result of the moral disassembly of their humanity. Consequently, without recognition of the Other's humanity, we are left with a moral void. Within this moral void we are unable to answer the following ethical questions. What is important? What is the right or most fitting thing to do? How should I act? From a relational ethics perspective, a lack of relationship between the self and the Other is an ethical concern. There is currently no research that has documented the depictions of the relationship between psychiatric nurses and the people they care for with mental illness using a relational ethic framework. Relational ethics will be discussed in more detail in chapter five.

The language used within the Social Model of Disability facilitates the articulation of the experiences of people with disabilities as a human rights issue (Morris, 2001). Within this framework “anatomy is not destiny” (Morris, 2001, p. 2), instead it is the disabling barriers of society that determine quality of life. For example, in her short story, *Eye of the Beholder*, Joan Aleshire (2004) describes how having misshapen arms due to medication her mother took while pregnant affected her life. She describes herself as being born with malformations below my elbows, three fingers on my left hand, two on my right. My right arm is shaped like a wing, forearm and upper arm connected by skin; my left arm twists strangely, bunched at the elbow but mobile. (Aleshire, 2004, p. 30)

These malformations, and the resulting impairments require her to do things, like writing and typing, differently than others. However, she does not see herself as disabled. Unless, someone prevents her from doing something because of her misshapen arms. For example, if she had the adaptive devices that allowed her to play piano would we value her performances less because she is not using her own fingers? Within the social model of disability, she is only disabled when others make assumptions, often misinformed ones, about her abilities or inabilities. These assumptions form the basis of oppressive and discriminatory attitudes. They form the basis of stigma. These assumptions interfere with the development of an ethical relationship. When extrapolated to the provision of nursing care, when there is stigma present between the nurse and the person he/she is caring for, stigma can undermine the possibility of an ethical relationship. When there is not an ethical healthcare relationship, the

voice of the Other cannot be heard which leads to prejudice and discrimination.

Not only can stigmatizing and disabling opinions be formed on the basis of appearance, they can also be a result of assigned roles. One such role is that of “the patient.” Vivian, in the film *Wit* (Nichols & Thompson, 2001), is a person being treated for cancer. She describes what it is like to have her physical impairments increase as her cancer grows. The impairments she describes are her experiences with fatigue, pain and despair. Even though her physical abilities decrease, it is not these impairments that lead to her disability; it is the attitudes of others. Vivian is treated as a non-person - “she’s research!” cries her young physician at one point in the movie. She is viewed as the specimen container for the cancer – what happens to her self/essence/being is irrelevant. Her humanity is disassembled.

The doctors do not treat her as someone with whom they need to connect. They practice on the premise that they do not have a connection with her. Their actions reveal prejudice, discrimination, and social exclusion. The dynamic of their relationship is that the doctors have power-over Vivian, even though they cannot exterminate the cancer. The doctors seek perfection in their treatment of Vivian; perfection to them means ridding Vivian’s body of cancer. Egoism and narcissism are unavoidable consequences in this quest for perfection. When it is obvious that perfection will be unattainable, the physicians experience vulnerability.

It has been hypothesized that this sense of vulnerability can easily lead to a quest for power-over the Other. Olthuis (1997) writes:

in this model we have a world of ceaseless conflict and endless competition until one proves him/herself superior. But in such a world, when neither is able to surrender voluntarily, striving eventually becomes empty and meaningless because each person remains alone, disconnected, incapable of change and development. (p. 14)

*Wit* (Nichols & Thompson, 2001) provides an example of healthcare practitioners' quest for perfection, regardless of the relational consequences that this quest may have. The discriminatory attitudes and practices of Vivian's physicians impose a greater burden on her than the biological aspects of her physical impairments.

There is a complex interaction between the depictions of people with disability in contemporary media and the public's understanding of disability. This is due to the ideological, sociological, financial, historical, technological, and political forces which determine how people with disabilities are portrayed in contemporary media (Gabbard & Gabbard, 1987). Yuan (1996) further clarifies this thought when he states "freakishness cannot be understood without interrogating the culture in which [we] live" (p. 377). It is important to understand that contemporary media is one way a culture can stereotype a group of people, then base and justify social treatment upon the generated stereotype. Watson (2004) writes that "popular entertainment contributes to the cultural climate in which we all live. Ideas have power; words and images have consequences" (p. 146). More specifically, words and images have ethical consequences; they have the power to influence public opinion and subsequently shape public policy. For example, there is sufficient evidence to indicate that if the cultural representations of a marginalized group depict them

as a burden, government policies and resulting legislation will change toward removing and reducing such a burdensome population (Alberta Alliance on Mental Illness and Mental Health, 2003; Bickenbach, 2001; Bryne, 1999; Burris, 2002; Canvin, et al., 2002; Corker, 2001; Cox, 2004; Crawford & Brown, 2002; Edney, 2004a; Ennis, 2004; Garske & Stewart, 1999; Lyons & Ziviani, 1995; Morris, 2001; Rose, 1998).

Due to the fact that the portrayal of people with disability in media has consequences, we must be cognizant of the messages that are peddled. Hodder (1994) suggests that the “meaning [of the film] does not reside in a film but in the making and the viewing of it” (p. 394). Ethics has a central position in the portrayal of people with disabilities in media that typically goes unnoticed, and uncommented upon, until viewed by someone for whom impairment or disability has a personal meaning (Morris, 2001). My choices of media demonstrate my preoccupation with certain ethical questions and I do not pretend to address all of the salient questions/concerns related to the portrayal of people with disability in contemporary media. However, as I watch the media’s depiction of people with psychiatric disabilities, and the depiction of the psychiatric nursing care provided, I find myself asking ‘what is important?’ and ‘what is the right or most fitting thing to do?’ or asking ‘as a psychiatric nurse how should they/I act?’ These questions are the questions of ethics (Bergum, 1994).

According to Nussbaum (1990), it is reasonable to use literature to help examine these types of pressing questions and perplexities and search for images of what is important, and what we might be and do. Literature has many forms. For example Hall (1999) includes written and visual texts in what

he understands as literature. It is this understanding that is used throughout this research. In pursuing the answers to the questions of what is important and what we might be and do, it is “through explicit comparison and explanation not diminution of the novels [literature] at all, but rather an expression of the depth and breadth of the claims that those who love them make for them” (Nussbaum, 1990, p. 29). I think this argument can be extended to films. Hall (2003b) supports this notion and extends it to include films, and all genres of contemporary media in his exploration of the Other.

In contemporary cinema people with disabilities are consistently displayed in the context of the relationships they have with others. The dynamics of these relationships can take many forms. For example, the person with the disability can be displayed as an angel or a special messenger. This is the case in Rick Scott’s music video *Angels Do* (Peltier, 1997). Scott’s granddaughter has Down’s Syndrome. In this video she is dressed up as an angel, and Scott sings about the relationship this special child has with his family. On the other end of the spectrum is the portrayal of the baby in *Rosemary’s Baby* (Polanski, 1968). Although we never actually see this baby, the characters in the film can “tell just by looking at him” that he is the son of Satan. It is left up to the viewer’s imagination to determine what type of horrible deformity signifies such evil. Does this baby have horns? Or, has this baby some type of birthmark? Polanski (1968) projects the stereotype of the demonic cripple (Kriegel, 1988). This stereotype is so powerful that we do not even need to actually see a corporeal being to link disability with profound evil. We only need to see the reactions of others to believe that there is something profoundly abnormal. This movie demonstrates that the less we are



able to know (or see) of the Other, the more frightening they can be. Other negative portrayals include comical characters (Norden, 1994) who cannot establish mutually respectful relationships, as Bob in his relationship with Dr. Martin in *What about Bob?* (Oz, 1991), Tiny Tim in *A Christmas Carol* (Dickens, 1843/2003) or *Forrest Gump* (Zemechis, 1994) as canonized versions of the charity cripple (Kriegel, 1988), they are consistently seen as an object of pity.

It is clear that the media impacts ethical decision-making. Specifically, the media influences public opinion regarding “what is a disability?” and “how do we relate to a person with a disability?” The danger of harm rests within a society that has not yet examined its stereotypical, socially constructed, views of disability, or how relationships are constructed with people with a disability. This includes relationships between psychiatric nurses and people with a disability – such as mental illness.

## **Chapter 4**

### **Roles of the Psychiatric Nurse in Relationships with Patients**

Nursing practice is the behaviour used by nurses to achieve patient goals identified through the application of a unique and specialised body of knowledge, which is constantly undergoing evaluation and research. The unique and specialised body of knowledge is a synthesis of the interaction among the concepts of person, health, environment, and nursing. Using this description of nursing practice, nurses practising without integrating and synthesising nursing theory into their behaviours are not practising nursing.

There are several nursing theories from which nurses can choose as a foundation of their practice (Cutcliffe, McKenna, & Hyrkas, 2010; Fawcett, Newman, & McAllister, 2004; Laurent, 2000; McCarthy & Aquino-Russell, 2009; Reed, Shearer, & Nicoll, 2004; Snowden, Donnell, & Duffy, 2010). A nursing theory developed by Hildegard Peplau, a major figure in the development of contemporary psychiatric nursing practice, is the Theory of Interpersonal Relations (1952/1988). Although Peplau's theory may be used by, or may inform the practice of any nurse, nurses practicing in the area of psychiatric and mental health nursing find it particularly relevant (Beeber, 1998; Beeber, 2000; Beeber & Bourbonniere, 1998; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006; Lego, 1980; Merritt & Procter, 2010; Thelander, 1997; Vandemark, 2006). This relevance lies in its focus on interpersonal relationships.

### **Relationships in Psychiatric Nursing Care**

The importance of the interpersonal relationships is identified by many researchers (Austin, et al., 2003; Bauman, 1993; Bergum, 2004; Cameron,

1992; Corley & Goren, 1998; Courey, Martsolf, Draucker, & Strickland, 2008; Gastmans, 1998; Lego, 1980; McCarthy & Aquino-Russell, 2009; Moyle, 2003; Peplau, 1952/1988; Peplau, 1992, 1997).

Lego (1980) completed a review of one-to-one nurse-patient relationships from 1946 to 1980. She defines the nurse-patient relationship as:

the relationship between the psychiatric nurse and his/her patient, formed for the purpose of brief counselling, crisis intervention, and/or individual psychotherapy. The emphasis is on the interpersonal relationship between the nurse and the patient, with all its vicissitudes, as opposed to the physical care of the patient. (Lego, 1980, p. 4)

These types of relationships are used as therapeutic tools. Lego (1980) identifies that Peplau's theoretical framework was the first to emerge and that it had far reaching influence related to providing an "organizational scheme for describing and explaining certain recurrent existential states of affairs" (p. 9).

Peplau's work continues to have a significant impact on the conceptualization of interpersonal relationships between the nurse and the patient, according to L. S. Beeber, who documented the development of the concepts related to the nurse-patient relationship from the years 1980 to 2000 (Beeber, 1998; Beeber, 2000; Beeber & Bourbonniere, 1998). Beeber and Bourbonniere (1998) identify the nurse-patient relationship as a critical, data rich concept. They note the conceptual linkage between the interpersonal patterns within the nurse-patient relationship and aesthetic knowing. Aesthetic knowing is defined as:

a complex process that is a conglomerate of the perceptions and activities of the nurse used to arrive at the appropriate intervention. It

requires the processing of data that is collected from the patient, from the nurse and through the empathetic linkage between the nurse and the patient. (Beeber & Bourbonniere, 1998, p. 189-190)

Given that Lego (1980), Beeber (1998, 2000), and Beeber and Bourbonniere, (1998) have analyzed the literature related to the nurse-patient relationship up to the beginning of the 21<sup>st</sup> century, the remainder of this chapter will be focused on the last 10 years. The work of Peplau will be addressed as a key concept in the analysis of psychiatric nursing care in film.

Relationships are considered essential in all areas of nursing, whether the nurse practices in highly technical areas, such as in an intensive care unit or an emergency unit, or in an area such as psychiatric or mental health nursing (Coatsworth-Puspoky, et al., 2006). The Canadian Federation of Mental Health Nurses (2006) identifies that the relationship between the nurse and persons he/she provides care for is central to the delivery of competent, ethical, and safe psychiatric nursing care. The importance of the relationship is echoed by several nursing theorists (Newman, 1990; Parse, 1992; Peplau, 1952/1988; Watson, 1985). All of these theorists argue for a nurtured relationship “between” the nurse and their patients. However, Peplau (1952/1988) views nursing as a goal directed interpersonal process that “demands certain steps, actions, operations, or performances that occur between the individual who does the nursing and the person who is nursed” (p. 5). This “between” is an essential aspect in the development of a therapeutic relationship.

In her theory, Peplau (1952/1988) identifies characteristics that encompass caring relationships. These characteristics include an assumption that there is interaction between the nurse and the patient – there is an invited

conversation (McCarthy & Aquino-Russell, 2009). Another characteristic is that the relationship is a professional relationship, and exists to support the patient's overall health and well-being (Gastmans, 1998). To establish this type of relationship nurses must "respect their patients as having unique value in themselves" (Gastmans, 1998, p. 1317). This leads to the third characteristic of a caring relationship, nurses seeking to learn about the uniqueness of the other person (McCarthy & Aquino-Russell, 2009). Nurses try to understand what is important to the patient, their history, and their motivation. The fourth characteristic is that there is an opportunity for a connection between the nurse and the patient (Gastmans, 1998) that will affect the patient's health and well-being and the nurse.

It is through a caring relationship that a dialogue can be established and efficacious nursing care delivered. Peplau's theory of Interpersonal Relations (1952/1988) identifies four overlapping phases of the nurse-patient relationship: orientation, identification, exploitation, and resolution phase. These have been redefined by Forchuk (1991) as three overlapping phases – the orientation phase, the working phase, and the resolution. Within the orientation phase an understanding is developed of how the patient arrived at this point in time. The nurse seeks or gathers information on the uniqueness of the particular patient's perspective. This is done through listening to the patient as they tell their story related to their "situation, procedures to be carried out, events that occur around him provide contacts for observing and finding out what the patient expects of nurses and how he feels about illness" (Peplau, 1952/1988, p. 28). The working phase has been subdivided into identification and exploitive sub-phases (Forchuk, 1991). During the identification sub-

phase, patient needs and the issues to be worked on within the nurse-patient relationship are identified. This is the planning portion of the working phase (Forchuk, 1991). Once the nurse and the patient have started taking action, they have moved into the sub-phase of exploitation. It is during this stage that the patient makes “full use of the services offered to him. In various ways he attempts to derive full value from the relationship” (Peplau, 1952/1988, p. 37). The final phase of the relationship is resolution. Resolution begins when “all plans have been implemented and ends when no further nurse-patient encounters occur” (Forchuk, 1991, p. 56). The focus of this phase is to reduce any dependency on the nurse. Peplau (1952/1988) viewed this stage as a “gradual freeing from identification with helping persons and the generation and strengthening of [the patient’s] ability to stand more or less alone” (p. 40).

### **Psychiatric Nursing Roles**

Within the nurse-patient relationship the nurse fulfills a number of roles in an effort to work with the patient to achieve the identified goals. These roles offer a cogent nomenclature to think about and describe nursing care. Hildegard Peplau (1952/1988) discusses 14 nursing roles. However, Forchuk (1991) identifies that the “specific roles are limited only by the imagination and skill of the nurse” (p. 56). The roles Peplau (1952/1988) describes include: role of stranger (nurse and patient become acquainted), role of resource person (supply of knowledge and technical procedures), teaching role (provide instruction regarding health related issues), leadership role (involves collaboration, guidance, direction and support), surrogate role (functions as advocate or substitute for another), role of counsellor (engages with patient to explore current situation), consultant role (provides speciality knowledge),

tutor role (mentors others), safety agent role (facilitates patient's and staff member's safety), mediator role (assists in negotiations and conflict resolution), administrator role (functions to oversee operations), recorder role (ensures documentation is completed), observer role (monitors), and role of researcher or study-maker (investigates phenomena of interest).

Several researchers have tested Peplau's Theory of Interpersonal Relations (1952/1988). For example, Coatsworth-Puspoky, Forchuk and Ward-Griffin (2006) found this theory to be a valuable nursing tool that can be used to restore and promote the patient's health and well-being. Feely (1997) also found that when she used Peplau's theory she could identify that the nurse engaged in a number of nursing roles when care was provided to a person experiencing a depression. These roles included: stranger, resource person, teacher, surrogate, and counsellor (Feely, 1997).

In areas other than the speciality area of psychiatric mental health nursing, Peplau's theory also has relevancy. For example, Marchese (2006) found that this theory provided a conceptual foundation upon which to base nursing actions related to the education of patients undergoing urinary diversion procedures. In further support of the applicability of this theory, McCarthy and Aquino-Russell (2009) and McCamant (2006) have demonstrated the usefulness of Peplau's Interpersonal Theory in an emergency room. It is also argued that Peplau's theory is applicable to surgical settings (McCamant, 2006).

Interpersonal Relations Theory (Peplau, 1952/1988) has also been tested in a public health setting that focused on providing pre and post natal support through home visits. McNaughton (2005) found that her research

supported the use of Interpersonal Relations Theory (Peplau, 1952/1988) as a relationship-based theoretical framework to guide home visits and monitor relationship development. Although McNaughton (2005) did not specifically list the roles the nurses engaged in during these visits, she did identify a number of tasks they performed. These included: assessment, teaching, discussion of plans, engaging in supportive social talk, giving advice, affective support, referral, and advocacy. Although not specifically linked with the roles of the nurse identified by Peplau (1952/1988), these tasks could potentially correlate to the nursing roles of: resource person, teacher, surrogate, counsellor, and mediator.

Regardless of the research setting, when the process of care was studied, nurses were required to engage in different nursing roles. These included roles such as stranger, teacher, leader, surrogate, counsellor, mediator, and resource person to ensure that the needs of the patients were met (Courey, et al., 2008; Marchese, 2006; McCarthy & Aquino-Russell, 2009). Therefore, Peplau's Interpersonal Relations Theory (1952/1988) has been shown to be relevant in a number of clinical settings, and is of particular importance in mental health settings. As a result, it has been chosen as the nursing theory for use in this research project.



## Chapter 5

### **Relational Ethics: A Framework for Ethical Practice**

Nurses use theories other than nursing theories to guide their practice. Theories of ethics, for instance, are important for guiding action and decision-making processes. As I am particularly interested in the relationship between the nurse and the patient, relational ethics, an approach to ethics grounded in the assumption that ethical action is situated in the relationship, is particularly meaningful. It offers a framework with which to consider and analyze such relationships, and is congruent with Peplau's Theory of Interpersonal Relations. In this chapter, relational ethics and its core elements are reviewed.

Ethics in clinical settings are complex, multifaceted, and often confusing. Clinicians have long searched for paradigms that can be used to help guide them to make ethical decisions. However, many clinicians have been exposed to theoretical frameworks that were not robust enough to capture all the different variables they must consider when making ethical decisions and determining what action to take. Based in the postmodern paradigm in which the "critical search for truth is constrained to be tolerant of ambiguity and pluralism, and fallible rather than absolute or certain" (Tarnas, 1993, p. 396), relational ethics has the capability to consider the specifics of a clinical situation and embrace the uniqueness of each participant in a way that other frameworks may not. As a result, this perspective has a great deal of appeal to many healthcare clinicians.

Clinicians are able to use their past experiences and knowledge to help guide ethical actions while using a relational ethic framework. The multidimensional nature of reality, the complexity of the human spirit, and the

growing theoretical knowledge are all appreciated within relational ethics. Through “allowing” the consideration of alternative views and perspectives the possibilities for resolution and action are almost limitless. The generous flexibility that the “postmodern vantage point allows is unlikely to make moral life *easier*. The most it can dream of is making it a bit more *moral*” [italics are in original source] (Bauman, 1993, p. 15). The increased morality can be seen when an individual or group, whose needs are not captured by an existing rule or principle, can have their differences acknowledged and considered as decisions are made (Shanner, 2000). Furthermore, if there are unjust social structures, we are moved to react to them and thereby address systems that are ineffective. The action focus of relational ethics fits well with clinicians’ axioms of duty and beneficence.

Relational ethics reflects the web of judgements, feelings, and perceptions that arise from the complexity of life and attempts to find a balance between/with the dialectic of the general and the particular. Understanding our relationships with others, and the ethical actions to be taken, requires knowledge of traditions, universal principles, rationality, our subjectivity, and our interconnectedness (Austin, et al., 2003; Bergum, 2004; Gadow, 1999; Rodney, Pauly, & Burgess, 2004). This connection of knowledge is at the heart of relational ethics. This contrasts with other approaches that require a disembedded and disembodied self. For example, Rawls’ (1971) believes that political ethical decisions should be based on the premise of justice. He argues for the requirement of assuming an “original position” when making moral judgements as a means of being unbiased and

being able to distance oneself from one's own needs. This is not possible from a relational ethic perspective.

Within a relational ethic framework it is recognized that all the participants have their own views and opinions. During interactions with others it is not possible to set these aside and "become unbiased". It is possible, however, to recognize our biases and the impact they may have on our interactions. Furthermore, the Rawlsian model for moral judgements is a closed model as compared to a relational ethic model in which there is no closure of reflexivity. This reflexivity addresses the normative consequences due to the impossibility of shedding productive and/or disruptive biases and beliefs as required by Rawls's concept of the 'veil of ignorance'. I will discuss this concept in more detail later in this chapter.

Relational ethics can be seen as a way to empower all those involved in the clinical situation. With issues and concerns considered within the context of a relationship, problems are envisioned and solutions/decisions determined collectively (Bergum & Dossetor, 2005). There is explicit attention to the possibilities of power-over relationships being established and individuals being marginalized. Effort is directed at the nurturance of power-with relations.

The primary axiom of relational ethics is that the relationship developed between the self and the Other is based on a power-with relationship. The power-with relationship occurs only when there is an expression of mutuality, a shared power between the self and the Other that occurs with the demonstration of mutual respect and engagement. Olthuis (1997) describes the potential for this relational dynamic to occur with the

“intention of making/restoring mutual partnerships” (p. 131). Although relationships are most often thought of as a relationship with another individual or group, relational ethics also considers relationships with family, the organization, the community, and global connections. One can compare “the relationship” to a tapestry. The fabric of our relationships are unique identities which are works in progress, a growing tapestry whose thread is our experiences in our environment, our interactions with others (our society, our culture, our community, our world), our knowledge, and our uncertainty. This tapestry is intrinsic to our humanity.

A sense of responsibility is inspired (required) by our interaction with others, thus precipitating ethical action (Olthuis, 1997). The context of the relationship is a dynamic and fluid interaction of the participants. This relationship is not a mathematical equation to be figured out; nor is it a black and white phenomenon to be described. It is an experience to be appreciated and honoured. From a relational ethic perspective, the fulcrum for ethical action (how to be, how to act) is the relationship (Austin, et al., 2003).

It is within this relationship that possibilities can be identified. There are multiple possibilities that can be identified and acted upon. In identifying alternate possibilities Habermas’ (1991) notion of discourse ethics contributes to our understanding of the need for the creation of a space for the other’s voice to be heard. It is within the context of discourse ethics that a dialogue must be established for recognition of the needs and interests of the other. The space needed to create the potential for the dialogue must be absent of coercive forces, open to the speakers, and the participants must be willing to learn about the other’s experiences (Pajnik, 2006; Pomeroy, 2009).

Benhabib (1992) builds on this interpretation; however, she concludes that there is a need to reject the dichotomies between “justice versus the good life, interests versus needs, norms versus values upon which the discourse model, upon Habermas’ interpretation of it, rests” (p. 170). The premise with which she is most concerned is the dichotomy between the sovereignty of the self and the relation to others. Benhabib (1992) argues that

the neat separation between ego and moral development, as drawn by Kohlberg and Habermas,<sup>[2]</sup> is inadequate to deal with this problem, since certain ego attitudes – defensiveness, rigidity, inability to empathize, lack of flexibility – do seem to be favoured over others like nonrepressive attitudes toward emotions, flexibility, presence of empathy. (p. 172)

However, like Habermas (1991) and Benhabib (1992), Bergum and Dossetor (2005) believe that moral feelings cannot monopolize the truth, and that there are times in which other factors must also be considered. These factors include the individual taking responsibility for their actions, that we strive for an environment in which everyone has opportunities to reach their maximum potential, and that we are interdependent. These thoughts lay the foundations for following discussion about the central elements of relational ethics: mutual respect, engagement, embodied knowledge, interdependent environment, and uncertainty.

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<sup>2</sup> Within this quote she is referring to Habermas’ ideas related to the evolution of judgements of justice being intimately tied to the evolution of self-other relations.

## **Mutual Respect**

Bergum (2004) suggests that mutual respect is probably relational ethics' central theme. "When we respect something [someone], we heed its call, accord it its due, [and] acknowledge its claim to our attention" (Dillon, 1992, p. 108). Mutual respect is an intersubjective experience arising from a non-oppositional perception of difference. This perception of difference precipitates affective, behavioural, and cognitive responses (Callahan, 1988; Dillon, 1992).

Benhabib (1987) describes two conceptions of the "self – other" relations that delineate moral perspectives and interaction structures. These are congruent with the foundations of relational ethics. These two perspectives reflect the theoretical differences between "autonomy and nurturance, independence and bonding, the public and the domestic, and more broadly, between justice and the good life" (Benhabib, 1992, p. 158). The first is the standpoint of the generalized other. From this perspective we assume that the Other is like ourselves, and therefore is entitled to the same rights and responsibilities to which we are entitled. The relations with others are governed by the assumption that we can expect the same from the other as we expect from ourselves. The norms are those of institutional and public, and represent formal equity and reciprocity. "The moral categories that accompany such interactions are those of right, obligation and entitlement, and the corresponding moral feelings are those of respect, duty, worthiness and dignity" (Benhabib, 1992, p. 159).

In comparison, the perspective of the concrete other requires that we recognize that every individual has a history, identity, and an affective-

emotional constitution that may or may not be different from our own. We seek to understand what motivates the other, their feelings, and their needs. Our relations are governed by equity and complementary reciprocity. Our differences are seen to complement each other; therefore the norms are friendship, love, and care. The moral categories that accompany such interactions are those of responsibility, bonding, and sharing. The corresponding moral feelings are those of love, care, sympathy, and solidarity (Bauman, 1993; Benhabib, 1992; Bergum & Dossetor, 2005; Olthuis, 2000).

Bergum (2004) states that within a relational ethic “there is no clear high mountain vantage point from which to view the situation with complete objectivity” (p. 486). In healthcare settings when difficult decisions are being made, for example, the allocation of very limited resources such as organ transplants, or placement in a long-term care bed, I have often heard people say “it does not matter who the person is [the concrete other] everyone needs to be treated the same.” This statement reflects the healthcare worker’s value of the generalized other. There are inherent risks in approaching the situation from only the perspective of the generalized other.

One scholar who approaches political ethical theory from the perspective of the generalized other is Rawls. Rawls (1971) has stated that the self does not need to know

his place in society, his class position or status; nor does he know his fortune in the distribution of natural assets and abilities, his intelligence and strength, and the like. Nor, again, does anyone know his conception of good, the particulars of his rational plan of life, or even

the special features of his psychology such as his aversion to risk or liability to optimism or pessimism. (p. 137)

The concept of the “veil of ignorance” refers to ignoring our own identity when attempting to make moral judgements – removing all preconceived notions and biases. This will then, hypothetically, allow for the perfect reversibility of the judgement. The normative outcome of this concept is that then everyone in the same situation would make a similar decision. This presupposes a “universalistic-egalitarian interpretation of reciprocity, fairness and equality, according to which all humans, in virtue of their mere humanity, are to be considered beings entitled to reciprocal rights and duties” (Benhabib, 1992, p. 175). Rawls’ notion of the ‘veil of ignorance’ can be challenged based on the premise that it is impossible to completely disembod and disembody the self. By ignoring the standpoint of the concrete other this “leads to epistemic incoherence in universalistic moral theories” (Benhabib, 1992, p. 161). It needs to be recognized that each individual participating in an interaction with another has their own values and beliefs.

Bergum and Dossetor (2005) would have great difficulty holding the viewpoint of the extreme generalized other, in which differences between individuals are irrelevant. Although Rawl’s (1971) does recognize that differences matter through his difference principle, it is to argue that it is acceptable to have inequality if it is for ensuring the best possible circumstances for the worst-off members of society. The notion of the extreme generalized other does not support mutual respect. From a relational ethics perspective, striving for mutual respect provides the basis for ethical interactions. One can argue that the application/development of mutual respect



is a universal norm advocated by Bergum and Dossetor (2005) that applies to both the concrete and generalized Other. Mutual respect may be enacted in ways that appear very different between different persons and situations.

Once the Other disappears there is no longer a possibility of mutual respect. When mutual respect does not occur there are negative consequences, which include stigmatization and dehumanization. The most destructive sequela, within a relational ethic framework, is the dehumanizing effect of the Other. Bauman (1993) has described dehumanization as “effacing the face” (p. 127). It is essential that the face of the Other, in other words the personal identity, or the humanness of individuals remain intact for moral action to be initiated. However, it is important to understand that the development of mutual respect is a mutual process that we cannot demand that the Other initiates.

### **Engagement**

Engagement is a connection between the self and the Other. Through this connection nurses can develop a meaningful understanding of the patient’s experience (Bergum, 2004). It is a means of nurturing a mutually respectful relationship. The core element of engagement requires “a true movement toward the other as a person” (Bergum, 2004, p. 495). With this movement ethical responsibility and insight are developed (Bergum & Dossetor, 2005). This positioning and movement are quintessential to ethical decision-making and the initiation of ethical action.

Engagement is a conscious decision. “Engagement does not ask for selflessness on the part of the nurse, but for both the nurse and the patient to be recognized as whole beings” (Bergum, 2004, p. 498). This is also congruent

with Peplau's (1952/1988) belief that the nurse and the patient bring their own personal histories and experiences to the nurse-patient relationship. We can determine if we will engage with the Other. As we engage with the Other "the aim is not to eradicate, accommodate, suppress, or repress difference, but to allow contact with difference to move, enhance, and change us as we become ourselves more fully" (Olthuis, 1997). Engagement allows us to hear the Other's voice. To establish this in a relationship we must position ourselves *with* the Other (Olthuis, 2001). It is not merely being willing to exchange places with the other person. On the contrary, once the concrete and the generalized other have been identified and recognized it is no longer plausible to view ethical judgements as adequate if you are willing to trade places with the other person. The plurality of situations and individuals makes the notion of "changing places" with another impossible. In order to evaluate an ethical situation, we must have adequate knowledge of the Other's motivations, history, attitudes, and desires to even imagine their situation. In summary, we must see the Other and ourselves as embedded and embodied.

When the principles of universality, based on the premise of the generalized other, are applied to ethical situations the goal is to treat "like" situations the same. However, "like" situations are not possible because each individual is unique, with his or her own history and life narrative that is not replicable. Each individual is a concrete other, and as a result there are no fully "like" situations. Therefore, it is impossible to assume that an individual could make ethical decisions that would be acceptable to all at all times and in all places. A

definition of the self that is restricted to the standpoint of the generalized other becomes incoherent and cannot individuate among selves. Without assuming the standpoint of the concrete other, no coherent universalizability test can be carried out, for we lack the necessary epistemic information to judge my moral situation to be “like” or “unlike” yours. (Benhabib, 1992, p. 163-164)

It is only once we engage with the concrete and generalized other that we are able to nurture understanding. It is within this context that we can challenge and shape a civic ethos which celebrates differences and embraces strangers, not for the purpose of exclusion or domination, but to affirm the special giftedness of others (Olthuis, 2000). Engagement allows us to both raise and answer the questions the following questions. What should we do now? What would be most fitting?

### **Embodied knowledge**

Embodied knowledge is another central element in relational ethics. This type of knowledge utilizes our cognitive, affective, and emotional experiences. It is multidimensional and correlates with the underlying principles of interactive universalism.

Interactive universalism acknowledges the plurality of modes of being human, and differences among humans, without endorsing all these pluralities and differences as morally and politically valid, while agreeing that normative disputes can be settled rationally, and that fairness, reciprocity and some procedure of universalizability are constituents, that is, necessary conditions of the moral standpoint,

interactive universalism regards differences as a starting point for reflection and action. (Benhabib, 1992, p. 153)

Interactive universalism does not deny our unique identifies but allows us to develop attitudes, ideas and actions that are acceptable to all. This type of universalism defines the self within the context of “concrete embodied selves, striving for autonomy” (Benhabib, 1992, p. 153).

Substitutionalist universalism, which is based solely on the notions of the generalized other, a vision of the self that has been seen as typically reflecting the male experience (Benhabib, 1992). This view of universalism is generally associated with those of the Enlightenment; which paradoxically are incompatible with the very criteria of reversibility and universality advocated by the defenders of [substitutionalist] universalism. A universalistic moral theory restricted to the standpoint of the “generalized other” falls into epistemic incoherencies that jeopardize its claim to adequately fulfill reversibility and universality (Benhabib, 1992, p. 152).

Embodied knowledge is action orientated and utilizes practical insight embedded within our own history and present, as well as the history and present of the Other. “Practical insight is like perceiving in the sense that it is noninferential, nondeductive; it is an ability to recognize the salient features of a complex situation” (Nussbaum, 1990, p. 74). In many ways embodied knowledge resembles phronesis, “the capacity to determine rightness ... the right thing in the right way, at the right time, in the right situation, with the right people and for the right reasons” (Shanner, 2000, p. 124). This could be interpreted as relativistic; however, Bergum and Dossetor (2005) advocate for

an ethical approach that recognizes the dignity of the generalized other through an acknowledgement of the moral identity of the concrete other. Where “substitutionalist universalism dismisses the concrete other behind the façade of a definitional identity of all as rational beings, while interactive universalism acknowledges that every generalized other is also a concrete other” (Benhabib, 1992, p. 164-165). The embodied knowledge and interactive universalism are not binary alternatives established as counterpoints to substitutionalist universalism. It is an option that embraces empathy, benevolence, and equal concern for others as for the self. One uses the “principles, institutions and procedures to enable the articulation of the voice of ‘others’” (Benhabib, 1992, p. 168). People are unable to set aside their own beliefs, attitudes, motivations, desires, endowments, and identities behind a “veil of ignorance.” Consequently, the only option is to engage in a moral dialogue that is truly open and reflexive. It is only through this dialogue that the voice of the Other can be heard, epistemic limitations shed, and respect for the self and Other developed. Through a dialogue that recognizes our interconnectedness we can start to understand the needs of the other person and use this in our decision-making processes.

### **Interdependent environment**

The most important aspect of this relational ethic theme is that when deciding what is the most fitting course of ethical action, context matters. The importance given to context does not suggest that everything is relative, but that the relationships and the situation shape the experience and impact what is fitting. We are social beings constantly effected by our connectedness, in other words, our relationships. Peplau (1997) has written “people need relationships.

At their best, relationships confirm self-worth, provide a sense of connectedness with others, and support self-esteem. Relationships are the social fabric of life” (p. 166). These ideas are congruent with the application of relational ethics.

Within the context of a relational ethic interdependent environment we are not thought of as separate entities but exist as a part of a larger society, a larger system. Several authors have reflected on this connection and the interdependence we have with one another. For example, Cassell (1991) has written: “there is no person without others, virtually no idea, belief, or concept which, when traced to its origins, will not entail a peopled world” (p. 26). Sherwin (1998) goes on to describe that all people are “to a significant degree, socially constructed, that their identities, values, concept, and perceptions are, in large measure, products of their social environment” (p. 35).

Researchers using a relational ethic framework have a slightly different viewpoint. However, this difference has profound meaning. In contrast to being effected by the system, in relational ethics I/we are the environment; I/we are the system (Bergum, 2004). Bergum’s (2004) opinion closely parallels Olthuis’s (1997). He states, “there is no I without a We” (Olthuis, 1997, p. 147). When considering the environment in this manner practitioners are able to respond to the complexity and uniqueness of each situation and with those around them assess the best course of action. This allows the healthcare team, the professions, the patient, and their family, to answer the question “what is most fitting?”

Such an approach is not relative – it does not consider all decisions or positions equally valid – rather, it enables the recognition that the

ethical decision in one situation does not necessarily mean it will be the same in another, and it calls upon practitioners to consider all relevant factors, obligations, and interests (e.g., principles, Codes of Ethics, social responsibilities, individual opinion). (Austin, et al., 2009, p. 844)

All aspects of how we are in relation to the Other is considered. For example, when an individual with a mental illness is posing a threat to the community, threatening to kill his wife and children because they have become possessed by demons and want to harm him, the rights of the individual and the rights of the rest of the community must be considered. An involuntary admission to a mental hospital is probable. The involuntary admission could mean that the police are required to apprehend this individual and convey him to hospital. As a result, his rights are restricted and it reinforces his belief that his family is trying to harm him.

In this situation mental health practitioners are required to balance the rights of the individual with the rights of others. When mental health practitioners use a relational ethics framework as a guide all aspects of the situation interact when ethical decisions are made. However, by using a relational ethics framework you are completely aware that your knowledge is constructed within the context of the situation and is incomplete as you can never completely and totally understand the Other – I am uncertain. Ipperciel (2003) suggests that ethical uncertainty does not arise from the facts of the situation, but the “subsequent hermeneutical identification of the *relevant* factual elements that will give form to the *contextual* aspect of decision-making” (p. 215). Due to the complexity and interdependency within the

environment, uncertainty is also an important factor in this dimension of relational ethics.

### **Uncertainty**

Uncertainty has been identified by Bergum and Dossetor (2005) as another important theme in relational ethics. However, this theme has thus far been the least explored in the relational ethic literature. If the purpose of ethics is to transcend and achieve the greatest good (McPherson, et al., 2004), how do we determine what is the greatest good? Nussbaum (1990) concurs with Aristotle's conclusion that "there can be no single common notion of good" (p. 58). This lack of singleness evokes uncertainty. Furthermore, "the context of life, constantly under pressure of unhinged and uncoordinated motives and forces, is messy – confused and confusing" (Bauman, 1993, p. 182). The postmodern movement has given voice to a growing anxiety and uncertainty that has become "a permanent feature of life" (Olthuis, 2001, p. 35). Therefore, uncertainty lies at the heart of every ethical healthcare practice.

The College and Association of Registered Nurses of Alberta (2008) embraces the Canadian Nurses Association Code of Ethics (Canadian Nurses Association, 2008) in which Jameton's definition of ethical uncertainty is used. He defines ethical uncertainty as arising when one is unsure what ethical principles or values to apply, or even what is the moral problem (Jameton, 1984). Through Jameton's (1984) writings, we can extrapolate that ethical uncertainty is a consequence of involvement in an ethical situation. As our world increases in complexity, in relation to technology, globalization, and scientific advancements, what was once certain is now uncertain. We now face situations that we have never faced before. With improved research and data



collection methods, in our quest for the truth or truths, some types of uncertainty have been reduced while others have increased. For example, the uses of technology at the end or the beginning of life were, at one time, questions that we did not need to ask. Other authors suggest that uncertainty occurs when value-based questions create difficulty in selecting a course of action or decision (McPherson, et al., 2004). Ethical quandaries are also a result of differing cultural values.

Uncertainty can give rise to confusion and ambivalence resulting in not knowing how to proceed. Based on our narcissistic tendencies, which maybe a defence against our inherent frailty and the fear of uncertainty, we generally prefer to perceive ourselves as having all the answers (Olthuis, 2001).

Amundson, Stewart, and Valentine (1993) have written:

by holding fast to our pursuit of certainties we attempt to gain power over the chaos and ambiguity problems engender. These attempts may paradoxically weaken us by closing off options, seizing us up, and reducing flexibility. While power is the state certainty hopes to attain power/certainty as a fixed perspective [that] represents distinctions and practice which can freeze up a system. (p. 114)

The reality is that not knowing will be a constant part of our lives.

Acknowledging this fact can result in existential angst. Bauman (1993) believes that such angst can result in proteophobia. Proteophobia refers to the “dislike of situations in which one feels lost, confused, disempowered” (Bauman, 1993, p. 164) . Furthermore, the multidimensional nature of ethical quandaries may bring on a potentially debilitating anxiety (Tarnas, 1993), meaninglessness, despair, ironic detachment, lost hope (Downing, 2000),

fearfulness (Olthuis, 1997), and ethical numbness. As a result of these experiences, Scofield (2000) describes healthcare practitioners, patients and their families, and the courts being caught in a storm of values. This storm is generated by competing theoretical ethical frameworks, which are used by each person/group to form the basis of “correct” ethical decision-making. Each school of thought is “as certain that it is right as it is that the others are wrong” (Scofield, 2000, p. 335).

Ethics is about asking questions, deliberation, self-reflection, contemplation, and uncertainty (Bergum, 1999). Uncertainty can allow us to explore possible alternatives. The process of deliberation and contemplation is not always positive. For example, inaction or continued deliberation resulting from uncertainty can make decision-makers impotent. Calam, Far, and Andrew (2000) found that when physicians are unsure of how to initiate a discussion of code status with their hospital inpatients, and delay in doing so, patient autonomy is compromised. Deliberations, self-reflection, and contemplation of the issue “should be carried on as long as the probable advantages resulting from a discussion compensate for the time and effort spent discussing” (Ipperciel, 2003, p. 214). Relational ethics is an action ethic (Bergum, 2004). Through the use of this theoretical framework uncertainty can be embraced and ethical decisions made. Thus, the paradox of relational ethics is revealed. We must always wonder if we are being ethical enough. Bauman (1993) has written that “*the moral self is always haunted by the suspicion that it is not moral enough* [original in italics]” (p. 80).

Uncertainty has become a part of our daily lives. We live at a time when “both inner and outer realities have become unfathomably ramified,

multidimensional, malleable, and unbounded” (Tarnas, 1993, p. 398). Few issues are straightforward or simple. Scofield (2000) believes that uncertainty need not be a destabilizing influence. Recognizing that we may not have all the answers can liberate and free us to see and seek alternatives not previously recognized (Amundson, et al., 1993). Austin, Bergum, and Dossetor (2003) support this idea. They state that “the uncertainty inherent in human existence is thus acknowledged and should even be embraced. It is uncertainty that opens possibility to us” (Austin, et al., 2003, p. 47). Furthermore, possibility gives way to creativity, courage, and opportunities for discovery. This discovery occurs only when there is “intention [to] making/restoring mutual partnerships” (Olthuis, 1997, p. 131). There must be a shared power *with* the self and the Other to construct a normative model of relational ethics. This will eliminate the epistemological blindness toward the concrete other and the consequence of substitutionalist universalistic moral theories when we are unable to comprehend the standpoint of another.

### **Criticisms of Relational Ethics**

Despite the appeal relational ethics has for healthcare practitioners, there are others that do not view a relational ethic approach as an appropriate means of ethical decision-making. The principle argument used against a relational ethic approach is derived from the sequelae of dashing the “modern ambitions of the universal and solidly grounded ethical legislation” (Bauman, 1993, p. 223). Postmodern ethical frameworks, including relational ethics, are criticized for being ethically relativistic (Beauchamp & Childress, 2001; Benatar, 1997; Macklin, 1998; Pellegrino, 1993; Strong, 2000). Ethical relativism is based on the belief that there is a lack of criteria for judging what

would be good or bad, and right or wrong. Critics using this argument have not understood that relational ethics is calculated and structured. It takes into account general ethical theories and principles *and* uses the situational context to guide ethical action and decisions. There may be components of the situation that are relative; however, from a relational ethics perspective not *everything* is relative all at once. Basically, arguments of ethical relativism are attempts to combat uncertainty inherent in relational ethic approaches (Scofield, 2000).

Another argument used to negate the appropriateness of a relational ethics approach is its lack of commensurability. In our current market economy climate, healthcare practitioners must report cost-effectiveness, accountability, and performance indicators. The outcomes and indicators that are typically used with a relational ethics approach are not exclusively “hard” facts and figures. There are often qualitative aspects of action described and reported. Critics of this type of scientific reporting may dismiss the power of relational ethics and humanistic philosophy based on their modernistic worldview (Playle, 1995).

Further complaints are raised criticizing relational ethics as an incompletely developed approach that lacks theoretical testing (Shanner, 2000). For example, relational ethic proponents do not explain *how* to relate to the Other. Yes, relational ethics describes what is important in a relationship, but there are no guidelines as to how to establish an engaged, mutually respectful relationship mindful of embodied knowledge, the environment, and uncertainty. The premise of this argument is again based on the modern

paradigm. There are no “recipes” for the relationship with the Other, but there are components and dynamics of the relationship to consider.

Others are cautious of a relational ethic as it may perpetuate oppression and inequality of the patient or caregivers as servants or caretakers (Shanner, 2000). However, this argument presumes that there is a power-over dynamic within the relationship. When using a relational ethic framework, the experience is power-with. There is not an adversarial relationship established.

Despite the above criticisms of relational ethics, it is increasingly recognized as a valuable ethical framework for guiding questions, deliberation, and action. Mental health is an area where an ethical practice is complex. For example, “power imbalances, including the possibility of involuntary treatment, add a dimension to therapeutic relationships that is often absent in other specialty areas” (Austin, et al., 2009, p. 835). Therefore, the ethical framework used to guide decision-making, in this specialty area, must be robust enough to consider all the salient aspects of each unique situation. Relational ethics has the capacity to guide clinicians as they recognize the particulars of a situation, as well as recognizing and valuing the more universal factors related to the situation. Due to the applicability of Relational Ethics within a mental health or psychiatric setting, a relational ethic framework is used to guide the analysis portion of this research.

## Chapter 6

### Research Method

#### Purpose

In this study the portrayal of psychiatric nursing care in the media, specifically movies, is examined to identify the way the relationship between nurses and patients is depicted. With this information, nurses can better understand the way in which psychiatric nursing care may be perceived by the public, including those entering the system with mental health problems and disorders, and their family members. It also offers insight into potential barriers when individuals are choosing psychiatric nursing as a career or area of specialty. By making explicit the ethical thematic representations of psychiatric nursing care in film it opens up opportunities to mediate inaccurate stereotypes, reinforce accurate information, and present alternative perspectives to that representation.

The core question of this research is *how does cinema portray the relationship between psychiatric nurses and persons with mental illness?*

This chapter delineates the significance of this question and the visual inquiry method I use to answer it.

#### Significance of Study

With worldwide audiences of over a billion being admitted to movie theatres a year (Neale & Smith, 2005), the cinema has become a powerful tool in the formation of societal values and ethics. Such profound influence has affected the development of public opinion, and the formation of public policies, related to psychiatric nursing care and the treatment of people with mental illness. Film and other genres of contemporary media provide the

audience with a portrait of psychiatric nursing care, upon which public attitudes and expectations are influenced and developed. Cinematic and literary portrayals can include depictions of the nurse's motives, attitudes, moral dilemmas, and how he/she relates to others.

Once this particular information is assimilated by the viewer, it may go unchallenged. Cinematically derived images and meanings of psychiatric nursing care are not easily challenged by typical day to day experiences (Kalisch & Kalisch, 1983a; Kalisch, et al., 1980; Kalisch & Kalisch, 1981b), as most people do not have personal experiences with psychiatric nursing care or psychiatric treatment. In order to challenge the stereotypes portrayed in contemporary media, it is imperative that nurses understand the images displayed; along with the messages these images communicate. Images make statements that cannot always be expressed in words (Harper, 1994); therefore, we must become aware of the holistic meaning of the depiction.

Images of nursing typically encompass two predominant facets; the role or function the nurses are performing and the relationship they have with their patients. Peplau (1952/1988) has described a number of nursing roles that are important in developing professional relationships with patients. The ability to skilfully use these roles influences the outcomes for patients (Simpson, 1991). The roles include: stranger, resource person, teacher, leader, counsellor, surrogate, tutor, safety agent, mediator, administrator, recorder, observer, and researcher. Each role provides a "set of norms that a person [nurse] uses in different situations. ... because nursing is a special kind of caring asking for special skills to be employed so that nurse-patient relationships can flourish" (Simpson, 1991, p. 28). Simpson (1991) advocates

for nurses to “have the self confidence to use roles with patients and to use their professional interpersonal skills to allow the relationships to mature” (p. 19). The relationship between the nurse and the patient, especially in psychiatric/mental health nursing, is considered to be therapeutic and the nurse is expected to be skilled in therapeutic use of self. Consequently, psychiatric/mental health nursing provides the context for examining healthcare relationships in this research project.

The Canadian Federation of Mental Health Nurses uses the following description of a therapeutic relationship in their 2006 Canadian Standards of Psychiatric-Mental Health Nursing. “The therapeutic relationship is grounded in an interpersonal process that occurs between the nurse and the client(s)” (Canadian Federation of Mental Health Nurses, 2006, p. 16). The College of Nurses of Ontario (2006) further describes that

the nurse establishes and maintains this key relationship by using nursing knowledge and skills, as well as applying caring attitudes and behaviours. Therapeutic nursing services contribute to the client’s health and well-being. The relationship is based on trust, respect, empathy and professional intimacy, and requires appropriate use of power inherent in the care provider’s role. (p. 3)

Therefore, the relationship psychiatric nurses have with people with mental illness not only impacts their subjective experience of healthcare, but also effects the efficacy and the efficiency of their treatment, and subsequently their potential recovery. As a result, it is imperative for people with an interest in psychiatric nursing to have an accurate knowledge about what constitutes a therapeutic relationship, and the qualities needed to ensure professional



success. Again this question needs to be asked, *how does cinema portray the relationship between psychiatric nurses and persons with mental illness?*

There are several expected outcomes for this research project. The first is the encouragement of others to engage in critical discussions related to the depictions of psychiatric nursing care in cinema. Secondly, the findings should contribute to the body of knowledge concerning relational ethics. Thirdly, the study should add to the dialogue related to the depiction of care for individuals with disabilities. And finally, this research hopefully furthers interest and knowledge of interpretive visual inquiry methods within the discipline of nursing.

### **Interpretive Visual Inquiry**

Visual inquiry is not a new research technique for nursing. Nurse historians have long used visual images as a rich data source in their research. These images are used as data and then interpreted (Speziale & Carpenter, 2003). For example, what are the nurses wearing? The images include information about the apparel of the nurses. What was the status of the nurse - are all the nurses seen in the background of the picture? Are there nurses in the picture at all? Through these images we can also gain information related to the activities of the nurse. Did the nurse work in isolation? In the pictures is there more than one nurse. What is the nurse doing in the picture? Is she caring for patients, walking down the halls, arranging supplies? Images of nurses also reveal information related to their working conditions, and the location they worked. For example, the nurses may be depicted in hospitals, on battlefields, in schools, or in the community. All of the above information is used by nurse

historians to answer their research questions. Other nurse researchers typically do not use visual material as a data source.

Recently, however, the use of *photovoice* has emerged in nursing research. The goal of photovoice “is to use people’s photographic documentation of their everyday lives as an educational tool to record and to reflect their needs, promote dialogue, encourage action, and inform policy” (Wang & Burris, 1994, p. 171-172). For example, Thompson, Hunter, Murray, Ninci, Rolfs & Pallikkathayil (2008) gave people with chronic mental illness cameras to document their lived experiences. This documentation (still images) was then used to facilitate discussion with each participant about the meanings of the pictures. The goal was to provide the researchers with a better understanding of what it is like for an adult to live with chronic mental illness.

For the most part, nurses who use visual images as their primary data source have typically been invisible and silent. There are no nursing research method texts that focus specifically on the use of images in nursing research. Additionally, there are no published, English language, nursing studies found using critical visual methods or interpretive visual inquiry through any of the following data bases: Cumulative Index to Nursing and Allied Health Literature, Medline, Health Source: Nursing/Academic Edition, Psychology and Behavioural Sciences Collection, or SocIndex with Full Text. However, there is one published, English language, study that identified the authors as using a visual inquiry method to “evaluate students’ perceptions about case management for community-based children with disabilities, and to examine the differences in two student groups’ [baccalaureate and generic nursing students] perceptions” (Lehna & Tholcken, 2001, p. 403). These researchers

had the nursing students use words and photographs to show how they would provide case management services for a family caring for a child with a disability. Lehna and Tholcken (2001) then analyzed the photographs looking for common themes related to the students' perceptions of case management.

Based on the lack of nursing studies using a visual method it can be deduced that the discipline of nursing has repressed the visual by privileging the written word. As a result, the messages contained within this data source have been ignored and have gone unchallenged. Researchers have rarely given their energy, or used their critical thinking skills to work with this rich source of data. There are no funding sources that specifically support nursing research that focuses on the use of images. Yet a variety of nursing images have been used in mass media for years. As a result, many iconic nursing images have been developed, for example Florence Nightingale, Sairey Gamp, and Nurse Ratched. Although nursing academics have focused on the written word, to the exclusion of images, the general media has not.

Despite the commonness of the nursing image, the only nurse researchers (publishing in English) to systematically explore it are the Kalischs (Kalisch & Kalisch, 1983a, 1985a; Kalisch, Kalisch, & Belcher, 1985; Kalisch, et al., 1980; Kalisch, Kalisch, & McHugh, 1982; Kalisch & Kalisch, 1981b, 1987), Hereford (2005), de Carlo (2007), and Stanley (2008). In their research, the Kalischs utilize content analysis to study the image of the nurse. Content analysis is only one of the diverse visual analytical methods at the disposal of the visual researcher. Hereford (2005) uses a phenomenological approach to explore the meanings that baccalaureate nursing students associate with fictional images portrayed in television and media. De Carlo (2007) uses

an ethnographic approach to examine how film portrays psychiatric/mental health nurses practicing within a hospital. Finally, Stanley (2008) uses a mixed method approach to examine the portrayal of nurses and nursing in feature films between 1900 and 2007. Stanley (2008) identifies the number of films quantitatively and the themes related to the image of the nurse and nursing is gathered through qualitative analysis.

Therefore, to expand the discussion and develop this area of research within nursing, I draw on material from the areas of sociology, anthropology, psychology and literary studies to explore the diversity of visual inquiry methods. Within this research project, I focus on the contributions of Gillian Rose, Jon Prosser, and Stuart Hall. Although these individuals are not nurses, the methods they have developed can be used to examine any image – including the images of nurses and the depictions of the care they provide.

### **Contributions of Gillian Rose and Jon Prosser.**

Rose (2005) has described six different types of visual inquiry. They are compositional interpretation, content analysis, semiology, psychoanalysis, discourse analysis, and a mixed method approach. All of these modes of visual inquiry rely on the utilization of a critical visual approach based on three underlying assumptions. First, the researcher must take the images seriously. In doing so the images must be looked at very carefully, as they are a rich source of messages/data and have the potential to generate multiple meanings. They are not simply reflections of objects. Careful reflection is necessary because images are not entirely “reducible to their context. Visual representations have their own effects” (Rose, 2005, p. 15). The images may themselves evoke thoughts and feelings related to their context. For example, a

particularly gruesome scene may cause some viewers to turn away or to become distressed. Cinematic portrayal of a person with a mental illness as dangerous and violent may precipitate reactions of suspiciousness and distrust of people with a mental illness. Secondly, the researcher must consider the social conditions and the effects of visual objects. For example, the effect of a visual image may contribute to the prejudice, oppression, and stigmatization of persons with disabilities (Clarke, 2004; Fiedler, 1982; Wahl, 2003). Lastly, researchers must reflect on their ways of viewing the images (Rose, 2005). This refers to the need/requirement of the researcher to practice reflexively. In summary, this means an approach that thoughtfully reflects on the “visual in terms of the cultural significance, social practices and power relations in which it is embedded; and that means thinking about power relations that produce, are articulated through, and can be challenged by, ways of seeing and imaging” (Rose, 2005, p. 3). Reflexivity is discussed in more detail in the Rigor section of this chapter.

Gillian Rose (2005), and Jon Prosser (1998), describe three general factors, or sites, that generate meanings for a visual image. Their approaches to visual inquiry suggest that the meanings/messages within the images can be studied from any one or any combination of these sites. The first site is related to how the images are made. The medium effects the message of the image (McLuhan, 1964/2003). For example, an image could be a painting, a drawing, a photograph, a film, and so on, which impacts the images’ potential meaning. Another site is the image itself, and the meaning ascribed directly to/from the image. For example, a black and white photo compared to a colour photo of the same subject may have different interpretations. Images may be processed

differently to effect how they appear to the viewer. The third site where meaning is generated, which some would argue is the most important aspect of an image's meaning (Fiske, 1994), and the focus of this research, is the interpretation of the image made by the audience.

An audience can be several thousand people, or the audience may be only one person. Investigation of the audiencing aspect of an image can occur either by studying audiences' reactions to the image, or by investigating the potential meaning of the visual image directly (Hall, 1999, 2003a). Research that focuses on the reactions to images typically use very small audiences (Ali, 2004; Barley, 1990; deVries, 2004; Fiedler, 1982; Fiske, 1994; Hall, 1999; Harper, 1994; Leon & Angst, 2005; O'Connor, 2002; Prosser, 1998; Snyder, 1988; Tanner, Haddock, Zimmerman, & Lund, 2003; Weber, Mitchell, & Nicolai, 1995; Winston, 1998). These audiences are limited to a few people or have even focused exclusively on the researcher. Investigations studying the potential meaning of visual imagery typically use a psychoanalytic or feminist perspective to guide analysis. In the choice of a perspective, the researcher invites dialogue and critical thinking about the meaning of the image. The essential aspect of investigating the potential meaning of visual imagery directly is to have a well-articulated perspective to provide a worldview to consistently deconstruct and analyze the image.

In this study, it is a relational ethics framework that is used to guide the analysis of a visual image as it relates to the relationship between the nurse and the person with the mental illness. Relational ethics provides the worldview for analyzing the meanings encoded within an image. I chose relational ethics as the analytical framework by asking the question – what would be most fitting?

It is the portrayal of the relationship within a healthcare context that is of particular interest in this research. As a result, a relational perspective is needed. In clinical practice using a relational ethics framework to facilitate decision making allows clinicians to consider the multifaceted and complexities of situations. For example, it is not only the uniqueness of the nurse and the patient that contribute to the relationship, it is also the environment. Relational ethics allows the user to consider factors that impact the relationship. An additional factor is the purpose/function of the interaction. What is the role of the nurse? The Theory of Interpersonal Relations (Peplau, 1952/1988) is used to help guide the analysis of this aspect of the nurse-patient interaction contained within the image.

At this point, it is critical to clarify the contributions made by Stuart Hall in this area, particularly his work on encoding and decoding of messages.

### **Contributions of Stuart Hall.**

Four prominent structural theorists, Saussure, Barthes, Althusser and Marx, and one post-structuralist, Michel Foucault, influence Stuart Hall's thoughts on encoded and decoded messages. Saussure's major influence relate to his model of communication. Saussure proposes a linear communication model between the sender and the receiver, which focuses almost exclusively on signs (Hall, 2003). The signs have two corresponding parts – signifier and the signified. The signifier is the physical aspect of the sign, for example, a picture or a word. The signified is the concept that the signifier refers us to, for example, a table or a cow. Saussure's crucial point is that while we depend on this relationship between signifier and signified to produce meaning, it is an arbitrary connection. Hall (2003) differs from Saussure, in that his theory of

communication embodies active interpretation and features an interactive dialogue. It is from this perspective that Hall raises questions about the power and influence of social discourses, where Saussure does not. Although Saussure does speak about the rules of language (*langue*) and the way utterances are selected (*parole*), these concepts do not relate to power. Hall is also critical about Saussurean structuralism because it neglects the material world outside of language. Language is viewed by Saussure to occur at a particular moment (synchronically), its historical and contextual (diachronic) dimension are ignored. Thus, its formalism along with its tendency towards abstraction and high theory, limits the normative applications of a Saussurean structuralist model.

The second competing theorist is semiotic structuralist Barthes. Barthes makes the crucial distinction between a sign's literal meanings (denotative meanings) and a sign's connotative meanings (associated meanings). Hall uses Barthes work to further theorize on the intersection between language, ideology, and myth. This allows him to expose the relationship between culture and power.

Althusser is also an influential theorist for Hall, particularly Althusser's re-readings of Marxian texts. Althusser argues that ideology "is not an illusory veil (false consciousness), but a 'system of representations' (images, myths, ideas or concepts) through which we live, in an imaginary way, our real conditions of existence" (Procter, 2004, p. 45). Hall uses Althusserian ideas to move beyond the humanism of traditional culturalists; but finds it limiting, as the potential for resistance and struggle is undeveloped in Althusser's work.



Hall's theory addresses this normative void as he attends to the issues of agency and the possibility of political intervention.

Although Hall uses Marxian ideas of class, struggle, conflict, and ideology, Hall does not use Marx as a primary theorist to guide his work due to Marx's emphasis on the economy. However, the Marxian vocabulary allows Hall to develop his unique communication model, a semiotic paradigm, which is inserted into a social framework where the production and the consumption of messages, and the meanings they contain, are thought of as an active process. Specifically, it is Marx's theory of commodity production that allows Hall to develop an alternative to the linear sender-message-receiver communication model. Hall's model is based on a circuit. This circuit is primarily concerned with the moments of coding/production and decoding/consumption.

Hall further utilizes the Foucaultian ideas of discourse and referent, as he develops his semiotic paradigm. For example, Hall views language<sup>3</sup> as not reflecting the real, but constructs or distorts it on our behalf. So even at a very basic level, visual discourse translates a three-dimensional world into two-dimensional planes; therefore, it cannot of course, be the referent or concept it signifies. The traditional example of this concept is the dog in the film can bark, but it cannot bite (Barthes, 1994). A nurse in a film can comfort you by using speech, vocal intonations, and/or gaze, but cannot physically touch you. However, it is important to note that Hall, following the ideas of Foucault, is

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<sup>3</sup> The term language was used by Hall to refer to all mediums of communication such as verbal, non-verbal, music, visual, electronic, etcetera.

not saying that there is not a “real world” but that the “real world” acquires meaning through discourse. Like Foucault, he is also interested in “larger systems of representations (discourse); and whole clusters of narratives, statements and/or images on a particular subject that acquire authority and become dominant at a particular historical moment” (Procter, 2004, p. 60). Foucault’s thoughts appeal to Hall as they provide a more contextualized and politicised conception of representation than the structural theorists had provided, especially in terms of the production of knowledge and power. However, it is Foucault’s genealogical approach and lack of normative theory that requires Hall to develop his semiotic paradigm. It is from this standpoint that Hall is able to address issues related to the patina of objectivity. To date, there are no nursing researchers that have tried to address or challenge the “patina of objectivity” that is projected because of nursing’s bias towards the written word.

Hall (1999) views the purpose of communication as a transmission of meanings and messages, using signs within the rules of language, and describes the process of communication in terms of a circulation circuit or loop. He offers an alternative means of viewing communication as a complex structure of relations, located within competing discourses, through which there is an articulation of distinctive, but interdependent moments of production, circulation, distribution, consumption, and reproduction. When a message is circulated and distributed, the discourse must be “translated – and transformed again into social practices if the circuit is to be both completed and effective” (Hall, 1999, p. 508). Unfortunately, Hall does not fully elaborate on what means he would use to determine if the communication circuit has

been effective. Possible outcome indicators could be if the message is interpreted as intended, or if the meaning is decoded, then precipitates action. Hall suggests that meaning must be taken for the circuit to be complete, but this is not synonymous with effectiveness.

For Hall, the critical aspect of the communication process is meaning. “If no ‘meaning’ is taken, there can be no ‘consumption’. If the meaning is not articulated in practice, it has no effect” (Hall, 1999, p. 508). I believe that Hall is trying to overcome the normative theoretical weaknesses of earlier authors with his focus on practice. Hall does not discuss the implications of this model in praxis. As a result of meaning being articulated into practice, the images of nursing are socially and culturally determined through particular discourses, at particular historical moments. These images change as people interact and in terms of the time and the place at which they occur (Aroskar, 1980). For example, nursing images have evolved from men providing nursing care during the Crusades (Aroskar, 1980), to female unprofessional drunkards unable to find any other work, to a female heroine, to a female sex object, to militant groups of women, and most recently to a careerist. Each of the images has emerged within a specific historical context; however, the image of a nurse created at one time in history does not eliminate the preceding images of nurses; it just adds another dimension for public consideration/consumption (Bloomfield, 1999). We can expect the image of the nurse to continue to change and evolve, as history and culture are not static.

All aspects of communication need to be considered; Hall emphasizes that all the moments of the communication process are connected and dependent on all of the other processes which occur within an open system.

However, he sees this “open system” being heavily influenced by the dominant forces in society. Using television as an example, he writes that “production and reception of the television message are not, therefore, identical, but they are related: they are differentiated moments within the totality formed by the social relations of the communication process as a whole” (Hall, 1999, p. 509).

It is the decoded meanings that have the effect on the audience, not the message itself. However, the “audience reception and ‘use’ cannot be understood in simple behavioural terms” (Hall, 1999, p. 509). For example, children are violent because they have watched a violent TV program is not a correct assumption. And one cannot assume that you will receive psychiatric nursing care, as depicted by Louise Fletcher, Nurse Ratched in *One Flew Over the Cuckoo’s Nest* (Forman, 1975), because this kind of “care” is demonstrated in a movie.

Hall also advocates for an appreciation of the isolated positivistic research elements, such as content analysis, which are framed by the structures of understanding, and are shaped by social and economic relations. This is particularly relevant to the work of Kalisch and Kalisch (1983a; 1980; 1982; 1981b, 1987), as Hall views media research as being historically situated within the social structures of the time. Hall would likely argue that the context of the Kalischs’ decoding is missing from their discussions.

According to Hall (1999), within his proposed semiotic paradigm, researchers must acknowledge and respect an individual’s agency which is impacted by the historical or contextual experiences of the individual. Media messages are not behavioural inputs, as assumed when researchers use only a content analytical research method. He argues that this approach fails to

recognize that there are polysemic interpretations of representations, text, and language. The key message is that there is an epistemological distinction between “real” events and those depicted within the media. The media communicates a story about the event, but not the event itself. For example, the media reports on psychiatric nursing care and communicates messages about psychiatric nursing care, but their representations are not psychiatric nursing care. *Nurse Ratched* does not deliver the epitome of psychiatric nursing care. Psychiatric nursing care is an experience that has discursive meaning, which cannot be shared through story telling or media representations. For example, the image of the nurse has gone through many historical changes (Bloomfield, 1999; Bridges, 1990; Kalisch & Kalisch, 1987); at times the nurse has been idealized, degraded, and/or trivialized. None of these portrayals represent “real” psychiatric mental health nursing.

All of the above examples are interpretations of reality. Suggesting that nursing encompasses any one or even all these portrayals undermines the complexity of the profession. It needs to be recognized that the depiction of nurses in the media is a compilation of facts, fiction, history, and myth. In summary, “reality exists outside language, but is constantly mediated by and through language: and what we know and say has to be produced in and through discourse” (Hall, 1999, p. 511). Hall defines discursive knowledge as the “product not of the transparent representation of the ‘real’ in language but of the articulation of language on real relations and conditions” (Hall, 1999, p. 511). There is an articulation between the sign and the referent that must be decoded. Articulation refers to the connection and resulting unity of concepts or elements.

Hall emphasizes that the meaning of the message the sender circulates and distributes to the receiver may not have the same meaning once it is decoded. This is because the sender and the decoder may not have the same historical or contextual experiences through which they can interpret the message. He refers to this phenomena as degrees of understandings and misunderstandings, which are dependent on relations of equivalence (Hall, 1999). The relations of equivalence are determined by the different structural and positional factors influencing the encoder and decoder. This has particular importance to the representations of psychiatric and mental health nurses in contemporary media.

Ideological effects of codes occur when the codes have been “profoundly naturalized” (Hall, 1999, p. 511). This occurs when there appears to be universal acceptance of the code as representing the “real” to such an extent that the sign becomes the real. Hall uses the example of a cow. When people see a picture of a cow they interpret this as a cow, rather than as representing a cow. We could also extend this analogy to include representations of people with mental illness and psychiatric nurses. When a person is represented as being violent and mentally ill, this can easily be read/viewed or interpreted/decoded as the ‘real’ rather than a representation. Another example is that the depictions of psychiatric-mental health nurses as objects to be feared, scorned and hated could be read as “real” rather than as a representation within the context of a particular text/movie. Hall (1999) interprets these signs as iconic signs as they:

look like objects in the real world because they reproduce the conditions (that is, the codes) of perception in the viewer. These

‘conditions of perception’ are, however, the result of a highly coded, even if virtually unconscious, set of operations – decodings. This is as true of the photographic or televisual image as it is in any other sign. Iconic signs are, however, particularly vulnerable to being ‘read’ as natural because visual codes of perception are very widely distributed and because this type of sign is less arbitrary than a linguistic sign.

(p. 511-512)

Hall uses the terms denotation and connotation differently than other traditional linguistic theory researchers. In *Encoding, Decoding* (Hall, 1999), these terms are used for analytical purposes only. Denotative meanings refer to aspects of a sign that appear to be taken as its “literal” meaning versus connotative meanings that require the generation of a sign’s associative meanings. In the real world, signs are made up of both denotative and connotative aspects. “It is at this connotative level of the sign that situational ideologies alter and transform signification. At this level we can see more clearly the active intervention of ideologies in and on discourse: here, the sign is open to new accentuations” (Hall, 1999, p. 512).

In Volosinov’s *Marxism and the Philosophy of Language*, accentuality refers to “the way in which language produces different, even opposing meanings depending on how it is ‘accented’ by those who ‘speak’ it within a given social context” (Procter, 2004, p. 31). It is the accentuations that project a whole range of social meanings and practices onto the sign and intended meaning for the decoder. The contemporary media has accentuated varying aspects of the depictions of the psychiatric nurse. To some extent the work of Kalisch and Kalisch (1983a, 1983b, 1983c; Kalisch, Kalisch, & Belcher, 1985;

Kalisch, et al., 1980; Kalisch, Kalisch, & McHugh, 1982) could be viewed as articulating the historical accentuations of the image of nursing. Specifically, their interpretation of the five dominant nursing image types between 1854 and 1982; 1) the Angel of Mercy, 1854-1919; 2) the Girl Friday, 1920-1929; 3) the Heroine, 1930-1945; 4) the Mother, 1946-1965; and 5) the Sex Object, 1966-1982 (Kalisch & Kalisch, 1987) reflect the changes of accentuations in the images of nurses.

Hall recognizes that there are polysemic connotative transformations of signs. However, he believes that this is not synonymous with pluralism as there are preferred meanings. Embedded within these “preferred meanings” is the knowledge of social structures, ordering of power and interests, structure of legitimations, limits, and sanctions. This non-equality is determined by the degree of closure within any society. The degrees of closure determine or “impose its [societies] classifications of the social and cultural and political world” (Hall, 1999, p. 513). As a result, Hall sees the study of communication, particularly mass media, as interpretive work because the coding and decoding systems are not closed but “structured in dominance.” Hall does not see the individual decoder as having sole responsibility for decoded interpretation. He sees mass media, focusing on the television broadcaster, as having responsibility for the “relations which disparate signs contract with one another in any discursive instance, and thus continually rearranges, delimits and prescribes into what ‘awareness of one’s total environment’ these items are arranged” (Hall, 1999, p. 514). Therefore, the television producers attempt to structure their messages, so the message will be decoded and understood the way they intend for their audience.



Encodings have an effect on the limits and parameters on what decoding is possible; however, discrepancies in the decoding of meanings are hypothesized to be related to “selective perception.” “‘Selective perception’ is almost never as selective, random or privatized as the concept suggests” (Hall, 1999, p. 514-515). As a result, there are three hypothetical positions by which decoded meanings can be constructed. First, there is the “dominant-hegemonic” position, in which decoded meanings are congruent with the connoted meaning intended by the encoder.

Second, the “negotiated” position is when decoded meanings are understood as the encoder intended, but the decoder selects under what situations or circumstances the intended meanings apply. Hall (1999) uses the example of television newscasters reporting stories that wage reductions are needed to deal with economic problems. The viewer/decoder agrees with the need for wage reductions, but then strikes to improve their own wages. Another example is the viewer who agrees with a story that contains the message that all people with mental illness are violent and should be confined, but then assumes that this does not apply to him even though he is seeing a therapist and is on antidepressant medication.

The “oppositional” position is the third position from which the message could be decoded. When this position is taken to interpret meanings, the decoders use a different framework than the one used by the encoder. Hall (1999) used the example of the individual watching the newscast on the need for wage reductions to serve national interests and interpreted all references to national interests as class interests. Hall (1999) views this position, as “one of the most significant political moments ... it is the point when events which are

normally signified and decoded in a negotiated way begin to be given an oppositional reading. Here the ‘politics of signification’ – the struggle in discourse – is joined” (p. 517). The meanings/messages within the images can be studied from any of the above positions.

Visual images contain a variety of messages that can be explored using a number of approaches. The approaches include: compositional interpretation, content analysis, semiology, psychoanalysis, discourse analysis, and a mixed method approach (Rose, 2005). However, to conduct an analysis of images they must be taken seriously, the researcher must appreciate that the images have consequences, and recognize that the image is interpreted from your own perspective. This interpretation and the understanding of meanings are generated because of the uniqueness of the individuals viewing the image. There are several sources of potential meaning within an image. The sources include analyzing how an image is made, the image itself, and the interpretation/meaning of the image by the audience. It is the interpretation/meaning of the image in which I am interested. Hall (1999) has indicated that the researcher can investigate the potential meaning of the image directly. However, in order to do so, researchers must use a framework/perspective to guide their analysis. I will use a relational ethic framework (Bergum & Dossetor, 2005) and Peplau’s Theory of Interpersonal Relations (1952/1988) to guide my analysis.

### **Representations of Psychiatric Nursing Care.**

This research project focuses on making the representations of psychiatric nursing care more explicit through identifying the role of the nurse, and the salient factors within the nurse-patient relationship. The roles of the

nurse were identified based on the Theory of Interpersonal Relations (Peplau, 1952/1988, 1997). The roles identified in this theory are stranger, resource person, teacher, leader, surrogate, counsellor, consultant, tutor, safety agent, mediator, administrator, recorder, observer, and researcher. The salient relational factors are identified using a relational ethic framework. The questions asked of the images include what is the function of the nurse, what is the nurse's role, how is engagement, mutual respect, embodied knowledge, the interdependent environment, and uncertainty demonstrated (or not) by the nurse in the film?

Both Relational Ethics (Bergum & Dossetor, 2005) and the Theory of Interpersonal Relations (Peplau, 1952/1988) are goal directed and action orientated. These researchers view the relationship is an interactive and dynamic process, and both underscore the importance of the nurse-patient relationship. The identification and acknowledgement that the patient and the nurse bring their own perspectives and history to the interaction is an important relational factor for Bergum and Dossetor (2005) and Peplau (1952/1988). They also recognize that there is uncertainty in each situation as we do not know everything about the other person, and both reiterate the importance of understanding the other (Bergum & Dossetor, 2005; Peplau, 1952/1988, 1992).

### **Film Selection**

#### **Selection criteria.**

The cinematic images used in this study were pre-existing, located within the public domain, and available/accessible. All the films selected were required to contain images of nurses interacting with people with mental illness. Films were excluded from the research sample if there were no

individuals with a mental illness, or if there were no nurses that interacted with the individuals with a mental illness, or were responsible for their care. In previewing the films, in order for them to be included, at least one character in the film was required to either self-identify themselves as a nurse or others needed to identify them as a nurse. This was determined through the character's dialogue or dress/uniform, or they were referred to as a nurse by other characters in the film.

The individuals with mental illness were identified in either of the following two ways. One, they referred to themselves as having a mental illness. For example, the character stated that they were depressed, crazy, insane, had nerve troubles, had flashbacks, and so forth. Alternatively, the character was in the process of being treated by a healthcare team specializing in the treatment of mental illness. For example, the individual resided in an asylum or sanatorium, sought services from an outpatient psychiatric setting, or sought services from a community-based therapist, and so on.

The sampling plan was based on the fact that it was not the sample size (number of films) that was important, but rather the amount of information that was critical in determining sample size adequacy (Morse, 1994). Eighty films were initially screened for inclusion in this research project (see Appendix B). However, based on the requirements of the research, it was necessary for a film to depict people with identified mental illness, to show psychiatric nurses interacting with or responsible for the care of these individuals, and to possess relational ethic theme representation. As the core research question is "how does cinema portray the relationship between psychiatric nurses and persons with mental illness?" and the relationship will be viewed within the context of

relational ethics, depiction of all of the major relational ethic elements was required – mutual respect, engagement, embodied knowledge, interdependent environment, and uncertainty. Based on these requirements, fifteen films from the eighty films screened were selected as data sources.

### **Selected films.**

The corpuses of films represent the major sub-speciality areas of psychiatry: inpatients, forensics, and community psychiatry. As the literature reveals that many films depict psychiatric nursing negatively (Kalisch & Kalisch, 1981b, 1982a), an attempt was made to include at least one film that portrays psychiatric nurses positively. Unfortunately, no film, screened for inclusion in the research, depicts psychiatric nurses positively throughout the film. However, there are a few scenes in most of the films that portray positive aspects of the nurses and the care they provide.

The following fifteen films are included in this research project: *The Sleep Room* (Wheeler, 1998), *Girl, Interrupted* (Mangold, 1999), *Cosi* (Joffe, 1996), *High Anxiety* (Brooks, 1977), *Titicut Follies* (Wiseman, 1967), *Frances* (Clifford, 1982), *Harvey* (Koster, 1950), *The Caretakers* (Bartlett, 1963), *One Flew Over the Cuckoo's Nest* (Forman, 1975), *Persona* (Bergman, 1966), *The Snake Pit* (Litvak, 1948), *Gothika* (Kassovitz, 2003), *The Jacket* (Maybury, 2005), *Terminator 2: Judgment Day* (Cameron, 1991), and *The Cobweb* (Minnelli, 1955). The films selected represent the work of film makers from the following countries: United States of America, Canada, Australia, and Sweden. The films also represent the work of both independent and mainstream studio system filmmakers. The genres of the films selected encompass comedy, documentary, horror, and drama. These films were found

either through word-of-mouth, internet movie databases, or through written references. This method of sampling is consistent with that used by other image-based researchers (Edney, 2004a, 2004b; Gabbard & Gabbard, 1987; Kalisch, et al., 1980; Levers, 2001; Prosser, 1998; Rose, 2005; Wahl, 2003; Welch, 1997).

### **Data Collection**

Data collection focused on the image's meanings from an audience perspective using a relational ethic framework (Bergum & Dossetor, 2005) and the Theory of Interpersonal Relations (Peplau, 1952/1988) for analysis. This is consistent with Hall's (1999) views on the study of communication, including film, as interpretive work that is structured by the politics of the audience. The use of Relational Ethics (Bergum & Dossetor, 2005) and the use of the Theory of Interpersonal Relations (Peplau, 1952/1988) are "ideologies" that have had a significant impact on the dominant decoding structure I used. As a result, the films analyzed were driven by a prominent ethical discourse.

The audience was defined as myself, the researcher. This definition was consistent with the method used in other studies which applied a psychoanalytic or feminist framework during data analysis (Ali, 2004; Hall, 2003b; Tanner, et al., 2003; Yontz, 2002). The audience need not be a large number of people – it may be limited to one person – in this case, the researcher.

I, the researcher, gathered information on the meanings of the images depicting psychiatric nursing care. Through the use of an interpersonal relations perspective, information was collected related to the role the nurse is performing within the scenes demonstrating a nurse-patient relationship. I then

used a relational ethics lens to collect information related to the dynamics of the relationship between the nurse and the person with mental illness. Transcripts were made of salient situations that characterized the relationship between the psychiatric nurse and the person with mental illness. The important scenes were decoded, within the context of the film as a whole, and within the historical placement of the film, to provide information about the compositionality of the image. Information about the temporality of the image in the film was also collected. Field notes were made, while watching the films, on the components of the relationship and on what role the nurse was performing. These notes specifically reflected the areas relating to nursing role/function, mutual respect, engagement, embodied knowledge, the environment, and uncertainty.

A research journal was also used to record personal thoughts and feelings during the study. This facilitated the documentation related to the sequencing of events, thought processes, and new ideas. This journal was also used to record personal biases and assumptions and to engage in reflexivity. In this type of research it was important to regard the use of self as an instrument for data collection. Since the primary method of data collection was observation and interpretation, I was part of the data.

### **Data Analysis**

Data analysis occurred throughout the research process. “The process of critical scholarship is one that rests on the reflection and insight” (Thompson, 1987, p. 33); therefore, the data analysis was not a distinct stage of the research process but rather, began in the pre-fieldwork phase (literature review) and continued until the conclusion of this project.

A thematic analysis was performed on the selected films and began with a longitudinal viewing of the film. This allowed me to look at the film as a whole. Thereby, enabling me to narrate the general plot of the film, to comment on character development, to monitor and discuss the changes to health care decision-making, and to describe the nursing roles depicted within the context of the entire film. Particular attention was given to varying degrees of mutual reciprocity and power balances/imbbalances. These imbalances were given significant consideration when they were related to the elements of mutual respect, engagement, and interdependent environment. The longitudinal viewing, or developmental reading, allowed a “map” of each film to be constructed using the relevant relational ethic concepts. These concepts were: mutual respect, engagement, embodied knowledge, interdependent environment, and uncertainty. Following this longitudinal viewing a cross sectional analysis was conducted to compare the ‘maps’ of the films to each other and the relevant relational ethic concepts demonstrated in each film.

Because analysis is the product of an inductive and emergent process in which the analyst is the central agent, achieving this order is not simply a mechanical process of assembly-line steps. Even though there are several concrete and even routine activities involved in the analysis (described below), the process remains, and is intended to be, significantly open-ended in character. (Lofland & Lofland, 1995, p. 181)

The data collected was organized and analyzed using a three-part process: first level coding, analytic coding, and journaling (Lofland & Lofland, 1995; Miles & Huberman, 1984). During first level coding the attributes of



phenomena were described using broad relational ethic themes to disaggregate the data. It was also at this time that longitudinal reflections of the films occurred. Data was organized and indexed according to the role of the nurse, and the themes of mutual respect, engagement, interdependent environment, embodied knowledge, and uncertainty to simplify the raw data into manageable parts for analysis. The roles of the nurse as described by Peplau (1952/1988) were used to analyze the nursing functions depicted in the films. The discourse of relational ethics was used to as a framework to guide the analysis of the images depicting the nurse patient relationship. Relational ethics was the “place where I stood” when I looked at the data – it was the analytic framework through which interpretations about the relationships were made. As I read each of the films, I asked myself, are the themes of relational ethics demonstrated? If so, how are they demonstrated? If the themes of relational ethics are not present within the interaction between the nurse and the person for whom they provided care - what are the consequences? What are the consequences if they are present?

With the second step of analysis, I moved beyond description to inference thereby establishing patterns or analytic codes. This pulled the material together and allowed me to amalgamate material into more parsimonious units of analysis – more encompassing themes and constructs within the themes of relational ethics. This allowed me to derive meaning from the indexed material.

The third component was journaling. This technique captured my thoughts and ideas that occurred while analyzing the data. Journals were made up of conceptual notes and provided insight into the evolving

themes/constructs that emerged from the data. They were reflective comments that were comprised of comments of a few words or sentences that recorded hypothesis, links, and interpretations seen in the data.

Data analysis concluded when no new analytical codes were found, and when the categories reached saturation. Data from all sources – transcripts, field notes, and reflexive journal were analyzed to provide a total picture of the research and respond to the posed research question. Although these steps have been outlined in a linear fashion, they were not tidy. All of one step was not completed before moving on to the next step. This was at times a messy and sometimes confusing process, characterized by false starts, re-groupings, and doubt. At the same time there was tantalizing insights and intrigue at deconstructing the relationships portrayed in the films and seeing relational ethics “come to life.”

### **Rigor**

Visual inquiry requires that the visual be regarded as data rather than representation. As researchers move beyond using images as representations (the use of images for illustrative, archival, and documentary purposes) images can be given more analytic treatment. A particular understanding is produced by this analytic treatment of the image. But how do you distinguish if this particular understanding that has been developed through the use of visual interpretive inquiry is good or bad research?

Researchers have long been concerned about how to demonstrate that their findings are “true” and much effort has been exerted to establish the criteria upon which such truth claims can be grounded. Traditional research approaches emphasize a rigorous application of research methodology as a

means of ensuring valid results. An approach to the problem of validity with relevance to visual interpretive inquiry is proposed by Mishler (1990).

Validation is defined as “the process(es) through which we make claims for and evaluate the ‘trustworthiness’ of reported observations, interpretations, and generalizations” (Mishler, 1990, p. 419). He prefers to use the term “validation” rather than validity to indicate the ongoing nature of the processes through which claims are made and appraised by a community of scholars in a particular field.

For this research the community of scholars resides in nursing. The critical component of validity is this community’s “willingness to act on the basis of, as well as pay attention to a study, and on the continuing social process through which claims are contested, assessed, and warranted” (Mishler, 1990, p. 419). Mishler (1990) proposes the use of exemplars which, as a mode of knowing, contain embedded knowledge of the disciplinary matrices of a research community, rather than technical descriptions of rules and criteria. The disciplinary knowledge I use in this research is the relational ethics framework (Bergum & Dossetor, 2005) and Peplau’s Interpersonal Relations Theory (1952/1988). Although relational ethics is interdisciplinary in scope, this scope encompasses nursing and is relevant to all healthcare settings (Bergum, 2004; Bergum & Dossetor, 2005).

Mishler (1990) emphasizes that researchers need to include text-based explications of how they transform their observations into the findings and how the interpretations are grounded. Rather than presuming the presence of unquestionable truths, researchers working in image-based research suggest that there are multiple perspectives and multiple meanings (truths), however,

some are more meaningful than others (Ali, 2004; Hall, 1999; Harper, 1994; Prosser, 1998; Rose, 2005). Therefore, visual researchers must specify the constraints, conditions, and boundaries under which research constructions/interpretations are made.

Reflexivity has been cited as “the virtue that distinguishes between good and bad research [visual research]” (Pink, 2003, p. 187). Reflexivity is described by Rose (2005) as:

an attempt to resist the universalizing claims of academic knowledge and to insist that academic knowledge, like all other knowledge, is situated and partial. Reflexivity is thus about the position of the critic, about the effects that position has on the knowledge that the critic produces, about the relation between the critic and the ... materials they deal with. (p. 130)

Reflexivity is the researcher’s self-reference and self-awareness of theory and analysis. In short, reflexivity is about the researchers’ awareness of the discourse of their analysis. Reflexivity has special significance to visual researchers where the researcher is considered to be **the** essential research instrument (Hall, 1999; Harper, 1994; Prosser, 1998; Rose, 2005). In this context, reflexivity implies a self-awareness of the reciprocal relationship between the researcher, the research data and data analysis, and a consciousness of one’s self as an instrument of observation. Therefore, through reflection on one’s role, the researcher comes to understand his/her motivations and choices – the discourse through which their accentuations are developed. The researcher’s biases can be clearly articulated throughout the analysis by the use of a reflexive journal. It is very clear that the “tangled web

of practical, personal and theoretical agendas” (Barley, 1990, p. 220) influence the development of outcomes of all research. Therefore, reflexivity is an important part of this research process and is geared toward the clarification of my biases.

Visual inquiry also accommodates peer review. In the case of film, the film may be watched and discussed with colleagues which further clarify biases and competing interests. Although Creswell (2003) suggests “counts” as a strategy to ensure the integrity of research, this approach is philosophically inconsistent with an interpretive method as it is not the number of occurrences that determine the significance of meaning (Fiske, 1994).

The issue of the trustworthiness of my interpretations is addressed by attempting to explicate the process I engaged in as I analyzed the data. Validation of the interpretations occurs when peers find that the interpretations are warranted, given the data. I acknowledge that my final interpretations are not the only interpretation of the images that could be told.

I also attempted to ensure the trustworthiness of the data analysis through the following more standard techniques. For example, field notes were recorded at the time the film was viewed. This technique ensured that data was not lost and that data analysis began promptly. The films were viewed a second time to ensure that the information in the field notes was reflective of the cinematic portrayals. I also used a reflective journal. This journal was used to record my thoughts, feelings, my reactions to the depiction of psychiatric nursing care, and my ideas about analysis. This journal was an important tool for me as it was also a record of my doubts, hunches, and plans.

While acknowledging the discursive strategies that establish the authority of visual interpretations, researchers are bound by scholarly traditions and the “necessity” to attempt to establish their accounts as more than mere fiction. In establishing the validity of my interpretations I use reflexivity as an attempt to bring into awareness and critically examine my personal and intellectual biography and philosophical positions that predispose me to see/read the images in a particular way. In addition, I attempt to present the processes that I followed to analyze the data, so that it could be evaluated. What I hope to achieve by this is to “situate” myself so that readers could assess the trustworthiness of my conclusions, constructions, and interpretations.

### **Strengths and Limitations**

While this study will provide unique insights, as a result of the method used and the theoretical perspectives, there are some limitations that will affect the scope of the findings. Most of the nursing research conducted in the area of the media has involved content analysis to analyze the depictions of the nurses. The portrayal of the nursing care has typically not been analysed. Therefore, direct comparison of methods and conclusions with other nursing research that has used images is inadvisable. No published studies were found that focused on the filmmaker’s depiction of the relationship between nurses and the people for whom they provide care. As a result, there are no “methodological recipes” for this researcher to follow. There is no means for this researcher to ensure that there is epistemological consistency with this project and the discipline of nursing by using a traditional nursing research method. As visual research is not an approach typically used by nurse researchers.

Attempts are made to ensure depth, breath, and richness of the data by analyzing several films that depict psychiatric nursing care. This increased the confidence that the interpretations are not based on the peculiarity of one film. In addition, the movies were purposefully selected to reflect the diverse specialties of psychiatric nursing. However, as not every film that portrays psychiatric nursing care is analyzed, caution must be used when generalizing the findings of this study. Additionally, many of the films that are available reflect psychiatric nursing care prior to the mid-1970s. Even more recent films, such as *Girl, Interrupted* (Mangold, 1999), are set within the context of the 1970s. This has the potential to limit interpretation.

Distortions, or using Hall's (1999) term "accentuations," are inevitable in any type of inductive research process. The act of selecting specific exemplars effectively ignores some interpretations while focusing on others. For example, I am interested in engagement, mutual respect, embodied knowledge, the environment, and uncertainty, and as a result my exemplars will likely focus on these concepts. I do not choose exemplars that demonstrate other interpretations that focus specifically on nursing virtues, autonomy, beneficence, nonmaleficence, or justice. As a result of this limitation, I attempt to make my biases clear throughout the research process so other researchers can follow my decision making process and determine where they may have made different interpretations and conclusions.

When analyzing the potential meaning of the image directly there is a one-way flow of information between the subject (the film) (Filmer, 1998) and the researcher. For example, I am not able to go into the film and ask the characters for clarification of their actions. There are times in which this would

be valuable. For example, does the patient feel engaged by the nurse? How does the nurse make a decision – what is her critical thinking process? Does the nurse and the patient feel respect for one another? As a result, triangulation of data sources is challenging. However, this limitation essentially questions the validity of the data, data analysis, and interpretation which have all been previously discussed.

The real strength of interpretive visual inquiry is its ability to go beyond surface meaning (the result of traditional content analysis) to attempt to understand the wider significance of the text, be it narrative (written word) or images (moving or still). This allows for the exploration of visual images that have gone unchallenged and previously been accepted uncritically. Many people believe the messages conveyed by images, particularly when accompanied by a well respected voice, or provided by mainstream media (Winston, 1998). Despite its drawbacks, visual inquiry provides an opportunity, though imperfect, to critically analyze the messages contained within images that nursing researchers can no longer ignore.

### **Ethical Issues**

In consultation with the University of Alberta Health Research Ethics Board-HREB (Charmaine Kabatoff, personal communication, July 18, 2006), it was determined that this research project did not require review by HREB as there were no biomedical, psycho-social-behavioural, or health research activities involving human subjects. Although there were no human research subject ethical concerns, there were ethical issues related to the use of images from the publicly available films. The main ethical considerations of this research were related to copyright issues associated with the publication of the



dissertation. In an effort to address this concern, no images from the films were used in this document. The images of nurses used as examples have been properly referenced to acknowledge the contributions of others.

### **Researcher Preparation**

As this was a novel project within the discipline of nursing, it was imperative that I adequately prepared myself. Preparation consisted of identifying a mentor with expert knowledge of relational ethics, selecting supervisory committee members with a depth and breadth of knowledge and experiences in psychiatric nursing, analyzing portrayals/representation in contemporary media, and the use of image in historiographic research. My graduate education was tailored to ensure that coursework nurtured and exposed me to critical and reflective ideologies. Coursework in nursing, interdisciplinary studies, educational psychology, philosophy, comparative literature, and sociology coupled with significant work experience in the area of psychiatry positioned me to successfully complete this project.

## Chapter 7

### The Role of the Psychiatric Nurse Care in Film

This chapter provides a general overview of the fifteen films selected for this research project. The films are: *The Sleep Room* (Wheeler, 1998), *Girl, Interrupted* (Mangold, 1999), *Cosi* (Joffe, 1996), *High Anxiety* (Brooks, 1977), *Titicut Follies* (Wiseman, 1967), *Frances* (Clifford, 1982), *Harvey* (Koster, 1950), *The Caretakers* (Bartlett, 1963), *One Flew Over the Cuckoo's Nest* (Forman, 1975), *Persona* (Bergman, 1966), *The Snake Pit* (Litvak, 1948), *Gothika* (Kassovitz, 2003), *The Jacket* (Maybury, 2005), *Terminator 2: Judgment Day* (Cameron, 1991), and *The Cobweb* (Minnelli, 1955).

The overview for each film encompasses a plot summary followed by a description of the nursing roles depicted, using the nursing roles described by Peplau (1952/1988). When analyzing the films, my goal was to make the representations of psychiatric nursing care more explicit. Therefore, the following question was asked. What role or roles did the nurses fulfill? As psychiatric nursing care is based upon the relationship between the person with mental illness and the nurse, this exploration was critical to answering the core research question – *how does cinema portray the relationship between psychiatric nurses and persons with mental illness?*

#### Overview of Films and Roles of the Nurse

##### The Sleep Room.

##### *Overview.*

In 2005 Cookie Jar Entertainment Incorporated released, on DVD to both Canadian and American audiences, an independent Canadian film titled *The Sleep Room* (Wheeler, 1998). This film was inspired by the non-fiction

work of Anne Collins: *In the Sleep Room: The Story of the CIA Brainwashing Experiments in Canada* (1988). This film was also shown on Canadian public television, by the Canadian Broadcasting System, in the format of a four-hour mini-series, titled *The Sleep Room*, which aired on January 11 and 12, 1998 (MacAulay, 1998). *The Sleep Room* (Wheeler, 1998) was recognized as one of the most outstanding motion picture releases of that year. Through their work on this film, individuals involved won a total of five Gemini<sup>4</sup> awards. These included best television movie or mini-series, best direction in a dramatic program or mini-series, and a special award for outstanding achievement in make-up (Canada's Awards Database, 1998). In 1998, the year the film was originally seen by audiences, there was growing public interest in the ethical conduct of scientists experimenting with human subjects. For example, the *Tri-Council Policy Statement, Ethical Conduct of Research Involving Humans*, (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 1998 [with 2000, 2002 and 2005 amendments]) was released the same year this film was originally released.

*The Sleep Room* (Wheeler, 1998) depicts events that occur during a time in history in which medical hegemony overshadows a person's right to informed consent for any treatment or research. Dr. Edmund Pellegrino (1993) describes the medical ethics of the 1940's and 1950's as "solely the domain of

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<sup>4</sup> The Gemini Awards are an annual Canadian ceremony that celebrates the achievements of the English television members on the Academy of Canadian Cinema and Television. Quebec holds its own counterpart of the Geminis, Les Prix Gémeaux for French television members of the Academy.

the profession [medicine], protected from the mainstream of cultural change” (p. 1158). It is with this authoritative perspective that Dr. Cameron, the founder of McGill’s Psychiatry department and chief of the Allen Institute from 1944 to 1961 (Charron, 2006), conducts experiments using various paralytic drugs, lysergic acid diethylamide (LSD) and electroconvulsive shock therapy (ECT).

These experiments involve people who are admitted to the institute for depressive and anxiety disorders. Although he believes he is behaving beneficently, through the use of “cutting edge” and “progressive treatment protocols” , many of the individuals who receive his experimental treatments permanently suffer from his actions (Griffin, 1991; Hannant, 1999). For example, some experience permanent memory loss. Others never regain the level of social or emotional functioning they had prior to admission.

Dr. Cameron’s research focuses on the concept of psychic driving. Psychic driving proposes that madness can be corrected by erasing existing memories and completely rebuilding/repatterning the psyche. The repatterning or rebuilding of the psyche is not only of interest to the medical community, the American Central Intelligence Agency is also very interested in the outcomes that Dr. Cameron proposes. They view the rebuilding/repatterning as a potential means of mind control. In the height on the 1950’s Cold War hysteria, the Central Intelligence Agency funded Dr. Cameron’s research in their hopes to better understand and control the phenomena of “brainwashing” (Cleghorn, 1990; Griffin, 1991). Hannant (1999) suggests that “the global and domestic confrontation with a perceived monolithic communist threat gave

free rein to people of indifferent morality. ... Enter Dr. Ewen Cameron” (p. 704).

At the time, Dr. Cameron was not unique in his application of medical ethics. For example, researchers involved with the Tuskegee Syphilis Study did not believe that informed consent for the participation in the study was necessary, as they believed they were acting for the greater good of the American people. They reasoned that if they could better understand the natural course of syphilis, it could result in better treatment regimes for patients at various stages of the illness. The Tuskegee Syphilis Study was carried out in Alabama from 1932 to 1972 (Center for Disease Control, 2005; Georgia Perimeter College, 1998; San Diego State University, 2002). It involved 600 black men being told that they were being treated for “bad blood.” In 1947 when penicillin became the drug of choice for the treatment of syphilis it was not offered to the participants. Additionally, the participants were not informed that this treatment was available, nor were they given the option to withdraw from the study (Centers for Disease Control and Prevention, 2009).

At the time of these experiments, there was also the emergence of student protests, the counter culture, and the increased activities of the civil rights movement (Tone, 2005). These events were symbols of a historical period embodied by the transition of dominant world views, as evidenced by shifting ethical priorities from a focus on outcomes to that of individual and communal rights and responsibilities.

Interestingly, Dr. Ewen Cameron was one of the doctors who determined whether Nazi war criminal Rudolf Hess was mentally competent to

stand trial. This was part of Dr. Cameron's role when he served as a member of the Nuremberg Medical Tribunal (Lawrence, 1945). At trial he accused several German medics of unethical treatment of their patients – performing procedures without consent.

The story line of *The Sleep Room* (Wheeler, 1998) has been summarized in a number of ways. Dianne Turbide (1997), a reporter with Maclean's Magazine, describes the film as a

docudrama that chronicles how, in the 1950s and '60s, Dr. Ewen Cameron, a world-renowned psychiatrist at a respected Montreal Hospital, used experimental treatments – including massive doses of electroshock, and injections of LSD and the muscle relaxant curare – on unsuspecting psychiatric patients. (p. 60)

In comparison, a writer with The Internet Movie Database describes *The Sleep Room* (Wheeler, 1998) as a “tale of two American lawyers who try to bring the U.S. government to it's [sic] knees” (Richer, 1998, Plot Summary section, para. 1). The *Globe and Mail* reports that *The Sleep Room* (Wheeler, 1998) “tells how mental patients in Montreal were once subjected to CIA-sponsored brainwashing” (Conlogue, 1998, p. 2). These conclusions are all garnered from a movie with its first scene portraying a woman (Natalie) trying on dresses in an upscale department store. She leaves her own clothes behind in the dressing room and runs out of the store, wearing a dress she has not paid for. She is followed by a security guard up to the roof. She dances on the ledge and yells “I am free” just before she jumps off the ledge. She survives and is admitted to a psychiatric hospital. Her father contacts Dr. Ewen Cameron, wanting his help to get his daughter out of the psychiatric institution which he refers to as a

“hell hole.” From this hospital/institution Natalie is taken to the Allan Memorial Institute, where Dr. Cameron assumes responsibility for her psychiatric care.

The primary plot of the film centres on several patients and their treatment, which is primarily experimental treatment by the staff of the hospital. The plot culminates with a legal investigation and a trial, regarding the treatments/experiments given to many of Dr. Cameron’s patients at the Allan Memorial Institute. The following statement is displayed as the last scene - in “1992, the Canadian Government offered \$100,00 OOPS [sic] compensation to each of Doctor Cameron’s patients. To this date, 127 people have come forward” (Wheeler, 1998).

### *Nursing roles.*

The film depicts several nurses. The first appears in the background entering the Allan Memorial Institute. She is walking past Ruth Farmer, a 37-year-old in patient who is later described by Dr. Cameron as having depression, being frigid, and having an addiction to barbiturates. This nurse does not reappear in the film, nor is she cited in the credits. The next nurse, Nurse Kelly, appears crawling on the floor away from two male patients who are engaged in a physical fight. As she is crawling away from the altercation, the male orderlies are trying to physically intervene in the patients’ battle. This nurse character has a few speaking scenes and diligently follows the directions given to her by the head nurse and the medical staff.

These first introductions to the nurses in the film set the stage for the other nurses depicted in the film. The strongest of these is Nurse Stephens. She should of had leadership role within the nursing staff – she is the head nurse.

However, she is not shown providing direct leadership or mentoring to the other nurses at the institution. Nurse Stephens is having an affair with Dr. Cameron; she is deeply committed to working with him in an effort to support his research efforts, and ultimately, continuing their romantic relationship. She provides emotional support to Dr. Cameron, by reassuring him of the importance of his work, himself, and when he questions the efficacy of his work and the fundamental value of psychiatry as a medical specialty she reassures him of its importance.

There are four other nursing characters in the film. The first is Nurse Mandruciak. She questions the direction of the care being provided after she observes patients screaming and ripping at their skin due to hallucinations precipitated by LSD. She is the nurse who recognizes that there are potential ethical concerns with the treatments that the patients have been receiving. Although the treatments are administered with beneficent intentions, there are no conferring benefits. At the very least, the patients are more distressed after receiving the treatments.

The other three nurses in the film are not addressed by name and the actors playing these roles are not acknowledged in the credits. These other nurses do not make a significant contribution to the nursing care provided in the film – they are bystanders.

There are 34 scenes in the movie involving nurses. The nursing roles depicted in these scenes include: observer (9 scenes), safety agent (8 scenes), resource person (15 scenes) and recorder (2 scenes). There are ten nursing roles absent from this film: stranger, teacher, leader, surrogate, counsellor, consultant, tutor, mediator, administrator, and researcher.



The nursing observation role is enacted here as a primarily passive role. For example, while engaging in an observer role the nurses attend conferences. During these meetings the nurses listen to the physicians speak about the planned treatment for the physicians' patients. The physicians also address the ethics of the planned treatment. One of the physicians questions the appropriateness of the treatments currently being administered to the patients by Dr. Cameron. Dr. Cameron does not agree with the concerns raised; the experimental treatments are continued. The nurses are passive observers to these discussions. They do not directly contribute nor express an opinion; they sit quietly.

The nurses are also observers in scenes where two or more patients become agitated and a physical altercation ensues. The nurses merely get out of the way and the orderlies intervene with physical restraints. Nurses in these scenes make no attempt to verbally intervene or direct the orderlies. The nurses are portrayed as passive observers, albeit on their hands and knees, of the interaction and the intervention.

The nurses in this film also demonstrate the role of safety agent. Their safety agent role is depicted when they plan to bring a patient back to the doctor's office after she, the patient, had fled. There are also several scenes when the nurses check on patients in response to screaming, or because, according to the routines of the unit, it "was time" to do so. The nurses also restrain patients in an attempt to keep them safe. Restraints are applied when patients are confused and disoriented. The nurses then use this confused and disorientated state as evidence of patients being at a risk of harming themselves. Although the delirium is induced by the medical treatment, the

application of the restraints is not a part of the experimental treatment protocol. The restraints are applied as a means of reducing this risk of self-harm. Despite the benevolent motivations for the restraints, they do interfere with the patients' mobility, and potentially increases their sense of vulnerability.

The safety agent role is governed by the rules of the institution/hospital rather than independent nursing judgment, which is typical for the time period of the film. The nurses are not depicted as evaluating patient care needs to determine the most appropriate intervention. For example, when one of the patients flees during an interview with her doctor, the nurse's response is to ask the doctor if he wants her to go and bring the patient back. Another example of the lack of independent judgement is when two nurses enter a patient's rooms in response to her screaming. The dialogue begins with the younger of the two nurses stating, "Christ, the poor thing – what did they give her?" The head nurse responds "a new drug LSD." "Well, I don't think it is working," replies the younger nurse. The head nurse tells her "it's not your job to decide what's working nurse; you just follow Chief's orders, alright." This scene ends as the nurses leave the patient crouched under the sink in her room screaming. The nurses are portrayed as rule-bound by the system rather than as professionals who use their ability to critically analyze a situation and then respond.

The most common nursing role in this film is that of a resource person. This role is depicted when the nurse administers medication, assists with a procedure, administers a prescribed procedure, or assists with the admission of a patient. In the movie the nurses are "just doing their job" and as a result robotically administer medication or assist with a procedure. The management

of physical symptoms is given priority over responding to the emotional turmoil many of the patients experience as a result of the experimental treatment. This reflects the lack of engagement and the lack of use of embodied knowledge during these scenes. In order for the nurse to engage with patients, the nurse must make an effort to understand the others' perspective and their vulnerability. Through understanding and nurturing the "between" then nurses are able to give equal weight to scientific knowledge and compassion for/with the patient (Bergum, 2004).

This film reveals the nurse as a recorder. It shows a nurse engaging in documentation and identifies nurses as the staff member who completes patient discharge documentation. In the films selected for this research, this film is one of only three films that shows the nurse in the role of recorder.

This film depicts nursing care in the 1950's and 1960's. The dominant psychiatric nursing activities at this time would have been those of safety agent and resource person. However, it was still the responsibility of nurses practicing to ensure that the people for whom they cared were treated ethically and with dignity. This responsibility was clearly outlined in the code of ethics followed by Canadian nurses. At the time it was the International Council of Nurses Code of Ethics (Tate, 1977). This code of ethics was first introduced in 1953 and identified that nurses had the fundamental responsibilities of alleviating suffering, the promotion, and when necessary, the restoration of health, and the prevention of illness (International Council of Nurses, 2006).

The nurses depicted in the film do not fulfill their ethical responsibilities. They do not respond to the suffering of the people for whom

they care even when it is directly caused by the experimental treatments they receive.

### **Girl, Interrupted.**

#### ***Overview.***

Susanna Kaysen was admitted to McLean Hospital, a psychiatric affiliate of Harvard Medical School (McLean Hospital, 2006), in April 1967. She remained at this facility until January, 1969. Based on her experiences in the hospital, Susanna Kaysen wrote an American national non-fiction best seller, *Girl, Interrupted* (1993). Her book was later developed as a movie by Columbia Pictures and released under the same title – *Girl, Interrupted* (Mangold, 1999). In the film the fictitious name used for the hospital was Claymoore.

Despite the all-star cast, the movie received poor reviews based on the episodic nature of the filmography and the one dimensional character development (Berardinelli, 1999; Ebert, 2000; Kerrigan, 1999; Leong, 2000). Although many critics did not like this film, Angelina Jolie won an Oscar for Best Supporting Actress in 2000 (Academy of Motion Picture Arts and Sciences, 2006) for her role as Lisa, a teenage patient.

*Girl, Interrupted* (Mangold, 1999) opens with a close-up of window bars and then pans to people crying in a basement surrounded by old pipes. The intent appears to be to evoke thoughts and feelings in the audience related to desolation and hopelessness. As the audience sees this image, the following voice-over monologue begins:

*Have you ever confused a dream with life?*

*Or stolen something when you have the cash?*

*Have you ever been blue?*

*Or thought your train moving while sitting still?*

*Maybe I was just crazy.*

*Maybe it was the '60s.*

*Or maybe I was just a girl...interrupted.*

(Mangold, 1999)

From this monologue the viewer is immediately shown a hospital emergency room, where Susanna is receiving treatment for an overdose after a suicide attempt.

After her discharge from the emergency room, Susanna sees a psychiatrist who encourages her to admit herself into Claymoore, a psychiatric treatment facility. She agrees and arrives at the facility via cab. Nurse Valerie is waiting for her and provides an orientation to the unit. During the orientation, as Susanna and Nurse Valerie walk down the hall, Susanna observes a nurse being reprimanded for letting a patient into the music room without supervision. Once they arrive at her room, Nurse Valerie introduces Susanna to her roommate. Shortly after this orientation, Susanna sees another patient, Lisa, being brought back to the facility in a police car and forcibly placed into a private room without a bed, linens, or other furniture – a seclusion room. Susanna also observes the nurses, and the orderlies, administer an intramuscular injection to Lisa despite her pleas that she does not want the medication. They administer the medication against her expressed wishes.

Susanna stays at Claymoore for approximately two years. During this time she befriends a number of other patients, all of whom are portrayed as having varying degrees of mental illness. The mental illnesses portrayed in the film include depressive illnesses, personality disorders, and anxiety disorders. These disorders have varying degrees of impact on the other patients' functioning. For example, one of the patients "appears normal" and appears to be coping with the sexual abuse she experienced at the hands of her father, yet once discharged she commits suicide. Other patients are completely incapacitated by their anxiety and are unable to make social connections with others.

Susanna is seen by a psychiatric resident and by a psychiatrist on a number of occasions. She is diagnosed as having a Borderline Personality Disorder. Borderline Personality Disorder is defined as a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins in early adulthood and is present in a variety of contexts" (American Psychiatric Association, 2000, p. 706). Persons with Borderline Personality Disorder experience difficulty controlling their moods; they experience difficulty maintaining personal relationships, and experience difficulties developing and maintaining a sense of self. As a result, these individuals will often live their lives experiencing one crisis after another – job losses, relationship break-ups, financial difficulties, etcetera.

Susanna is initially portrayed as resisting treatment and being non-compliant by breaking a number of the hospital rules. For example, she sneaks off the unit with several other patients to explore other areas of the hospital. She also leaves the hospital without permission to stay briefly with an ex-

patient. During this stay Susanna discovers her friend's (the ex-patient's) body hanging in the bathroom from the shower rod. Her friend has killed herself. Susanna then returns to the hospital and engages with her treatment. She complies with the rules of the institution, and makes progress as determined by the psychiatrist, and is subsequently discharged.

This movie is set in the turmoil of the 1960's. There was a political shift at this time from a relatively stable political climate to one filled with uncertainty. Political anti-war sentiments about the conflict/war in Vietnam were escalating. The civil rights movement was also escalating and was fuelled by the assassination of Martin Luther King.

One film critic suggests that the protagonist in the film, Susanna, could represent the American people at this particular time in history as being confused, lacking direction, and in turmoil (Leong, 2000). If this is the case, then the staff of the hospital could represent the conservative influences in western society. The film depicts Susanna shifting from "fighting the system" to working within its structure to achieve the goals for which she is striving. Leong (2000) suggests that *Girl, Interrupted* (Mangold, 1999) is a subtle treatise on the value of adhering to conservative values.

From a relational ethic perspective, this movie reflects how the environment is shaped by the social dialogue; essentially "each action we take affects the whole system" (Bergum, 2004, p. 488). Therefore, each of the interactions that occur between the nurses and the patients shapes the context of the environment. An example of this is during a scene in the day room. Medication is being dispensed by a nurse. Both Susanna and Lisa do not want their medication. When the nurse realizes that Susanna does not want her

medication she asks Susanna if there is going to be any trouble. Susanna responds there won't be any trouble. She will follow the rules – at least she will make the nurse believe she is following the rules.

In the next scene it is revealed that neither Lisa nor Susanna took their medication; they hid the medication under their tongue. They are in Daisy's room (another patient) and show each other the hidden medication. Daisy is angry that she is not able to get the medication that she wanted, a laxative. Daisy decides to take Susanna's medication and Lisa takes Daisy's medication. The viewer is left thinking that these patients have fooled the nurse. The audience is also asking if mental patients can be trusted? In the same scene it is revealed that Daisy hides chicken carcasses under her bed. Susanna is shocked by this strange behaviour. Daisy tells her that once she has accumulated five carcasses Nurse Valerie makes her throw them out. Nurse Valerie recognizes that the collecting of food is a means that Daisy uses to try to control her anxiety. Nurse Valerie decides that it is most fitting to limit the collection of carcasses rather than trying to permanently remove them. Daisy and Nurse Valerie establish a connection. Nurse Valerie attempts to understand Daisy's uniqueness and her vulnerabilities.

### ***Nursing roles.***

*Girl, Interrupted* (Mangold, 1999) is filmed primarily in a psychiatric hospital. There are 38 scenes with nurses. Despite the negative reviews of the film, the nurses are described as perceptive, having the best interests of the patients at heart, no-nonsense, hearts of gold, caring, and wise (Berardinelli, 1999; Clisby, 2000; Kerrigan, 1999; Leong, 2000). Compared to the other films included in this research the nurses in *Girl, Interrupted* (Mangold, 1999)



are depicted in a more positive manner.

The nurses in the film perform seven different roles. These are resource person (12 scenes), observer (4 scenes), teacher (1 scene), safety agent (12 scenes), counsellor (3 scenes), surrogate (3 scenes), and leader (2 scenes). There is also one scene in which the nurse does not perform any nursing role. In this scene the nurse is sleeping. She is in the nursing station and is unaware that the patients are leaving the unit. In this scene, if the nurse had been awake, she could have been performing any number of roles. She may have been completing documentation – the recorder role, or she could have been acting as a safety agent if she was monitoring/observing the patients on the unit. However, as she is sleeping she is not performing any role. She is on duty and has a responsibility to be competently nursing; which she is not.

The activities performed in the resource person role include: responding to a patient's overdose attempt, dispensing of medication, responding to the requests from patients for medication, and informing patients when they have their appointments with the psychiatrist. The nurse is using her specialized knowledge.

The observer role occurs when the nurse is part of the scene but does not engage in any verbal or non-verbal interactions with other characters. For example, when one of the patients arrives at the hospital via a cab, the nurse waits and watches the cab drive up the lane. She does not speak and does not move – she observes. Another example is during the admissions process. The admissions clerk asks for information from the patient and the nurse sits in the background. She watches the interactions but she does not speak or move.

The teaching role is demonstrated when the nurse provides new

patients with an orientation to the unit and the unit routines. Nurses also engage in a teaching role when they respond to patient's questions. Typical questions asked related to information about procedures, routines or medication.

When the nurse acts as a safety agent there can be several different activities performed. All activities are directed at ensuring that the patients are safe. These activities include: conducting room checks, monitoring potentially suicidal patients who are using a razors to shave their legs, and escorting patients back to the unit. The focus of the nursing activities is to ensure that the patients are following the institution's rules.

The counselling role is performed to help the patient "become aware of the conditions required for health" (Peplau, 1992, p. 61). During the scenes that the nurses are acting as counsellors, they are either exploring the patient's feelings and reactions or facilitating behaviours that will not draw public attention. For example, when a group of patients and a nurse are on an outing the nurse tries to reduce a patient's word clanging<sup>5</sup> so the patient does not draw unwanted attention to the group. The nurse also provides some suggestions for outlets for the patient's emotions that had previously been difficult for the patient to accept.

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<sup>5</sup> Word clanging refers to a form of speech pattern where there is word association based on sound rather than on meaning. For example, in the movie, the patient was saying: peppermint, peppermint dick, peppermint clit ... This is one of the symptoms linked with the irregular thinking demonstrated by some individuals with a thought disordered psychotic illness.

In three scenes, nurses act as surrogates. One of the scenes involves a nurse participating in a birthday party with the patients. In another scene, the nurse is playing board games with the patients – just as you would with a group of friends. The final surrogate scene depicts one of the patients leaving the hospital. She says good-bye to the nurse in a way similar to saying good-bye to a family member.

The leadership role is specific to the nurse providing direction to the orderlies. For example, the nurse instructs the orderlies to take the patient to seclusion. This role is not a major focus of the nurses portrayed in the film.

### **Cosi.**

#### ***Overview.***

Critics describe the film as “cute but predictable” (Null, 2000, para. 1) and “a fast, funny and cleverly acted film” (Stratton, 1996, para. 1). Berardinelli (1997) only gives the film 2.5 stars out of four because of a shallow script, a predictable story line, being dramatically weak, and not having enough consistent humour to sustain the comedy. *Cosi* (Joffe, 1996) is loosely based on Louis Nowra’s experiences as a drama therapist at a psychiatric hospital in the 1970’s (Hoffman, 1996). The film is set within a large psychiatric hospital. All of the treatment services are provided by the staff of the hospital and are provided within the walls of the institution; with one exception, several patients and staff members go on a community outing to see a local theatre company perform a play.

The overall plot of the film is to have the patients perform in a talent show. The occupational therapist suggests that a pantomime would be appropriate. The person hired to direct the talent show (Lewis, an amateur

director) is convinced that the patients are capable of successfully delivering a more challenging performance. Through the lobbying of one of the patients (Roy), the play chosen for the patients to perform is Mozart's *Così fan tutte*.

The film centres on the antics of the patients as they prepare for their performance. There are many setbacks experienced. One of the setbacks occurs when one of the patients, who is to participate in the performance, burns down the rehearsal hall and is placed on a secure unit.<sup>6</sup> As a means of preparing to deliver their performance, Lewis arranges for the hospital performers/ patients to attend a stage play. One of the actors is Lewis's friend who delivers a grimly pretentious performance. However, the performance impresses many of the hospital performers/patients. The film ends with the patients performing of *Così fan tutte*. Their audience is made up of other hospital patients, hospital staff and the Minister of Health.

At the time this film was released, there was some concern over the appropriateness of the depictions of the people with mental illness in films and other means of visual communication. This concern developed as a result of the mid-90's advocacy movement for people with mental illness and anti-stigma campaigns. There was the potential that the public would negatively receive the content of the film. However, due to the depiction of the positive relationships with the characters, those with mental illness and those without, *Così* (Joffe, 1996) was received very positively by the general public. The depiction of the engagement and mutual respect that was demonstrated

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<sup>6</sup> A secure unit is a locked unit that typically houses patients who are either dangerous or are a flight risk. Patients are unable to leave the unit without a staff member unlocking the door.

between Lewis and the patients was a significant factor in the positive portrayal of people with mental illness. One of the significant strengths of *Cosi* (Joffe, 1996) is that it does not cause us to laugh at “the patients”; we laugh at all the people, some whom happen to be patients.

### ***Nursing roles.***

There is one strong nurse depicted within this film – Errol. Errol is the head nurse. In addition to leading the team of nurses he also provides leadership and mentoring to Lewis, who has never previously worked with a person who has a mental illness. Compared to the rest of the characters in the film, Errol is a supporting character. However, Errol develops relationships with all of the patients under his care. His nursing care and approach varies from patient to patient, depending on their needs. He also mentors younger staff, who appear to be less experienced. Other nurses in the film include nurses who are providing care on a locked unit and those who are assisting patients with mobility problems. In contrast to other films, there are no female nurses with any speaking roles. It is also difficult to tell who is a nurse, with the exception of Errol who is identified as being the head nurse. Some of the characters that appear to be doing nursing tasks, such as escorting patients, ensuring that the unit is secure, etcetera might be nurses or they might be orderlies. This is not made clear in the film.

The lack of female nurses is a significant variation to the other films used within this research project. Most of the other films have female nurses and male orderlies. This film is also one of a few that depicts nursing positively. Although not all the nurses are depicted positively, Errol is seen as a competent and caring nurse. Despite the deviation in the typical depiction of

the gender of the nurse, the roles and functions of the nursing staff do not vary from the other films studied.

*Cosi* (Joffe, 1996) depicts nurses caring for patients in 14 different scenes. The nursing roles depicted are those of an administrator (4 scenes), leader (5 scenes), safety agent (4 scenes), and resource person (1 scene).

When in the role of the administrator, the nurse interviews potential new staff. The nurse also advocates for additional resources for patient care and negotiates with the hospital administrator. The head nurse, Errol, demonstrates an ability to critically analyze the care needs of the patients and is able to determine what resources are necessary to provide the required services. He communicates these needs to the hospital administrator.

The leadership roles in this film are demonstrated when the nurses provide orientation to new staff members, provide direction to other staff regarding how to initiate a project, and provide staff feedback on how they (the less experienced staff) are interacting with the patients

In *Cosi* (Joffe, 1996) the style of nursing leadership facilitates an interdependent environment. Errol recognizes that each nursing action has a direct impact on the patients and the overall culture of the unit. For example, when he finds a patient on the grounds that is to be on the secure/locked unit he returns the patient to the unit. Upon his arrival to the unit, he sees that the staff have confused Lewis for this patient. Lewis is medicated and locked on the unit rather than the intended patient. Errol speaks to Lewis to determine what has happened and facilitates his release, and facilitates the real patient's admission to the unit. In recognition that an error had occurred, Errol seeks to understand what has happened and rectify the situation. This demonstrates

openness and transparency in relation to the error. It strengthens his relationship with Lewis and shows the other patients that people on the unit are respected, treated honestly, and treated with compassion.

Scenes involving nurses in the role of safety agents include nurses restraining patients. For example, patients are restrained when they are going to be given a medication and arguing that they do not want this intervention. Patients are also restrained when they are taken to the locked unit. This occurs after a patient set the rehearsal hall on fire, and is then taken to the locked unit. Redirecting patient behaviours to reduce risk of harm to others is also depicted. For example, with the patient that had the propensity to start fires; the nurse redirects his offer to light a cigarette for another person and removes the lighter from that patient's possession in order to reduce the risk that he would subsequently light another fire. The nurse recognizes that this patient should not have a lighter.

The role of the resource person is also seen in the film. The tasks performed are similar to the other films included in this research. These tasks include administering medication and assisting with the admission of a patient to a new unit.

### **High Anxiety.**

#### ***Overview.***

Mel Brooks' satirical comedy *High Anxiety* (Brooks, 1977) is an integrated parody of several films: *Spellbound* (Hitchcock, 1945), *Family Plot* (Hitchcock, 1976), *North by Northwest* (Hitchcock, 1959), *Vertigo* (Hitchcock, 1958), *Psycho* (Hitchcock, 1960), *The Birds* (Hitchcock, 1963) and Milos Forman's film *One Flew Over the Cuckoo's Nest* (Forman, 1975). The parody

extends to include the witch from *The Wizard of Oz* (Fleming, 1939). For example, in one scene Nurse Diesel falls to her death holding a broom and cackling like the witch. Another film included in this extensive parody is the James Bond film – *The Spy Who Loved Me* (Gilbert, 1977). There is a character in *High Anxiety* (Brooks, 1977) that has metal teeth similar to the assassin Jaws, from the James Bond film. Nurse Diesel is a parody of previous cinematic psychiatric nurses – Nurse Ratched and Nurse Terry. *High Anxiety* (Brooks, 1977) grossed \$31,063,038 in sales since its release December 23, 1977 (Nash, 2005) and in 2006, Twentieth Century Fox re-released this film on DVD.

The film takes place primarily at a mental institution, called the Psycho-Neurotic Institute for the Very Very Nervous. The plot centres on the actions of Dr. Montigue, the interim chief psychiatrist, Dr. Thorndyke, the new chief psychiatrist, and Psychiatric Nurse, Charlotte Diesel. Dr. Montigue and Nurse Diesel act as antagonists who are engaged in a sadomasochistic sexual affair. There are many scenes that suggest this pair regularly abuse patients and have likely murdered the previous chief psychiatrist to maintain control over the operations of the institution.

Schwartz (2004) writes that “some sketches are indeed very very [sic] funny and some sketches just stink stink[sic]” (para. 2). He goes on to describe this film as one of the more entertaining films that Brooks has created. By the level of satire within this film it is fairly clear to the audience that there are limited degrees of truth. For example, depictions of the Nurse Diesel in her uniform with the cone shaped breast darts, to the psychiatric patient who is on his hands and knees and barks like a dog then leg-humps his visitors. As the



audience watches this film we are left wondering on what basis of reality, if any, this satire has been created. Film Freak Central Reviewer (Chambers, 2006) also gives a mixed review to *High Anxiety* (Brooks, 1977). While assigning two out of four stars to the film he describes the film as having a few clever gags and as being a “disingenuous love letter to Alfred Hitchcock” (Chambers, 2006, para. 1). Although, Don Willmott (2003), a critic from Film Critic.com gives this movie several accolades he prefaces his review by indicating that unless you are in the mood to see a Mel Brooks film you will not like this film. Not all of the critics have connected positively with this satirical film. Roger Ebert (1978) does not believe that Mel Brooks is able to satirize the sophistication of an Alfred Hitchcock film; he identifies that it is very difficult to spoof work that is funny itself. It is like trying to create a satire of National Lampoon (Ebert, 1978).

### ***Nursing roles.***

There are no scenes in this movie that depict Nurse Diesel interacting with patients. At the very beginning of the film there are two nurses providing assistance to patients with their mobility needs. One is pushing a patient in a wheelchair and the other is assisting another patient to walk. With this level of assistance we are left to wonder why can't these people walk? Are they over medicated? The movie never returns to the nursing staff, or the patients, in these scenes. These questions are left unanswered.

This film has seven scenes in which Nurse Diesel appears. She is the only speaking nurse in the film. At no time during the film does she provide care to any patient at the institution. Her actions are directed towards the management/control of other staff. The scenes depict her role as that of an

administrator. She coordinates the activities of the physicians at the institute but is not seen coordinating or supervising other nurses.

### **Titicut Follies.**

#### ***Overview.***

In *Titicut Follies* (Wiseman, 1967), the director uses a cinéma vérité style of film making<sup>7</sup> to take a provocative look at the conditions within the Massachusetts Correctional Institute – Bridgewater. He achieves an extreme naturalism using non-professional actors, nonintrusive filming techniques, a genuine location, and sound without substantial post-production mixing or voice-overs. This film is described as a reality fiction, a black-and-white picture, laconic, abrasive, awkward, compelling, an educational force, providing insights into cold truth, and a despairing documentary (Canby, 1967; Ebert, 1968; Levit, n.d.; Null, 2005; Price, 2002). The term, reality fiction, is used to point to the constructive nature of the documentary film (Anderson & Benson, 1991). The film speaks to us about the power of the American institution; and about difficult legal, social, educational, and scientific matters. Vincent Canby (1967), a writer with the *New York Times* describes the visual acuity of *Titicut Follies* (Wiseman, 1967) as speaking for itself. It provides the viewer with a horrifying look at the conditions within the Bridgewater institution.

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<sup>7</sup> When using this technique the director uses unobtrusive techniques to record scenes under the most natural conditions as possible to convey candid realism.

The location of this documentary is the Massachusetts Correctional Institute – Bridgewater. When viewing the film, it is important to recognize that the department of corrections, not the department of health, administered the institution (Anderson & Benson, 1991). These two state units represented different and even contradictory goals. As a result, these two departments formed a precarious alliance at Bridgewater. At the time of filming, it was a large complex with 139 buildings spread over 1500 acres. There were four distinct patient groups within this institution: the criminally insane – approximately 600 men, alcoholics sentenced by the courts and voluntarily committed for drug addiction and inebriety – 600 to 1000 men, individuals with profound mental retardation – 150 men, and the sexually dangerous – 150 men (Anderson & Benson, 1991). There were only approximately 15% of the population that had ever been charged with a crime. Most had been sent there for a 20 to 30 day observation period.

In the mid-sixties, Bridgewater used the services of foreign physicians practicing on partial licenses to care for the patient population (Anderson & Benson, 1991). During the filming of *Titicut Follies* (Wiseman, 1967), two psychiatrists and one “junior physician” cared for 600 men in the hospital section of the Massachusetts Correctional Institute – Bridgewater. Gross shortages existed in all personnel areas: security, medical, nursing, and social work. These shortages are noticeable in the film. Shortly after the documentary was released, approximately three hundred men were transferred from Bridgewater after the superior court sat on the grounds for months and conducted hearings into the allegations of mismanagement (Anderson & Benson, 1991).

In December 1974 the new Bridgewater State Hospital opened. In July 1987 a new superintendent was appointed, Gerard Boyle, and he insisted that all men confined to the prison be treated as “patients”; even those transferred from maximum security prisons. He transferred and even dismissed correction officers who resisted his emphasis on treatment. Wesley Profit, director of forensic services at Bridgewater, described *Titicut Follies* (Wiseman, 1967) as a “two-by-four” in getting the attention of the state legislature in the 1960s, but at the same time stresses the continuing struggle to hold that attention in the 1980s and beyond (Anderson & Benson, 1991).

After the film was released there were several legal moves by the state of Massachusetts to prevent the public viewing of the film, resulting in several trials (Anderson & Benson, 1991). Although Wiseman was just beginning his film career when he made *Titicut Follies* (Wiseman, 1967), it was clear he anticipated criticisms of the film when he offered the following disclaimer. “The Titicut Follies does not seek to judge or condemn; it is not meant as an exposé of backward mental health or prison practices nor is it a circus freak show” (Anderson & Benson, 1991). During his testimony, Wiseman indicated that the motives behind making the film were to gain experience in filmmaking, particularly documentaries (Anderson & Benson, 1991). He further declared that his original intention was to educate the public. Other motives, presented during testimony included trying to let the public at large understand some of the conditions and problems/situations at Bridgewater that the crew observed while filming (Anderson & Benson, 1991). To date, there are still limitations on the sale of this film. The film may not be sold to

individuals and may only be purchased by libraries or post-secondary institutions (Zipporah Films Inc., 2007).

In some sequences in *Titicut Follies* (Wiseman, 1967) the director is obviously guiding the viewer through the use of editing. The most conspicuous example of editorial point-making occurs when an inmate/patient is force-fed by a physician, so unconcerned with the patient's well-being, he dangles his cigarette over the intake funnel of the feeding tube. It looks as if cigarette ashes are going to fall into the tube. This image is cross cut with images of the same inmate, now dead, being carefully prepared for burial. His body is handled carefully and gently. Once dead, this inmate's body is given more respect than he was alive.

The documentary makes an issue of uncertainty. The theme of uncertainty is introduced immediately. The first sound we hear is a group of male voices singing "Strike Up the Band." The camera pans across a row of men singing in a theatrical performance. They stand in front of a glittering lettered sign attached to a stage curtain that reads "Titicut Follies." The audience is given no background information. We gradually discover we are watching activities at a prison, then at a prison hospital for the mentally ill, but this information is never stated directly. It must be extrapolated from the clues given to the audience within the "text" of the film. Reading/watching backward and forward, we note that some of the men in the opening chorus number are guards and some inmates/patients. Some of the others we are never sure what role they have within the institution. The interpretive possibilities are vast as the director keeps the audience uncertain about several aspects of the

film – who are the patients, what are they doing, why is this being done, what are they thinking?

The political tensions of 1966 – 1967 created the context of discord that the Bridgewater documentary entered and extended. Politically, the Massachusetts voters had responded and supported the national trend to reject the social programs. State political feuds took on an edge of particular seriousness, even bitterness, as politicians and their constituencies became polarized over national issues such as civil rights and military involvement in Vietnam. Furthermore, in Massachusetts, the bussing of school children to integrated Boston schools continued to divide the city.

Against the general background of political volatility came the sudden explosiveness of several incidents at Bridgewater. One of the patients, a suspected murderer, was found naked and dead in his cell (Howard, 1993). Autopsy revealed that he had died of rat poisoning. The reaction to the cause of his death and the revelation that some men at Bridgewater were kept naked because they were possibly suicidal provoked the media's interest and resulted in increased media coverage for the hospital/prison. There was public outcry about the conditions and the need for immediate reform. Prompted by this scandal, a legislative investigation was conducted and a state legislative committee heard Superintendent Gaughan, medical and legal experts, and social workers describe Bridgewater as a "dungeon," a throwback to the Dark Ages (Howard, 1993). Subsequent to the hearings, minor changes were made in some procedures at the prison hospital; patients were no longer kept naked if they were suicidal.

### ***Nursing roles.***

The film is an extraordinary demonstration of indifference and patronizing concern. The staff depicted in the film are a warden, guards, aides, and a nurse. Despite this film being a documentary in a mental hospital, there is only one forty-five second scene that shows a nurse. During this scene, she describes a Bridgewater ex-patient who was treated for alcoholism. After being discharged from the facility, this gentleman sent her a letter and a locket. In describing the letter and gift she states the following. “Makes you feel good. Even if at the time you don’t think you’re helping them because they have such a problem. At least you tried.” It is not clear as to the relationship, or the role, that this nurse had with this patient. During this scene there are patients sitting around the perimeter of the room. The nurse, focuses her attention on showing the cameraman and the other staff the letter and locket. She does not interact with any of the patients.

### **Frances.**

#### ***Overview.***

For their work in *Frances* (Clifford, 1982), actors Jessica Lange and Kim Stanley are both nominated for Academy and Golden Globe Awards (Internet Movie Database, 1983). Despite these nominations the film does not impress the critics. One critic describes the film as a

mixed up movie that still seems to be unfinished, as if Graeme Clifford, the director, and the writers hadn’t yet discovered the real point of the Frances Farmer story. It contains too many show-down scenes, too much raw material that hasn’t been refined, and more brutality than

either the movie or the audience can make dramatic sense of. (Canby, 1982, para. 6)

The life of actress Frances Farmer inspired the movie *Frances* (Clifford, 1982). The opening scenes of the movie depict Frances' rural upbringing. It shows a country girl developing into an impassioned and outspoken woman who is not understood by her family or community. This lack of understanding contributes to her being institutionalized and labelled as mentally ill. Frances grows up/emerges during an era of heightening fears about communism and the cold war. She is told several times by her mother, and the studio executives, that it is her job to act and not to concern herself with everything else that is going on in the world. They do not want her making public political statements. However, she continues to do so despite their objections. This lack of conformity to social expectations contributes to Frances' social ostracization. To deal with her lack of connection, Frances starts to take prescription pills to help her cope with life. This means of coping contributes to Frances developing an addiction. Consequently, she begins to drink more heavily, take more pills and becomes more impulsive. Frances' impulsivity leads to her getting into fights. After being sentenced to prison, as a result to her unruly behaviour, she negotiates an admission to a mental hospital instead of prison. She sees going to the mental hospital as the lesser of two evils. During her admissions Frances is treated with insulin shock treatment,<sup>8</sup> hydrotherapy, electroconvulsive shock treatment, and then ultimately with a periorbital lobotomy.<sup>9</sup>

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<sup>8</sup> Insulin shock treatment was a form of treatment in which patients were given large doses of insulin to produce a coma.



The movie fails to take a stand on whether Frances' breakdowns are a result of her own bio-psycho-social make up, or if they are a result of the treatment from her mother and the Hollywood establishment. Roger Ebert, finds that it was this aspect of the movie that makes it fascinating (Ebert, 1983).

### ***Nursing roles.***

There are six scenes depicting nurses in the movie *Frances* (Clifford, 1982). In the first scene a nurse appears for approximately 3 seconds. She is sitting in the back of a courtroom, wearing a white uniform with a nurse's cap. She says nothing. The second scene portrays a nurse administering an injection. The nurse tells Frances she is giving her vitamins and minerals. Although this is plausible, in the next scene it is revealed to the audience that this nurse has lied to Frances. The nurse has given her insulin. It is clear that this nurse is in control and does not have any regard for Frances' wishes. She is not concerned with issues of informed consent, ethical treatment of patients, or constructing a trusting therapeutic relationship.

The next nurse seen is sitting at Frances' bedside. Frances has a nasogastric tube in place and has had a seizure. The nurse in this scene tells Frances that she received insulin and it has put her body into shock. She responds honestly to Frances' query about what is happening to her. This nurse touches

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<sup>9</sup> During this procedure a pick like instrument was forced through the back of the eye sockets to pierce the thin bone that separates the eye socket from the frontal lobes. Then the frontal lobe was damaged, by sweeping the instrument from side to side or up and down, which interrupted the normal functioning of this area of the brain.

Frances gently and states, “alright dear, I will be here.” Although these two statements could be construed as potentially condescending and belittling, in the context of the situation Frances appears to find these words reassuring and supportive. This behaviour demonstrates that this nurse is recognizing Frances’ care needs and the importance of being honest with her.

These are the only two scenes in which nurses are talking to patients. In the next two scenes the nurse is either watching Frances being restrained by male orderlies, or is helping with a restraint during electro-convulsive shock therapy. The nurses do not speak. The last scene depicts two nurses standing quietly in the back of a classroom where a physician is demonstrating how to perform a periorbital lobotomy.

The nurses in this film have the roles of resource person, observer and safety agent. The nurses fulfill the resource person role when they nurse give patients an injection or dispense medication. The depiction of the resource person role is consistent with the depiction in the other films included in this research.

The observer role is demonstrated when the nurse is observing Frances being restrained. The audience also sees the enactment of this role when the nurses are sitting in the back of the courtroom or when they stand in the back of the classroom and do not participate.

The only scene where there is recognition of a connection, between any patient and a nurse, is the one that depicts the nurse is sitting beside Frances after she has been given insulin. In this scene this nurse is acting as a safety agent.

## **Harvey.**

### ***Overview.***

Bosely Crowther (1950), a writer with the *New York Times*, describes this film being full of warm and gentle whimsy with charming fanciful farce. Another critic describes the film as a “delicate fantasy with a big-hearted plea for acceptance and tolerance at its core, as well as an almost subversive protest against conformity and the nascent rat race” (Grady, 2000, para. 3).

The plot of the movie involves Elwood P. Dowd, played by Jimmy Stewart, and his friendship with a human-sized rabbit, Harvey. The rabbit is an apparition/a pooka. Except for a few occasions, Elwood is the only one who can see the pooka. As a result of Elwood seeing Harvey, Elwood’s sister tries to commit him into a mental institution. During her attempts, a comedy of errors ensue beginning with her commitment rather than Elwood’s.

*Harvey* (Koster, 1950) was originally developed as a stage play and was later made into a movie in 1950. It was re-released on DVD in 2000. Like the play, the 1950 production garnered several nominations and awards for the actors who worked on this film. For example, an Oscar and a Golden Globe were won for best supporting actress. This film also received nominations for: best actor, best motion picture, and best dramatic presentation (Internet Movie Database, 1950).

### ***Nursing roles.***

There are two nurses portrayed in this film; one is in love with the psychiatrist and the other is providing care to newly admitted patients, but is unable to tell who is a patient and who is not. The two nurses in this film are easier to distinguish than in other films because they are addressed with their

title and last name, such as Nurse Kelly. There are ten scenes in which at least one of these nurses appears. The first nurse appearing in the film answers the door to a physician's office after she hears a knock. She interacts with a potential patient. She looks down and sees a man lying on the floor and states "the doctor will see you in a minute." She closes the office door without further interaction with the new patient. All but one of the remaining scenes takes place in Chumley's Residence – a sanatorium.

The nurses are featured performing tasks such as admitting a patient (collecting demographic information), supporting the physicians (assisting in the preparation of an injection, getting the physician's coat and hat), giving a patient a bath, and looking for a patient who has gone missing.

The relationship between the main physician and Nurse Kelly is initially revealed as one in which the physician is condescending to her. For example, when Nurse Kelly does not respond as quickly as the doctor desires, he states "sorry to wake you." Her response is to look longingly at the doctor. There is only one instance in which she rebuts his disrespectful behaviour, and she does so in a very defensive way. In this instance, she suggests that the doctor is egotistical.

The interactions with the patients and the nurses are supportive. For example, Nurse Kelly speaks with a soft tone, and maintains appropriate eye contact while she interacts with the patients. She leans forward, demonstrating non-verbally, her interest in what the patient is saying. Nurse Kelly is not involved in any physically restraining any of the patients.

The two nurses in the sanatorium have roles as a resource person, leader and safety agent. The nurses are familiar with the site, and direct the

new patients and visitors to where they can find what they are looking for. They also have technical knowledge about the bathing facilities and how to prepare for and give an injection. Both act as safety agents when they look for a patient who they believe to be lost.

Despite the comical overtones to the film, hospital staff are depicted as being ready to commit someone without just cause. Generally, this film shows nurses in respectful and engaging relationships with patients. However, the relationships with the physicians are submissive, and the nurses are not treated as professional equals. This is further exacerbated with Nurse Kelly “looking longingly” at one of the physicians as she sought to develop a social relationship with him.

### **The Caretakers.**

#### ***Overview.***

In 1963 *The Caretakers* (Bartlett, 1963) was released by Metro-Goldwyn-Mayer. This film stars Joan Crawford, as the head nurse, and Robert Stack, as new psychiatrist, in a mental hospital. Individuals who worked on this film were nominated for several awards. Included in these were nominations for an Oscar – Best Cinematography and several Golden Globes – Best Motion Picture, Best Actress, Best Director (Internet Movie Database, 1964). There were very few reviews available for this movie as it did not receive the same degree of success as *The Snake Pit* (Litvak, 1948) or *Harvey* (Koster, 1950). However, one reviewer does indicate that the movie is well photographed but is overwrought and compellingly bad (Bmacv, 2002).

The plot of the film focuses on the relationship and power struggle between the Director of Nursing and a new psychiatrist. Lucretia Terry (Joan

Crawford), Director of Nursing resists what she perceives as the optimistic treatment of mental illness by Robert Stack's character, Dr. MacLeod. He begins an outpatient group therapy program and believes in treating the patients without violence or punishment. Dr. MacLeod's program is based on the importance of understanding the patient and listening to them as individuals. This approach is consistent with Peplau's Interpersonal Relations Theory. However, this model contrasted sharply with Nurse Terry's approach of dealing with the patients with force as a means of ensuring that the nurses have control.

### ***Nursing roles.***

There are a number of nurses in this film. Director of Nursing - Lucretia Terry and Nurse Horn are the predominant nursing characters. The nurses interact with the physicians, the patients, and with the hospital administration. The nurses in this film have roles in providing direct care to the patients, observing and documenting group therapy, assisting with electroconvulsive shock therapy, assisting with the restraint of patients, and they also have a significant role in the administrative functioning of the hospital. The new nurses are mentored by more experienced nurses and their development is monitored by the Director of Nursing. Through this orientation/socialization the Director of Nursing reinforces that the nurses are different from the patients; and the patients need to be treated as such.

There are twenty-seven different scenes depicting psychiatric nursing care in this film. Within these scenes the nurses have the following roles: leader (3 scenes), resource person (8 scenes), safety agent (5 scenes), teacher (3 scenes), administrator (4 scenes), counsellor (1 scene), having the observer

role (1 scene), and having the recorder role (2 scenes).

The leadership nursing role is demonstrated when a nurse is either giving direction to the orderlies or to other nurses. This direction includes telling the other staff where to transport patients, what to report to the Director of Nursing, and questioning the methods that the psychiatrist is using with a particular group of patients. The director of nursing uses her leadership role to control the other nurses, doctors, patients, and the environment. For example, she requires that the other nurses report to her the dynamics and treatment methods used in a particular group. She is not supportive of the treatment methods used by the psychiatrist. He is using an indirect leadership style to facilitate self exploration of the group members. Nurse Terry believes that the only effective group is through the use of a direct leadership style where the leader strictly controls the interactions of the group members. Although she is not convinced that group therapy can be effective. She functions using a harsh authoritarian manner. The purpose of her interactions is to ensure that everyone follows the rules and the traditions of the institution.

Similar to the other films reviewed, the nursing role of a resource person is fulfilled when the nurse assists with procedures, such as electroconvulsive shock therapy, administers medication, or when they assist with the care of a physically injured patient.

A nurse functioning in the role of a safety agent is also a common depiction in this film. Tasks involved in this role are the supervision of sleeping patients, restraining patients, intervening when patients are involved in a physical altercation, confiscating alcohol that is brought on to the unit without staff permission, or when trying to remove a burning torch from a

patient intent on setting fire to the chattels of the unit. When engaging in this role the nurses are in a power-over relationship. They exercise control over the behaviours of the patients. In most of these situations, the nurses are balancing the care needs of the population of patients against the care needs of the individual patient.

The teaching role of the nurses in this film extends beyond teaching patients; it also focuses on teaching new nurses the skills they require to work “successfully” in this facility. In essence, this teaching role facilitates the socialization of the new staff. Teaching of new staff includes watching a live group therapy session via camera and then discussing the group dynamics and group variables. The new nurses are also taught judo by more experienced nurses. Teaching physical intervention strategies aligns with the care philosophy of the Director of Nursing, that the patients must be “managed with the intelligent use of force.” The only scene which depicts a nurse doing patient teaching is when a nurse is explaining what the patient could expect over the course of her electroconvulsive shock therapy treatments. The approach the nurse uses to conduct this teaching results in a very frightened patient. There is no demonstration of uncertainty or reflection as the nurses are teaching. The Director of Nursing believes she knows the best course of action. The nurses do not allow the patients to have a voice in their treatment. It is the nurse who decides what they need to know.

The Director of Nursing exclusively performs the administrator-nursing role. There are scenes when she voices her concern about staff safety, her care philosophy and the appropriate allocation of resources. The concern over allocation of resources includes the assignment of new nurses to various units.



Nurse Terry is an important factor in the establishment of the environment. Through her authoritarian leadership style, people who do not follow her rules are disciplined – staff through reprimands and patients through the “intelligent use of force.”

In another scene, a nurse speaks to a patient about the patient’s difficulty sleeping. This is the only scene where a nurse is in a counsellor role. The nurse tries to engage with the patient in a mutually respectful manner to determine what difficulties the patient is experiencing and to develop/suggest strategies to overcome these difficulties.

There is also one scene where the nurse is an observer. In this scene, at a hospital picnic, the nurse is standing behind a hotdog stand watching the activities of the patients. She does not interact with any of the patients, she merely observes.

The last nursing role depicted in this film is that of recorder. The nurse performs this role when she documents what occurs in the group therapy sessions; she does not speak or physically interact with any of the patients. There are 2 group therapy scenes in which the nurses perform this role. The nurses then use their documentation to report back to the Director of Nursing regarding which of her rules were broken.

### **One Flew Over the Cuckoo’s Nest.**

#### ***Overview.***

*One Flew Over the Cuckoo’s Nest* (Forman, 1975) won the following Academy Awards: Best Picture, Best Actor, Best Actress, Best Director, and Best Adapted Screenplay, and had gross sales in the United States of nearly \$109,000, 000 (Nash, 2005). This movie was filmed on location at the Oregon

State Mental Hospital, which was founded in 1883. At that time, it housed over 3000 patients. In 1975, when *One Flew Over the Cuckoo's Nest* (Forman, 1975) was filmed, the patient population was approximately 600. Many of the actual hospital staff participated in the filming of this movie. For example, Dr. Spevy, the psychiatrist who interviews Randle McMurphy, is an actual psychiatrist at the Oregon State Hospital.

Vincent Canby, a movie reviewer for the *New York Times*, describes this movie as a “comedy that can’t quite support its tragic conclusion, which is too schematic to be honestly moving, but it is acted with such a sense of life that one responds to its demonstration of humanity if not to its programmed metaphors” (para. 5, 1975). *One Flew Over the Cuckoo's Nest* (Forman, 1975) may have been meant to have the audience

make connections between Randle’s confrontation with the oppressive Nurse Ratched and the political turmoil in this country [USA] in the 1960’s – more specifically to characterize the attempts of an autocratic force to squash the individual. The connection doesn’t work. All it does is conveniently distract us from questioning the accuracy of the film’s picture of life in a mental institution where shock treatments are dispensed like aspirins and lobotomies are prescribed as if the mind’s frontal lobes were troublesome wisdom teeth. (Canby, 1975, para. 10)

However, not all of the critics agree with this conclusion (Berardinelli, 2006; Murphy, 1975). *One Flew Over the Cuckoo's Nest* (Forman, 1975) can be interpreted as an allegory of what happens when too much power is given to those in authority. Berardinelli (2006) identifies that the messages in this film have just as much relevance for G.W. Bush’s administration as they did for

Nixon's. However, Roger Ebert (1975, 2003b) concurs with Canby (1975) that this film tries to communicate much larger messages than the story can really carry. Berardinelli (2006) does not believe that Nurse Ratched represents evil incarnate, but rather is an individual who believes she is doing good, therefore not inherently malevolent, but ends up causing harm to those in her care despite her good intentions.

The general plot is that a patient is admitted to a forensic psychiatric institution for evaluation under false pretences. This patient believes that it would be easier to serve his sentence for rape in a mental hospital, rather than in jail. He becomes an advocate for the rights of all the patients on the ward. This engages/enrages his adversary, Nurse Ratched – the head nurse. Once in the mental hospital, he enters into a power struggle with the head nurse. This nurse, Nurse Ratched, is one of the most coldly monstrous villains in cinematic history. The nurse character is seen consistently abusing the patients through an inappropriate use of power. This abuse culminates when the lead character Randle McMurphy, as played by Jack Nicholson, receives a lobotomy.

### ***Nursing roles.***

There are twenty-one scenes in this film depicting psychiatric nursing care. Compared to the other films cited thus far, the scenes are typically longer and more complex. The roles of the nurses are also more diverse in this film. There are nine different roles represented in the film. These include safety agent (3 scenes), resource person (7 scenes), recorder (1 scene), counsellor (5 scenes), observer (1 scene), tutor (1 scene), consultant (1 scene), surrogate (1 scene), and leader (1 scene).

The role of the safety agent is typical to those roles depicted in other films. The nurses do rounds to observe the patients to ensure that they are safe. They also ensure that the unit is secured; unauthorized people cannot enter or leave. The head nurse, Nurse Ratched, ensures that the rules are strictly enforced. She does so through her verbal and non-verbal actions as she tries to maintain a safe environment. Through the conflicts with the patients, the audience can see the scope of the interdependent environment in this film. As the rules, or Nurse Ratched, are challenged, the enforcement of the rules escalates, as does the means in which they are enforced. This enforcement culminates when one of the patients gets a lobotomy to significantly modify his behaviours. The audience can see the patients' behaviours influencing the nurses' reactions. Reciprocally, the nurses' behaviours influence the patients' reactions.

The nursing role of resource person is depicted in a similar manner as in other films. For example, nurses dispense medication, assist with procedures, and direct staff and patients. During the unit orientation, information is provided to the staff and patients regarding rules. When the rules are broken Nurse Ratched also reminds the staff and patients about the rules and their importance. In relation to the depiction of this nursing role, there are no significant differences portrayed in this film when compared to other films viewed.

The recorder role is demonstrated when the nurse documents what belongings patients bring to the hospital. In one of the scenes that portrays the nurse doing this task there is no engagement and a relationship is not fostered.

The nurse simply writes down what the patient had brought with him to the hospital.

Nurse Ratched demonstrates the nursing role of observer when she stands at the window and watches the patients play basketball outside. She does nothing to catch their attention, nor does she say anything to anyone on the unit. She merely observes the men outside. The information she gathers during this observation is not directly discussed later in the film. However, she may be making some conclusions about McMurphy's role when he is trying to get the other patients to play basketball. He is observed trying to be a leader.

The tutor role is not depicted in other films. This role is used when Nurse Ratched tells the men to stop their disruptive behaviour; when they are pretending to watch the World Series, after being told they could not turn on the television. Nurse Ratched is trying to control the men's behaviour and get them to conform to the behaviour she expects. The expected behaviours are: sitting quietly, looking out the window, walking around the unit, quietly playing cards, and so forth. When they are pretending to watch the World Series the patients are cheering, yelling at their favourite players, and jumping up when a good play is made.

Nurse Ratched demonstrates the consultant role during a meeting with other senior hospital staff. The purpose of the meeting is to review Randle McMurphy's care and treatment. Randle McMurphy is not at this meeting. Nurse Ratched's opinions and ideas are solicited by the psychiatrist. She offers her opinions on how McMurphy's care should proceed. She does not demonstrate this role in any of her direct interactions with the patients; it is only performed in the context of this care/case review.

The nurse surrogate role is performed by the nurse when the patients are going to bed and she says “good night, see you in the morning.” She says this in a manner that would not be unexpected of a mother. It is in this scene that mutual respect is most closely demonstrated.

The leadership role in this film is demonstrated when the nurses direct the orderlies to perform specific tasks, or give them instructions on what they want completed and in what order of priority. When in the leadership role the nurses demonstrate that each person’s actions impact the reactions of the other people on the unit, whether they are staff or patients.

There are many similar aspects between *One Flew Over the Cuckoo’s Nest* (Forman, 1975) and the *Caretakers* (Bartlett, 1963). For example, there are very strong nursing roles in each of the films. The functions of the nurses are critical in establishing the social milieu on the units, and in both films the nurses in leadership roles attempt to emasculate the male characters, whether they are patients or physicians. Lucretia Terry may be the inspiration for Nurse Ratched as they had very similar personal attributes. For example, both work diligently to maintain control on the units, and they both believe that a significant power difference between the patients and staff should be fostered and maintained. They ensure that less experienced staff are socialized to recognize and maintain this difference.

### **Persona.**

#### ***Overview.***

*Persona* (Bergman, 1966) is a Swedish made film about a young nurse assigned to work with an actress who became mute during a performance. Other than not speaking the actress appears to be healthy. The movie begins

with the doctor assigning Sister Alma, the young nurse, to look after Mrs. Vogler, the actress. Nurse Alma talks to the doctor about her uncertainty. She wonders if she will be able to manage this patient. Nurse Alma comments that the patient appears to have more physical strength than she does; she is also not sure she will be able to manage her psychologically. It is not clear why the nurse was trying to link the patient's physical strength with the patient's psychological injury. Later in the film it becomes clear that the patient is indeed psychologically stronger than the young nurse.

The movie progresses as Nurse Alma begins to care for Mrs. Vogler. This care begins in the hospital and then extends to Nurse Alma acting as a private nurse during Mrs. Vogler's recovery period at a secluded seaside cottage. Nurse Alma has many conversations with Mrs. Vogler, even though Mrs. Vogler does not say a word. The relationship begins on a very professional level. The conversations progress; some may say deteriorate, to Alma disclosing very personal information. The relationship culminates with a sexual encounter between the two women.

Nurse Alma believes that Mrs. Vogler betrays this intimate experience. In a letter to her husband the patient writes that she finds studying the nurse interesting. She shares intimate details about the nurse's experience at an orgy and a subsequent abortion. When the nurse finds out about this, by opening and reading a letter she was to mail (the letter is addressed to Mrs. Vogler's husband), Nurse Alma becomes upset and realizes that her feelings for Mrs. Vogler are not reciprocated. In her anger and hurt, Nurse Alma lays broken glass on the steps which cuts Mrs. Vogler's feet. The film does not show Nurse Alma providing any care for these injuries.

Nurse Alma tells Elisabet, Mrs. Vogler, that she is angry. She goes on to say, that she has been deeply hurt, as she feels she has been used and thrown away. During this scene Alma threatens to throw boiling water on Elisabet; Elisabet speaks – she yells “don’t.” There are times during the movie it is difficult to tell who is the caregiver. It is evident that both women are damaged. Elisabet is psychologically stronger than Nurse Alma; Nurse Alma eventually feels that her soul is overcome by the other woman’s strength. “Elisabet chooses to be who she is, Alma is not strong enough to choose not to be Elisabet” (Ebert, 2001, para. 13).

Although this film was nominated for and won many awards, such as Best Foreign Actress, Best Actress, Best Film, Best Director (Internet Movie Database, 1990), critics found the film to be difficult and frustrating (Anderson, 2004; Crowther, 1967; Ebert, 1967; Nusair, 2004; Sullivan, 2004). This is due in part to Ingmar Bergman’s intent to combine illusion and reality in ways that are unexpected to highlight themes within the plot.

### ***Nursing roles.***

There are twenty-four scenes in this film depicting psychiatric nursing care. Like *One Flew Over the Cuckoo’s Nest* (Forman, 1975) these scenes are longer and more complex than the other movies described. The nursing roles encompass: resource person (4 scenes), counsellor (5 scenes), consultant (1 scene), surrogate (12 scenes), and safety agent (3 scenes).

As a resource person the nurse is asked to assist with the treatment of a mentally ill patient. She participates in providing interventions that are initially meant to facilitate patient comfort. Nurse Alma, recognizes that the patient has a great deal of experience with life. During a conversation with the physician,



she questions whether or not it would be better for the patient to have a nurse work with her who has had more experience than herself.

Although, the nurse identifies that there is hope this patient will recover, the recovery is linked to the context of the patient's life, which the nurse recognizes she may have difficulty understanding because of her own limited perspective. This reflection may have been the beginning of the use of embodied knowledge to guide critical thinking. "Embodied knowledge is not just the knowledge that we think about and discuss" (Bergum & Dossetor, 2005, p. 137). "Embodiment expresses the recognition that people live in a specific historical and social context as thinking, feeling, full-bodied, and passionate human beings" (Bergum & Dossetor, 2005, p. 137).

In the counselling role the nurse facilitates processes of self-renewal, self-repair and self-awareness within the patient. This is done through a variety of didactic therapeutic techniques. There is engagement between the patient and the nurse, but it is questionable if there is mutual respect as the nurse and patient never engage in a power-with relationship. The relationship swings from the patient having power over the nurse, to the nurse having power over the patient.

The one scene that cast the nurse in a consultant role is when the doctor asks the nurse what her impressions are of the patient. Although the nurse is asked directly, she is not confident with her interpretations or her abilities to perform this role.

The surrogate role is the most common nursing role in this film. The nurse is frequently in the role of friend, sibling, wife, and lover. There are interpersonal difficulties that arise as the nurse's boundaries blur; specifically,

when she sees herself as a friend, confidant, proxy wife, and lover. There is no mutual respect demonstrated in this relationship.

The safety role of the nurse is depicted when the nurse checks on the patient to ensure she is comfortable and safe. Her actions include checking the patient's pulse and breathing when the nurse is not sure if the patient is still alive. There is one negative example of being in the safety agent role – this is when the nurse becomes angry and does not take actions to prevent the patient from stepping on glass and cutting her foot. To the contrary the nurse placed the glass in a location so the patient would likely get cut.

### **The Snake Pit.**

#### ***Overview.***

Since its release January 1, 1948 *The Snake Pit* (Litvak, 1948) has had \$10,000,000 total gross sales in the United States and has made \$4,100,000 from rentals (Nash, 2005). The film is based on Mary Jane Ward's best selling autobiographical novel. *The Snake Pit* (Litvak, 1948) was nominated for six Academy Awards and won awards for Best Actress, Director, Picture, Music, Writing, and Sound (Internet Movie Database, 1949). Kim (2004) and a *Variety* writer (Anonymous, 1948) suggest that the awards are likely due to the boldness of the subject matter and the frankness of the portrayals in 1948. However, today the movie would likely not generate the same degree of fascination or provocativeness. Although, the movie may not get the same level of reaction now as it did in 1949, reviewers still think viewers today could make a connection with the depictions of the treatment of the mentally ill (Kim, 2004; MacDonald, 2004).

The title of this film reflects the historical treatment of mental patients. In the middle ages it was believed that if you put a sane man in a snake pit he would go crazy, but if you put an insane man in the snake pit he would become sane. The “snake pit” in the movie is a metaphor for Unit 33. This unit houses the most insane of the insane. The patients there are violent, and grossly psychotic.

This movie is filmed from the perspective of Virginia Cunningham, a young newlywed, who is admitted to Juniper Hill State Hospital with amnesia. While there she receives electroconvulsive therapy, pharmacotherapy, didactic therapy, and hydrotherapy. The goal of her treatment is the recovery of her memory.

### ***Nursing roles.***

There are several nurses in this film. However, two psychiatric nurses figure predominantly - Nurse Davis and Nurse Summerville. Nurse Davis is in charge and ensures that the rules are followed. Nurse Summerville is now a patient – residing on unit 33; the sane man (woman) gone crazy from being in the snake pit.

*The Snake Pit* (Litvak, 1948) has twenty-nine different scenes that portray nursing care. In twenty-five of the scenes the nurse acts in a resource role. The knowledge supplied and the technical procedures performed are related to: ensuring the patients conform to the rules and protocols of the institution, and supporting the physician during electroconvulsive shock therapy or the administration of intravenous medication. The nurses share their expectations with the patients related to how they (the patients) are to behave, and what rules they are to follow. However, when doing so there is only one

nurse, Nurse Davis, who acknowledges that the expectations are her own. Nurse Davis clearly recognizes that she has a function in establishing the environment on the unit. In other words, she recognizes that she is the system. The other nurses attribute the rules to the hospital, the doctor or their supervisor. There is no recognition that they are part of an interdependent environment. They are socialized to conform to the expectations of the system/environment. Despite the lack of insight into their own contributions, in establishing and maintaining the system, the nurses' behaviours are important factors in perpetuating the system.

Nurses perform counselling roles in two scenes. In these scenes the nurse provides reassurance to a patient who is emotionally upset. The nurses in these scenes attempt to assist the patients in finding comfort and relief from their anxiety.

There is one scene in which a nurse performs a teaching role. In this scene the nurse provides suggestions to a patient. The suggestions are intended to make the patient's stay on the unit easier. The nurse tells the patient that the ease of her stay depends on the patient's ability to comply with the requests/instructions/demands of the nursing supervisor.

The leadership role was also seen in this film. In this role, the nursing supervisor, Nurse Davis, provides direction to the other nurses and patients. She coordinates the care and ensures that there are rules that, she believes, will ensure that the units run "smoothly." The leadership roles are similar to those in *Cosi* (Joffe, 1996). However, Errol, the head nurse in *Cosi* (Joffe, 1996) creates a positive interdependent environment.

## **Gothika.**

### ***Overview.***

*Gothika* (Kassovitz, 2003) grossed \$78,280, 896 in worldwide sales (Nash, 2005). Most reviews of this film are filled with harsh comments such as: “a train wreck of a motion picture” (Berardinelli, 2003, para. 1), “thinly developed characters and pedestrian plotting” (Rooney, 2003, para. 1), “in trash as in art there is no accounting for taste”(Ebert, 2003a, para. 1), and the movie was “like a plastic houseplant that has been given too much water” (Scott, 2003, para. 2). This movie is an example of a Hollywood filmmakers’ portrayal of a forensic mental institution and its employees, including psychiatric nurses. None of the reviewers commented on any of the nursing characters in the film.

The primary character, in this film, is a forensic psychiatrist (Dr. Gray) who is accused of her husband’s murder. She is admitted to the same forensic hospital in which she practiced. She has amnesia. She does not remember that her husband is dead or that she has been accused of killing him. She starts to experience paranormal events. She witnesses a girl bursting into flames, a girl being brutalized, and then experiences cuts on her arms. Dr. Gray escapes from the hospital and soon realizes that her husband and the local sheriff have tortured, raped and killed a local girl. Dr.Gray is able to expose her dead husband and the sheriff. The movie climaxes as Dr. Gray saves a missing girl whom the sheriff has hidden for his next victim.

### ***Nursing roles.***

The nursing roles in this film are of minor significance. They do not contribute to the overall development of the plot or to the development of any

of the lead characters. However, this same criticism could also be made regarding the main characters. A reviewer, has even gone as far as wondering how, during the filming of this horror-thriller-suspense movie, could any of the cast members could keep a straight face (Dargis, 2003).

Within *Gothika* (Kassovitz, 2003) there are ten scenes involving forensic nursing care. The nurses in this film perform the roles of a resource person (7 scenes), leader (2 scenes) and a counsellor (1 scene). However, in only three scenes does a nurse speak to a patient.

The first nurse is seen approximately 10 minutes into the film. In this scene the nurse is wearing a starched white uniform and talks to the psychiatrist about two patients fighting. She argues that the medications need to be increased in order to control the patient's behavioural outbursts. There is no critical thinking demonstrated by the nurse. There is no discussion about other methods of controlling behaviour, or even the precursors or the precipitants to the attack. The nurse is focused on utilizing pharmacological interventions.

The next scene has the nurse in a hallway with a flashlight. The power is out and she meets the psychiatrist in the hallway. There is a casual exchange of conversation. The psychiatrist asks what she is doing; she responds "doing my job." "Doing my job" is a phrase that is heard repeatedly in the film. Not only does this phrase describe the focus of the nurse, it foreshadows the lack of engagement the nurses have with those entrusted in their care.

Additionally, the power going out is a common motif in the films reviewed. The symbolic representation of the power within the films is ironic

as the electrical power is outside the control of the nurses but the power they have over the patients is unyielding.

In the next three scenes the nurses administer medication or escort patients to the day room. During these tasks the nurses do not speak to any of the patients. Despite the lack of verbal interaction, the power structure within the hospital is clear. For example, in a scene that takes place in the day room, the patients are in the centre of the room and the nurses stand around the outside perimeter. It is from this vantage point that the nurses make their observations. They do not speak to the patients and none of the patients attempt to speak with the nurses. The rules are clear - boundaries are not to be crossed.

The next scene has a nurse waking a patient and administering medication. When the patient asks why the nurse is doing this to her, the nurse states "I am just doing my job." When the patient is hesitant to take the medication the nurse responds with the following: "you don't want me to get Jim to help me now do you?" The nurse stands over the patient until she swallows and opens her mouth to show the nurse that the pills are gone. Once the nurse is sure that the pills had been swallowed, in a demeaning and belittling tone she says "good girl... you're doing good." As she leaves the room she tells the patient "come on sweetheart – now it is time for a shower." This scene captures the means that the nurses use to control the patients. These include forms of intimidation, belittling and distancing themselves from the Other. Bauman (1993) described this distancing, the attitude of "just doing my job," as a consequence of effacing the face of the Other.

The penultimate scene has a nurse escorting a patient to the shower room and stating “come on honey now it is time to wash away your sins.” When a patient becomes distressed because of an hallucination, gets cut, bleeds, and requires first aid, the nurse reports to the doctor that she (the nurse) only looked away for a second and that it is unacceptable. The nurse believes that she has failed in her control of the patients. The focus of the nurse is on her own actions, she is not engaged in a mutually respectful relationship with the patient. The doctor reassures her that it is not her fault. He tells her that “patients always find a way to hurt themselves, if that is what they want.” The nurse responds “I never pegged her for a cutter – that’s all.”

The last nurse-patient interaction in the film is when a patient meets with her lawyer, becomes upset and begins to remove the bandages from her wound. The nurse tries to reassure her that all will be ok. The nurse, guard and psychiatrist then remove her physically from the meeting room and place her in a four point restraint. Although this may be a nursing resource person role, the manner in which it was done was neither supportive nor engaged.

### **The Jacket.**

#### ***Overview.***

In *The Jacket* (Maybury, 2005) the leading character is a Gulf War veteran, Jack Starks, who is admitted to a mental institution, and is treated with an experimental device known as “The Jacket.” The movie is set in 1991-1993. The movie is used to question the reality of mental illness. For example, does Jack Starks really have Post Traumatic Stress Disorder or can he really time travel? This question is not specifically answered for the audience.



A reviewer from the *London Times* describes this movie as a combination of *Jacob's Ladder* (Lyne, 1990) and *Memento* (Nolan, 2000) which has gone terribly wrong, and suggests that viewers do not waste their time seeing the film (Ide, 2005). "It starts out trying to be craftily clever – with lots of fast, disorientating visual effects, echoey [sic] music and intimations of politics and paranoia – and ends up artlessly dumb. In other words, it improves as it goes along" (Scott, 2005, para. 3). Others find that the movie bludgeons its points. As a result, the reviewers report that the movie was unbelievable and lacked meaning (Berardinelli, 2005; Ebert, 2005; Urban, 2005).

### ***Nursing roles.***

There are eleven scenes in this movie portraying psychiatric nursing care. There are two different nurses, who are of minor importance, in the film. Only one scene has a nurse speaking with a patient and there are no scenes that have nurses interacting with other nurses. There are no reciprocal relationships with the doctors. The communication is from the doctor to the nurse with no exchange of opinions. The nurse takes the doctor's orders and then carries them out.

The nurses have three different roles in this film: resource person (9 scenes), leader (1 scene) and counsellor (1 scene). When nurses carry out a resource role they perform several tasks. These tasks include the nurses caring for the dead bodies in a military hospital, administering medication, assisting with a restraint, or putting a patient in an experimental treatment chamber.

The nurse performs a leadership role when she provides direction to an aide. She tells him what duties the aide has and how these duties should be performed.

The counsellor role is performed when the nurse is doing rounds and notices that two of the patients are talking to each other. She asks them what they are talking about. When they tell her they are talking about their ability to time travel she strikes one of them on the arm with a stick. This can be understood as non-verbal instruction to the patients that it is not acceptable for them to be discussing potentially delusional topics. Although this is not an acceptable means of providing counselling to others, the nurse is trying to maintain control and adjust the behaviour of the patients. This is the only scene in which a nurse directly speaks to a patient.

### **Terminator 2: Judgment Day.**

#### ***Overview.***

*Terminator 2: Judgment Day* (Cameron, 1991) is the second movie in a trilogy about a 21<sup>st</sup> century war between computers and humans. The plot involves a terminator, a human-like robot that is sent back in time to kill the future leader of the human resistance, John Connor. Another terminator, played by Arnold Schwarzenegger, is also sent back to protect John. This boy's mother, Sarah Connor, having been told about the terminators in the first movie, is now in a mental hospital because of her "paranoid delusions" about cyborgs and an upcoming nuclear disaster. Sarah is freed from the mental institution by her son and the good terminator. After she escapes from the institution, she, John and the terminator sent to protect them, work together to defeat the terminator sent to exterminate John.

Although some of the reviews mention that Sarah is in a mental hospital, none refer to the type of treatment she receives (Ebert, 1991; Maslin, 1991), other than that she is being held prisoner (Ebert, 1991), suggesting that

her freedoms have been withdrawn. Other reviewers found this facet of the plot to be of only minor consequence and did not mention that Sarah was in a mental hospital at all (Brown, 1991; Rosenbaum, 1991). Despite all reviewers determining that the experience in the mental hospital is not worthy of further comment, it has sent a message to the millions of people world-wide, who have cumulatively spent over 650 million dollars to see this movie, that psychiatric nursing care is at the very least malevolent and repressive.

### ***Nursing roles.***

The nurses in *Terminator 2: Judgment Day* (Cameron, 1991) appear in six different scenes. All of these scenes took place in the fictional Pescadero State Hospital – California and focus on the care of Sarah Connor. Sarah Connor is admitted to the facility after she tries to blow up a computer factory, is shot and then arrested. After her admission she is diagnosed with acute schizo-affective disorder. She demonstrates violent behaviour, depression, anxiety, and is viewed as having delusions of persecution. The psychiatrist in the film describes her delusional architecture as unique; she believes that her child was fathered by a soldier from the future and that a machine, a terminator, has been sent to kill her.

Using Peplau's (1952/1988) nomenclature of nursing roles, all of the scenes depict nurses in a resource person or counselling role. In the resource role the nurses are typically giving medication or restraining. The counselling role is shown in a scene in which the nurse tells Sarah to follow the rules. There are nine different characters that could be nurses. This supposition is made as these individuals are either giving medications, receiving direction from a physician, monitoring patients, documenting in patient files, or using

strategies to facilitate a therapeutic<sup>10</sup> milieu. All of these interventions or functions are within the scope of a nurse.

Although there are no characters that are verbally referred to in the movie as “nurse,” there are individuals in white uniforms, male and female, who administer medication, apply restraints, check on the patients at night, document in charts, speak to the doctor in the nursing station, attend patient interviews/treatment sessions with the psychiatrist, and facilitate entry and exit from the units. In contrast, there are individuals in brown/grey uniforms that function as guards; for example, they watch video monitoring equipment. There is some overlap between the functions of the guards and that of the nurses. The guards and nurses both monitor/facilitate entry to the unit and restrain patients. The guards are not observed putting on or taking off mechanical patient restraints – arm, leg and chest; nor are they involved in the administration of medication.

The interaction between Sarah, the nurses and the general milieu of the hospital is an example of an interdependent environment. The scenes described below illustrate how the nurses of the institution set the rules, determine how they will be enforced and determine what the consequences will be if the rules are broken. The nurses have a key role in determining the social structure of the system/environment – the unit.

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<sup>10</sup> I use the word therapeutic in this sentence; however, the therapeutic value the techniques used can be challenged on ethical and professional grounds. Although the strategies used to create the therapeutic environment in this film are questionable, the environment is critical factor in developing ethical healthcare relationships with others (Bergum & Dossetor, 2005).

The nurses' primary function in this film is to ensure that control is maintained. This control is achieved through administration of medication and physical domination. For example, medication is administered to Sarah involuntarily, that is, she has refused it and is being forced to take it. Prior to administration of the medication, the nurse, Doug, tells her that it is time to take her meds and that she needs to be good as she is coming up for review. Sarah then looks at Doug, and the other staff in the room, and states she does not want any trouble. Despite this statement, prior to the administration of the medication, Doug hits her in the stomach with a club then after she falls to the floor kicks her. The other nurse in the room, who is never named, administers a shock through a tool that has a similar appearance to an electric cattle prod. She is brutally incapacitated by these men/nurses who are physically much larger than her. Doug then states "last call sugar," and they proceed to hold her head back, push the pills in her mouth, and then hold her mouth shut until she swallows. It is at that point that Doug states "sweet dreams" and then leaves the room.

This scene does not demonstrate ethical engagement between the nurses and the patient. What this scene does demonstrate is physical and emotional abuse – force, intimidation and actual harm. All of the other scenes involving Sarah and a nurse have similar themes. The pinnacle scene demonstrating the nurses' level of abusiveness and the degree of their control occurred when Doug applies leg, arm and chest restraints to Sarah. As he applies them, there are strong sexual overtones to his movements. Because of the previous treatment/care he had given her, one might expect that when he applies the chest restraint he might use this opportunity to fondle her breast,

yet he does not. Tension is built, and the audience wonders what will he do now that she is tied down and unable to move? How will he take advantage of Sarah? Once all the restraints have been applied, he licks her face and leaves the room, but as he turns away from her bed he grunts sarcastically “huhm.” Once again, the message is given that he is the person with the power and there was no point fighting. When he left, he drags his club along the wall and doors of the other patients creating a sound similar to that of fingernails on a chalkboard.

In another scene a guard asks the nurse if she would like a cup of coffee from the vending machine – she says no but “how about a beer?” The guard does not respond. This brief moment demonstrates the non-professionalism of the nurse. In comparison, the guards are portrayed as being professional. They are not seen abusing the patients or seen to be doing something other than their job. The non-professionalism of the nursing staff is also demonstrated in another scene. A security guard and two nurses are in the nursing station. The guard is watching the video monitoring equipment and one nurse is on the phone and another is reading the newspaper. It is clear that the telephone call is of a personal nature and that reading the newspaper is not part of regular nursing responsibilities.

Only one out of the six scenes shows a nurse positively. This nurse is in the nursing station talking to the doctor. This conversation only lasts a few seconds before Sarah hits the back of the nurse’s head with a mop handle, which renders him helpless. She then gives him an intramuscular injection just before she breaks the doctor’s arm.

## **The Cobweb.**

### ***Overview.***

*The Cobweb* (Minnelli, 1955) is based on the novel, of the same title by William Gibson. This melodrama is set in a mental hospital where a debate about who gets to decide on the new drapes for the library sparks conflict. The drapes become a catalyst for arguments between the doctors, the doctors' wives, the administrator, the activity director, and the patients. Through the conflicts the audience observes that all the characters have some disturbance in their psyches.

The decision about the drapes takes on a central position in the film. One reviewer argues that the drapes reflect aspects of aesthetics but also deeper moral and value issues (Levy, 2007). The way in which individuals in the film make decisions about the drapes does reflect their values. For example, the administrator, who is primarily concerned about money, chooses the cheapest drapes. The Activities Director, played by Lauren Bacall, advocates for one of the patients to design the pattern for the fabric. The focus of the interactions she has with the patients is aimed at improving their confidence and supporting the model of self-governance that the new psychiatrist, Dr. McIver, is trying to implement. The nurses in the film do not contribute any input into the decision about the drapes. There is only one scene where a nurse is directly involved with the drapes. This scene has Dr. McIver instructing the nurse to take down the drapes as they are not made of the fabric designed and chosen by the patients. Symbolically, at the end of the film, the library is still without drapes.

There is a fine line between sanity and madness in the film, as there are really no significant differences between the staff and the patients. For example, one patient states “you can’t tell the patients from the doctors.” Another example is Rosie, one of the psychiatrist’s daughters, who says that she wants to be a mental patient when she grows up so she can spend more time with her dad. The continual blurring of the differences between the staff and the patients is reinforced when Stevie, one of the patients, indicates that the difference between the staff and the patients is that the patients improve, but the doctors do not.

Although Minnelli in *The Cobweb* (1955) sets out to reveal the inner workings of a sheltered and closed society – the mental hospital - he is not completely successful. Reviewers describe the film as a talkative and ludicrous soapier (Schwartz, 2003), overwhelmingly grim and lacking in authenticity (Levy, 2007). Other reviewers thought the film is choreographed and filmed like a musical – the only thing missing is the music (Grost, 2008; Kehr, 2001; Schwartz, 2003). This film did not receive any awards.

### ***Nursing roles.***

There are several nurses appearing in this movie. They all wear uniforms and work within the institution. The nurses do not have a dominant role in the plot of this movie, but do provide background support for the main characters. There are 12 scenes with nurses. The nurses perform a variety of roles. These include safety agent (6), resource person (3), consultant (1), counsellor (2), teacher (1), and surrogate (1). The activities performed within these roles are consistent with the other films reviewed. Within a single scene some of the nurses perform more than one role. For example, a nurse is trying



to get into a patient's room to ensure that the patient is safe, a safety agent role. In the same scene, the doctor asks the nurse what brought on these patient behaviours and the nurse gives a report of what happened and what she believes brought on these behaviours, a consultant role.

The significant difference in this movie is that a nurse is shown to change her attitudes towards the patients. This positive change is foreshadowed in a scene in which the head psychiatrist describes one of the nurses as a "police woman in disguise," but he goes on to say that he believes that she will learn. Her change in attitude is shown by a change in her approach to patients. For example, in one of the early scenes in the film, this nurse is reporting that one of the patients has contraband (alcohol) in his room and is sharing it with the other patients. The nurse does not explore this patient's motivation. For instance, the reason this substance is important to him or the possibility that he might be using it to draw others into his room. This nurse is predominantly concerned with enforcing the rules of the institution, and does so with neither a therapeutic assessment of the patient's behaviour nor empathy towards him. Later in the movie, the nurse finds a patient sitting in a day room by himself – crying. She speaks to him in a soft voice and listens to what he is saying. After she listens to him, the nurse touches him in a supporting, professional and comforting manner. Then she helps him return to his room. This scene illustrates the way the nurse has shifted in her approach: she tries to understand what is happening for the patient and the reason he is upset. She is revealed as valuing his perspective and responding therapeutically to it.

### **Summary of Nursing Roles in Selected Films**

This chapter has provided an overview of the psychiatric nursing roles depicted in a cross section of films representing the genres of drama, science fiction, documentary, comedy, and horror. Using Peplau's model of Interpersonal Relations in Nursing (1952/1988), the role of the psychiatric nurse was examined in each of the films (see Appendix C). Peplau (1952/1988) describes 14 different nursing roles including: stranger, resource person, teaching, leadership, surrogate, counsellor, consultant, tutor, safety agent, mediator, administrator, recorder, observer, and researcher/study maker. The films in this research project depict all of the nursing roles except that of stranger and researcher/study maker.

Peplau (1952/1988) indicates that nurses are first strangers to patients. The patient, however, must be seen as a stranger for the nurse to assume this role. When the nurse exercises her/his stereotypes about patients, such as they all need to be controlled through the intelligent use of force, they are not in a stranger role. The nurse thinks she knows exactly who they are. His or her patients are stereotypes.

The role most predominantly depicted in the selected films is that of a resource person. Thirteen films have nurses performing services within this role: the nurse is a source of knowledge and performs technical procedures. "A resource person provides specific answers to questions usually formulated with relation to a larger problem" (Peplau, 1952/1988, p. 47). Peplau (1992) comments that, when the nurse is cast in this role, it is frequently not the most useful way to provide psychiatric nursing care. When the nurse focuses on providing answers and advice, openings can be lost for the provision of more

in-depth care and services, resulting in lost opportunities for constructive patient learning. The most common task associated with this role is the dispensing of medication or assistance with procedures, such as electroconvulsive therapy. Whenever there is more in-depth care provided, it is delivered by a physician. In these scenes the nurse becomes an observer.

Leader, counsellor and safety agent are the next most common depictions of nursing roles. When the nurse is performing leadership activities she/he is usually providing direction to other staff. These staff include other nurses, orderlies, or activity staff; for example, occupational therapy, recreation or housekeeping staff. The direction provided to the other staff is typically linked to outcomes that the nurse wants for the patients. These outcomes are associated with the patients' behaviour or activities. It is through these roles that the nurses are able to provide structure to and control the environment.

The counselling role of the nurse is depicted in eight films. The counselling role focuses on the nurse promoting experiences that lead to health (Peplau, 1992). The interactions depicted in the films focus on increasing the patients' awareness of their illness, of the consequences of treatment, or the impact that their illness has on their significant others. It was not clear, if as a consequence of these interventions, if the patients had improved health.

The role of the safety agent is also depicted in nine of the films. Within this role the nurse is attempting to intervene with patient behaviour or control environmental factors. The behavioural interventions include physically intervening in patient altercations or the application of physical restraints. Environmental factors addressed include ensuring that the doors to the units

are locked or that contraband substances are removed from the unit.

In the next chapter, the depiction of psychiatric nurses in film is furthered explored using a relational ethics framework. The focus remains on understanding the portrayal of the relationships between psychiatric nurses and persons with mental illness in film.

## Chapter 8

### Relationships between Psychiatric Nurses and People with Mental Illness

The roles discussed in the previous chapter have set the stage for the discussion, in this chapter, of how the relationship between psychiatric nurses and people with mental illness has been portrayed in film. Nurse Ratched has become the archetypal psychiatric nurse; therefore, many of the referents are drawn from *One Flew Over the Cuckoo's Nest*. As the relationship between nurses and the people for whom they provide care is a central tenet to the delivery of competent and ethical psychiatric nursing care, this is explored here in more detail using a relational ethic framework. The depictions of the relationship are elucidated in terms of the core elements of relational ethics. I begin with the element of mutual respect.

#### Mutual Respect

Mutual respect is an intersubjective experience arising from a non-oppositional perception of difference (Olthuis, 2000). Both Callahan (1988) and Dillon (1992) have described how perceptions of difference precipitate affective, behavioural, and cognitive responses. These responses are identified in the films' demonstration of mutual respect. Although the presence or absence of mutual respect is found in all the films reviewed, *The Snake Pit* (Litvak, 1948), *Girl, Interrupted* (Mangold, 1999), *The Cobweb* (Minnelli, 1955), and *Persona* (Bergman, 1966) have scenes that most strongly demonstrate either the presence or absence of non-oppositional perception of difference required for mutual respect. I will begin by describing a scene from *The Snake Pit* (Litvak, 1948).

In this film there is only one scene in which the nurses and the patients are not portrayed in an “us versus them” relationship. A non-oppositional relationship is depicted when a nurse and a patient are engaged in a dialogue aimed at ensuring the patient’s success on the unit. The nurse and patient are aligned in an effort to achieve a mutual goal – the happiness of the nursing supervisor. While engaged in the teaching role, the nurse, through the use of open body language and active listening skills, speaks to the patient in a way that recognizes the patient’s humanity. She recognizes there are differences between them, but this recognition does not evoke a power differential between the nurse and the patient. The relationship is mutually respectful and there is recognition of differences.

Although *Girl, Interrupted* (Mangold, 1999) has 38 scenes with nurses, there are no distinct portrayals that demonstrate mutual respect. All of these scenes depict a power differential that indicates either the nurses or the patients have more power than the other group. This results in an oppositional perception of difference.

*The Cobweb* (Minnelli, 1955) has 12 scenes that depict nurses. One of the early scenes has a nurse reporting to a doctor. She tells him that one of the patients has contraband (alcohol) in his room. It is revealed in a subsequent scene that the nurse’s concern is indicative of a lack of respect for the patient, as the nurse is primarily concerned with the amount of control she has over that patient’s behaviour. The doctor reminds her that the patients have rights. He goes on to tell the nurse that searching a patient’s room without consent is a violation of that person’s rights. She has made a failed attempt to align the doctor with her efforts to control the patients. The nurse does not recognize

that the doctor's motivations are not the same as her own and does not attempt to understand his values and ideas. She is not acting in a way deserving of respect as a professional. She does not demonstrate respect to the patient or towards the doctor. This is further emphasized when the doctor refers to her as a "police woman in disguise," which reinforces that she is not engaged in caring and supportive relationships.

However, the counterpoint to this scene is when the same nurse discovers a patient crying in the dayroom. She sits down beside him and listens to what he says. In this scene, the nurse is supportive and caring. She touches the patient on the shoulder and is engaging in a mutually respectful relationship.

In *Persona* (Bergman, 1966) the nurse, Alma, has a strong protagonist role. Although she tries to be respectful of Elisabet, her patient, the latter shows apathy about their relationship. Despite the nurse seeing herself as a friend, confidant and lover, the feelings are not reciprocated. When the nurse realizes the patient does not share her feelings she becomes angry at the patient and demonstrates an oppositional reaction to the difference. Alma needs to recognize that many caring relationships have an imbalance of power and therefore risk being exploitive (Marcellus, 2005). Gallop and O'Brien (2003) believe that a lack of self-awareness puts "nurses ... at a tremendous disadvantage and at risk of acting in an inappropriate and at times sadistic manner" (p. 214). Nurse Alma is unaware that she is having difficulty establishing a therapeutic relationship. In attempting to meet her needs to connect with the patient, she becomes Elisabet's lover. As a result the relationship transitions to being non-therapeutic when the nurse engages in

activities that are meant to meet her needs rather than the patient's needs (Canadian Nurses Association, 2008; College of Nurses of Ontario, 2006).

The film demonstrates the risk for the patient when the nurse intentionally puts broken glass on a step that results in the patient cutting her feet. Audience members seeing the malicious actions of the nurse may come to the conclusion that if you anger a psychiatric/mental health nurse you will be harmed. The audience may also come to the conclusion after watching *One Flew Over the Cuckoo's Nest* (Forman, 1975) that McMurphy should not have angered Nurse Ratched. The nurses see the patients as less-than. When this occurs, the nurses jeopardize patient safety and do not provide ethical psychiatric nursing care.

Many nurses struggle in their practice when respect is not reciprocated by the patient.

Nurses have certain ideas about what the ideal patient roles should be. Such stereotyped perceptions – such as that a patient should ideally be sociable, appreciative, telling the nurse what she wants to hear, and showing certain expected clinical signs associated with the health as diagnosed – affect how the nurses behave with the patient. (Simpson, 1991, p. 19)

Peplau (1952/1988) recognizes that nurses need to develop an ability to delay their desired gratification and become comfortable with conflict and anxiety. Within some nurse-patient relationships patients may not be ready to open a connection with the nurse. This may be a result of the client's preconceptions of the nurse and/or their social support systems (Forchuk, 1992). However, for



the development of a therapeutic relationship, the nurse is responsible for consistent well-paced interactions (Forchuk, et al., 2000).

Nurse-patient dyads can experience power differences within the relationship. This is one factor that can impede the development of a mutually respectful therapeutic relationship (Forchuk, et al., 2000). A means of overcoming the risks associated with the potential concerns of oppositional differences is the development of mutual goals.

Many authors reflect on the polemic and social concepts interwoven between/within the perception of oppositional differences. These reflections take many different forms. For example, Conrad (1899/1990) uses a novella, Livingstone (1998) and Stanley (1998) use journal entries, and both Foucault (2003) and Freud (1913/1998) use discourse analysis. Within these reflections and within the films used in this research project, when individuals involved are not able to engage in a mutually respectful relationship with the Other, they fail to meet the expectations of the other and are consequently marginalized.

The process of marginalization is based upon the foundations of stigmatization and othering. Thus, the foundation of discrimination, prejudice, and oppression is laid through the development of expectations related to “this kind of person.” Engagement with the Other cannot occur. The next section will discuss the portrayals of engagement in cinematic psychiatric nurse-patient relationships.

### **Engagement**

Engagement allows us to hear the voice of the Other. The ability to engage is fundamental to the role of the nurse. It is through engagement that a mutually respectful relationship can be nurtured. The core element of

engagement requires movement toward the other person (Bergum, 2004). It is through the process of engagement that we are able to understand the Other's motivations, history, attitudes and hopes. If we are not engaged, we know little of the Other and engage only in shallow interactions (Bauman, 1993; Norden, 1994).

In practice it is very easy to influence or destroy the potentially positive relationship with an ill person if nurses label people and allocate them into categories for their own psychological convenience. The feelings generated from such labelling or stereotyping outweigh the more productive rational thinking of professional relationships dealing with people as individuals. (Simpson, 1991, p. 21)

Within these shallow interactions prejudice is developed. Through the lens of prejudice, mental illness can be equated to unpredictableness and dangerousness. This prejudice can then be extended to psychiatric nurses as being dominating misandrists – for example, Nurse Ratched in *One Flew Over the Cuckoo's Nest* (Forman, 1975). Assigning people to groups based on these prejudices destroys the potential to see them as being fully human or worthy of moral action. This idea can be extended further to include the potential to see psychiatric nurses as even having the potential to act in an ethical way. Did Nurse Ratched in *One Flew Over the Cuckoo's Nest* (Forman, 1975), Nurse Davis in the *Snake Pit* (Litvak, 1948), or Nurse Diesel in *High Anxiety* (Brooks, 1977) have the potential to treat others as being fully human or see the patients as being worthy of moral action?

Engagement is a powerful factor that sets the stage for the relationships depicted in several of the films included in this research. Depictions of

engagement are drawn from the following films: *Snake Pit* (Litvak, 1948), *One Flew Over the Cuckoo's Nest* (Forman, 1975), *Harvey* (Koster, 1950), and *Girl, Interrupted* (Mangold, 1999). I will begin by describing an example from *Snake Pit* (Litvak, 1948).

This film has one scene that demonstrates a significant level of engagement, as compared with other scenes in this film. This is the scene described earlier in the chapter as having demonstrated mutual respect. The nurse engages with the patient, who is newly admitted to the unit, and helps her to understand the rules. In order for engagement to occur, the nurse and the patient work toward meeting common goals. The common goal in this scene is to ensure that there is a positive relationship with the nursing supervisor. The nurse is attempting to move toward the patient and better understand the patient's needs.

Factors relating to engagement are also demonstrated in *One Flew Over the Cuckoo's Nest* (Forman, 1975). Nurse Ratched has several goals for all the patients on her unit. These include: safety, structured communication, the sharing of feelings, and the provision of a predictable environment. The patients do not have these same goals. Although not specifically stated in the film, the viewer can infer that the patients' goals consist of resuming a "normal" life, participating in activities they enjoyed prior to being admitted to the hospital, and being able to negotiate – to communicate and have their needs and wants heard by the nurses. If these patient goals had been met, the patients would have been allowed to watch the World Series. Although these goals may not be mutually exclusive, the strategies the nurses and patients use to achieve them limit the development of an engaged relationship. As a result, an

oppositional perception of difference is fostered. The effect of this is that a power struggle develops between staff and patients, particularly between Nurse Ratched and patient Randle McMurphy. Nurse Ratched does not treat the patients as though they were her equals – they are things to be controlled. They are different than she is. She does not attempt to understand their motivations, history, attitudes, or hopes.

Another example of engagement is depicted in the film *Harvey* (Koster, 1950). The relationship between the nurses and their patient, Elwood, is significantly different than the relationship developed by Nurse Ratched and her patients. The nurses typically demonstrate respectful interactions with the patients; they listen to what they have to say, and they do not belittle the patients when they speak to them. Despite this, the treatment goal developed by the hospital staff (doctors and nurses) is not congruent with Elwood's goal. The staff's goal is to separate Elwood and his pooka. However, Elwood is not bothered or distressed by the presence of his pooka and does not see a need to get rid of it. He is more concerned about his sister's worries. This lack of understanding negates the possibility of developing a therapeutic relationship.

There are also scenes in *Girl, Interrupted* (Mangold, 1999) that demonstrate engaged relationships. The scene best demonstrating this is when nurses and patients go into town for ice cream. The nurses and the patients are engaged. They have the common goal of participating in an activity outside of the hospital. Even when Nurse Valerie needs to redirect a patient who has begun loudly word clanging, and is drawing negative attention to herself, she is able to stay engaged with the group as they all want to “fit in” while in town. Despite the scene's demonstration of engagement, mutual respect is not

present, as there is still a very clear power differential between staff and patients. There is a strong visual representation of “us versus them”; the uniform worn by the nurse makes a very clear distinction between who is the nurse and who are the patients.

When there is a space created in an engaged relationship, the voice of the Other can be heard. When this occurs there is a potential for a mutually respectful relationship to develop and for the nurse to use embodied knowledge to guide critical thinking and decision-making. The discussion now turns to embodied knowledge in the portrayal of the relationship between psychiatric nurses and persons with mental illness.

### **Embodied Knowledge**

Embodied knowledge is multidimensional and utilizes cognitive, affective, and emotional experiences. From within this central element of a relational ethic, we recognize the plurality and differences between others and use this as a starting point for reflection and action. Embodied knowledge is action-oriented. It uses practical insight, which is noninferential and nondeductive, as the impetus for this reflective action. It is a means of embracing empathy, benevolence, and equal concern for others and for the self. Nurses can use embodied knowledge in all the roles they perform.

The role most predominantly featured in the films is that of a nurse being a resource person. Within this role, nurses use their knowledge of specific procedures or therapeutic techniques. Consistent with Peplau’s (1992) opinion, when nurses are cast in this role, it is not the most useful way to provide psychiatric nursing care. The nurses in the films rarely demonstrate a recognition that there are several factors to consider when providing care. The

nurses frequently utilize the same approaches with different people, regardless of their motivations, history, attitudes, or desires.

Nurse Ratched in *One Flew Over the Cuckoo's Nest* (Forman, 1975) and Nurse Terry in *The Caretakers* (Bartlett, 1963) are both portrayed as experienced nurses who have worked with many patients. However, both use similar approaches with all their patients, regardless of any patient's needs or history. Nurse Terry, in a discussion with a new psychiatrist, identifies that she is responsible for her patients and has protected them for twenty years "through the intelligent use of force." This statement is representative of the nursing approach used by both Nurse Terry and Nurse Ratched. There is little regard for individual needs or responses. It is assumed that all patients will respond in a similar manner. Neither of these characters demonstrates a reflective use of embodied knowledge. Rather, they both use environmental structure to control the behaviours of patients and other staff.

In *Girl, Interrupted* (Mangold, 1999), Nurse Valerie does demonstrate embodied knowledge when she is in town with the patients getting ice cream. She has to redirect several patients when their behaviours are drawing negative attention from the shop's other patrons. She uses a variety of techniques when she interacts with the patients. For example, she verbally intervenes with one of the patients, she touches another patient and provides verbal instruction, and she asks another patient if she is doing alright and uses this to determine if any intervention is required. There is not one standard care plan or "recipe of care" used with the people in her care. The nurse appears to decide what intervention is required based on her previous experiences with each patient.

When using embodied knowledge the nurses use their critical thinking skills to reflect upon and determine the most fitting course of action in situations. The ability to use embodied knowledge has a significant impact on the environment, which is the next element of relational ethics discussed.

### **Interdependent Environment**

Within this element of relational ethics, the environment is determined by our interconnectedness – our relationships with others. The environment is a fluid, dynamic, socially constructed product. In essence, we are the environment (Bergum, 2004); as we change, the environment changes. For example, the environment in *One Flew Over the Cuckoo's Nest* (Forman, 1975) is constructed by the physical setting – the barred windows, the locked doors – but it is also constructed through the behaviours and attitudes of the staff and patients. The nurses' strict enforcement of rules in this film establishes an inflexible environment.

This is also consistent with the environment portrayed in *The Caretakers* (Bartlett, 1963); specifically, when group therapy is introduced on the borderline unit. The commencement of a didactic group is seen by Nurse Terry as one that will jeopardize the safety and security of staff and patients. If the patients speak about their concerns or have conflict with others in the group, they will act out. She views the group as reducing the control she has over patients and staff. She cannot control what is being said in the group or the actions of the group's patients. The lack of openness to new techniques is also reflected in her approach to the patients. All the patients are to be treated the same – the borderlines are no different than any of the others. The most important factor in her nursing care is that order and control be maintained.

Another example of how the environment is interdependent is from *Terminator 2: Judgement Day* (Cameron, 1991). Initially, when thinking about this movie, the environment of the psychiatric hospital may be thought to consist of barred windows, locked cells, uniformed staff, and stark rooms. However, from a relational ethic perspective, the environment is also constructed by the staff and patients. If Doug – the nurse who hits Sarah Connor in the stomach before administering medication to her, and who licks her face after she is restrained – did not behave in this manner, we could have thought of the environment differently. Potentially, if he had behaved in a non-abusive and empathetic manner, the locked cells and the emptiness that surrounded the patients may not have seemed so isolating. Conversely, if Sarah Connor had not tried to follow the rules, and had not been portrayed as being abused, we could also have had a different perception of the environment. It is through the interactions between Doug and Sarah that we formulate our ideas about this environment. Thus the interdependency of the environment is demonstrated.

The movie that best portrays an interdependent environment is the *Snake Pit* (Litvak, 1948). This is demonstrated when the main character, Virginia, is moved to different units within the same hospital. Her symptoms do not significantly change as she moves from unit to unit, but each of the units has very different cultures and environments. The first unit that Virginia is admitted to is for approximately 50 patients. On this unit the audience sees the nurse and a physician doing rounds and a nurse assisting one of the patients to get comfortable in bed. The nurse is supportive and non-confrontational with the patient when she tells her to return to bed. The nurse on this unit helps



patients dress for visiting day, and she tells Virginia that she looks “like a million dollars” in her suit, though it is too large for Virginia and fits her very poorly (she has lost weight since being admitted to the unit).

Virginia is subsequently moved to another unit after a visit with her husband upsets her. This is a locked unit. The nurses walk around the unit and have very little verbal interaction with the patients. They are seen unlocking and locking the door. They enforce unit rules by frequently reminding the patients of the rules. For example, one of the rules is that no one is to go on to the rug in the middle of the dayroom. Most of the patients adhere to this rule, and accommodate the nurses’ requests. Interestingly, neither the nurses nor the patients walk or stand on the rug. Another example occurs in the dining room, when the nurses instruct the patients to remain silent, as there is to be no talking during meal times. They do not interact with the patients and the patients do not interact with them. Even this lack of interaction in an interactive environment is a factor that constructs the environment. These behaviours help to communicate the rules of interaction and exchanges between patients and staff.

Virginia is then moved to another unit where there are no locked doors. The patients have access to personal belongings in their rooms – nurses and patients communicate with each other. Virginia asks her admitting nurse about the unit rules. The nurse tells her about them and empathizes with her feelings of isolation and loneliness. This interactive environment facilitates the development of mutual respect and engagement. On this same unit there is another interaction with Virginia and the nursing supervisor, Nurse Davis, which has a very different tone than that of the dialogue with the admission

nurse. Nurse Davis tells Virginia that, for those who are willing to cooperate, the ward can be quite pleasant. Nurse Davis makes it very clear that there are distinct rules and roles for the patients and for the staff. Virginia disobeys the rules of the unit and is subsequently moved to another locked unit – the staff/nurses control who enters and exits.

Once Virginia is moved to this locked unit, the audience observes very little staff-patient interaction. For example, in one scene the patients are yelling and there is an incident where one of the patients chokes another patient. The staff do not intervene. This environment is much more restrictive than the other units. The restrictions are not only physical, they are also relational. The nurses physically and emotionally distance themselves from the patients. The nurses and patients interact very little with each other – they rarely speak and there is very little touching.

From the depictions of the various units, it is evident that the environment changes significantly for Virginia. The nurses respond differently to her, depending on the unit – even though the intensity of her symptoms does not change and she is still able to have a meaningful dialogue with the nurses. But, depending on the environment, the nurses are not consistently available to her. This is a poignant example of the significance of an interactive environment. Within a relational ethic framework, there cannot be an environment without interaction.

Another example from *Snake Pit* (Litvak, 1948) is the admission of the institution's own Nurse Summerville to Unit 33. She requires care herself and is now a patient. Unit 33 is a locked unit – there is little interaction between the staff and the patients. This is the last unit to which Virginia is admitted. Nurse

Summerville was a caring nurse, but the institution affected her, and she is no longer able to practice nursing competently. The institution and her experiences there changed her. She is not able to survive within the environment of Juniper State Hospital. The dynamics of an interactive environment can also give rise to the next relational ethic theme of uncertainty.

### **Uncertainty**

Like the other elements of relational ethics, uncertainty has a profound impact on determining how we treat each other. How do we determine what is the greatest good? From within a relational ethic framework, this is uncertain. This is exacerbated when nurses face situations that they have never faced before. Is Nurse Ratched uncertain as to how to manage McMurphy's behaviours? Potentially, she is absolutely certain of the correctness of her interventions. Is this the seed of the oppositional perception of difference? Her pursuit of certainty closes off options and reduces her ability to be flexible. Uncertainty is the beginning of practicing reflectively. Without critically thinking about the different ways to treat or help a person with mental illness, we are cast into a decision-making tunnel that has no capacity to handle the diversity of the Other. When we have no capacity to recognize this diversity, the identification of relevant elements that provide the contextual aspect of decision-making are not available.

The film that depicts the nurse who appears to be the most uncertain is Nurse Alma in *Persona* (Bergman, 1966). This nurse is caring for Elisabet, a woman who has inexplicably stopped talking. Nurse Alma indicates that she has never cared for a person like Elisabet before. She talks to Elisabet's doctor about her apprehensiveness related to the assignment of "trying to get this

woman to come out of her shell.” Nurse Alma recognizes that she does not really know what is going on. The uncertainty expressed by Nurse Alma dissipates as the film progresses. With this dissipation also comes a mutation in the relationship between the patient and the nurse. The nurse soon finds herself questioning her own identity and seemingly switches personas with Elisabet. Although the nurse is uncertain as to who she is, and her own persona, the apprehension and uncertainty of providing psychiatric nursing care to this patient no longer seems to be of concern. Could this lack of uncertainty precipitate the boundary violations seen in the film? The boundary violations constitute patient abuse. The nurse is causing emotional harm to the patient. Nurse Alma’s critical thinking skills are no longer being used. She proceeds in the relationship without uncertainty, embodied knowledge, or mutual respect.

Uncertainty is also depicted in *The Sleep Room* (Wheeler, 1998) when two of the nurses respond to a screaming patient. The younger nurse’s uncertainty is displayed when she communicates that she is not confident in the treatments that they are administering to the patients. She tells the older nurse that she believes these treatments are not working. The older nurse informs the younger nurse, in an authoritarian manner, that it is “not her job to decide what’s working, your job is to follow the chief’s (doctor’s) orders.” After this response, there are no further discussions about treatment efficacy by the nursing staff. Despite other medical staff questioning the ethics of the treatments, this is the only scene in which a nurse shows she is uncertain with the care and treatment being provided to the patients.

The relationship that the cinematic psychiatric nurses develop with the people with mental illness is complex. All of the relational ethic elements are demonstrated in the films, but the demonstration is often of their absence. For example, when there is no mutual respect, an engaged relationship does not develop. Although the development of a therapeutic relationship does not have a linear progression, there are specific elements that must be present for the relationship to be ethical. Through the use of a relational ethic framework, nurses can become aware of all the factors that must be present for ethical delivery of safe and effective psychiatric nursing care – mutual respect, engagement, embodied knowledge, interdependent environment, and uncertainty.

## Chapter 9

### Discussion

When I had journeyed half of our life's way,  
 I found myself within a shadowed forest,  
 for I had lost the path that does not stray.  
 Ah, it is hard to speak of what it was,  
 that savage forest, dense and difficult,  
 which even in recall renews my fear:  
 so bitter – death is hardly more severe!  
 But to retell the good discovered there,  
 I'll also tell the other things I saw.  
 (Dante, trans. 1982, Canto 1, lines 1-9)

Psychiatric nursing has been portrayed in many different films. The films chosen for this research project reflect several different genres and time periods. The depictions of the nurses themselves parallel the media images of nurses described by Kalisch and Kalisch (Kalisch, et al., 1980; Kalisch & Kalisch, 1981b, 1982a). Unfortunately, there has been little attention given to the nature of the nurse-patient relationship as depicted in film. In this research, this relationship as depicted in the selected films is viewed through a relational ethic lens.

All the elements of relational ethics appear in the films. Although no film depicts psychiatric nursing care being delivered in an ethically sound manner throughout, there are scenes in each that demonstrate salient relational ethic elements.

Unfortunately, most of the nursing activities focus on fulfilling a resource person role. This limits the nurse's ability to establish engaged and mutually respectful relationships in which they would be able to fully utilize their embodied knowledge. The audience is able to make the assumption that the nurse's role in psychiatric settings is primarily to administer medication and help with procedures. However, the most problematic scenes are those that have nurses acting with profound certainty that they are doing the "right" things for the patients. Uncertainty is a key factor in facilitating reflective and ethical psychiatric nursing care.

The use of a relational ethic lens reveals that there are several common discourses embedded within the relational ethic themes of mutual respect, engagement, embodied knowledge, interdependent environment, and uncertainty. The chapter begins with a discussion of the embedded primary discourses of otherness and power/control. Also discussed are the sub-discourses relating to otherness and power/control: stigmatization, prejudice, domination, and marginalization. The chapter concludes with an overview of the implications for nursing.

### **Otherness**

Otherness is an essential component in developing or not developing mutual respect and engagement. Otherness also impedes the development of an interdependent environment, as the "us versus them" approach does not allow nurses to view patients as contributing to the common space or to the system. The nurses use rule-governed processes that ensure that the different social identities of the staff and the patients are made clear. These processes lead to differentiation and inequality. The majority of nurses in the films stigmatize

the patients in their care. They determine that the patients have weaknesses – their mental illness – that leave them less than human. They are to be treated differently than the staff – there is an oppositional perception of difference. The nurses, in most scenes, do not attempt to engage with the patient. As a result, they know little of the person for whom they provide care, and engage only in shallow interactions. The patients are assigned into groups. For example, in *Girl, Interrupted* (Mangold, 1999) a patient is labelled as Borderline, which means that the patient is going to be unpredictable and dangerous. The process of assigning the patients into groups destroys the nurses' ability to see them as fully human and worthy of mutual respect and engagement.

The relationship is left with a moral void. As a result, there are negative effects on both the person who is stigmatized and the stigmatizer. The person with the mental illness is not treated in an ethical manner and the nurse does not practice competently. In order to practice competently, especially in the area of psychiatry and mental health, nurses must create a space in which they are able to hear the voice of the Other. When the nurse uses processes that stigmatize the patient, the space to hear the Other is not created. It is the nurse's responsibility to link the patient's voice to clinical decision-making, resource allocation, the determination of service priorities, and so on.

The stigmatization leads to a disconnection between theoretical knowledge and human compassion. The patients are, at the very least, seen as passive recipients of their healthcare. In many instances the patients are seen as resistant recipients of their healthcare. When patients are passive/resistant recipients of healthcare, additional ethical concerns arise due to the



consequences of stigma. Healthcare practitioners may assume a superior and an authoritative relationship with the patient and behave as if they know what is best for them. Rather than engaging in a dialogue with patients to develop a relationship that can foster self-help and healing, the nurse has already decided the best course of action for the patient. Marland (1999) has noted that when nursing involvement tends to be paternalistic, a trusting therapeutic relationship is unlikely to develop. Without a therapeutic relationship, people with mental illness are at an increased risk to loss of personal freedom, social rejection, job loss, limited career advancement, relationship breakdown, declarations of incompetence, diminished self-efficacy, exclusion, dehumanization, distrust, shame, fear, grief, anger, and hopelessness (Broadhead, 1994; Corley & Goren, 1998; Crisp, 2001; Garske & Stewart, 1999; Gray, 2002; Hayward & Bright, 1997; Hinshaw & Cicchetti, 2000; Moyle, 2003; Playle & Keeley, 1998). The negative consequences described above are not part of the biological pathogenesis of the disease process, but are due to social stigma and subsequent stigmatization of mental illness. As stigmatization is internalized by the one who experiences it in a relationship, there are also consequences to those who stigmatize.

There has been no published research documenting the effects of stigma on the stigmatizer. Researchers have made the assumption that the experience and effects of stigma are unidirectional. However, working within a perspective that assumes we are interdependent and connected, stigma affects everyone in the relationship. Therefore, through the use of a relational ethic framework I will extrapolate the consequences of stigmatizing on those who stigmatize.

One of the basic ethical questions from a relational ethic perspective is: Who am I? Bergum (2004) has written, “Relational ethics is really about understanding and knowing ourselves as we engage with others” (p. 502). A sense of self emerges as we engage and enter into dialogue with the Other. The ability to have a meaningful (engaged) dialogue is essential to overcoming the seductive power of stigma. An engaged dialogue challenges our “rational” attempts to follow societal rules that tend to group strangers together based on attributes and thus generate stigma. By exclusively following these rules, we limit the possibility of engaging in ethical action. Until we engage we cannot determine an ethical action (Austin, et al., 2003). Bauman (1993) writes:

I know a stranger so little that I cannot be even sure that she ‘fits’ with any of the types I am familiar with. There is always the danger of the ‘stranger sitting across the barricade’, blurring the boundaries which ought to be kept water tight, and thus sapping the securely ‘typified’ world. The stranger carries a threat of wrong classification, but – more horrifying yet – she is a threat to classification as such, to the order of the universe, to the orientation value of social space – to my world as such. (p. 150)

Without engagement the other remains a stranger to us. The “strangeness” of strangers results in not knowing how to act or what to expect and results in further unwillingness to engage. This issue has the potential to ethically paralyse us. As a result, we cannot initiate ethical action. Ethical inaction leaves those who stigmatize unable to develop a moral sense of themselves.

Bauman (1993) describes the ‘primal scene’ of morality as the “realm of ‘face to face’, of ‘intimate society’ of the ‘moral party’” (p. 110). He

supports the vision that our humanity is not captured in common denominators (traits or attributes), but is found in the relational space among us. “This is the space between body and mind, between self and other” (Austin, Bergum & Dossetor, 2003, p. 48). The essence of a moral life is embodied in our humanity, and our humanity is developed through relationships with others. Furthermore, the development of our moral self requires an appreciation for embodied knowledge, the environment, and the role of an engaged and mutually respectful relationship. Without having a grounded ‘moral compass’ (knowing who I am), the stigmatizer will experience continual assaults to his/her moral integrity as he/she finds out he/she is unable to control all situations and decisions. For example, a nurse may repeatedly experience a lack of commitment to the patient and an inability to build a relationship with others. These consequences can lead to frustration, anger, caustic uncertainty, and a sense of powerlessness. These consequences are linked to burnout (Cronin-Stubbs & Brophy, 1985; Kilfedder, Power, & Wells, 2001; Stevens-Guille, 2003).

The stigmatizer is without a relationship and experiences the unmitigating negative effects of uncertainty. The most predominant of these effects is a sense of isolated vulnerability. The stigmatizer experiences no sense of interconnectedness and interdependency with the other. When isolated, the stigmatizer attempts to decrease this vulnerability with a quest for power over the other. Stigmatizers take the position of basic opposition and seek control. This opposition and need for control is of exceptional importance to them – it becomes part of their master status (Goffman, 1963). It defines who they are and how they interact with others.

Each one of us approaches life with biases, as we are a compilation of our past socialization and experiences. We are all potential stigmatizers. Without engaging in relationships, “blind spots” will not be revealed and potentially stigmatizing attitudes and beliefs will continue to influence our actions and behaviours. It is only when these biases are tested in relationships with others that we become aware of them and can honestly answer the question: Who am I? The answers to this question directly impact a nurse’s ability to enter and sustain a therapeutic relationship (Forchuk, et al., 2000; Gallop & O'Brien, 2003; Peplau, 1952/1988; Vandemark, 2006). Peplau (1952/1988) believes that a nurse can learn to help others “by working through her own problems and concerns that arise in her relations with others. Aiding nurses to learn the process of tackling human problems, including her own, is a task of every basic professional school” (p. 135-136).

### **Power and Control**

As I watch and reflect on the films included in this research study, I am acutely aware that the discourses related to power, prejudice, control, and marginalization are complex and never straightforward. For example, there are polarized representations of people with mental illness and polarized representations of psychiatric nurses. Some of the people with mental illness are portrayed as violent and dangerous – as some of the patients in *Gothika* (Kassovitz, 2003); others are portrayed as being misunderstood but very likeable – as Elwood is in *Harvey* (Koster, 1950). Yet all the individuals are portrayed as patients having a mental illness. Despite the difference in depictions, dangerous versus likeable, there are experiences that the patients have in common. These experiences relate to being controlled and

marginalized by the staff/psychiatric nurses. This is consistent with other researchers' findings that influential factors in the development of a negative or deteriorating nurse-patient relationship include nurses' behaviours that "promoted power, control and authority over the client" (Coatsworth-Puspoky, et al., 2006, p. 352).

The nurses are also depicted with polarized representations. There are nurses portrayed as misandrinistic and power hungry – as Nurse Ratched in *One Flew Over the Cuckoo's Nest* (Forman, 1975), and there are others that are depicted as helpless love-struck women – as Nurse Kelly in *Harvey* (Forman, 1975). However, the experiences of these nurses' have some similarities. For example, they are both marginalized and they are invested in ensuring that the patients, staff, or the environment around them conform to the rules of the institution. Thinking of Nurse Ratched as marginalized may seem impossible initially. However, she has become a prototypical psychiatric nurse who is viewed as being unable to establish respectful relationships and as a power-hungry spinster. This has led to the degrading of psychiatric nurses and the perpetuation of people entering the field having a skewed perception of the requirements of a psychiatric nurse. Viewed through a relational ethic lens, Nurse Ratched acts unethically with the patients. However, through the use of another lens that focuses on the importance of governance and the enforcement of institutional rules, one may determine that she behaves ethically and performs her duties in a competent and efficient manner.

Despite the differences between Nurse Ratched and Nurse Kelly, both nurses see the patients as "less-than." There is recognition of oppositional difference – you are the patients, we are the staff. The functions of the

psychiatric nurses in the films are primarily related to surveillance and control over the individual, regardless of time, source of material, or culture. The examples that are drawn from the films are also reflected in literature.

The metaphor of a panopticon can be used to uncover the means of surveillance and control. Psychiatry has been viewed by many authors as a means to control (Deacon, 1999; Keller, 2001; Littlewood, 2001). Historically, this control enabled the medical profession to segregate individuals who were not behaving in a manner “conducive” to achieving the goals and the objectives of society. As seen in Canadian experiences of aboriginals and settlers, any individual who did not contribute to the overall growth of the society was identified and labelled as mentally ill and subsequently controlled (Margetts, 1975).

There are several literary examples, paralleling those in the films, of how people with mental illness are controlled when they are not conforming (Anderson, et al., 2003; Conrad, 1899/1990; de Jong, 2001; Deacon, 1999; Eldridge, 1996; Littlewood, 2001; Livingstone, 1998; Stanley, 1998). Interestingly, this control extends to people without mental illness and it is only when the “controls” fail that an individual is labelled as needing psychiatric treatment. Randle McMurphy from *One Flew Over the Cuckoo’s Nest* (Forman, 1975) provides an example of social non-conformity that needs to be “fixed.” Society determines when it is appropriate for people to start having sex; McMurphy is sentenced/admitted because he had sex with an underage girl. The following passage from Conrad (1898/1998) reflects on the importance of social control.

Society, not from any tenderness, but of its strange needs, had taken care of those two men, forbidding all independent thought, all initiative, all departure from routine; and forbidding it under pain of death. ... They did not know what use to make of their faculties, being both, through want of practice, incapable of independent thought. (p. 251-252)

The factor that is necessary for society to maintain control over its people is a need to foster self-monitoring behaviours. By never forgetting the staff's gaze, the patients are forced to engage in self-monitoring behaviours - surveillance. This is seen in both *One Flew Over the Cuckoo's Nest* (Forman, 1975) and in the *Snake Pit* (Litvak, 1948). In *One Flew Over the Cuckoo's Nest* (Forman, 1975) the patients are, at least initially, very concerned with and intent on avoiding behaviours that may agitate Nurse Ratched. In the *Snake Pit* (Litvak, 1948) the patients avoid walking on the rug as this also aggravates the staff. Therefore, it could be argued that the organizational structure of the cinematic mental institution is based on the principles of a panopticon and can be a metaphor for society as a whole.

Conrad (1898/1998) has written about the coercive force of institutions:

The courage, the composure, the confidence; the emotions and principles; every great and every significant thought belongs not to the individual but to the crowd: to the crowd that believes blindly in the irresistible force of its institutions and of its morals, in the power of its police and of its opinion. (Conrad, 1898/1998, p. 250)

The nurses are also impacted by the force of the institution. In a scene from *Girl, Interrupted* (Mangold, 1999), Susanna observes a nurse being

reprimanded for letting a patient in the music room without supervision. The nurse is trying to respond to the patient's needs, potentially making the patient happy, but the institution/the hospital will not allow her to do so. The other nurses observe the other staff and ensure they are conforming to the rules. Although there are different rules for the patients and the staff, both groups must follow the rules of the institution.

Individuals are at the mercy of the dominant forces within their society. It is the social morals and values that determine what a great idea is, what attributes are to be valued, and what behaviours are to be avoided. However, it is only by making the invisible visible that we can determine the extent of the discourse of power. One way to do so is through hearing the messages contained within the films; we can begin to identify the discourses and discuss them. Embedded in the discourse of power and control is the expectation that individuals are aware of the morals, norms, and goals used to determine their degree of success, and an assumption that everyone has the ability to self-monitor.

I propose that it is when this ability to self-monitor fails that individuals are marginalized, whether someone has a mental illness or is a psychiatric nurse. Should behaviours or actions differ from what is expected by the institution, it will result in the individual being deemed as having a mental illness, regardless of their status as a patient or a staff member. One example is related to the experiences of Nurse Summerville in *Snake Pit* (Litvak, 1948). Her acts and behaviours differ from those expected by the institution and she is then institutionalized. We could also speculate about Nurse Ratched. If she practiced in today's setting – her actions could/would be labelled as



incompetent. She may also be identified as being a “control freak,” having narcissistic personality disorder<sup>11</sup> and/or potentially as having an antisocial personality disorder.<sup>12</sup>

Foucault (2003) has described many similarities between the primitive (I have chosen to use the words “primitive society” to be consistent with the translation cited in this passage) and modern societies’ treatment of their mad. The most important parallel is that treatment begins when people with mental illness can no longer contribute to the larger group. Foucault (2003) has

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<sup>11</sup> This disorder is characterised by a pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration, and lack of empathy. In addition to having this behavioural pattern other symptoms include: has a grandiose sense of self-importance, preoccupied with fantasies of unlimited success, power, a sense of entitlement – that other will automatically comply with her expectations, lack of empathy and shows arrogant, haughty behaviours or attitudes (Adapted from American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition – Text Revision*. Washington, DC: American Psychiatric Association.)

<sup>12</sup> This disorder is characterized by a long-standing pattern of disregard for other people's rights, often crossing the line and violating those rights. In addition to having this pattern of behaviour, other symptoms include: failure to conform to social norms, deceitfulness, irritability and aggressiveness, and a lack of remorse. (Adapted from American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition – Text Revision*. Washington, DC: American Psychiatric Association.)

indicated that he believes mental illness is attributable to a capitalistic society; any individual who is not productive is deemed mentally ill. Mental illness in this context may be characterized by Western notions of initiative, drive, success, perfection, and competitiveness. Is it reasonable to ask ourselves if mental illness is a capitalist disability? This question is highlighted in *Harvey* (Koster, 1950). Elwood does not have a job and is content living with his pooka. Is he disabled? Does he contribute to society? Does he need to be treated – he is not in distress, nor is he harming anyone?

In many of the films it is not clear who actually has a mental illness. Does the nurse in *Persona* (Bergman, 1966), who sets out to injure her patient, have a mental illness? Who has the mental illness in *The Cobweb* (Minnelli, 1955): the patients? Is it the family members of the staff or is it the staff themselves? There is a quote from the movie that highlights this confusion: “You can’t tell the patients from the doctors.” In this situation the self-monitoring has failed. The actions of the nurse and doctors are no longer controlled by society – they are not doing what is expected.

When the loss of control is attributed to failings of the individual and not of society, the individual is labelled ill, mad, or burnt out. When the self-monitoring fails and the individual is disconnected from society, he/she is labelled as an Other. Once disconnected, determining ‘what is most fitting’ is no longer decided based on societal morals and ethics. From the gaze of the society, the empiric gaze, this individual has become unpredictable.

The empiric gaze is a means of surveillance that influences individuals’ behaviours and actions. This gaze leads to an evaluation of whether or not individuals are contributing to the goals of society. When individuals no longer

contribute toward achieving these goals, they are identified as deviant; controls are then instituted to enforce social norms and expectations. Consequently, the individuals who fail to meet these expectations are marginalized. This process of marginalization is based upon the foundations of stigmatization and othering. This aspect of othering can be explained from a social disability perspective. Although it is unique to look at the consequences of surveillance and control from a social model of disability perspective, there are several commonalities to both positions. For example, both positions subscribe to the notion that social values and attitudes have consequences for individuals. The dominant culture uses surveillance to identify when individuals are not adhering to prescribed norms. Dominant society then uses a variety of controls in an attempt to ensure compliance with typical expectations. Several examples can be drawn from literary sources that also demonstrate the marginalization of the mentally ill and their subsequent stigmatization as the Other. This concept forms the basis of how difference is perceived and how moral decisions are determined.

Mental illness has been viewed from many perspectives. In the literature analyzed, there is not a general consensus as to what it means to be mentally ill. However, individuals determined to be mentally ill are, at the very least, seen as different from most other people. This difference is not always a tangible proof.

In a broader context, societal forces shape our intuitive and reflective abilities. These forces vary between groups, and as a result, the personal meaning ascribed to madness or mental illness differs between cultures. For example, Conrad (1899/1990) in *Heart of Darkness* describes Kurtz as being

mad; how his “nerves, [which] went wrong” (p.45), caused him to engage in unspeakable ceremonies. From the perspective of the English society, or the Company, Kurtz was mentally ill. However, from the perspective of the Africans Kurtz may appear to be one of the sanest foreign men they have ever encountered. Kurtz has become familiar with their customs and even participated in their ceremonies. His behaviour and actions could have met the expectations of the Africans. This could be compared to the following passage in which Marlow is described as being unable to tell what is going on around him.

The steamer toiled along slowly on the edge of a black and incomprehensible frenzy. The prehistoric man was cursing us, praying to us, welcoming us – who could tell? We were cut off from the comprehension of our surroundings; we glided past like phantoms, wondering and secretly appalled, as sane men would be before an enthusiastic outbreak in a madhouse. We could not understand because we were too far and could not remember, because we were traveling in the night of first ages, of those that are gone, leaving hardly a sign – and no memories. (Conrad, 1899/1990, p. 32)

Marlow’s lack of perspective could easily lead to the conclusion that he is ‘out of touch with reality’. Depending on the perspective, or in which social context the determination is made, one can conclude that both Marlow and Kurtz are mentally ill. Both men were viewed as outsiders and marginalized. The Company marginalizes Kurtz because he is no longer producing and adding to their profits. Marlow is seen as an outsider to Africa as he cannot

even determine the function or intent of basic communication. This experience of marginalization is a shared experience of the colonizer and the colonized.

For both men, Kurtz and Marlow, identification and belonging are important aspects of their relationships. It is through this identification that they can determine who they are and what is most fitting for them to do. Vangie Bergum and John Dossetor (2005) identify that determining ‘what is most fitting?’ is an ethical question. This ethical question forms the basis of how we interact with others and depends on engagement, embodied knowledge, mutual respect, the environment, and uncertainty. In order to answer this question the self must engage in reflexivity. Kurtz is unable to engage and has lost his sense of coherent self. Kurtz’s self-identification has changed, as depicted in the following passage:

Soul! If anybody had ever struggled with a soul, I [Marlow] am the man. And I wasn’t arguing with a lunatic either [Kurtz]. Believe me or not, his intelligence was perfectly clear – concentrated, it is true, upon himself with horrible intensity, yet clear... But his soul was mad. Being alone in the wilderness, it had looked within itself, and, by heavens! I tell you, it had gone mad. (Conrad, 1899/1990, p. 60)

Kurtz is not able to successfully integrate his experiences with the ethics of the Africans. There are residual English morals that lead to the moral confusion that results in Kurtz being unable to satisfactorily answer the question what is most fitting. This failed integration has left Kurtz being the Other, even to himself. He is also the Other to the Company; a dangerous Other than has the potential to threaten the Company’s social structure. He no longer sees himself as one of his countrymen. He does not know where he

belongs. Still influenced by the empiric gaze, he is not able to engage in the self-controlling behaviours expected and has deemed himself to be a failure. In essence he has become disassociated with the Kurtz he once knew.

Marlow also experiences an altered perception of self after his time in Africa. As the following passage demonstrates:

They were intruders whose knowledge of life was to me an irritating pretense, because I felt so sure they could not possibly know the things I knew. Their bearing, which was simply the bearing of commonplace individuals going about their business in the assurance of perfect safety, was offensive to me ...I daresay I was not very well at that time. I tottered about the streets – there were various affairs to settle – grinning bitterly at perfectly respectable persons. I admit my behavior was inexcusable, but then my temperature was seldom normal in these days. My dear aunt's endeavors to 'nurse up my strength' seemed altogether beside the mark. It was not my strength that wanted nursing, it was my imagination that wanted soothing. (Conrad, 1899/1990, p. 66)

The "imagination that wanted soothing" could be referring to the flashbacks of the images and experiences Marlow had as he journeyed to retrieve Kurtz. This could also refer to no longer being certain that his or other colonial morals are best and should be given beneficently to others. He is starting to believe that what determines the most fitting action depends on the context, not on the rules of the empire. Marlow can no longer be confident that colonial morals will ensure his infallibility. This uncertainty is exacerbated when he reflects on Kurtz's experiences. Marlow believes that Kurtz is an

intelligent man who had been schooled in the English ways, and yet they did not ensure his mental fortitude. Furthermore, Marlow believes that he has no contemporary peers, as he indicates others will not be able to understand because they have not had his experiences. He also thinks of himself as the Other. He is different. Just as Kurtz is different.

A contemporary interpretation of the experiences of Kurtz and Marlow is that they both have a disability. This disability is mental illness and is socially determined. This social determination defines what a disability is and also how people with a disability are to be treated. The treatment of people with mental illness manifests itself in two ways. One is through marginalization, and the other is through control of the individual.

Once the expectations are established of “this kind of person,” the person and his/her potential contributions to society are discounted (Goffman, 1963). The person then experiences discrimination, prejudice, oppression, and further marginalization. In other words, stigma leads to disability in any society or community. As it is not about the domination of one individual by another individual, it is the social structure that facilitates the surveillance and the self-monitoring that instigates compliance. There is no distinction between the patients and the staff; both groups control individuals they see as outsiders.

The consequence of seeing these groups as outsiders is that there is limited engagement, and shallow interactions develop. Thus, impersonal rules for the “Others” are developed. The foundations of prejudice are formed and they are objectified. Their humanity is disassembled; we are left with a void. Ethical decision-making cannot occur within this void, as psychiatric nurses are unable to hear the voice of the person in their care. The people receiving

psychiatric nursing care may also have expectations for the psychiatric nurse. These may be that he/she will not listen to them, lack empathy, and ensure that the patients follow the rules by whatever means necessary. These prejudices further reinforce the moral void and make the delivery of ethical care difficult.

### **Implications**

The movies chosen reflect almost a sixty-year time period (1948-2005). Unfortunately, the depiction of the nursing roles or the relationships between the nurses and the people with mental illness has not significantly changed. For example, the nurses in *The Snake Pit* (Litvak, 1948) and those in *The Jacket* (Maybury, 2005) are depicted in the roles of resource person, counsellor, and leader. The nurses in both of these movies value power and control. Along with the static depiction of nurses is the static depiction of the relationship between the nurse and the patient. For example, the treatment team decides for the patient what the best course of action is. There are few relationships developed between the nurses and the patients. If there is a developing relationship, it is typically for the purpose of ensuring that the patients conform to the rules of the institution.

The World Health Organization (2001) emphasized that there should be no discrimination based on the grounds that an individual has a mental illness, that people should be treated in their own community, and that everyone has the right to be treated using the least restrictive or intrusive methods in the least restrictive environment. One person in every four will be affected by mental illness at some stage of life (World Health Organization, 2001); however, such treatment barriers as stigma, discrimination, and inadequate services (World Health Organization, 2001) prevent people from receiving the



treatment and care they deserve. Due to these barriers, even in countries where services are well developed, less than half of the individuals needing care and treatment for mental illness receive the services they require (World Health Organization, 2001).

To address these barriers there are a number of possible approaches. Action could be taken to monitor, remove, or prevent the use of images, messages, or stories in the media that potentially would have negative consequences for people with mental illness or psychiatric nurses. For example, if a movie depicts a psychiatric nurse negatively, nurses can write to inform producers, directors, or writers of the misrepresentation and offer to consult with them on their next project; request that a disclaimer be added to the beginning of the movie, referring to the negative depiction and the consequences it may have; or suggest that the movie no longer be distributed. If there are advertisers linked with the movie, nurses can write to the advertisers indicating their concerns and that they plan to boycott their products.

As well, nurses could take a more pro-active approach to fostering a more realistic psychiatric nursing image. They could be instrumental in sharing potential plot-lines that would be interesting to audiences. Nurses could facilitate the development of theatrical plays linked to nurses and nursing care that have a more accurate depiction. They could, as well, promote discussion of the such plays and create opportunities to increase the knowledge of psychiatric nursing practice and the values that underpin it.

Although those who work in the media have artistic freedom, this freedom should not interfere with the rights of others. If there have been

thoughtless depictions of psychiatric nurses or people with mental illness, nurses have a responsibility to engage in an active dialogue with the media in an attempt to impact and change the image of the nurse and the general depiction of people with mental illness. Nurses are now recognizing that the strong stigma associated with mental illness also impacts the view of psychiatric nurses, and they are beginning to respond.

There are a number of other approaches for those working with the “orphan child” of the Canadian healthcare system (Romanow, 2002) to address the treatment barriers of stigma and discrimination. And addressing the negative public image of psychiatric nurses may interest more people in this challenging yet rewarding speciality area. Nursing associations could run public education campaigns that highlighted the common myths about mental illness and psychiatric nursing. Additionally, employers could also support psychiatric nurses to be members of community service agencies. This could potentially impact the development of community programs related to education, labour and employment, housing, social welfare services, and criminal justice system services. Finally, nurses can support patients to form and maintain strong consumer groups that are able to advocate for system changes from the patient’s point of view.

#### **Areas for further research.**

The messages contained within the images of nurses and people with mental illness are very powerful (Berry, 2004; Hall, 2003a; Kalisch & Kalisch, 1983a; Wahl, 2003) but have gone relatively unnoticed by nursing researchers. As a result, it is critical that the discipline of nursing continue to explore the impact of these images. This study demonstrates that there are salient messages

about psychiatric nursing care contained within movies that can impact the viewer. However, further research is needed.

For example, as the majority of the movies included in this research reflect the depiction of psychiatric/mental health nursing prior to the mid-1970s, a broader sampling may become available as films that represent other times in history are produced. These new films could become data sources in future study of the depiction of psychiatric nursing care in film.

Building on the current project, a study that is designed to expand the audience seems a next step. Such a study could utilize the same films but seek to understand the interpretation and meaning of the images for various groups. These groups could be patients, psychiatric nurses, the general public, and nurses working in areas other than psychiatry. As well, other data sources such as still images or texts (novels, poems, and so forth) that present the nurse-patient relationship could be included.

## **Chapter 10**

### **Conclusion**

Contemporary media has become a powerful influence in the formation of societal values and ethics. The profound influence has affected the development of public opinion and the formation of public policies relating to the nursing care of people with mental illness (de Carlo, 2007, Hereford, 2005; Kalisch & Kalisch, 1981b; Kalisch & Kalisch, 1982a) . Audiences are consistently encouraged to see psychiatric nurses as having considerable power. Unfortunately, most of the cinematic nurses are shown as misusing this power, and are frequently obsessed with preserving their authority. Hollywood filmmakers have created a potent negative stereotype of the successful psychiatric nurse. As powerful cultural tools, the movies play a major role in perpetuating mainstream society's disdain for psychiatric nurses and psychiatric nursing care. More often than not, the nursing images borne in those movies differ sharply from the realities of psychiatric nursing or psychiatric nursing care.

Most movies tend to portray the psychiatric nurse as a frustrated, aging, unmarried, female dominatrix who occupies a position of power within a psychiatric institution. The nurses are routinely depicted implementing interventions that result in social control, whilst they simultaneously hold therapeutic aspirations. This is reflected, not only in the typical storylines of the films, but also to a large extent in the ways that filmmakers depict the characters interacting in their environments. Using the basic tools of their trade – framing, editing, sound, lighting, and set design - they project a significantly more negative image of psychiatric nursing than the rest of nursing. For

example, the environment that the psychiatric nurse is seen working (the set) is typically a mental hospital. The hospital is usually an old building with bars on the windows, paint falling off the walls and large doors on the patient rooms that can be easily locked. It is interesting that the physical environment has many of the characteristics of the psychiatric nurse. Both are barren and void of comforts. For example, the bars ensure that the patients are unable to leave the hospital just as the “bars” for the nurse are her rigid and inflexible approach. The bars for the hospital and the nurse are used to ensure that the patients are controlled.

By encouraging the audience to perceive psychiatric nursing in this way has a fourfold effect: 1) it reduces psychiatric nurses to objects that should be feared, scorned, and hated; 2) it contributes to the self-loathing, shame, guilt among the audience members who are psychiatric nurses; 3) it may attract individuals to psychiatric nursing who are without the required attributes of caring and empathy; and 4) it provides an inaccurate depiction of the care a person can expect to receive from a psychiatric nurse. It is not unreasonable to assume this depiction then has consequences for persons deciding whether or not to seek psychiatric treatment and for the nursing discipline itself.

In the films, psychiatric nursing care is delivered consistently without any reflection on the uniqueness of the situation, especially if interventions are overtly motivated by beneficence. When motivated solely by beneficence, the nurse provides totalitarian style care. This characterized the paternalistic attitude prior to the mid-1970s: nurses know what is best for her/his patients. This type of approach totally negates the value of the Other. Furthermore, nurses using this approach assume that the Other is a disembodied, rational,

autonomous, separated, and isolated being. It is this view of the Other that leads to an oppositional relationship. The dangerousness of this approach is further compounded by the nurse's myopic view of power. The seductive charm of paternalism's rationality, "I know best," is seen in many of the films. In the hands of the cinematic psychiatric nurse, power and influence are turned into the ruthlessness pursuit for personal advancement, revenge, sadism, or greed. Attitudes and behaviours demonstrated toward the Others by these powerful nurses are a deep sense of distrust, intense dislike to revulsion, and extremely harsh discipline. None of the films have the psychiatric nurse consistently demonstrating professional concern for her/his patients. This warped imagery of psychiatric nurses, and the care they provide, not only does a great disservice to the thousands of psychiatric/mental health nurses, but also to the nursing profession as a whole.

The relational aspects of psychiatric nursing are usually taught through role modeling of preceptors, as there has been little direct discussion about relationships built into the education of nurses. There are full courses, in nursing education programs, on communication and the importance of clear communication with patients and their families – the therapeutic relationship has taken a "back seat." Despite this common representation, in order for psychiatric nurses to practice competently, we must engage in a dialogue about our relationships with the people for whom we provide care. Fortunately, with the advent of relational ethics we can engage in dialogue specifically about the relational aspects of relationships within an ethical professional healthcare practice.

The relationships we establish with the people for whom we provide care has a direct impact on our ability to make sound ethical decisions. It is through this relationship that understanding is nurtured. We must attend to “the quality of relationships in all nursing practices, whether with patients and their families, with other nurses, with other health care professionals, or with administrators and politicians” (Bergum, 2004, p 487). Relationships are fundamental to uncovering the most fitting course of action.

How can psychiatric nurses determine what is the right thing to do? This question demands a moral decision. Gadamer (1982) reminds us that “the task of a moral decision is that of doing the right thing in a particular situation, is seeing what is right within the situation and laying hold of it”(p. 259). To determine what is “the right thing” psychiatric nurses must negotiate the requirements of care and responsibility *with* their patients within the context of a relationship. The paradigm shift required of nursing is reflected in the statement “*with* their patients.” The past practice of nurses that reflected an oppositional relationship would determine the requirements of care and the responsibility “for their patients.” Although the difference in these phrases may superficially seem subtle – their difference in the meanings of these phrases is profound. This difference is reflected in the complex power relationship between the nurse and the patient. To negotiate *with* their patient requires that the nurse base her interactions on two new suppositions. First, that a non-oppositional relationship is possible; and second, that the self is not viewed as individualistic but rather as embodied, interdependent, and connected.

Through this project, I hope that I have contributed to the fields of nursing and the study of popular culture. Both these fields, at present, lack detailed assessment and evaluation of the phenomena of relationship between psychiatric nursing and the persons with mental illness for whom they care. Research using the medium of images in nursing is relatively new. Despite the lack of previous nursing research using this rich data source, it is critical that nurses begin to reflect on the impact of images and the messages contained within the images. It is my hope that this research will be a stimulant for further dialogue and reflection on the impact that images have on our profession.

My guide and I came to that hidden road  
 to make our way back into the bright world;  
 and with no care for any rest, we climbed –  
 he first, I following – until I saw,  
 through a round opening, some of those things  
 of beauty Heaven bears [sic]. It was from there  
 that we emerged, to see – once more – the stars.  
 (Dante, trans. 1982, Canto 34, lines 133-139)



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Cambridge, MA.

## Appendix A

### Historical Images

Pre 1854.



**Source:**

<http://images.google.ca/imgres?imgurl=http://www.jkcc.com/evje/picturesrc/pic13.jpg&imgrefurl=http://www.jkcc.com/evje/rcpictorial2.html&h=306&w=550&sz=36&tbnid=nEicHuokOrMJ:&tbnh=72&tbnw=129&start=1&prev=/images%3Fq%3Dgrey%2Bnuns%2Bnurse%26hl%3Den%26lr%3D%26c2coff%3D1%26sa%3DN>



**Source:**

<http://www.fidnet.com/~dap1955/dickens/characters/prig-gamp.gif>

**The angel of mercy 1854-1919.**



**Source:**

[http://images.google.ca/imgres?imgurl=http://www.satucket.com/lectionary/Florence\\_Nightingale3.jpg&imgrefurl=http://www.satucket.com/lectionary/Florence\\_Nightingale.htm&h=256&w=173&sz=5&tbnid=IseiGf7rDsQJ:&tbnh=107&tbnw=72&start=7&prev=/images%3Fq%3Dlady%2Bwith%2Bthe%2Blamp%26hl%3Den%26lr%3D%26c2coff%3D1%26sa%3DN](http://images.google.ca/imgres?imgurl=http://www.satucket.com/lectionary/Florence_Nightingale3.jpg&imgrefurl=http://www.satucket.com/lectionary/Florence_Nightingale.htm&h=256&w=173&sz=5&tbnid=IseiGf7rDsQJ:&tbnh=107&tbnw=72&start=7&prev=/images%3Fq%3Dlady%2Bwith%2Bthe%2Blamp%26hl%3Den%26lr%3D%26c2coff%3D1%26sa%3DN)

# Girl Friday, 1920-1929.



## Source:

<http://images.google.ca/imgres?imgurl=http://www.lindapages.com/nurses/art1920.jpg&imgrefurl=http://www.lindapages.com/nurses/nurses-pics.htm&h=684&w=498&sz=74&tbnid=oi5gR-BPU1oJ:&tbnh=136&tbnw=99&start=6&prev=/images%3Fq%3Dnurses%2BIn%2Bthe%2B1920%26hl%3Den%26lr%3D%26c2coff%3D1>

**Heroine, 1930-1945.****Source:**

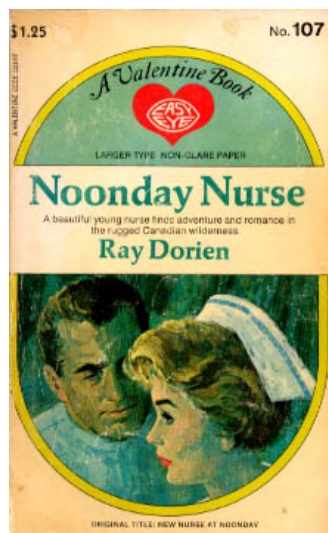
[http://www.bluejacket.com/usn/poster/post\\_navy\\_ww2\\_wanted-more-nurses.jpg](http://www.bluejacket.com/usn/poster/post_navy_ww2_wanted-more-nurses.jpg)

### Mother, 1946-1965.



#### Source:

<http://classicmoviefavorites.com/dehavilland/notasastranger196.jpg>



#### Source:

<http://images.google.ca/imgres?imgurl=http://www.gregtulonen.com/nurses/covers/noonday.jpg&imgrefurl=http://www.gregtulonen.com/nurses/archive/noonday.html&h=358&w=221&sz=32&tbnid=kKDQrIaeV4QJ:&tbnh=117&tbnw=72&start=1&prev=/images%3Fq%3Dnoonday%2Bnurse%26hl%3Den%26lr%3D%26c2coff%3D1%26sa%3DN>



**Sex object, 1966-1982.**



**Source:**

<http://www.allposters.com/gallery.asp?aid=64046&search=nurses>



### Militant, 1980-1995.



### Source:

<http://images.google.ca/imgres?imgurl=http://dbacon.igc.org/Strikes/StriBig/strike09.jpg&imgrefurl=http://dbacon.igc.org/Strikes/strike09.html&h=266&w=400&sz=26&tbnid=xVAWuHSZLnQJ:&tbnh=79&tbnw=119&start=1&prev=/images%3Fq%3Dnurses%2Bon%2Bstrike%26hl%3Den%26lr%3D%26c2cof%3D1%26sa%3DG>

**Careerist 1980-present.****Source:**

<http://images.google.ca/imgres?imgurl=http://www.chnonline.org/2003/2003-10-30/nurse.jpg&imgrefurl=http://www.chnonline.org/2003/2003-10-30/newsstory2.html&h=252&w=165&sz=9&tbnid=JUMeihpXvk0J:&tbnh=105&tbnw=69&start=35&prev=/images%3Fq%3Dthe%2Bexpert%2Bnurse%26start%3D20%26hl%3Den%26lr%3D%26c2coff%3D1%26sa%3DN>

## Appendix B

### Movies Screened for Inclusion in Research

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## Appendix C

### Nursing Roles in Films Included in Research

#### **Stranger.**

- No films chosen depicted this role

#### **Resource Person.<sup>13</sup>**

- Terminator 2
- Gothika
- The Jacket
- The Snake Pit
- Harvey
- Frances
- Girl, Interrupted
- Cosi
- The Sleep Room
- Persona
- One Flew Over the Cuckoo's Nest
- The Caretakers
- The Cobweb

#### **Teacher.**

- The Snake Pit
- Girl, Interrupted
- The Caretakers
- The Cobweb

#### **Leader.**

- Gothika
- The Jacket
- The Snake Pit
- Harvey
- Girl, Interrupted
- Cosi
- One Flew Over the Cuckoo's Nest
- The Caretakers

#### **Surrogate.**

- Girl, Interrupted
- Persona
- One Flew Over the Cuckoo's Nest
- The Cobweb

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<sup>13</sup> Missing – Titicut Follies & High Anxiety

**Counsellor.**

- Terminator 2
- Gothika
- The Jacket
- The Snake Pit
- Girl, Interrupted
- Persona
- One Flew Over the Cuckoo's Nest
- The Caretakers
- The Cobweb

**Consultant.**

- Persona
- One Flew Over the Cuckoo's Nest
- The Cobweb

**Tutor.**

- One Flew Over the Cuckoo's Nest

**Safety Agent.**

- Harvey
- Frances
- Girl, Interrupted
- Cosi
- The Sleep Room
- Persona
- One Flew Over the Cuckoo's Nest
- The Caretakers
- The Cobweb

**Mediator.**

- No films chosen depicted this role.

**Administrator.**

- High Anxiety
- Cosi
- The Caretakers

**Recorder.**

- The Sleep Room
- One Flew Over the Cuckoo's Nest
- The Caretakers

**Observer.**

- Frances
- Girl, Interrupted
- The Sleep Room
- One Flew Over the Cuckoo's Nest
- The Caretakers

**Researcher.**

- No films chosen depicted this role.