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VEILING SEXUALITIES IN A PSYCHIATRIC NURSING CONTEXT: A GROUNDED THEORY STUDY

THESIS
8124

VEILING SEXUALITIES IN A PSYCHIATRIC NURSING CONTEXT: A GROUNDED THEORY STUDY

A thesis presented to the University of Dublin, Trinity College for the Degree of Doctor in Philosophy

by

Agnes Higgins

RPN, RGN, BNS, RNT, MSc.

October 2006

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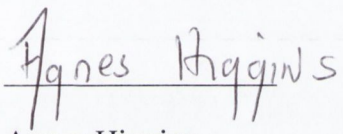

Agnes Higgins

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Title: Veiling Sexualities in a Psychiatric Nursing Context: A Grounded Theory study

SUMMARY

Background: Since the World Health Organisation first identified the need for health professionals to be educated in the area of sexuality, sexuality has gradually become a legitimate area of concern for nurses across all nursing disciplines. In the last ten years, with the growing awareness of the needs of people with disability and the advocacy network, the discourse around sexuality and people with mental health problems has also come to the fore. However, there is very little research available that explores this complex issue of psychiatric nursing practice.

Aim: The aim of this study was to develop a grounded theory that explained how psychiatric nurses, within a mental health service in the Republic of Ireland, respond to issues of sexuality in a clinical practice context.

Methodology: This study was guided by a constructivist epistemology and the principles of Grounded Theory as described by Glaser. Data were gathered in one mental health service in an urban area in the Republic of Ireland. Participants consisted of twenty seven nurses who were working in a variety of clinical areas within the service. Data were collected through interviews and documentary analysis and analysed using the concurrent processes of constant comparative analysis, data collection, theoretical sampling and memo writing.

Results: The participants' main concerns about sexuality were related to their desire to protect their own and clients' vulnerabilities. The participants dealt with this desire through a process conceptualised as *'Veiling Sexualities'*, which had five subcategories. Three of these subcategories formed a *'Veiling-Re-veiling Sexualities Cycle'* and consisted of the following categories: *'Hanging the Veil'*, *'Lifting the Veil'* and *'Re-veiling'*. The antecedent to the *'Veiling-Re-veiling Cycle'* was a pattern of thinking created through a process conceptualised as *'Weaving the Veil'*. The *'Veiling-Re-veiling Cycle'* of action was sustained and perpetuated, subsequently, by a number of rationalisations and justifications, conceptualised as *'Maintaining the Veiling-Re-veiling Cycle'*.

The strategies that participants developed to *'veil'* clients' sexualities were *'woven'*, as a consequence of exposure to, and engagement with various sexual discourses, during primary, secondary, and professional socialisation. These discourses provided participants with a view of sexuality that emphasised taboo, privatisation, sin, pathology, deviance and control. Absent were social, political, cultural, interpersonal, or rights-based discourses that could have provided participants with the knowledge and clinical competence necessary to include sexuality in an open, constructive and confident manner within the horizons of psychiatric nursing.

Participants *'hung a veil'* around client sexuality using a number of strategies. These strategies had a dual function. Firstly, they enabled the participants to shade over, mentally and verbally, the clients as sexual beings. Secondly, they allowed participants to protect themselves from personal discomfort and professional exposure. In the absence of participants' willingness to acknowledge the sexual

dimension of the client's life and to engage proactively in therapeutic conversation with clients on sexual issues, opening up discussion, or *'Lifting the Veil'* became the role of another. Most frequently it was the client who *'Lifted the Veil'*. When this occurred, the sexual dimension of the client's personhood was revealed clearly to the participants. Once the veil was lifted, participants could no longer ignore, consciously or unconsciously, the sexual dimension of the client's personhood. Participants responded by *'re-veiling'* the client's sexual expression, thus, *'re-veiling'* their own discomfort.

The *'veiling'* and *'re-veiling'* strategies were not used with conscious intent, but were the result of the participants' socialisation into the culture and practice of psychiatric nursing. During the course of the interviews, participants became more conscious that their actions were not congruent with their espoused theories of holistic client centred care. While acknowledging that sexual issues were not adequately addressed, participants justified their action by using a number of rationalisations, which *'Maintained the Veiling-Re-veiling Cycle'*. These rationalisations were conceptualised as *'Mythical Self Talk'*. The participant professional socialisation into the culture of psychiatric nursing was where this pattern of talk was woven.

Although presented as five discrete categories, the relationship between the categories was neither hierarchical nor linear, but iterative and cyclical, as each category shaped and influenced the other. Participants were not simply passive agents in the process, but played an active part in the reproduction and weaving of both the veil and the veiling actions, and in socialising and cultivating more junior colleagues into this way of working. Consequently, the *'Veiling-Re-veiling Cycle'* was perpetuated and sustained within practice.

Conclusions: The findings provide a mechanism to understand the intricate and complex issues that surround the area of sexuality in a psychiatric nursing context. The findings generate some valuable insights into the strategies that psychiatric nurses use to address issues of sexuality in practice, and provide enlightenment into how these strategies were developed. The findings also contribute to our understanding of the processes of thinking that motivated participants to use the *'veiling'-'re-veiling'* strategies, as well as the processes that helped produce and maintain the patterns of behaviour and thinking, which resulted in the veiling actions. In so doing the findings also offer guidance into the educational needs of psychiatric nurses and provide direction for future research in this underdeveloped and under researched area of psychiatric nursing practice. I also consider that this theory has practical relevance, as it gives complex issues an articulated form and creates a wider discourse within the profession of psychiatric nursing on the sexual right of clients.

CHAPTER ONE: AN OVERVIEW OF THE THESIS

Introduction

Human sexuality is an immensely complex area involving somatic, emotional, intellectual and social aspects of the individual (World Health Organisation, 1986). Sexuality is defined by the Pan American Health Organisation and World Health Organisation as:

> 'A core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles, relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors' (Pan American Health Organisation/World Health Organisation, 2002:6).

Unlike other European countries, Ireland does not have a national sexual health policy. However, promoting healthy sexuality and sexual health is recognised as an integrated and significant element of total health care, and has been identified as a component of government strategy (Department of Health and Children, 2000b; 2001). It is also reflected in other health policies such as the AIDS strategy (Department of Health and Children, 2000a).

In the last ten years, with the growing awareness of the needs of people with disability and the advocacy network, the discourse around sexuality and people with mental health problems has become focused within a rights based discourse. Sexual rights include: the right to express one's full sexual potential; the right to sexual autonomy, privacy, equity and pleasure; the right to make free and responsible reproductive choices; the right to comprehensive sexual health education and the right to sexual health care (Pan American Health Organisation/World Health Organisation, 2002). The UN Principles for the protection of persons with mental illness and for the improvement of mental health care (the MI principles) state that people 'shall have the right to exercise all civil, political, economic, social and cultural rights' (Office of the High Commissioner for Human Rights, 1991:2). Although not explicitly stated, the term 'civil rights' does include the right to sexual expression. The UN convention (to which Ireland is a signatory) also assigns people with mental health problems the right to be sexually active and the right to

knowledge. The Report of the Commission on the Status of People with Disability in Ireland in 1996 marked a watershed in Irish disability policy, setting out a legislative, policy and service framework for people with disabilities and the realisation of their economic, social and cultural rights, including their sexual rights (Government of Ireland, 1996). Discrimination on the grounds of sexual orientation or disability are also included within the nine grounds covered by the Irish equality legislation (Government of Ireland, 1998).

Davidhizar et al. (1991) suggested that the topic of sexuality is controversial under normal circumstances but when discussed in a psychiatric and mental health context it has the potential to generate opposing views and open a heated debate. At a time when clients'[1] rights are increasingly emphasised, the sexual dimension and sexual rights of people experiencing mental health problems cannot be ignored. There is now a growing body of evidence that suggests people experiencing mental health problems have problems in relation to sexuality. A high number of clients attending psychiatric services have experienced sexual violence prior to coming to the service, and an equally high number of clients experience side effects of drugs, which impact on sexuality. Some client groups, such as people who experience 'chronic' mental health problems, have poor knowledge on sex related issues, engage in high rates of sexual risk behaviour, and due to poor adherence to antiretrovirals have poor health outcomes if diagnosed with Human Immunodeficiency Virus (HIV) (Kelly et al., 1992; Kalichman et al., 1994; McDermott et al., 1994; Uldall et al., 2004). Clients who have been in long term care also experience deficits in sexual health care, especially in the area of health screening such as breast checks (Department of Health and Children, 2003). The emergence of a younger group of clients with quite different expectations around sex and relationships poses new challenges for mental health professionals as many of these individuals are striving for a 'normal' life in the community (McCann, 2000). There is some evidence, albeit limited, suggesting that people experiencing mental health problems look to health care professionals for support, advice and

[1] Although I am aware of the ongoing debate around the suitability of using terms such as patient, client, consumer and service user, in the interest of consistency I decided to use the term client as this was the term most frequently used by the participants in the study.

education in this area of life and living. Deegan (1999), who described herself as a mental health consumer, reminds us that people:

> '...who have been diagnosed with major mental illness do not cease to be human beings by virtue of that diagnosis. Like all people we experience the need for love, companionship, solitude and intimacy. Like all people we want to feel loved, valued and desired by others' (Deegan, 1999:21).

Psychiatric nurses are in a unique position to provide sexual health care to people with mental health problems. Indeed, numerous writers have asserted that nurses have a clinical and professional responsibility to care for the sexual health needs of clients (Royal College of Nursing, 1996; 2000; 2001; McCann, 2000; 2003; Dobal and Torkelson, 2004). This increased emphasis on sexuality and the role of the nurse is also evident in the nursing theory literature, with several nurse theorists identifying sexuality within their conceptual frameworks (Roy, 1976; Roper et al., 1980).

The proliferation of texts and articles published on sexuality would suggest that this aspect of nursing practice is widely researched. However, the vast majority of the literature is anecdotal in nature or pertains to nurses working in general nursing. Despite numerous assertions that sexuality and mental illness raise issues of clinical, social and legal concern, and that psychiatric nurses have a key role to play in this area of practice, research into psychiatric nursing and sexuality suggested that the evidence base is sparse. This may be due to lack of research funding in this area or a lack of awareness among nurses of sexuality as a dimension of client care. It could also reflect a belief that psychosocial issues are such a part of the psychiatric nurse's remit that this aspect of personhood is well understood and is an acknowledged aspect of care that is comprehensively addressed.

Generating the idea

It is hard to say when this research project began. If one considers the beginning as when I wrote the application proposal for admission to the PhD programme, then its birth was in 2002. However, its true beginning was years earlier when I was

working as a psychiatric nurse[2] in clinical practice and was confronted with challenging situations related to my own and clients' sexuality. Over the years, my interest in the complex area of sexuality as it relates to clients with mental health problems grew.

Psychiatric nurses are frequently heard to speak with pride about the close relationships they develop with clients, their expertise in communication skills and their holistic approach to care, which includes the biological, psychological and social dimensions of personhood. In recent years, in relation to sexuality, this rhetoric, of which I was also part, started to present some incongruities. Being convinced that sexuality was an ever present issue within nurse-client relationships, I wondered how nurses coped and responded to its presence. Initially when I mentioned the idea for this study to some psychiatric nursing colleagues, they responded with 'we do nothing, we ignore it'. Instead of diminishing my enthusiasm these responses fuelled my curiosity further, as I was of the opinion that to 'do nothing' was to 'do something'. I also wondered how psychiatric nurses organised themselves and their practice so that they could respond by inaction and not be challenged by clients or the system. A review of the literature in psychiatric nursing suggested that no coherent theoretical framework or model existed that explained or aided understanding of this phenomenon. Thus, I set out to explore how psychiatric nurses responded to issues of sexuality. In other words, I wanted to understand what this phenomenon of non-action entailed.

Aim of the research

The overall aim of the research was to develop a substantive theory of how psychiatric nurses respond to issues of sexuality in a clinical practice context.

Research questions

Predefining exact research questions in a grounded theory study is contradictory, as the focus of the research problem should emerge through the process and from the participants. However, given the broad nature of the subject, and in an attempt to

[2] The term psychiatric nurse as opposed to mental health nurse, is used through out the study as nurses in the Republic of Ireland are registered as Psychiatric Nurses on the Nursing division of the register, with An Bord Altranais.

provide some focus for the early part of the study, the following were the tentative aims:

- to explore how psychiatric nurses conceptualise sexuality in the context of psychiatric nursing practice
- to elicit the mechanisms that psychiatric nurses employ to respond to the sexuality needs of people experiencing mental health problems
- to explore the factors that influence the way psychiatric nurses respond to issues of sexuality in practice

Selecting grounded theory

The study employed Glaser's approach to Grounded Theory (Glaser, 1978; 1998; 2001; 2003; 2005). The decision to use grounded theory was based on a desire to produce, as an outcome, some model or theory that might impact on practice. Following study of the various approaches to conducting a grounded theory study and the attendance at workshops facilitated by Dr. J. Corbin and Dr. B. Glaser, on their respective methods, I decided to adopt Glaser's approach to the study. Glaser's style of grounded theory was selected for a number of reasons. Firstly, it emphasises letting the problem emerge from the participants' perspective. Secondly, Glaser's approach, although no less rigorous, seemed flexible enough to allow me the freedom to follow leads and use a variety of data collection methods as ideas emerged. Thirdly, his notion of finding a latent pattern of behaviour also fitted with my idea of developing a theory of practice.

A personal statement

To help the reader judge to what extent this thesis is influenced by my personal prejudices, I provide here some statements about the person 'Agnes Higgins'.

First and foremost I do not believe that the private 'personal me' can be divorced or separated from the 'professional me', whether in my role as researcher, teacher or psychiatric nurse. That said, I do believe that what I disclose about myself should be context specific, while recognising that all my actions leave subtle fingerprints, which may be revealing.

Since I am the author of this thesis it is self-evident that I regard sexuality as a profoundly important part of human existence and living. I see it as a force that has the potential to promote intimacy, pleasure, self-esteem and support the deepest longing for human connection, while paradoxically being a force that can diminish, hurt and exploit the vulnerabilities of others. As a nurse with over twenty five years' experience in psychiatric, general and palliative care nursing, I see it as an important dimension of all clients' humanity and an important variable that influences the way we interact and work with clients in every day practice. This has led to an increased interest in reading and studying about sexuality and attempts to include sexuality within nursing curricula and courses that I am involved in teaching.

I am aware that I could be accused of professional colonisation of an aspect of a client's life that is private and personal. However, I make no apologies, as I believe that to ignore or refuse to give clients an opportunity to explore such issues leaves them without support or education. I also believe that, if one commences from the premise that working with clients is about creating context and permission for possible discussions, the client will direct the content of any such discussion.

Format of this thesis

The thesis is presented in three sections. Section One focuses on the literature in the substantive area (chapters two and three). Although a preliminary literature review was conducted prior to the enquiry, this was not used as a theoretical framework for the study but, as Glaser (1978:32) suggested, to help develop 'theoretical sensitivity'. To contextualise the issue of sexuality within the wider discourses in the field, the first chapter of the literature review examines various discourses that have shaped our understanding of sexuality (chapter two). In chapter three, I draw on a range of empirical research from health care disciplines, to build a picture of the interrelationship between sexuality, mental health problems and psychiatric nursing, and provide the reader with an overview of the current state of knowledge in this area of sexuality and psychiatric nursing.

In Section Two the epistemological, ontological and methodological propositions that informed the study are described (chapter four). A discussion on the Glaserian

approach to Grounded Theory, with particular reference to how this method differs from other Grounded Theory approaches is included. Practical issues in relation to the conduct of the study are addressed in chapter five. Issues in relation to access, sampling, data collection, data analysis and ethical issues associated with conducting research on a topic that could be considered sensitive are discussed. In this chapter (chapter five) I endeavour to capture the methodological, ethical and personal challenges I encountered and to document some of my own learning and reflections on the process of conducting the study.

Section Three presents and discusses the substantive grounded theory of '*Veiling Sexualities*', which represents the findings from the study. The emergent theory is described in chapters' six to nine. A discussion of the theory in the context of extant theoretical and philosophical literature is provided in chapter ten. Chapter eleven, the final chapter in the thesis, addresses the limitations and implications of the findings, and includes recommendations for education, clinical practice and research. The final section of this chapter uses Glaser's criteria of fit, workability, modifiability and relevance to evaluate the trustworthiness of the emergent theory.

CHAPTER TWO: DISCOURSES ON SEXUALITY: FROM PREMODERNISM TO POSTMODERNISM

'It is testament to the hegemonic power of discourse that it is often difficult to imagine our ancestors living with a radically different understanding of sex' (Hird, 2004:17).

Introduction to the literature review

To contextualise the issue of sexuality within the wider discourses in the field of sexology[3], this chapter examines various discourses in Western Europe that have shaped our understanding of sexuality. The discussion of sexuality is not intended to be a history of sexuality in a chronological sense. Neither does it suggest that there was a logical march of progress in knowledge development, or that we now know 'the truth' of sex. My focus, therefore, is to provide a reasonably comprehensive account of the various discourses and to reveal how these discourses, over time, have shaped our understanding of sexuality. By *discourse* I mean the way certain ideas and beliefs are put together, in this case about sexuality, in order to present an idea in a particular way, at a particular historical moment. Smith defines discourses as,

> 'systems of representations involving rules of conduct which regulate the production of meaning within the context of definite textual and institutional conditions – they regulate what can and cannot be said and read within historically and socially specific situations' (Smith, 1998:343).

The focus within the chapter is on written and spoken discourses within Greek, Roman and Christian cultures as distinct from discourses or texts, such as the Indian ancient text 'Kamasutram'[4], which have informed other cultures or discourses within art, cinema or music. Before I discuss these discourses, given the competing views on the role of theory and literature within a grounded theory enquiry, it is important to comment on and explain how the literature was used to inform this enquiry.

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[3] Although an imprecise term and associated with the science of sex, the term sexology is used to describe the field of knowledge in relation to sexuality.

[4] The Kamasutram is generally known to the Western world as the Kama Sutra.

Role of literature in a Grounded Theory enquiry

The role of prior theoretical frameworks and literature within a grounded theory study is a contentious issue. Mitchell and Cody (1993:171) critiqued grounded theory methodology on the grounds that the role of prior theory is obscure. There is no doubt that the role of existing theory in grounded theory differs from the more traditional research approaches. This is not to suggest, however, that the generation of a grounded theory proceeds in isolation of existing theory, or that a grounded theory is atheoretical. Glaser and Strauss (1967:3) acknowledged that the researcher 'does not approach reality as a *tabula rasa'*, and as such cannot erase from their mind all the theory they know, before beginning research. What Glaser (1998) objected to is the completion of an in-depth literature review prior to commencing a grounded theory study, and using this theory to preconceptualise the problem, theoretical framework or concepts. According to Glaser (1992:31) it is hard enough for researchers to generate their own concepts from the data, without having to contend with the 'derailment' provided by the literature, in the form of conscious or unrecognised assumptions of what ought to be in the data. Hence, Glaser (1992) suggested that literature should be reviewed as concepts and categories emerge and then used as a comparison with the emerging data. Morse (2001:9) strongly disagreed with this, fearing without a theoretical context to draw on, new researchers to an area may 'find themselves rapidly mired in data' without the ability to conceptualise or position their study or findings within the existing body of theory. Thus, she stated that literature should not be ignored but rather 'bracketed'. Like Paley (2005), bracketing as a concept is something with which I have a difficulty, as I am not sure I can mentally abandon and put aside previous knowledge.

In the context of this thesis, part of the requirement for funding[5] and academic registration involved the demonstration of an awareness of the state of existing theory and literature regarding the phenomenon under study, in order for the agency to evaluate the proposal. Although a preliminary literature review was conducted prior to the enquiry, it was not used as a theoretical framework to guide the study but, as Glaser (1978) suggested, to help develop theoretical sensitivity. Theoretical

[5] This study is being funded by a clinical nursing fellowship from the Health Research Board, Ireland.

sensitivity is the ability to sense the subtleties of the data. A distinction, therefore, must be made between using sensitising concepts to sharpen one's awareness and using concepts to impose a framework on the data. It is the latter with which Glaser took issue. According to Glaser, once theory development is at a stage that literature will not derail the researcher from seeing what is going on in the data, the required literature becomes apparent and may be reviewed. In other words, 'the literature is discovered as the theory is' (Glaser, 1998:69). In keeping with this view, a literature search also was conducted parallel to the data analysis and during the final stages of theory development and writing up. All literature read at this stage related to the emerging theory. The literature[6] presented in this chapter, was collected before the study and later refined by subsequent reviews as the study progressed.

Challenges in presenting the various discourses on sexuality

Despite the fact that numerous people from psychology, sociology, anthropology, biology, philosophy, theology, psychoanalysis and psychiatry have written about sexuality, compared to many other areas in scientific enquiry, Weis (1998b) suggested sexual theory remains in its infancy as no unifying theory exists. Why people initiate sexual activity, become aroused or respond to erotic activity in the way they do often seems self evident, as it is such a part of every day life. Yet there is little agreement regarding the source of sexual motivation or the basis for gender difference between men and women. In a capsulated review of the state of sexual theory, Weis (1998a) suggested that, discounting perspectives from theology, law, anthropology and communication studies, at least thirty nine different psychological and sociological theories exist that have influenced the study of sexuality and have shaped and reshaped how sexuality is understood. It is beyond the scope of the chapter to explore every theory or every writer; therefore, as said, it is limited to works and writers that are taken as indicative of a particular era, and have

[6] Literature was identified through a number of methods. Searches of electronic databases such as Medline, CINAHL, Psychlit, Pubmed were carried out using the keywords: Sexuality, sex*, intimacy, love, sexual behaviour, sexual attitudes, mental health, mental illness, psychiatric nursing. Key international websites in the area of mental health were also searched and some unpublished theses were accessed through interlibrary loan. Further information was accessed through books held in University of Dublin, Trinity College library and other libraries. In addition, relevant theses completed in the area of sexuality were accessed from England and Australia. Consultation with some key writers in the area also highlighted some relevant sources.

influenced Western and Christian cultures. I have conceptualised the various discourses using the three epochs of premodernism, modernism and postmodernism. These three epochs produced three very different ways of understanding sexuality. Each epoch was defined by a dominant philosophical belief system and it is the belief system as opposed to chronological time that is emphasised. The discourses presented highlight the different perspectives that were privileged and the manner in which permissions and prohibitions around sexuality were constructed based on each discourse. Table 1 provides an overarching framework, which I conceptualised to guide the discussion in this chapter. Discussing the various discourses lend insights into modern day sexual mores held by cultural institutions including family, school, religion, and nursing.

Table 1. An overview of the discourses on sexuality

Pre-modernist discourses	Modernist discourses	Postmodernist discourses
Sexuality – a source of pleasure	Sexuality – an adaptive evolutionary response	Sexuality – a site of 'governmentality'
Sexuality – a source of sin	Sexuality – an innate psychic drive	Sexuality – a site of male power
	Sexuality – a mechanical biological system	Sexuality – a highly unstable site of identity

Pre-Modernist discourses

The pre-modern epoch probably extended from the beginnings of western civilisation, in ancient Greece, through to the beginning of modernity in the late fifteenth and early sixteenth centuries. The primary epistemology of pre-modernism emphasised revealing knowledge from some authoritative source. This authoritative source was generally assumed to come from a divine 'logos' (Greek) or God's will (Christian), down to the naturally and divinely sanctioned hierarchical structures of society (Porter, 1998). Exploring pre-modern discourses, including reference to sexual mores in ancient Greece and Italy, and sexual codes of practice described by theologians within the Christian church, enables us to get an understanding of how sexuality moved from being conceptualised as a source of pleasure to a source of

sin and from an ethic of self mastery to a subjugation to pastoral authority as discussed by Foucault (1976).

Sexuality – A source of pleasure

Stretching from the Ancient Greeks though to Renaissance Italy, people's constructions of sex were radically different from our understanding today. Firstly, a 'one sex model' of anatomy dominated. Women's genitals were simply male genitals displayed internally. Men, being warmer, displayed their genitals externally. Thus, genitals did not signify the founding essence of sexual difference. Sexual difference was determined more by attention to such things as movement, temperament, clothing, posture and voice (Lumby, 1997; Hird, 2004; O'Connell-Davidson and Layder, 1994). Secondly, in some ancient societies, there was no outright condemnation of the pursuit of sexual pleasure. Sex was viewed simply as a pleasurable and physical act and male masturbation an act of natural elimination. Sexual behaviour was structured by difference in age and status, with sexual attraction being an issue of taste and preference as opposed to a moral issue. Adult free men, who had full status as citizens, had sexual relations with adolescent males, who had not yet achieved full status, and with women and slaves who were sexually passive. As sex between free men was problematic, after the age of twenty-three, free men always took on the sexually active role (Trumbach, 2003).

While there were codes around moderations, emphasis was on the proper use of pleasure; or in Foucault's words, it was about a 'stylization of attitudes and aesthetics of existence' (Foucault, 1985:92). To perfect the self, all excesses and desires including sexual had to be mastered and brought under the control of the will and rational thought, not just for the good of the self but in the interest of the relationship with others. Working on the principle of isomorphism between sexual and social relations, one had to govern oneself as one would govern one's household or city. A man who was not in control was considered a 'slave' to his desires and feminine, in that he was passive, submissive and weak (Foucault, 1985). Thus, the discourse of moderation was not about eliminating desire, or propagating a belief that abstinence was best, but about the need to balance one's physical desires with the need of the soul, for the benefit not just of self but of the whole

community. Thus, sexual behaviour and prohibition was not about biology or things of the flesh but about status, and location within the hierarchical chain of societal command.

Although an ethics of pleasure existed, it was an ethics for men. Hawkes (1996) suggested that the constant reiteration of the naturalness of the active masculine sexuality enshrined male sexuality as the prototype for all sexuality, in ways that reflected the cultural superiority of men and the sensual invisibility of women.

Sexuality – A source of sin

With the spread of Christianity, social order was seen as God given, thus emphasis was placed on revealing the truth of sexuality according to the scriptures. The church and theologians became, for centuries to come, the sole provider of strictures and advice on sexual behaviour (O'Connell-Davidson and Layder, 1994). Within Christianity, the discourse shifted from sex as pleasurable, to sex as sinful; and from the ethics of self mastery, to subjugation to pastoral authority (Foucault, 1976). Celibacy and self-denial, were elevated as the purest form of human existence. As universal adherence to the principle of celibacy, however, was not consistent with the survival of the human race, a compromise lay in the replacement of a desire for pleasure with a requirement for procreation (Hawkes, 1996). The sexual act, thus, became positively valued for reasons external to the self, reshaping sexuality as an 'act-centred rather than pleasure centred concept' (Hawkes, 1996:15). Consequently, it followed that 'natural' sex was sex within marriage, for the purpose of procreation. Sexual acts that did not have the generation of children within marriage, as their end, violated the natural order of copulation. Thus, male/female anal or oral sex were considered a grievous injury to God, sinful and prohibited, as were other sexual acts that were not in keeping with the right manner or natural order. In elaborating on the right manner and natural order, St Thomas Aquinas (1227-1274), medieval theologian and philosopher, distinguished four categories of vice that were contrary to natural patterns of sexuality. In descending order of heinousness, they were: bestiality; sodomy, which he considered male/male or female/female copulation; the sin of self abuse (masturbation); and not observing the natural order of copulation, which was vaginal penetrative sex (Davidson, 2001). This shift in the conceptualisation of desire, from pleasure to sin, laid the

ground for a stringent policing of desire in the form of the examination of conscience and the confession[7] (Foucault, 1976). Sex became a point of weakness where evil had the potential to enter; thus it required monitoring, self restraint and control, not just by self but by pastoral authority. It was within the privacy of the dark confessional, and with hushed voices, the activities of the physical body and mind could be examined, punished and a sense of shame, guilt and embarrassment about sexual practices instilled in each individual (Inglis, 1998b). Although the theological discourse is positioned here as a premodernist discourse, even to the present day, through reference to scriptures and the natural order of the world, the Christian church constructs and presents sexuality as a moral dualism, using a polarity of language: such as moral/immoral, sinful/pure, natural/unnatural and good/bad (O'Connell-Davidson and Layder, 1994).

This theological discourse was the dominant discourse within Irish society. Inglis (1998b) argued that the Catholic Church created a religious 'habitus', which held a moral monopoly over Irish morality from the foundation of the state until the late twentieth century. The cultural hegemony of the Catholic Church was built in a stable partnership between church and state, with the Catholic Church being guaranteed, until 1972, a 'special position' in the Irish Constitution[8]. Consequently, as NicGhiolla Padraig (1995:598) stated they 'gestated in mutual interdependence', as the Catholic hierarchy, through public statements and covert lobbying, pressurised the government to use legislation to impose Catholic moral codes on the state (McAvoy, 1999). Through its control on the education, health and social welfare systems, the Church disciplined the nation to its rules in relation to sexuality and extended its authority into the bedrooms of the nation (Milotte, 1997). Irish life became synonymous with Catholicism (Kennedy, 2002), and purity became a fundamental characteristic of Irish national being (Valiulis, 2001). Being

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[7] Confession or the sacrament of penance dates back to the Lateran Council of 1215. Canon 21, 'Omnis utriusque sexus' commanded that all the faithful of either sex, after they have reached the age of discernment, should individually confess all their sins in a faithful manner to their own priest at least once a year.

[8] The fifth Amendment of the Constitution Act, 1972, amended article 44 of the Irish constitution by removing after a national referendum the controversial reference to the 'special position' of the Roman Catholic Church as well as recognition of certain other named religious denominations. It was signed into law on 5th January 1973.

a good Catholic became associated with a disciplined control of the body. As all forms of sensuality were a source of temptation, sin and evil, the practices of confession and penance, which were central to Irish Catholic life, played a key role in controlling the body (Inglis, 1998b). Although there were examples of more radical perspectives, such as the writings of James Joyce and John McGahern, they were few and far between or driven underground due to strict censorship in the early to mid 20th century.

Modernist discourses

Modernism[9] is associated with the Enlightenment Project of the seventeenth century, and the emergence of western science, which 'emphasised a belief in human progress…through rationality and the methods of science' (Rolfe, 2006a:8). Within this discourse there was a sustained effort to put all behaviour on a scientific footing. Claims about human sexuality had to be based upon rigorous observation as opposed to scripture, divine revelation, speculation or personal beliefs. Science had two quests: firstly, to break though the sexual pruderies and ill-informed prejudices that were falling out from Victorianism (Hawkes, 1996), and secondly, to 'isolate and individualise the specific characteristics of sexuality, to detail the normal paths and morbid variations, to emphasis its power and to speculate on its effects' (Weeks, 1985:66).

The modernisation of sex involved the naturalisation of sex, as sex was to be subjected to the same scientific methods of the natural sciences (Weeks et al., 2003). The concept of a scientific and scholarly effort devoted to the understanding of sex was first proposed by the Berlin dermatologist Iwan Bloch[10]. Bloch also coined the term *Sexualwissenschaft* in 1907, which was subsequently translated into sexology. Thus sexology, or the science of sex, became closely associated with the research paradigm of positivism. The modernist approach examined sexuality as a

[9] Modernism is also used for the period of modernity from the late nineteenth century until the middle of the twentieth century. This period was characterised by the development of a branch of science called logical positivism.

[10] The first Journal of Sexology appeared in 1908, the first Society for Sexology was organised in 1913, the first Institute for Sexology was founded in 1919 and the first International Sexology congress was held in 1921. All of this took place in Berlin. However, when Hitler came to power in 1933, as most of the pioneers were German and Austrian Jews, they fled into exile to the USA, Soviet Union, Sweden, Switzerland, Great Britain.

fixed natural phenomenon that existed independent of history and culture. Exploring how people came to create the erotic or sexual meanings was considered unnecessary, as sexuality was treated as a constant that was not influenced by history or culture. Based on what was considered a statistical norm, it was assumed that heterosexuality was 'normal' sexuality, with reproduction its aim. In other words, unhampered by culture or social expectation, the penis found the vagina of its own accord, as its biological destiny (Bhattacharyya, 2002). This view of sexuality as natural, inevitable, universal and biologically determined is frequently described as sexual essentialism (Voss, 2000). Modernism or the science of sex produced what could be described as three perspectives on sexuality conceptualised as: sexuality – an adaptive evolutionary response; sexuality – an innate psychic drive; and sexuality – a mechanical biological system.

Sexuality – An adaptive evolutionary response

Evolutionary theory stretches from the work of Darwin (1859) to the present day, where there is a revival of evolutionary biology and evolutionary psychology in the area of human sexuality. Evolutionary theory began with the prior assumption that sex was enacted for the express purpose of reproduction and that sexual differences between men and women owed their existence to sexual selection. According to Darwin, sexual selection depended,

> '...not on a struggle for existence in relation to other organic beings or to external conditions, but on a struggle between the individuals of one sex, generally the males, for the possession of the other'(Darwin, 1859:65).

Accordingly, characteristics that gave organisms an advantage in the competition for mates evolved over the expanse of evolutionary time, and become part of one's genetic endowment (Buss, 1998; Delamater and Hyde, 1998). In other words, mating characteristics existed because they solved, in ancestral environments, specific problems of survival or reproduction.

More contemporary evolutionary psychologists such as Symons (1979) and Buss (1998) also positioned human sexuality under the discursive sign of sexual reproduction and drew on sexual selection theory. They argued that mating preferences are a result of evolutionary forces, aimed at maximising the individual's

reproductive advantage, through successful mate selection. Distinguishing between two types of mating strategies, short term and long term, they suggested that men and women evolved differently in terms of mating strategies. According to these theorists, because men and women differ in 'minimum obligatory parental investment' (Buss, 1998:24), men devote a larger portion of their total mating effort to short term mating with a variety of partners. This premise is based on the argument that in the currency of reproductive success, this behaviour produced greater benefit to men, in increased number of offspring. In other words, men are pre-programmed for promiscuity. Their 'selfish gene' will maximise their chances of producing offspring by programming men to have sex at every opportunity and with as many women as possible (Stainton-Rogers and Stainton-Rogers, 2001). Women, in contrast, having a higher 'minimum obligatory parental investment', evolved strategies to maximise their chances of survival by selecting a mate that will produce the strongest offspring and who will stay around to feed and nurture them (Buss, 1998:24). Women, in this analysis, are programmed for selectivity and settling down; thus, predicted to place a greater premium on a potential mate's external resources and shun men who emit cues that they are pursuing a short term mating strategy as opposed to a long term mating strategy.

Proponents of sexual selection theory have used it to explain and defend a number of other differences between men and women; including sexual jealousy and differences in preference based on physical characteristics. Buss (1998:28) argued that the higher intensity of jealousy and upset experienced by men, if a long term mate is sexually unfaithful, is related to the evolutionary problem of 'paternity uncertainty' faced by men. Men whose partners were unfaithful risked, from a reproductive perspective, all of their mating effort, thus jealousy was an evolutionary response. Women, on the other hand, experienced more upset from an emotional infidelity, as this is seen as a possible threat to her mate's investment, in terms of time, resources and parental investment. Similarly, men's attraction to youthful and attractive women, was explained by reference to the 'good genes' hypothesis as both are considered cues to fertility and reproductive value. Likewise, women's attraction to the older, mature man was said to be simply another establishing cue to financial and other resources (Buss, 1998; Delamater and Hyde, 1998).

The view of women as 'naturally' more programmed to be the nurturing mothers and men the hunter-gatherers was, according to Hyde et al. (2004), simply another way of maintaining the social order in life, perpetuating gender inequality. Other critiques emphasised the danger of using evolution to support the idea that the behaviour of men and women is predetermined and by implication 'natural', unavoidable, or uncontrollable, thus ignoring the ethics of how people should behave. Arguing from this perspective, Stainton-Rodgers and Stainton-Rodgers (2001) highlighted the dangers of, accepting uncritically, the view that men are 'naturally' promiscuous, unfaithful, and sexually predatory on women.

Sexuality – An innate psychic drive

The most influential of all writers in the modernist era of sexology was Sigmund Freud (1859-1939). Through what Foucault (1976:64) called the 'the confessional science'[11], Freud developed a theory of psychosexual development and then a theory of human sexuality. Freud's theory of sexuality was grounded on the assumption that all behaviour was instinctive and driven, and that sexual organisation had a central role to play in the formation of subjectivity (Bhattacharyya, 2002). Challenging the prevailing notion of the time, that children were asexual beings and that sexual life only began at puberty, he argued that not only did Infantile Sexuality exist, but it shaped future personality development.

In his three essays on the Theory of Sexuality, Freud (1905) proposed that a sexual drive or 'libido' (a biologically sexual energy), generated within the body of an infant, demonstrated what would bring pleasure to the body long before the infant learnt, from socialised interaction with others, what would bring pleasure (Bhattacharyya, 2002). The site of these sensual pleasures shifted sequentially as the child moved through a series of preordained stages of psychosexual development (oral, anal, phallic, latent and genital). With the exception of the latency stage, each stage was attached to a different erotogenic zone, corresponding to the maturational stages of the body. As the child matured, each stage presented

[11] Foucault's reference to the 'confessional science' relates to Freud's development of psychoanalysis as a therapeutic intervention and the requirement of the client to 'confess' to the therapist.

different psychological conflicts that needed to be resolved. Failure to resolve these conflicts led, in Freud's view, to a psychopathology, which took the form of a 'fixation' on, or 'regression' to the pleasures associated with that particular stage (Appignanesi and Forrester, 1992). Successful resolution, on the other hand, ultimately culminated in the individual moving from 'infantile' sexual pleasure, associated with the mouth, anus and own sexual organs, to 'mature' sexual pleasures, derived from intercourse between man and woman (O'Connell-Davidson and Layder, 1994).

Freud asserted that for the child to develop a sexual identity and a clearly defined sense of self, which was separate from the mother, they (boys and girls) had to reject the mother and align themselves with the father. Mothers and fathers, in this context, were symbolic representations for femininity and masculinity. Father stood for separation, maturity, as he represented a distinct self, the one that was not symbolically enmeshed with the mother. Mother represented the infantile, undifferentiated, lack of self state; thus 'a distinct self was symbolised by the one who bore the penis' (Beasley, 2005:53).

The movement towards selfhood was based on a differentiation of a biological sex characteristic, which is the phallus. Freud maintained that the sexuality of children of both sexes is of a masculine nature as girls had little awareness, even unconsciously, that they had a vagina until puberty. Boys noted that they are like their fathers, bearing a penis, and observed their symbiotic attachment to the castrated figure of mother. Although they wished to have their mother all to themselves, and viewed father as the rival (Oepidus complex), they came to see their continued desire for mother as endangering their selfhood. Consequently, out of 'castration anxiety', they sharply rejected mother/woman and identified with father, internalising the powerful male values. Girls, on the other hand recognised that they lacked a penis, or the inferiority of the clitoris, experienced 'penis envy' and turned to father (Appignanesi and Forrester, 1992). Thus instead of having a penis, girls tried to achieve one through heterosexual desire and heterosexual intercourse, which ultimately led to a kind of displacement into a desire for a baby, a substitute penis.

According to Freud, a girl's negotiation of sexual development was more difficult, since she must both change her desire from mother to father and shift the site of sexual pleasure from the 'inferior' clitoris associated with mother/female body, to vaginal pleasure associated with father/male body. In elaborating further on female development, Freud argued that because girls experienced less anxiety over castration, as they had no penis to loose, they experienced less of a demand to move away from mother and establish a strong sense of self. As a result, they had a weakened sense of self (weakened superego); thus rendering women morally inferior to men (Stainton-Rogers and Stainton-Rogers, 2001).

Freud introduced a complete new understanding of sexuality. By producing an account of why sexuality must be understood separately from reproduction, the concept of sexuality moved from being a biological urge that evolved in the service of evolution to an innate drive that was the basis for all future psychic development. According to Freud, all psychological problems in adulthood could be traced back to unconscious internal unresolved conflicts between the natural sex drive (libido) and external social events. From then on there was scarcely a malady or physical ailment to which 19th century medicine did not impute some degree of unconscious sexual etiology (O'Connell-Davidson and Layder, 1994). This view of sexuality, as always conflicting and pathological, shifted the discourse to one of pathology (Foucault, 1976). Instead of sexuality being the source of sin, within the discourse focusing on moral and immoral sexuality, the discourse was recast in the dualisms of infantile and mature, normal and pathological. By creating a theoretical norm for sexual development that extended from childhood to adulthood, albeit heterosexual development, all the possible deviations from that norm could be, subsequently, carefully described and codified.

Sexuality – A mechanical biological system

Biological theories worked from the premise that sexuality was an essential component of the person's biological make up and searched for their 'truth' in structure and function of the body. Drawing heavily on the medical model, the sexual was understood as a mechanical biological system like the renal system, and translated into taxonomies, histograms and percentages (Simon, 2003). Although

rarely articulated, built into biological theories were naturalistic assumptions about the overwhelming force of the male sex drive, the reactive character of female sexuality and the biologically given divide between heterosexuality and homosexuality (Weeks et al., 2003).

The ability to establish a physical geography of sexual organs, further removed the sexual from the social and cultural, and resulted in the sexual becoming a collection of cells, organs, hormones; an anatomy and physiology that could be dissected and measured. Using a functionalist perspective, early biological theorists interpreted anatomical differences as evidence of normative heterosexuality. The roomy female pelvis highlighted women's capacity for motherhood, and, as a logical correlate, a domestic role (Hird, 2004). Researchers also argued that biological evidence supported the belief that men were naturally more sexually assertive, wanting more sex and achieving orgasm more quickly (Kinsey et al., 1948; 1953). The most influential work by Masters and Johnson (1966) was premised on the belief that the human sexual response was largely a pre-programmed physiological response. From the study of over 650 men and women they developed a linear model of the sexual response, divided into four phases: the excitement phase, the plateau phase, orgasm and the resolution phase (EPOR model), which was later modified to include a desire phase (Gelder et al., 2000). Masters and Johnson's work changed the discourse from reproduction as the goal of a sexual encounter to orgasm. The introduction of oral contraception, around the same time,[12] also helped to further the separation and distinction between sexual activity for pleasure and sexual activity for procreation (Giami, 2002).

Biological theories have been critiqued for taking a mechanistic, determinist approach to the study of sexuality; thus, ignoring the impact of culture, learning and economics on sexual behaviour, and divorcing the sexual from personal meaning. A number of writers have also criticised the coital imperative, which was central to biological theories, on the grounds that it led to a genitally focused, masculine version of sexuality that eroticised male dominance and female submission (Potts, 2000; Beasley, 2005). Consequently, non-penetrative sexual activity tended to be

[12] In Ireland the 1979 Health Act allowed for the sale of contraception, but only with a medical prescription and for medical reasons. It was not until 1985 that condoms and spermicides became available to persons over 18 years, without a prescription.

constructed as secondary or supplementary to "real sex" (Beasley, 2005). Others have suggested that the emphasis on defining a norm for the human sexual response ultimately led to the medicalisation of sexual function, in the form of new identities such as the 'impotent male' and the 'anorgasmic women' and new interventions, such as behavioural, cognitive and pharmacological therapy for sexual dysfunction (Foucault, 1976; Levine, 1995; Hawkes, 1996). In Hawkes' (1996) opinion once researchers placed the orgasm as the pinnacle of sexual endeavour and the legitimate motive for sexual activity, fear of sexual dysfunction became the new anxiety. This fear simply replaced the fear of mental and physical danger as a result of unconscious unresolved sexual conflict – a fear, which was created previously by Freud (Hawkes, 1996). In addition, gay and lesbian activists, drew attention to the way the taken for granted norm of heterosexuality, that underpinned biological theories, resulted in homosexuality being constructed as other, and deviant, with the resultant quest to find both a cause and cure for the 'problem' of homosexuality (Wilton, 2000).

Postmodernist discourses

Postmodernism, although exceedingly difficult to define[13], is succinctly described by Lyotard (1984:xxiv) who stated that 'simplifying to the extreme, I define *postmodern* as incredulity towards metanarratives'. In post-modernity, overarching or grand theories claiming to explain reality are suspect and open to question. Postmodernists rejected many of the principles of the scientific revolution, and argued that trying to squeeze humanity, in all its diversity, into the confines of an over arching model or metanarrative inevitably led to the subjugation of those narratives that did not conform to the dominant discourse (Lyotard, 1984). They argued that society is characterised by difference as opposed to commonality; therefore, rather than trying to find a common theory or narrative to guide all actions, there was a need to be open to all possible explanations, as no one explanation held greater validity or truth. Thus, postmodern theorists adopted a critical approach to all knowledge, highlighting the inter-relationship between truth, knowledge and power.

[13] It is beyond the scope of this thesis to explore in any depth the ongoing debate within the literature on whether postmodernism is a successor to modernism or merely a critique of it.

In the context of sexuality, theorists within the postmodern epoch challenged previous discursive constructions of sexuality and questioned taken for granted assumptions that were used as a basis for knowledge construction. In so doing, they focused not on developing a new theory of sexuality, or on exploring sexuality from the perspective of the person, but on revealing the problematic nature of previously constructed theories. From a post modernist perspective, trying to understand sexuality by looking at chromosomes or brain structure is analogous to trying to understand Verdi's operas by carrying out a biopsy of Placido Domingo's vocal chords (Wilton, 2000:66). Thus, writers in this epoch, such as Foucault (1976; 1985; 1986), Weeks (1985), Dworkin (1981; 1988), Butler (1990), Beasley (2005) and Chodorow (1997) moved the discourse from genes, hormones, innate drives or sexual acts to a discourse that focused on the impact of history, culture, politics, language and economics on the meaning of sexuality and the sexual being. My discussion of the post modernist contribution is presented under the headings: sexuality – a site of 'governmentality', sexuality – a site of male power and sexuality – a highly unstable site of identity.

Sexuality – A site of 'governmentality'

The writings of French philosopher Michel Foucault (1926-84), a post structuralist, were very influential to post modern thinking on sexuality. Using a genealogical[14] approach to the history of sexuality, Foucault (Foucault, 1986; 1976; 1985) focused attention on how various discourses over time had constructed sexuality, creating new identities and subjectivities. Sexuality for Foucault was a site of 'governmentality'. 'Governmentalilty' was a term coined by Foucault to describe changes in technologies and attitudes towards governing, which occurred in Europe in the eighteenth century, and involved a greater emphasis on the state's involvement in the regulation of the lives of people. According to Foucault 'governmentality' has touched us all. We are not the free, autonomous individuals that liberal education would make us believe, because the self, personal identity, is constituted by others, by official discourses, and by what Foucault calls 'power/knowledge' (Foucault, 1986).

[14] Genealogical analysis presents a careful reconstruction of the way power and knowledge work through definite institutions, texts and practices. It avoids the tendency to explain changes in terms of underlying set of causes or foundational principles. It also avoids the tendency to construct a narrative in terms of a 'march of progress' (Smith, 1998).

Sexuality, according to Foucault,

> '...must not be thought of as a kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries to gradually uncover..., but a historical construct created through discourse' (Foucault, 1976:106).

According to Foucault, sexuality was constructed, with its desires, drive, libido and unconscious, through 'science'. By making sex an object of study, the body became the object of a new gaze, and through science a new group of specialist 'keepers of knowledge' – the scientists of sexuality emerged (Hawkes, 1996:50). In the word of Foucault,

> '...there emerged a political, economic and technical incitement to talk about sex. And not so much in the form of a general theory of sexuality as in the form of analysis, stocktaking, classification and specification, of quantitative or causal studies' (Foucault, 1976:23-24).

As a consequence, a multiplicity of discourses emerged, creating a whole thicket of different sexualities and imposing various imperatives upon sexuality.

Through the medicalisation of the confession[15], in the form of psychoanalysis, the sexuality of children, women, the insane and those who did not like the opposite sex came under scrutiny. From childhood to old age, norms of sexual development and sexual pleasure were defined, thus placing the sexual domain under the rules of the 'normal'. Heterosexual monogamous sexuality became the norm against which all other sexual acts were measured. By defining a norm, for development and behaviour, sexuality became defined as a domain susceptible to pathology, requiring therapeutic or normalising interventions. Associated with the proliferation of discourses there emerged what Foucault termed 'four great strategic unities, which formed specific mechanism of knowledge and power centering on sex': namely a hysterization of women's bodies; a pedagogization of children's sex; a socialisation of procreative behaviour and a psychiatrization of perverse pleasure. As a consequence, new personages, sexual identities and 'subjects' made their appearance in the form of the hysterical woman, the frigid woman, the masturbating child, the Malthusian couple and the perverse adult (Foucault, 1976:103).

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[15] Foucault viewed Freud's psychoanalysis as an adaptation and medicalisation of the ritual of the confession that was part of the Christian church.

The development of a science of sex, for Foucault, marked the beginning of an era of biopower, as the deployment of the various discourses (medicine, psychiatry, education, law, and economics) permitted the techniques of power to access the life of the body in the form of medical, educational and economic interventions. Thus, sexuality became a site for the regulation and control of the body. From that point on, sex became public property, and sex moved from the control of self by self, to control by institutional authority and from a secular concern to a state concern (Danaher et al., 2000). As a public property it was managed, administered, regulated and policed through a new regime of public discourses. By creating an entire physical and mental pathology, medicine made a forceful entry into the pleasures of couples; sexual irregularities were annexes to mental illness, deviant individuals became a target for surveillance and intervention, pedagogical controls were organised and legal sanctions against perversions multiplied. Through the study of reproductive rates and sexual health problems, sexual behaviour moved from an individual concern to a public health concern. In this way, sexuality became less about bodies and desires and more about technologies of government (Danaher et al., 2000). Although Foucault acknowledged that during the Victoria era a 'restrictive economy' existed, with increased censorship of vocabulary, and new rules of propriety; he contended that what occurred was not one of denial, repression and silence, as suggested by some writers (Van Ooijen and Chranock, 1994), but an explosion of discourses and the production of sexuality, which became an instrument in the surveillance, regulation, and control of the body and life spaces (Foucault, 1976:123).

Sexuality – A site of male power

Feminists, such as Chodorow (1997), Beasley (2005), and Dworkin (1981; 1988), building on the work of Foucault, took issue with the andocentric bias of western knowledge and the hegemony of male authorship. They drew attention to the way knowledge in the area of sexuality was heavily laden with male-centered heterosexual assumptions, and argued that the construction of sexuality, from the perspective of the male gaze, was oppressive to women's sexuality (Crabtree, 2004; Beasley, 2005).

In exposing the male gaze, feminism, firstly, highlighted how taken for granted assumptions and prejudices of a male dominated or 'patriarchal' society were often translated into 'scientific facts'. In critiquing evolutionary, biological and psychoanalytic theories, they suggested that these were not theories of sexuality or sexual difference but theories that simply rationalised and legitimised existing male and female roles, reproducing the gendered structure of the time (O'Connell-Davidson and Layder, 1994). In making this argument they drew attention to the way theorists used unquestioningly, in research, pre-existing theoretical perspectives, without recognising that these theories and concepts were complex social constructions that were historically and culturally situated. For example, by equating biological difference with gender difference, these theories simply attributed gender difference to biology. In so doing they took the social relationships between men and women as 'natural' and biological givens, and ignored the power differential between men and women that created difference in social roles. By repositioning sexuality within the realms of the social, feminism challenged the biological, essentialist, and fixed view of gender and argued that gender was designed, implemented and perpetuated by social organisations and structures that were androcentric.

Secondly, feminism highlighted the way many of the theories commenced with the assumption that male heterosexuality was the norm, thus female sexuality was constructed as either an imitation of the male norm or that which was 'not male' (Chodorow, 1997:17). This denied women a separate sexual identity and positioned female sexuality on the margins (Beasley, 2005). Freud's theory, in particular, was criticised for being phallocentric with an anti female bias, as his entire theory was constructed around the penis and male sexuality (Chodorow, 1997:17). Presenting female sexuality in terms of 'not male' or renaming female organs using male terminology continues to be prevalent in nursing and medical texts, such as Gelder et al. (2000:881) reference, in the *New Oxford Textbook of Psychiatry*, to the 'G spot' as the 'female prostate' and 'female secretions' as 'female ejaculate'.

Feminist writers also challenged the construction of women's sexuality as passive and essentially responsive to male sexuality, viewing this as a repression of women's right to enjoy their own sexuality and a way to ensure that women

continued to service men's sexual demands. Beasley (2005), for example, suggested that Freud's theory helped to reinforce this passivity by desexualising and subordinating the clitoral orgasm in favour of vaginal orgasm and heterosexual reproduction. To be considered a normal, non neurotic, feminine, mature woman, a woman had to abandon her active clitoral sexuality to accept the phallus and vaginal orgasm (Beasley, 2005). Women who continued to be interested in clitoral stimulation were considered immature sexually, neurotic and masculine having failed to repress fully or transform their infantile 'penis envy' (Appignanesi and Forrester, 1992). By viewing the clitoris as naturally inferior, while the penis was viewed as naturally pre-eminent, Freud was also accused of supporting the idea that male power is naturally preordained and charged with prescribing male dominance as the basis for all human culture (Beasley, 2005).

This challenge to previous understandings of sexuality is further developed by feminist writing on sexual violence (e.g. Dworkin). Dworkin (1988) viewed heterosexuality as something that was socially organised around eroticised dominance and submission. In other words, it was something defined by men and forced upon women, where marriage was simply an arrangement were men got sexual rights to women[16]. They viewed the threat of rape as another means of perpetuating patriarchy and maintaining social control of women. They also challenged the way female rape was portrayed in a manner that suggested the notion of female guilt. The more radical feminists, (e.g Dworkin) took this a step further and questioned if there ever could be mutuality and a true consensual relationship within a heterosexual relationship, given the power structures within society. Dworkin (1981) argued that heterosexual intercourse was an abuse of women because it required the male penetration of the female's vagina, which was a violent act.

For these feminists therefore, sexuality was a site of male power, not just in the wider context of patriarchal society but in all heterosexual interactions, as there was no real space for women to create a sexual identity that was not in some way influenced by men. For some feminists the option was lesbian sex. For others the

[16] In was not until 1990, with the introduction of the Criminal Law (Rape) (Amendment) act, 1990, that marital rape was criminalised in Ireland.

answer was not about lesbian sex or simply extending the discourse to include women, as suggested by early feminism, but a need to rethink and challenge the discursive construction of women's sexuality with counter-discourses (Redman et al., 2003). In particular, the need to create a discourse of heterosexuality that did not center on penile penetration.

Sexuality – A highly unstable site of identity

Arising from the consolidation of lesbian and gay studies in universities, queer theory entered theoretical discussion in the early 1990s (Beasley, 2005). The term queer is an identity marker that described a critical relationship to 'heteronormativity', and encompassed a broad range of sexual identities, such as gay, lesbian, bisexual and transsexual, that did not conform to 'heteronormativity' (Sherry, 2004:771). Not aligned to any specific identity category, the term queer had the potential to be annexed profitably to any number of discussions. Hennessy (1993:976) suggested that 'touting queerness was a gesture of rebellion against the pressure to be invisible or apologetically abnormal'. Queer theory was largely a deconstructive enterprise, which focused on taking apart the idea that self has a unifying core, whether sexual desire, gender, race or class (Gamson, 2003).

The Gay/Lesbian Liberation Movement of the 1970s fought to create a place for sexual minorities and reverse the pathologised and stigmatised status of gay and lesbians. In many cases they did this through the creation of a group gay identity and utilising the group voice for social change. Queer theorists, however, wanted more than tolerance, equality and a space to express themselves. Drawing on the work of Foucault and Derrida, their focus was not so much on studying populations but on deconstructing sexual categories that have been used to construct sexuality and sexual identity, through a focus on textual analysis (film, art, literature) (Gamson, 2003). Sexual categories were seen to be laden with their own politics and oppression (Gamson and Moon, 2004). By refusing to take any form of sexual categorisation for granted they offered a critique of homogonous fixed gender identity or sexuality categories, with the aim of destabilising cultural ideas of normality. Queer theory called into question all essentialised and fixed categories (man, woman), oppositions (male versus female; heterosexual versus homosexual),

and equations (gender = sex) upon which conventional notions of sexuality and identity had been constructed (Hennessy, 1993). By challenging the dominant notions of what was natural, and attacking traditional concepts and assumptions that have been used to construct sexuality and sexual identity, queer theory aimed to foster the freedom people needed to create their own sexualities.

A key contribution of queer theory was the manner it took issue with the woman/man binary approaches to identity. Queer theorists argued that feminists, in their quest to expose patriarchy, reinforced a binary division of human relationships. Although feminists rejected the idea that biology was destiny, they developed an account of patriarchal culture which assumed that masculine and feminine genders would inevitably be built, by culture, upon the idea that 'male' and 'female' bodies existed (Beasley, 2005). By accepting the category of women/men, female/male as relatively untroubled, they reinforced a binary view of gender relations in which human beings are divided into two clear-cut groups, women and men. According to queer theory, the unquestioning acceptance of the naturalness of the binary categories 'men' and 'women' affirmed institutionalised heterosexuality and closed down the possibility of a person forming and choosing their individual identity (Nagel, 2000).

Butler (1990), in her book *Gender Trouble*, questioned whether the category 'woman' had a common meaning. In her view, the category 'woman' did not designate a stable and coherent identity, as there was no essential 'core', that was natural to women or indeed men (Butler, 1990). She argued that gender is created in performance, and it is the dense and largely unconscious repetitive performance of every day norms that gives the appearance of some solid and stable centre to the category of woman or man. Thus she believed that the very idea of gender needed to be viewed independently of biological sex, stating,

> 'When the constructed status of gender is theorized as radically independent of sex, gender itself becomes a free-floating artifice, with the consequence that *man* and *masculine* might just as easily signify a female body as a male one, and *woman* and *feminine* a male body as easily as a female one' (Butler, 1990:10).

Ironically and interestingly, queer theorists also took issue with the gay and lesbian movement and the sexual identity politics it engendered (Nagel, 2000). They argued

that embedded in the assumption of the gay and lesbian movement was another binary. Just as the feminist movement, by focusing on women, had reified the female/male binary, the gay and lesbian rights movement had reified the homosexual/heterosexual binary. In addition, it assumed that the categories gay and lesbian were inherently stable identities and that there was a unitary, identifiable and coherent way to be gay (Gamson and Moon, 2004). In their view, taking any category, such as man, women, masculine or feminine, heterosexual, homosexual as fixed and representative of a homogonous group only served as a source of oppression, to exclude silently those who do not fit, and police those within it to ensure that they did (Beasley, 2005); thus, reproducing relationships of power (Gamson and Moon, 2004). In this way, queer theorists moved the discourse away from a fixed model of sexuality, grounded on the notions of fixed categories, to a model of sexuality that saw identity as thoroughly socially constructed and sexuality as variable, flexible, fluid and an unstable site of identity (Beasley, 2005). Although queer theory drew attention to the values and assumptions that underpin binary divisions and revealed the 'problematic' nature of holding any edifice as a fixed, knowable truth, it was not without its critics. Jackson (2003:70) suggested that 'queer theory is limited to the extent that it takes place at the level of discourse, paying little attention to social, structural and material social practices' that shape identity. Feminist response to queer theory has ranged from viewing it as a useful analytical tool from which to explore the connection of female oppression and the maintenance of heterosexual hegemony, to a view that it is simply another means of erasing women and lesbian women and their particular relationship to power by homogenising a range of differences (Jackson, 2003; Beasley, 2005).

This discourse, if taken to the extreme, could be described as philosophical pluralism or relativism, making a discussion about sexuality nearly impossible as meanings attached to words such as 'man' and 'woman' become contentious. It also makes the activity of research impossible as how does one even select a population without reference to some socially constructed category? Finally, there is the question of whether rejecting fixed categories and fixed identities is workable, as some core sense of self is fundamental to psychic health. As Beasley (2005:113) pointed out 'the distinction between an enabling fluidity and a paralyzing disaggregation associated with mental illness remains unremarked' in queer theory.

Summary and conclusion

In summary, this chapter explored the various discourses that have shaped our understandings of sexuality in Western Europe through pre-modernism, modernism and postmodernism. The epistemology that informed pre-modernist understanding of sexuality was related to the revelation of knowledge from some authoritative source. In contrast, modernism was associated with scientific rationality and the creation of a science of sexuality. Postmodernism, although difficult to define in terms of epistemology is associated with an approach to knowledge construction that challenged previous discursive formations of sexuality and adopted a deconstructionist approach to taken for granted sexual categories and norms. Within what could be classified as the pre-modern epoch, sexuality was constructed as both a site of pleasure that was to be governed by self, and a site of sin, or a moral issue, that required pastoral intervention. In a desire to move away from thinking that was considered to be irrational or metaphysical, the modernist agenda focused on producing what was considered an objective, unbiased view of the sexual. Working from the premise that heterosexuality was the normative and natural sexuality, modernist approaches took an essentialist, acultural and ahistorical approach to the study of sexuality. With this epoch, evolutionary theories searched for their answers in our ancestral populations; psychoanalytic theory focused on the interpsychic landscape and biological theories sought truth in the structure and physiology of the body.

The postmodernists strove to position sexuality within a wider discourse of culture, politics, language, power and history. Writers within this epoch challenged the idea of science as an apolitical and value neutral endeavour, highlighting how sexuality, as a social construct, changed over time and how frequently 'science' merely adopted assumptions that coincided with cultural conception of 'normal' and 'natural' sexuality. For Foucault, the creation of a science of sex and the relentless articulation of sexuality that followed represented a disciplinary procedure to create docile and disciplined subjects. Drawing on Foucault's notions of discourse, feminists drew attention to the way the andocentric approach to knowledge construction marginalised women's unique sexuality. As a consequence, female sexuality was a site of male power and constructed as other or an imitation of the

male norm. Queer theorists focused on destabilising the very idea of a unitary identity, whether man/woman or heterosexual/homosexual, and argued that sexual identities, desires and categories were fluid and dynamic. Thus, within this discourse, sexuality was viewed as a highly unstable site of identity with no fixed social or linguistic parameters.

In conclusion, the exploration of the history of the changing ideas around sexuality presented in this chapter suggests that sexuality is not an objective fact or a 'constant' (Foucault, 1985:4), neither is it a biological quality or natural inner drive (Delamater and Hyde, 1998) that remains the same in all historical periods and means the same in all cultures, but a name given to a socially malleable construct that has undergone significant changes over time. As a concept, there is no one definition of sexuality, but a series of discourses that have shaped our understanding of sexuality. What is important is not the number of discourses, but the way each discourse conceptualised sexuality, and in so doing created different permissions and prohibitions. The meaning of sex and sexuality mapped out in this chapter is, in the final analysis, a Judaeo-Christian story of sexuality within a western culture. Therefore, it is not the only story of sexuality that could have been told.

The next chapter will explore the literature on sexuality in the context of psychiatric nursing and people experiencing mental health problems.

CHAPTER THREE: SEXUALITY AND MENTAL ILLNESS

Introduction

The previous chapter focused on the various discourses that have influenced our understanding of sexuality. In this chapter I draw on a range of literature and empirical research from health care disciplines, to build a picture of the interrelationship between sexuality, mental health problems and psychiatric nursing and provide the reader with an overview of the current state of knowledge in this area of practice. The chapter is divided into three sections. Firstly, I discuss a brief historical perspective on sexuality and people with mental health problems. I then present research that explored nurses' and clients' perspectives on sexuality as a dimension of the nurses' role. In the final section of the chapter a précis of the research in the area of sexuality as it related to people who have experienced mental distress is presented.

Historical perspective on sexuality and mental illness

The history of sexuality and people with mental health problems has largely been a history of misunderstanding, misconception, stigma and myth (Deegan, 1999). Historically, the expression of sexuality by people with mental health problems has been constructed as either a site of mental pathology or a source of danger and risk to the human race. This section briefly explores these two perspectives.

Sexuality – A site of mental pathology

As an outcome of the modernist 'scientific' agenda, and in an attempt to enhance its professionalisation, psychiatry drew on a biomedical model of illness to explain mental distress (Shorter, 1997). Emphasis, therefore, was placed on constructing mental distress as 'illness' and locating its cause within the physical body. Consequently, Vandereycken (1993) suggested that it was not surprising that biological expressions of sexuality were frequently conceptualised as the cause of mental illness or a symptom of psychopathology.

Throughout the 19th century, gender differences in mental illness were strongly linked to reproductive biology, with women's reproductive biology being subjected to a more pathologising discourse than men's (Busfield, 1996). Generally, insanity in women was thought to be related to a defect or irritation in their reproductive system, especially their uterus. In what is often termed the 'ovarian model' of female behaviour, physicians saw women as driven by the tidal current of their reproductive system, which was bounded by puberty and the menopause. Gynaecologists such as Henry, when asserting the relationship between mental illness and female reproductive organs, insisted that eventually,

> '...nerve centres in the uterus, and possibly the tubes, would be found, which [would] have an important influence on mental equilibrium' (Henry, 1907:1001).

On this premise, he argued that mental disorder in women could be prevented and cured through radical hysterectomies. Cautioning against conservative surgery, and stressing the fact that 'many insane women who have pelvic trouble do not complain of it'; he urged the eradication of 'all [pelvic] irritation by what ever means necessary, no matter how radical the [surgery] work required' (Henry, 1907:1001). Others argued that it was plain to 'the casual observer that women become insane during pregnancy, after parturition, and during lactation' and testified to the fact that sudden cessation of menstruation was undoubtedly the cause of some manic episodes (Barrus, 1895:479). Subsequently, the concepts of puerperal mania and puerperal insanity gave formal expression to the link between birth and mental disorder. The concept of involutional melancholia, which was first introduced by Kraeplin in 1896, served as an important mechanism to link the menopause with mental disorder. Involutional melancholia was said to occur in both men and women; however, because of its link to the female menopause the diagnosis was more frequently assigned to women (Busfield, 1996). Busfield (1996) asserted that the psychiatric disorder hysteria, with its etymological roots in the Greek term 'hysteron', meaning the womb, was considered to be primarily a female condition, with the terms 'feminine' and 'hysterical' almost becoming synonymous.

Drawing on theories of conservation of energy, physicians also asserted that educating women would threaten their reproductive function, with the consequent results of atrophy of the breasts, interruption to the menstrual cycle, sterility, mental

breakdown or the bearing of sickly, neurotic children (Showalter, 1985; Busfield, 1996). Such views helped to confine women to their domestic roles and helped sow the seed that any desire, with its potential to interfere with mothering and the domestic role, was unfeminine, 'abnormal' and had the potential to damage the mental health of the next generation. It also helped to construct and reinforce images of women as hapless victims of biology, passive agents in life and more biologically predisposed to higher rates of mental illness (Busfield, 1996).

While men's reproductive system was given far less attention in the psychiatric literature, it did not completely escape attention. In explaining why the male reproductive system did not exercise a parallel control over men's mental health, medical wisdom believed that although men experienced developmental changes, they were less difficult to negotiate because of the absence of a uterus (Showalter, 1985). This view was supported and reinforced by Freud's theory of sexual development, which, as discussed, emphasised the difficulties experienced by women in negotiating sexual development. The conservation of energy theory, used against women, also offered a justification for limiting masturbation and provided a scientific rationale for the religious teachings of the time. Throughout the 18th and indeed part of the 19th century, masturbation was understood to be a cause of insanity in men and a special form of masturbatory insanity was identified (Busfield, 1996). Benjamin Rush, considered the father of American psychiatry, claimed that male masturbation produced seminal weakness, impotence, tabes dorsalis, pulmonary consumption, hypochondriasis, loss of memory, dementia and death (Showalter, 1985).

Although women were swelling the ranks of the institutions, only a few physicians commented on female masturbation. When commented upon, female masturbation was considered to be the antithesis of Freud's view on mature female sexuality and a contradiction to the prevailing notion of women as passionless and passive sexual beings. Consequently, female masturbation was considered a symptom of illness as opposed to causing mental illness (Barrus, 1895). Beard (1905) considered that masturbation had far more negative consequence for the more refined, upper-class woman and wrote that:

> 'Masturbation could rapidly deplete the nervous force of the refined, but strong, phlegmatic Irish servant-girls may begin early the habit of abusing themselves and keep it up for years, with but little apparent harm' (Beard, 1905 cited in Showalter, 1985:135).

As hardly any other condition among the mentally ill was considered as deplorable, the quest for treatments for masturbation consists of a history of abuse, served up in the guise of medical science. The mentally ill were subjected to a range of treatments including: concocted food products; physical restraint in straight jackets; bandaging of the genitals; the application of leeches to the genitals; cold baths and sedation (Kutchins and Kirk, 1997). In more extreme situations women were subjected to clitoridectomies[17] (Showalter, 1985; Whitaker, 2002).

Since the formal classification of mental illness, in the form of the Diagnostic Statistical Manual (DSM) in 1952 and the International Classification of Diseases and Related Health Problems (ICD) in 1900, over the years numerous other mental illnesses have been constructed as a consequence of their link to sexual behaviour. Based on a belief that sexual attraction to the opposite sex was the norm and an indisputable fact of nature, a view that was reinforced by theological, evolutionary and biological theories of the time, the American Medical Association, in conjunction with the American Psychiatric Association, included homosexuality as a psychopathic personality disorder in the first DSM that was published in 1952 (American Psychiatric Association, 1952).

To conceive homosexuality as a manifestation of 'ill health' rather than a sin was held to be a more liberal approach, as people were not seen as personally and morally responsible for their sickness (O'Connell-Davidson and Layder, 1994). However, considering the treatment given to people, the practical consequences of being judged sick instead of sinful were not always that different. Mental health care professionals, in an attempt to modify the person's behaviour, acted as agents of social control through the use of aversion therapy, psychotherapy, libido-reducing drugs and electroconvulsive therapy (Kutchins and Kirk, 1997). It is interesting to note that discussion of lesbianism was less prominent in the literature,

[17] Clitoridectomy was a surgery invented by an English doctor in 1858. Although some doctors may have found clitoridectomies objectionable, this surgery did not disappear from American hospitals until at least 1950.

which may reflect the invisibility of female sexuality and the ease with which close relationships between women could be explained (Trumbach, 2003). Despite the removal of homosexuality from DSM III in 1987 (American Psychiatric Association, 1987)[18], as recently as 1994 a doctor writing in the British medical press, urged the Department of Health in the UK to 'devote more attention to the risk factors that lead to homosexuality' and described homosexuality as 'biologically destructive' (Rayner, 1994:854).

The introduction of the concept of pre-menstrual tension in the 1930s and the subsequent publication of *The Pre-menstrual Syndrome* (Dalton, 1964) popularised the idea that pre-menstrual syndrome was more of a mental than a physical disorder. Despite numerous debates between gyneacologists and psychiatrists, over whether pre-menstrual syndrome should be viewed as a physical or mental disorder, it was included, under the title 'Late Luteal Phase Dysphoric Disorder'[19] in DSM-III-R, (American Psychiatric Association, 1987); this was subsequently relabeled as Premenstrual Dysphoric Disorder in 1994 (American Psychiatric Association, 1994). Since then, feminists have strongly criticised its inclusion, questioned the validity of it as a concept and argued that it has the potential for misuse against women (Kutchins and Kirk, 1997).

In addition, building on taxonomies of sexual perversities, identified by early sexual researchers such as Krafft-Ebing (1914) in Austria, Havelock Ellis (1897) in Britain, and Geddes and Thomson (1889) in Scotland, both DSM and ICD included a list of paraphilias and gender identity disorders. The work of Masters and Johnson (1966) also helped create a whole sexual pathology which found its way into the official classification of mental illness. For example, the 'normal' human sexual

[18] In 1952 homosexuality was included as a sociopathic personality disorder in the first Diagnostic Statistical Manual (DSM) of psychiatric disorders and included in the 6th revision of the International Classification of Diseases published in 1948 (American Psychiatric Association, 1948). In 1973 homosexuality was removed from DSM; however, it was replaced with Ego-Dystonic Homosexuality in DSM III, to include individuals distressed by their orientation (American Psychiatric Association, 1980). The American Psychiatric Association eventually dropped Ego-Dystonic Homosexuality from DSM IIIR, which was published in 1987. The International Classification of Diseases did not drop homosexuality as a diagnosis until 1992 (World Health Organisation, 1992). Changes made did not come about as the result of scientific insight but as a consequence of sustained protests of the Gay Liberation Movement in the United States of America (Kutchins and Kirk, 1997).

[19] Late Luteal Phase Dysphoric Disorder was included in the appendix of DSM IIIR, under the title 'Proposed Diagnostic Categories Needing Further Study' (American Psychiatric Association, 1987).

response cycle as identified by Masters and Johnson formed the basis for the diagnostic categories of hypoactive sexual desire, sexual arousal, and orgasmic disorders found in the DSM IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992).

Sexuality of people with mental health problems – A risk to the human race

The eugenics[20] movement, which was strongly influenced by Darwin's work on evolutionary theory and Spencer and Galton's theory on inheritance and moral degeneracy, had followers within psychiatry (Shorter, 1997). Premised on beliefs that mental illness had a strong genetic component and procreation among people with mental health problems would lead to social degeneracy and 'race suicide', social hygienists campaigned for restrictions on people's right to reproduce (Shorter, 1997). Adherents to the eugenics movement frequently cited evidence that people with mental illness were hypersexual, immoral and governed by animalistic sexual urges (Whitaker, 2002). Connolly Norman, a leading Irish psychiatrist in the early 1900s, presented what he considered proof that 'feeble minded' people produced larger families than did 'sound minded' people (Nolan, 1993:38). Supporters of the eugenics movement often referred their British audience to the position in Ireland where they claimed, hundreds of 'defectives' were being allowed to reproduce, leading to degeneracy on a large scale (Nolan, 1993:38).

In an attempt to prevent reproduction, staff were instructed to maintain gender segregation between the mentally ill who were confined to institutions[21], and guard against any 'illicit' associations between men and women (Shorter, 1997). The possibility that the mentally ill would marry each other was met with disapproval by families and health care professionals alike. For example, in 1903, Dr. Carr, a superintendent of the Omagh Asylum, beseeched both Protestant and Catholic clergy to refuse to consecrate marriages between people with a family history of insanity (Nolan and Sheridan, 2001). Within Ireland, the mental institution was also used to incarcerate and isolate pregnant unmarried women (McCarthy, 2001).

[20] In 1883 Galton coined the term 'eugenics', derived from the Greek word for well born, as a name for a science devoted to improving the human race (Whitaker, 2002).

[21] According to Foucault, the 'Great Confinement' commenced in the seventeenth century (Foucault, 1989).

Scheper-Hughes (1977) also made a link between the high incidents of mental illness and the culture of sexual repression that was prevalent in the 1977 west of Ireland culture she visited. As an outcome of her ethnographic field work, she stated that people 'who violated the strong Irish sanctions against the expression of sexuality ... are prime candidates for the mental hospital (Scheper-Hughes, 1977:157). In today's context it could be argued that the drug-induced suppression of sexual desire and the production of hyperprolactinaemia in women[22], is another more subtle way of maintaining old power relations and enforcing reproduction control, under the guise of therapy. Indeed, Vandereycken (1993) suggested that the image of people having no control over their sexual drives, especially people experiencing psychosis, supported the use of drugs to suppress sexual desire.

Taken to the extreme, in the early 1900s in some countries, degeneracy theory gave rise to such radical measures as the adoption of laws that authorised sterilisation without informed consent. In some cases arguments were made for the beneficial effects to people's mental health of the complete removal of testes and ovaries, such as the following comment from Barr:

> 'As sexual impulses dominate their lives, the removal of this excitation, as has been proven, not only makes them more tractable, as does gelding for the ox, but the general health improves, and nervous disorders, to which many are subject, become more amenable to treatment, therefore far from being an injury, the slight and nearly painless operation required, improves physical vigor and they become contented and happy... It is not always essential that testicles and ovaries be removed, but I prefer it, as it gives absolute security ...If, for sentimental reasons, the removal of the testes and ovaries will not be considered, ligation of the spermatic cord or vasectomy in the male and fallectomy or tuberectomy in the female, may be performed through the vagina' (Barr, 1912).

Shorter (1997) suggested that it was only after the atrocities of World War II that degeneracy theory and reference to eugenics became a social and professional taboo.

Although degeneracy theory has been discounted within the scientific literature, disapproval of people with mental health problems having children was reflected in

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[22] Neuroleptic drugs block the dopamine D_2 receptors in the hypothalamus, consequently the dopamine inhibiting effect on prolactin is reduced or abolished and plasma levels of prolactin are increased. Hyperprolactinaemia has a contraceptive effect and was found to be a primary main cause of sexual dysfunction in women (Smith et al. 2000).

a recent national survey of Irish people's attitudes (n=1,000) toward disability. When surveyed on people's rights, 83% (830) were of the opinion that people with learning disability and people with physical or sensory disability had the same rights as everybody else to fulfilling relationships. However, fewer respondents (59%) were of the opinion that people with mental health disability had those same rights. This negative attitude was also reflected in their views on reproduction. Forty percent were of the opinion that people with a mental health disability should not have children. However, opinion on whether people with physical disability (9%) or learning disability (13%) should not have children was far less negative (National Disability Authority, 2002). These views add support to Vandereycken's (1993) assertion that the idea of people with mental illness marrying each other and bearing children continues to be met with disapproval within society.

Sexuality and psychiatric nursing

Since the World Health Organisation first identified the need for health professionals to be educated in the area of sexuality (World Health Organisation, 1975), sexuality has gradually become a legitimate area of concern for nurses across all nursing disciplines. The publication of the *Introduction to Nursing: An Adaptation Model* (Roy, 1976) in America, and *The Elements of Nursing* (Roper et al., 1980) in the United Kingdom put sexuality firmly within the realm of nursing care. Roy (1976) identified sexuality as an area of adaptation within the psychosocial mode of her model of nursing, and Roper et al. (1980) included 'expressing sexuality' as an activity of daily living. The idea of sexuality being a dimension of the nurse's role was further established when the notion of 'sexual dysfunction' entered the list of nursing diagnoses of the North American Nursing Diagnosis Association in 1980. In 1986, this was later expanded to include 'altered sexual patterns' (McFarlane and McFarlane, 1986). In 2000, the RCN identified sexuality as a legitimate area of nursing activity, stressing that nurses had a professional and clinical responsibility to address issues with clients (Royal College of Nursing, 2000).

In the context of nursing, the literature is saturated with authors urging nurses, irrespective of discipline, to acknowledge the sexual dimension of clients' lives and

respond to their concerns in an open, empathetic and supportive manner (Lewis and Scott, 1997; Cort et al., 2001; McCann, 2003). The notion of holism, although a problematic and theoretically underdeveloped concept in nursing (Kolcaba, 1997), was a central tenet underpinning these writers' arguments. Holism is an attempt to conceptualise people as biological, psychological, social, sexual and spiritual beings, and is often perceived to be an oppositional discourse to the biological determinism of western biomedicine. That said, there were a number of authors, within other disciplines, who critiqued the medicalisation of every day life and the inclusion of activities, such as 'expressing sexuality' within the 'gaze' of health care professionals (Foucault, 1973; Armstrong, 2002). Viewed through the lens of these writings, it could be argued that the formal recognition of sexuality as a dimension of the nurse's role is a reflection of the 'rise in surveillance medicine' (Armstrong, 2002:112), or a form of 'governmentality' and colonisation (Foucault, 1973), with the nurse being charged with the tasks of assessing, monitoring and intervening in matters relating to intimate aspects of people's lives.

Nurses' perspectives of sexuality as a dimension of their role

Since the 1980s, several researchers have explored nurses' opinions about including sexuality as an aspect on their role. However, with the exception of Cort et al's (2001) study, the research participants were nurses working in clinical areas other than mental health. The majority of the studies located were small scale descriptive surveys, utilising a variety of researcher designed questionnaires that were frequently not tested for reliability and validity. The qualitative studies located either lacked theoretical frameworks to guide the study, or those using grounded theory did not develop a theory. The majority of the studies, with the exception of Lavin and Hyde (2006) and Long (1998), were carried out in countries other than Ireland.

Notwithstanding these comments, nurse researchers have consistently demonstrated that nurses, over three decades, regardless of their nationality or clinical specialty, perceived that they had a role in sexual health assessment and the provision of teaching and counseling to clients in the area of sexuality and sexual health (Conine et al., 1980; Williams et al., 1986; Shuman and Bohachick, 1987; Gamel et al.,

1995; Long, 1998; Butler and Banfield, 2001; Cort et al., 2001; Lavin and Hyde, 2006). However, whether one analysed American (Williams et al., 1986; Shuman and Bohachick, 1987; Kautz et al., 1990; Matocha and Waterhouse, 1993); Canadian (Conine et al., 1980; Butler and Banfield, 2001); UK (Lewis and Bor, 1994; Cort, 1998; Guthrie, 1999; Cort et al., 2001) Dutch research (Gamel et al., 1995), or research carried out in Taiwan (Tsai, 2004) or Ireland (Long, 1998; Lavin and Hyde, 2006), the challenging aspect of addressing this dimension of personhood in nursing practice continually emerged. Irrespective of location, methodology or sample size, the research indicated that although nurses held positive attitudes towards including sexuality as a dimension of their role, these positive intentions were rarely transferred into practice. The percentage of nurses who indicated that they rarely or never included questions about sexuality as part of their nursing assessment varied from 63% to 98% (Lewis and Bor, 1994; Gamel et al., 1995; Matocha and Waterhouse, 1993). In Cort et al's (2001) study of community mental health nurses (n=122), although only 10.6% (13) were of the opinion that clients would not experience problems in the area of sexuality, 67% (82) reported that sexual issues were seldom or only occasionally encountered in practice. This may be more a reflection of nurses' failure to raise and discuss sexual issues with clients as opposed to an indicator of the prevalence of clients' sexual concerns.

An analysis of the studies suggested nurses perceived the major barriers to talking to clients about sexuality originated from three sources: clients, themselves and the wider environment. Nurses perceived clients as: not wanting to talk or answer questions about sexual issues (Cort et al., 2001; Tsai, 2004); too ill, anxious or embarrassed to discuss sexual concerns (Conine et al., 1980; Kautz et al., 1990; Tsai, 2004), or unwilling to talk to nurses who were younger or of a different gender to themselves (Tsai, 2004). Nurses also reported reticence about talking with clients because of: lack of knowledge, lack of fluency of language around sexual issues, fearing invading client's privacy, fearing upsetting the client, and feelings of personal embarrassment (Guthrie, 1999; Tsai, 2004). Lack of time, lack of privacy and lack of referral sources should a client require further consultation were also identified as factors impeding nurses talking to clients (Lewis and Bor, 1994; Guthrie, 1999). In addition, 62% (75) of the mental health nurses in Cort et al's

(2001) study were of the opinion that family members would not appreciate nurses asking clients with mental health problems about sexuality. Consequently, nurses reported waiting for clients to raise concerns and feeling more comfortable talking if the discussion was initiated by the client (Kautz et al., 1990; Cort, 1998; Long, 1998).

Psychiatric nursing and assessment of sexuality

Needs assessment is important both for individual care planning and service provision for people experiencing mental health problems (Simons and Petch, 2002). McCann (2000) suggested if psychiatric nurses wanted to be truly responsive to people they needed to include sexuality as a dimension of assessment and ask about sexual and relationship issues. Some writers suggested that taking a sexual history should begin at the initial stages of care. In this way, nurses can act as role models, educating clients that sexuality and sexual relationships can be openly discussed without shame or guilt (Tsai, 2004). The three studies located that explored psychiatric nurses' assessment of sexuality suggested that psychiatric nurses do not perceive clients as having any unmet sexual and relationships needs, and generally ignore the sexual domain in assessment (Dorsay and Forchuk, 1994; Cole, 2000; McCann, 2004).

In England, McCann (2004) used the Camberwell Assessment of Needs questionnaire and compared clients with a diagnosis of 'schizophrenia' (n=30) and nursing staff's (n=30) perceptions of needs in relation to sexual expression and intimate relationships. Findings indicated that a large number of clients identified serious unmet needs in the areas of sexual expression (53%) and intimate relationship (73%). In comparison, only a small amount of the nurses perceived clients to have serious unmet needs in the areas of sexual expression (7%) and intimate relationship (23%). The vast majority of nurses were unable to say whether the person had an identified need in these areas, suggesting that they possibly never enquired about this aspect of the person's life. Similar findings were reported by Cole (2000), who reviewed the written records of fifty-six women discharged from an acute psychiatric unit. Despite all of the women being of reproductive age and 50% (28) having a recorded identifiable sexual partner, none of the care plans

mentioned advice on pre-conceptual care, sexual health, relationship issues or capacity to consent to sexual relationships. Although 73% (45) of the women were not protected with contraception, 80% (36) were prescribed a minimum of one drug deemed inadvisable in pregnancy. Dorsay and Forchuk (1994) in Canada, used a triangulation of methods to explore nurses' assessment of sexuality needs. Although staff (n=66) perceived themselves to be meeting the quality standard in relation to sexuality, findings from the audited records (n=100) and interviews with clients (n=38), suggested that this was not the case. In spite of the fact that the nursing assessment form included specific questions related to sexual abuse, contraception and sexually transmitted diseases, these sections were left blank in over 55% of cases. In addition, 65% (24) of the clients indicated that staff had not engaged with them in discussions about sexuality.

Clients' perspectives on nurses including sexuality as a dimension of their role

It is reasonable to expect that if nurses perceive clients as not wishing to discuss sexual concerns with them, they will be less likely to raise sexuality as an area for potential discussion or offer education in this area. However, in a Canadian postal survey, involving a convenience sample of clients with a diagnosis of either schizophrenia or personality disorder (n=151), Lewis and Scott (1998) reported that 92% (138) of participants were not opposed to discussing sexuality and were of the opinion that discussions with health care staff would be helpful. Participants expressed a desire, in order of importance, for discussion and education on issues such as: the effects of medication and illness on their ability to function sexually, how to maintain long term relationships, how and where to meet people, how to prevent unwanted sexual advances and information on sexually transmitted diseases. In a survey involving sixty clients referred for non-urgent psychiatric assessment to a London out-patient department, Crawford & Shaw (2000) reported that 86% (51) expected that there would be some inquiry about sexual issues. Thirty-nine per cent (22) stated they would be comfortable answering questions on all the listed topics, with the remainder indicating some degree of discomfort around questions relating to first sexual experience, sexual fantasies and masturbation. Patients who reported feeling uncomfortable were more likely to be younger (below 30 years), single and have received fewer years in full time

education. The majority of the patients had no preference regarding the age (72%) or gender (61%) of the health professional. However, 40% (14) of those who expressed some level of discomfort opted to speak to someone of the same gender. The gender of the health professional was also found to be less important than the quality of the interaction in Pryce's (2000) ethnographic study of men attending a Genitourinary medical clinic in London.

Research on sexuality as it related to people experiencing mental health problems

Research on sexuality as it related to people experiencing mental health problems mainly consisted of studies that explored sexuality from the perspective of sexual function, sexual activity, sexual violence and sexual diversity. The majority of research available was completed through the use of questionnaires and audits of medical and nursing records. Despite the fact that many of the issues researched impact on the everyday work of the psychiatric nurse, the majority of the research was completed by professionals other than psychiatric nurses, and published in non nursing journals. This section presents an overview of this research using the following headings: Sexual activity among clients in residential care; Sexual violence; Sexual diversity; Sexual risk behaviour; Sexual education of clients; and Prescribed drugs and sexuality. A small number of studies were located that explored psychiatric nurses' practice in relation to these issues and these are also discussed under the respective headings.

Sexual activity among clients in residential care

Historically, sexual activity among people in residential care, whether long term or short term, was considered dangerous to the mental health of the person (Cohen and Tanenbaum, 1985). Thus, irrespective of health status, legal status or place of residence, all sexual behaviour was prohibited. However, research in America (Akhtar et al., 1977; Welch et al., 1991; Civic et al., 1993; Buckley and Hyde, 1997; Buckley and Wiechers, 1999; Dobal and Torkelson, 2004), Switzerland (Modestin, 1981) and England (Cole et al., 2003; Warner et al., 2004) suggested that despite the presence of 'no sex policies', sexual activity between clients did occur within residential care and was considered a clinical problem, as it was exploitive,

predatory and interfered with the focus of treatment. This section explores the literature on sexual activity among clients in residential care.

Sexual activity among clients

Accurately determining the rates of sexual behaviour among people in residential care was difficult, due to the failure of studies to define clearly what they meant by sexual behaviour. The most common sexual behaviour reported was kissing and embracing, with mutual masturbation, oral sex and sexual intercourse between clients being reported less frequently (Akhtar et al., 1977; Welch et al., 1991; Civic et al., 1993; Buckley and Hyde, 1997; Buckley and Wiechers, 1999; Dobal and Torkelson, 2004). Sexual bartering for cigarettes and snack food was also reported (Civic et al., 1993). Of the 167 clients surveyed by Warner et al. (2004) in three psychiatric units across west London, 30% (50) reported engaging in some form of sexual activity, including ten who had consensual sexual intercourse. Of these, only two reported using condoms, with six stating that the sexual encounter happened within a relationship that had developed on the ward. Nine clients reported engaging in oral sex, with seven reporting incidences of mutual masturbation. The location of the sexual encounters included bedroom, dayroom, toilet, stairwell and garden. In Thomas et al's (1995) study, of 59 clients in an inner city UK psychiatric hospital, 49% (29) reported unwanted sexual experiences, in the form of sexual comments (16), molestation (11) and sexual assault (2). Women were significantly more likely than men to report unwanted sexual comments (2:1), and sexual molestation (4:1), with two women reporting sexual assault. It is impossible to say what the incidence of consensual or non-consensual sexual behaviour within the psychiatric services in Ireland is, as no research was located in this area.

Mental health professionals' reactions to sexual activity of clients

Research that explored mental health professionals' concerns regarding sexual activity among clients suggested that fear of litigation and pregnancy, as well as concerns over sexual assault and sexually transmitted disease were their primary concerns (Akhtar et al., 1977; Buckley and Wiechers, 1999; Cole et al., 2003). In addition, participants in Cole et al's (2003) study (n=109) also expressed a fear of being personally blamed in some way. Studies also suggested that in the absence of

policies and professional guidelines, participants responded to sexual behaviour using a variety of approaches. In Akhtar et al's (1977) study, participants reported responding with anger, denial and embarrassment, which the authors suggested reflected the perception that the behaviour was challenging the nurses' authority. Participants (n=70) in Keitner and Grof's (1981) study reported using a combination of strategies to control sexual behaviour including: discharge, medication change, confrontation, individual therapy, community meeting and interdisciplinary meetings to decide on a plan of care.

Commons et al's (1992) explored factors that influence 131 mental health professionals' decision making about sexual activity among clients. Findings suggested that, like most citizens, mental health professionals' judge clients' sexual behaviour based on conventional social norms and prejudices rather than legal standards. Using a series of narrative vignettes, Commons et al. (1992) explored which of the following factors affected professional decision making: competence, degree of consent, form of sexual activity (hug versus genital relations), location of sexual activity (bedroom versus grounds), sex of the initiating client and sex of the other client. Of the six factors explored, only location and form of sexual activity proved to be significant. Mental health professionals were most disapproving of homosexual acts and sexual activity that took place on the grounds. Most strikingly, whether the clients were competent and consenting, the norms used by law and due process, were not found to be relevant to the participants' decision making. The authors suggested that one possible explanation was that participants did not believe that the hypothetical clients could be consenting and competent even though it was stated in the vignettes. As an outcome, the researchers recommended the need for more education about the importance of competence assessment of clients in regard to decision making and sexual behaviour.

Policies on sexual activity among clients

Given the reality of clients engaging in sexual behaviour and the fluctuating capacity to consent, Warner et al. (2004) suggested that providers of health care face a near-impossible task in balancing the rights to sexual freedom as laid down under the 1950 European Convention on Human Rights and Fundamental Freedoms

(Council of Europe, 1950) and protecting people who engage in sexual activity. Simply adopting a 'policing' approach could be considered as violating rights. In Purdie's (1996) view it is no longer sufficient for nurses to consider their role completed once they had documented the 'incident' of sexual activity and separated the people concerned. Therefore, researchers urged services to revise the 'no sex' policies, and develop formal policies and guidelines that protect the rights of clients and protect services from legal implications (Buckley et al., 1999; Torkelson and Dobal, 1999; Warner et al., 2004). Researchers suggested policies needed to include guidelines on the assessment of: sexual risk, capacity to make decisions about sexual behaviour, propensity to engage in sexual behaviour during hospitalisation and knowledge of safe sexual practices. In addition, policies should include guidelines on the provision of comprehensive sexual health education and how to respond to sexual behaviour, whether it be consensual or non consensual, in a sensitive and compassionate manner (Buckley and Hyde, 1997; Ford et al., 2003; Dobal and Torkelson, 2004). Telling clients about policies and including statements about restrictions on clients' sexual expression, while in residential care, in information leaflets was also advocated (Buckley and Hyde, 1997; Ford et al., 2003).

In an attempt to reduce sexual behaviour in residential care and prevent sexual victimisation, there is a move in the UK away from caring for people on mixed sex wards (MIND, 1992). The UK mental health policy for women recommended that all residential accommodation should provide single sex accommodation, toilet and bathing facilities and pay special attention to women's safety, dignity and privacy, with no new mixed-sex units being approved (Department of Health (UK), 2002). The UK NHS executive document '*Safety, Privacy and Dignity in mental health units: Guidance on mixed sex accommodation for mental health services'* emphasised the need for managers and staff to be alert to the possibility of sexual assault and harassment and include a risk assessment to identify people vulnerable to being abused or abusing others (Department of Health (UK), 2000). They also emphasised the need for policy and procedures in relation to the following: choice of key worker and gender of key worker; assessment of sexual abuse history; engaging in intimate care and sexual harassment. More recently in Ireland, The Women's Health Council (2005) has joined the debate on single sex units, calling

for a more gender sensitive service and the provision of women-only facilities, both in community and hospital settings.

Sexual violence

Over the past two decades, sexual violence has been increasingly studied and written about. The complexity of the language used to describe sexual violence reflects the complexity of the issue itself (McGee et al., 2002). Terms such as sexual abuse, rape, sexual assault, and sexual violence were used throughout the literature. Research into sexual violence focused on: identifying the prevalence of sexual violence in the general population and other groups, such as people accessing the mental health service; relationship between sexual violence and mental health problems; and experience of survivors in accessing services. This section, firstly, discusses the psychological effects of sexual violence on the person's mental health and explores the rates of sexual violence among service users, with specific reference to the Irish context. This is followed by a discussion on disclosure difficulties and health professionals' attitudes to enquiring about sexual violence history. The final issue addressed in this section is sexual violence within mental health services.

Psychological effects of sexual violence on the person

Although not all people who have experienced sexual violence will suffer long term psychological consequences and many may struggle with their abuse unaided (Painter and Howell, 1999), a history of sexual violence significantly increases the person's chances of experiencing a mental health problem. The impact of sexual violence on the person is individualised and influenced by a number of factors such as: the nature of the abuse (penetration versus non penetration); duration (ongoing versus single episode); perpetrator (internal or external to the family); the age at which abuse started (childhood sexual abuse or adult sexual violence) and number of perpetrators (one versus multiple perpetrators). Research into the long term impact of child sexual abuse on both men and women repeatedly demonstrated that people who have been sexually abused experience low self esteem, decreased self worth, shame, stigma, and powerlessness; they have difficulty forming relationships, trusting people in intimate and sexual relationships and maintaining

sexual boundaries (Mezey and King, 1989; Ray, 1996; 2001; Painter and Howell, 1999; Fater and Mullaney, 2000; Nilsson et al., 2005). These writers reported that victims of abuse developed negative attitudes towards their own sexuality, and either avoided all sexual contact or unconsciously enacted aspects of early sexual abuse in subsequent sexual relationships.

There was evidence that victims of sexual abuse were frequently left vulnerable to re-victimisation. By engaging in unstable, transient, and violent interpersonal or sexual relationships, victims of abuse were at risk to further sexual assault or rape. (Mezey and King, 1989; Ray, 1996; 2001; Painter and Howell, 1999; Nilsson et al., 2005). This pattern of re-victimisation was also evident in McGee et al's (2002) Irish study. McGee et al. (2002) explored the prevalence of sexual abuse and sexual violence among men and women from the general population in Ireland (n = 3118). Women who experienced penetrative sexual abuse in childhood were found to be at a five-fold increase of adult contact sexual violence. For men, experiencing penetrative sexual abuse in childhood was associated with a twelve fold increase of adult contact sexual abuse. Although the authors pointed out that it was not possible to say conclusively that childhood abuse 'caused' adult re-victimisation they believed that it should be considered as an important marker of increased risk of adult sexual re-victimisation. In addition, adolescent survivors of sexual abuse were found to be significantly more likely than their peers without a history of sexual abuse to be sexually active, to use condoms inconsistently, to score significantly lower on the knowledge of HIV scale and the condom self-efficacy scale and to use alcohol and drugs (Brown et al., 2000). These authors suggested that clinicians should consider a history of sexual abuse as a marker for sexual risk-related behaviour among adolescents with mental health difficulties.

Survivors of sexual abuse were also found to be at risk of numerous other long term psychological effects, which brought them into contact with the mental health services and psychiatric nurses. High rates of sexual abuse were reported among people who experienced depression, anxiety, self harm, post traumatic stress disorder, personality disorders, eating disorders and alcohol problems (Beitchman et al., 1992; Glod, 1993; Moncrieff et al., 1996; Ghizzani and Montomoli, 2000; McGee et al., 2002; Bohn, 2003). A significant correlation was found between

depression, post traumatic stress disorder and the more severe forms of sexual violence, such as penetration or attempted penetration (O'Neill and Gupta, 1991; Cheasty et al., 1998). Childhood sexual abuse was also found to be a stronger predictor of current suicidality than a diagnosis of depression (Read et al., 2001). Other researchers reported a link between childhood sexual abuse and subsequent psychotic experiences, especially hallucinations, in people diagnosed with schizophrenia and bipolar affective disorder (Read and Argyle, 1999; Hammersley et al., 2003). A relationship between the content of the hallucination and sexual abuse was also reported, for example the voice telling the person to kill themselves being the voice of the abuser (Read and Argyle, 1999).

Prevalence of sexual violence experienced by people accessing the mental health services.

Numerous international studies reported a higher prevalence of sexual abuse among both men and women using the psychiatric service than the general population (Margo and McLees, 1991; Goodman et al., 1997; Spataro et al., 2004). Rates of childhood sexual abuse among male service users was lower than females, with the rates for men being between 24-39% and women between 36-85% (Jacobson and Richardson, 1987; Read and Fraser, 1998; Nilsson et al., 2005). The variation in findings can be explained, in part, by different definitions of abuse, and differences in research methodology. Irrespective of the variation, these rates were considered to be conservative due to under reporting (Read and Fraser, 1998).

No study was located that addressed the rates of people, who were sexually abused, accessing the psychiatric services in Ireland, although some estimated it to be in the region of 30% (National Counselling Service, 2003). In McGee et al's (2002) study of 1,603 women and 1,515 men in Ireland, 42% of women and 28% of men reported some form of sexual violence in their life time, with 10% of these women and 3% of men having experienced penetrative sex, the most serious form of sexual violence. Childhood sexual abuse was reported by 30% of women and 23% of men. One in four women and one in six men reported experiencing contact childhood sexual abuse and of these over a quarter (5.6%) of the women and one in six men (2.7%) reported abuse that involved penetrative sex. In view of McGee et al's

(2002) seminal report, it is reasonable to suggest that sexual violence against men and women is a pervasive dimension of contemporary Irish society and that a significant number of people accessing the psychiatric services have experienced sexual violence and require focused therapeutic interventions.

Disclosing sexual violence

Revealing a history of abuse may be the first step in dealing with the psychological burden that has been kept secret for years. However, stigma, self-hatred and shame often led to underreporting (Gallop et al., 1995a; Ray, 2001; McGee et al., 2002; Rahm et al., 2006). Women in Rahm et al's (2006) Swedish study of 10 victims of abuse felt that it was taboo to talk about sexual abuse, and remained silent for fear of being misunderstood or blamed. In addition, people did not believe that the health care person could or would help them (vanLoon et al., 2004). Alarmingly, in McGee et al's (2002) Irish study 57% (231) of the 424 men and 42% (282) of the 673 women who disclosed sexual violence during the course of the study reported never having disclosed the abuse to another. The most common reasons cited by the participants for not disclosing included: feeling ashamed; perceiving what happened to them as 'too trivial' to tell others; blaming themselves; and fearing that nobody would believe them.

Research that explored clients' willingness to report sexual violence if asked and the consistency of reports, indicated that people with mental health problems who are asked directly about abuse experiences disclose higher rates of sexual abuse, in comparison to people who are left to volunteer the information during ongoing clinical encounters (Dill et al., 1991; Wurr and Partridge, 1996; Read and Fraser, 1998). Where inconsistencies in reporting were found, they were related to underreporting rather than over reporting (Read and Fraser, 1998).

Mental health professionals' enquiring about a history of sexual violence

There is a danger that unless health care professionals make inquiries about sexual violence as part of their ongoing assessment, the needs of the person may go unmet. In order to provide optimal care, many researchers recommended that professionals need to indicate their willingness collectively and individually to hear disclosures of

sexual violence by sensitively and routinely asking specific questions about sexual violence (Read and Argyle, 1999; Brown et al., 2000; McGee et al., 2002).

Kreidler (2005) and Nilsson et al. (2005) identified mental health nurses as key people in the assessment of clients' possible experiences of sexual violence. However, the evidence available suggested that psychiatric nurses do not enquire about sexual violence history (Dorsay and Forchuk, 1994; Gallop et al., 1995b; 1995a). Although nurses (n=323) in Gallop et al's (1995a,b) study agreed that enquiry about sexual violence should be part of the nursing history, as disclosure could facilitate healing, they were reluctant to ask. Fear of intruding and causing further distress to the person, a belief that they should wait for the relationship to develop before engaging in any discussion were the reasons put forward for not enquiring. In addition, nurses reported that they lacked the necessary skills to respond to the person should they disclose sexual violence.

Other studies that audited medical records suggested a similar trend in not asking about sexual violence (Read and Fraser, 1998; Agar and Read, 2002; Chandra et al., 2003). Records suggested that male clients and clients with a diagnosis of schizophrenia were less likely to be asked about sexual violence (Read and Fraser, 1998; Agar and Read, 2002). The tendency not to ask men may reflect a lack of knowledge around the incidence of male sexual violence or a belief that men are not subjected to sexual violence. Adherence to the medical model, which assumes a biological or genetic cause of schizophrenia, together with a belief that people who experience a psychosis might imagine sexual violence and give unreliable or false information, may also account for professionals not asking people who had a diagnosis of schizophrenia (Agar and Read, 2002).

Sexual diversity and mental health

Being gay/lesbian/bisexual/transsexual (GLBT) is not in itself a mental health problem and GLBT people are not inherently any more prone to mental health problems than anybody else. However, coping with the effects of discrimination can be detrimental to GLBT mental health. Like many other minorities in society they face many forms of prejudice, harassment and discrimination, which are rooted

within the heterosexist structures of society and societal homophobic attitudes (Wilton, 2000). While most gay, lesbian and bisexual young people develop positive coping strategies to manage the ensuing stress and become healthy, productive adults, psychiatric nurses need to understand the relationship between sexual orientation and mental distress in order to be in a position to identify vulnerable individuals and promote mental health among this group of people (Robertson, 1998; McAndrew, 2004). King and McKeown (2003) suggested that disclosure of sexual orientation in the mental health care context is essential for the provision of effective, sensitive and individualized care. The final section in this chapter, explores the literature on GLBT mental health and their experiences of the mental health services.

Gay/lesbian/bisexual/transsexual and mental health problems

The invisibility of GLBT identity in main stream culture can damage people's self esteem and make it hard for people to feel a sense of belonging to a society that seems not to recognise they exist (Wilton, 2000). The negative internalisation of society's attitudes and the constant monitoring and censoring of one's thoughts and actions in social situations can result in feelings of social alienation, anxiety, loss of self esteem and an inability to express the 'true self' (Hettrick and Martin, 1987; Robertson, 1998; Friedman, 1999). The possible consequence of ostracism, stigma and reprisal in a homophobic culture makes 'coming out' extremely difficult. These feeling are exacerbated during adolescence and early adulthood, when many GLBT men and women remain isolated from the adult gay and lesbian movements (McAndrew, 2004). For those people who come out, the experience of being perceived as deviant and rejected by either family or society can have a profound effect on self image, identity and sense of worth. In addition, GLBT people with mental health problems often suffer a double or combined stigma, the stigma of their mental health problem and their sexual orientation (National Disability Authority, 2005).

In a study focusing on the mental health and social well being of gay men, lesbians, and bisexual men in England and Wales, despite similar levels of social support and quality of physical health, higher levels of psychological distress was found among

the 656 gay men and 430 lesbian women studied, compared with the 505 heterosexual men and 588 heterosexual women (King and McKeown, 2003). GLB men and women were more likely than their heterosexual counterparts to use recreational drugs and lesbians were more likely than heterosexual women to drink excessively. Bisexual men (n=85) reported the highest level of psychological distress, higher even than the gay men. Fergusson et al. (1999), in a 21-year longitudinal study of 1,007 people, found that participants who classified themselves as gay, lesbian or bisexual were at increased lifetime risk to major depression, generalised anxiety disorders and conduct disorders. Other studies suggested levels of alcohol and drug abuse in the gay, lesbian and the bisexual population were at least two to three times higher than the general population (Robertson, 1998; Farquhar et al., 2001; King and McKeown, 2003). Reasons suggested for this included the problems of dealing with societal oppression, using alcohol and drugs as a means of coping with depression, and the pivotal role of bars in gay social networks.

Although statistical data for completed suicides among the homosexual population are skewed, as sexual orientation is not recorded as part of mortality data (McAndrew, 2004) and the exact relationship between social prejudices and mental health problems has yet to be firmly established, there is a growing body of international research suggesting that lesbian, gay and bisexual people are at increased risk of mental health problems, particularly self harm and suicidal behaviour (Remafedi et al., 1998; Fergusson et al., 1999; Skegg et al., 2003). To what extent this vulnerability is dependent on the prevailing negative social attitudes is difficult to say, but probably accounts for a large part (Bancroft, 1989).

Gay/lesbian/bisexual/transsexual experiences of the mental health services

A number of research studies exploring lesbian, gay and bisexual people's experience of the mental health services in the UK suggested they can experience the same discrimination within the mental health service as they do in wider society (Golding, 1997; McFarlane, 1998; Robertson, 1998; King and McKeown, 2003). Many participants in these studies did not feel safe to be 'out' in the mental health service and reported experiencing insensitivity, prejudice and discriminatory

practices from staff in the form of homophobia, biphobia and heterosexism. Although participants in King and McKeown's (2003) study did identify sensitive practices, a number cited examples of overt homophobia and subtle forms of discrimination, including lack of empathy, the presumption of heterosexuality, and an unwillingness to discuss sexuality. Participants who reported discussing their sexuality with staff often received 'clumsy and ill informed responses' (King and McKeown, 2003:44). Both the researchers and participants emphasised the need for psychiatric nurses to create an environment where disclosure could take place and stressed the need for mental health professionals to educate themselves about gay and lesbian issues.

Sexual risk behaviour and people with mental health problems

The growing spread of the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) has led to an increased interest in the study of at risk populations and the development of prevention programmes (Grassi, 1996). The first studies addressing cognitive and behavioural factors that placed people with mental health problems at risk of HIV infection did not emerge in the literature until the beginning of the 1990s. Cates & Bond (1994) suggested that AIDS was not seen as a health threat to people with severe mental health problems because of prevailing stereotypes that they were asexual or not interested in sex. The belief that people with mental health problems had diminished sex drive was fuelled by studies in the early 1980s, which reported decreased incidence of sexual activity among people with mental health problems living in institutions (Buckley et al., 1999). This decreased incidence was possibly due to low reporting and institutional segregation as opposed to an aspect of the illness. This section explores the research on sexual risk behaviour.

Sexual risk behaviour

A number of researchers have explored the rates of HIV related risk behaviours among people with mental health problem. The majority of studies were completed in the USA with the exception of studies by Thompson et al. (1997) and Grassi et al. (1999), which were carried out in Australia and Italy respectively. No studies

were located that addressed these issues in an Irish or a UK context. Participants included men and women with mental health problems, in in-patient and out-patient settings. Although people with a diagnosis of bipolar and personality disorders were represented within the studies, the majority of the participants were people with a diagnosis of schizophrenia. Only one study addressed risk behaviour among people with mental health problems who were HIV positive (Tucker et al., 2003). The majority of the studies could be described as descriptive exploratory research, as only two studies used a control sample (McDermott et al., 1994; Grassi et al., 1999). In most cases, data were collected through a variety of interviewer administered questionnaires that relied on the participant to self report behaviour. Two studies accessed data through a retrospective audit of clinical records (Hellerstein and Prager, 1992; Susser et al., 1993).

Due to the variety of tools used to assess risk behaviour and a variety of sampling methods it was difficult to make direct comparisons between the studies. Despite this, and although sexual activity does not of itself pose a risk of infection, evidence suggested that this group of people engaged in sexual risk behaviour, such as having multiple partners, engaging in sex with high risk groups, trading sex for some material gain, and using condoms infrequently. Their disadvantaged social and economic status left them with transient living arrangements, which placed them in contact with high risk populations (Gottesman and Groome, 1997) and subjected them to 'survival sex pressures' and made them vulnerable to sexual abuse, exploitation and victimisation (Kelly et al., 1997:295). In addition, delusions, hallucinations and social dysfunction negatively affected the person's ability to sustain long term relationships; consequently they often engaged in sexual behaviour in the context of unstable and transient relationships (Kalichman et al., 1994; Gottesman and Groome, 1997).

In studies that explored multiple sexual partners, numbers ranging from 19-62% of participants reported having more that one sexual partner in the past six months (Kelly et al., 1992; Cournos et al., 1994; Kalichman et al., 1994; Knox et al., 1994; Menon and Pomerantz, 1997; Thompson et al., 1997; McKinnon et al., 1997). Having sex with an occasional partner or someone unknown to the person ranged from 19% of the 54 research participants in Katz et al's (1994) study to 34% of 100

participants in Grassi et al's (1999) study. Participants reported meeting casual sexual partners in the park, street (Kelly et al., 1992) or mental health clinic (Kalichman et al., 1994).

Having sex with intravenous drug users is a major source of HIV risk and several studies reported people engaging in sexual behaviour with a partner known to be an intravenous drug user (Kelly et al., 1992; Diclemente and Ponton, 1993; Cournos et al., 1994; Menon and Pomerantz, 1997; Grassi et al., 1999). Bartering or trading sex for money, cigarettes, a place to stay, alcohol and drugs was also reported by participants. For example, 20% of the participants in Kalichman et al's. (1994) study of 50 men and 45 women reported buying sex with drugs or money. Rates of buying sex specifically from a prostitute varied from 21% (n=61) (McDermott et al., 1994) to 57% (n=100) (Grassi et al., 1999). In studies where gender differences were explored, women were more likely to exchange sex for drugs, money or a place to stay and men were more likely to purchase sex (Cournos et al., 1994; Tucker et al., 2003).

Risk of infection can be reduced if latex condoms are used consistently and correctly (Carey et al., 1997). Condom use has been measured among people with severe mental illness using a variety of scales. Regardless of the measurement method, researchers consistently reported very low rates (8-32%) or infrequent and inconsistent condom use (Kelly et al., 1992; Diclemente and Ponton, 1993; McDermott et al., 1994; Cournos et al., 1994; Knox et al., 1994; Susser et al., 1995; Grassi et al., 1999). The only exception to this was Tucker et al's (2003) study of 154 people with 'severe' mental illness and HIV, where 97 people (63%) reported condom use. While many of the behaviours identified are important risk factors for people who do not experience mental health problems, the sequelae of severe mental illness, including: cognitive, social skills and problem solving deficits; the coexistence of substance abuse problems; and difficulty maintaining long term relationships, contribute to the risk of sexually transmitted infections (Kelly et al., 1997).

Sexual risk behaviour and diagnosis

Some studies explored the relationship between certain risk behaviours and the person's diagnosis. People with a diagnosis of bipolar illness were more likely than people in other diagnostic groups to have sex with a prostitute, engage in more homosexual activity (McDermott et al., 1994), and have intercourse with IV drug users (Volavka et al., 1992). Substance abuse was also linked to sexual risk behaviour in a number of studies. In several studies, participants reported using alcohol or drugs such as 'crack cocaine' before and during sex (Kelly et al., 1992; Kalichman et al., 1994; Menon and Pomerantz, 1997). By impairing judgement and disinhibiting behaviour, substance abuse increased both the risk of inconsistent condom use and the risk of engaging in sex with a high risk partner. Alcohol use before or during sex was significantly associated with receptive anal sex in females (Menon and Pomerantz, 1997).

Sexual risk behaviour and knowledge

Perhaps the most alarming HIV risk factor was the high rates of knowledge deficits about HIV and AIDS reported among participants in the studies (Kelly et al., 1992; McDermott et al., 1994; Kalichman et al., 1994). Forty-three percent (26) of the 60 participants in Kelly et al's (1992) study believed that heterosexual women cannot get AIDS and 45% (27) believed that a person's appearance signalled whether or not he/she was HIV positive. Similar deficits in knowledge were reported by Kalichman et al. (1994). For example, 37% (35) of the 95 participants believed that showering after sex prevented the person from getting HIV, 26% (25) thought a person had to have multiple sexual partners to get HIV and 24% (23) were of the opinion that people who got HIV from contaminated equipment when injecting drugs could not transmit the virus by sexual contact.

People with a diagnosis of schizophrenia were found to have significantly less knowledge about AIDS and HIV infection than other groups of people with mental illness such as depression and bipolar disorder (McDermott et al., 1994). Other writers reported anecdotal evidence of lack of knowledge around the reproductive system, with some women being unaware that sexual intercourse and urination involve separate body orifices (Davidhizar et al., 1991). This lack of awareness of

how behaviour might increase the risk of exposure to STD was possibly a contributing factor to risk behaviour. Although these studies were conducted with people outside Ireland, given the lack of knowledge around issues of sexuality published in studies involving the general public in Ireland (Rundle et al., 2004), it is reasonable to propose that similar deficits in knowledge in people with mental health problems in Ireland are possible and quite probable.

In the light of these findings, researchers stressed the importance of including a sexual health agenda for people with schizophrenia at policy, research and clinical practice level (Kelly et al., 1992; Gray et al., 2002a). However, McCann (2004) urged health professionals to exercise caution when exploring and debating this topic, so as not to stigmatise an already marginalised group. Given the historical view that mental health problems such as schizophrenia lead to unrestrained and socially dangerous sexual behaviour, this is advice worth heeding. However, it does not preclude nurses from taking an active role in sexual health education. The next section explores the research on sexual health education in relation to people with mental health problems.

Sexual health education and people with mental health problems[23]

The need for sexual education for people experiencing mental health problems is a recent theme within the literature (Ford et al., 2003). Some writers suggested that this is a direct result of the HIV/AIDS issue (Hajagos et al., 1998) and the sequel to public accounts of sexual abuse (Steiner et al., 1994). The majority of the papers published on sexual health education programmes focused on prevention of sexually transmitted diseases, negotiating safe sex and skill development in condom use. Twelve papers reported programmes in North America and two from the United Kingdom. The papers reviewed, subdivided into anecdotal accounts of positive outcomes (Sadow and Corman, 1983; Davidhizar et al., 1991; Assalian et al., 2000; Susser and Valencia, 1994; Woolf and Jackson, 1996; McCandless and Sladen, 2003), uncontrolled evaluations that incorporated some outcome measures, such as pre- and post-test evaluations (Goisman et al., 1991; Steiner et al., 1994;

[23] Some of the information presented here in relation to sexual health education has been accepted for publication in the Journal of Psychiatric and Mental Health Nursing (Higgins et al. in press).

Herman et al., 1994), and studies using randomised control designs (Kelly et al., 1997; Weinhardt et al., 1998; Kalichman et al., 1995; Otto-Salaj et al., 2001; Carey et al., 2004). The studies included both men and women diagnosed with what were described as 'chronic' or 'serious' mental health problems: schizophrenia, bipolar disorder or a major mood disorder. The education programmes varied in content and teaching methods and entailed between three (Goisman et al., 1991) and fifteen sessions of contact (Susser and Valencia, 1994). Some programmes were designed to be gender-specific (Otto-Salaj et al., 2001; Goisman et al., 1991), while others incorporated both male and female participants within the education group and were led by a male and female co-facilitator pair (Carey et al., 2004; Weinhardt et al., 1998). The vast majority of the reported work was carried out by members of the multidisciplinary team other than nurses; only two papers reported education by nurses (Davidhizar et al., 1991; Woolf and Jackson, 1996).

Outcome of education programmes

Due to variety in programme content and duration, and variations in participants (from in-patient or out-patient areas, differing genders and different mental health problems) it was not possible to make direct comparison between each programme. In addition, there were clear methodological limitations to many of the studies including: small sample size, lack of quality tools tested for reliability and validity, and short follow up period of the controlled studies. Only one study had a follow up interval of greater than 6 months (Otto-Salaj et al., 2001). Most outcomes were measured by self-reporting and participants were self selecting, raising the possibility of bias and recall problems. Many studies did not describe the method of random allocation, nor provide information on refusal or attrition rates. As the vast majority of the studies were undertaken in North America, this raised questions regarding transferability to cultures with different sexual values or customs. Additionally, many of the studies were completed with clients attending out-patient departments; therefore, the findings may not be transferable into in-patient acute units.

Despite these limitations, collectively, the studies provided evidence of both the feasibility and efficacy of sexual health education for people experiencing 'severe'

mental health problems. Findings demonstrated that clients who attended education programmes, which were facilitated in a sensitive and supportive manner, developed attitudes more favourable to condom use, improved knowledge of HIV risk and improved intention to avoid unsafe sexual practices (Otto-Salaj et al., 2001; Carey et al., 2004). Despite the difficulties in maintaining behaviour change, without follow up education booster sessions, clients who received education reduced the number of sexual contacts with multiple or casual partners and were less likely to engage in unprotected vaginal intercourse. The 'relapse' of behaviour, without booster sessions, is not unique to the people involved in the studies reported here. Relapse has been reported in studies involving gay men, a population sensitive to AIDS risk (Kelly et al., 1991), and is common with other health threatening behaviours such as smoking, alcohol and drug use. Accounts also suggested that the clients enjoyed the education programmes, developed an increased comfort in talking about sexual issues and felt more involved in decision making around their care (Sadow and Corman, 1983; Davidhizar et al., 1991; Assalian et al., 2000; Susser and Valencia, 1994; Woolf and Jackson, 1996; McCandless and Sladen, 2003).

Clients welcomed the opportunity to discuss sexual issues and appreciated being asked about a 'normal part of their lives' (Herman et al., 1994:100). Authors also reported positive interactions and free exchange of ideas within both the gender-specific and mixed group sessions (Woolf and Jackson, 1996). Contrary to reported staff fears, clients attended the education sessions, without any reported deterioration in their mental health or exacerbation of their distress (Herman et al., 1994; Steiner et al., 1994). Neither did clients have difficulty concentrating for the duration of the programmes, which challenged Welch and Clements' (1996) comment that many people, with 'chronic' mental health problems, lack the skills necessary to attend, process and transform information into behaviour. The findings also disputed other concerns reported in the literature, for example: discussing sexual issues encourages sexual disinhibition, increases or causes sexual 'acting out', worsens people's distress (Wasow, 1980; Goisman et al., 1991; Hajagos et al., 1998) 'provokes delusional preoccupations' (Assalian et al., 2000:29), and educating clients about condom use or their provision encourages promiscuity, as

people with mental health problems are not capable of handling their sexuality responsibly (Sadow and Corman, 1983; Davidhizar et al., 1991; Purdie, 1996).

Prescribed drugs and sexuality[24]

Although highly contested, the use of prescribed drugs is considered, by some, an essential part of the treatment of many people with mental health problems (Fortier et al., 2000). Medication treatments are based on the premise that mental distress is largely a function of some underlying pathology of the brain, some biochemical imbalance that has yet to be explained or demonstrated (Barker and Buchanan-Barker, 2005). Currently, in the Republic of Ireland the focus of the mental health services is on drug treatment (Government of Ireland, 2006), with a significant number of service users being prescribed three or more drugs (Schizophrenia Ireland, 2002). However, antipsychotic, antidepressant and anticholinergic drugs can have many adverse side effects, which severely impact on the quality of life of the person and add to the burden of distress (Gray et al., 2005). Among the many adverse effects is the impact of the drugs on sexual function.

The biological view of sexuality suggested that sexual function involves a complex interplay of neurotransmitters, hormones, and peptides that act both centrally and peripherally (Milner et al., 1999). Fortier et al. (2000) highlighted that our current scientific knowledge regarding sexuality cannot fully explain the neurophysiology, neuroendocrinology and psychological mechanism induced by drugs. In most cases, side effects that impact on sexual function are idiosyncratic and unpredictable (Assalian et al., 2000), with no apparent relationship between the type of drug used, dose and the incidence of a specific sexual dysfunction (Fortier et al., 2000). However, it is thought that drugs that enhance serotonin or decrease dopamine tend to diminish sexual function and desire (Keltner et al., 2002). In addition drugs that block the cholinergic and alpha-adrenergic receptors may have 'asexual properties' (Keltner et al., 2002; Baldwin and Mayers, 2003). It is beyond the scope of this chapter to do an in-depth discussion on the physiological theories that explain

[24] Some of the information presented here in relation to prescribed medication and sexual function has been published previously (Higgins et al. 2005)

iatrogenic sexual dysfunction[25]; therefore, this section, the final section in this chapter, explores the research evidence on the rates and types of iatrogenic sexual dysfunction induced.

Rates of drug induced sexual dysfunction

All conventional neuroleptics (Phenothiazines, Butrophenones, Thioxantines) can lead to sexual dysfunction (Fortier et al., 2000). The reported rates of sexual dysfunction in people treated with conventional neuroleptics ranged from 45-60% in men to 30-93% in women (Ghadirian et al., 1982; Teusch et al., 1995; Wallace, 2001). Reported rates of sexual problems as a result of antidepressant drugs were also high. In a multicentered, prospective, Spanish study involving 1,022 people, Montejo et al. (2001) reported a 59.1% overall incidence of sexual dysfunction when all antidepressants were considered as a whole. Men reported a slightly higher frequency of sexual dysfunction than women (62.4% and 56%). Similarly, in a review of research studies on antidepressants and sexual function, Rothschild (2000) concluded that 40% of people taking antidepressants will develop some form of sexual dysfunction.

Smith et al. (2002:52) attempted to challenge the frequently held view that mental illness 'ipso facto' leads to abnormal sexual interest. They studied the frequency of sexual dysfunction in a group of clients receiving conventional neuroleptics (n=101) and compared the findings to people attending a general practice clinic with minor respiratory infections (n=57 acting as normal controls), and people attending a sexual dysfunction clinic (n=55 acting as ill controls). Based on findings from a sexual functioning questionnaire they reported that clients' libido and masturbatory activity did not differ significantly from that of people attending a general practice clinic. However, the clients receiving conventional neuroleptics reported higher levels of sexual dysfunction (45%) than the group attending the general practice clinic (17%) but similar to the levels seen in the sexual dysfunction clinic (61%).

[25] A more in-depth exploration of neurophysiology, neuroendocrinology and psychological mechanism of drugs on sexual function can be located in Smith et al. (2002)

Impact of prescribed drugs on sexuality and sexual function

Sexual difficulties reported by female participants who were taking neuroleptic medication included arousal problems, poor vaginal lubrication, anorgasmia, irregular menses, amenorrhoea and menorrhagia (Teusch et al., 1995; Tran et al., 1997; Smith et al., 2002). In male clients, sexual dysfunction problems reported included difficulty in achieving an erection, including morning erections, to complete inability to achieve and maintain an erection sufficient for penetration. In addition, ejaculatory difficulties were found and included reduced ejaculatory volume, retrograde ejaculation, delayed ejaculation or total inhibition of ejaculation (Ghadirian et al., 1982; Bhui and Puffel, 1994; Smith et al., 2002). Isolated incidents of priapism have also been reported (Fortier et al., 2000). Gynaecomastia, galactorrhoea and breast discomfort has been reported by both sexes (Milner et al., 1999). Other adverse effects, from neuroleptic drugs, such as fatigue, sedation, extrapyramidal effects and weight gain can also reduce sexual desire and impact on one's sense of sexuality (Baldwin and Mayers, 2003; McCann, 2004).

The last decade has seen the introduction of the so-called atypical antipsychotics including olanzapine, risperidone, and the atypical drug clozapine. These drugs, when compared to the older antipsychotics were considered to be more effective in the treatment of positive symptoms and had a significantly lower incidence of extra pyramidal side effects (Campell et al., 1999). The efficacy of these drugs in relieving positive symptoms as well as negative symptoms was suggested to have favourable effects on interpersonal relationships, sexual interest and activity (Covington and Cola, 2000; Baldwin and Mayers, 2003). While rispirodone was known to be associated with galactorrhoea (Gupta et al., 2003), both olazapine and clozapine were considered to cause less sexual side effects[26] as they had a negligible effect on prolactin levels due to their weaker dopamine binding capacity (Campell et al., 1999). However, Mendhekar et al. (2004) reported on an incident of olanazapine-induced galactorrhoea in a female client and there was an increasing number of case reports of retrograde ejaculation and priapism with all three drugs (Emes and Milson, 1994; Compton et al., 2000; Songer and Barclay, 2001; Jagadheesan et al., 2004). Gregorie & Pearson (2002) reported on four cases of

[26] This may be due to the newness of the drugs and the reluctance of clients to report side effects.

unplanned pregnancy in women who had been changed from older, typical oral or depot antipsychotics to atypical drugs. They suggested that this can be explained by the loss of the contraceptive side-effect produced by the drug-induced hyperprolactinaemia, associated with typical oral or depot antipsychotics, in these women.

Treatment emergent sexual dysfunction has also been reported with virtually all antidepressant medication. The selective serotonin reuptake inhibitors (SSRIs) and clomipramine were most commonly associated with sexual dysfunction, followed by the monoamine oxidase inhibitors (MAOIs) (Milner et al., 1999). The sexual problems reported include decreased sexual desire, decreased sexual excitement, diminished or delayed orgasm, erection and delayed ejaculation problems. Painful ejaculation has been reported in association with a variety of antidepressants including the tricyclics, SSRI's and MAOI's (Aizenberg et al., 1991; Demyttenaere and Huygens, 2002). In addition, decreased nocturnal erections (Kowalski et al., 1985), galactorrhoea (Egberts et al., 1997) and although rare and mainly associated with Fluoxetine, loss of sensation in the vagina, nipples and penis were also reported (Neill, 1991; Michael and Mayer, 2000). In recent publications there was mention of a relationship between the withdrawal of SSRIs and the onset of persistent sexual arousal syndrome in women (Leiblum et al., 2005; Freed, 2005).

Anticholinergic drugs are frequently used to treat acute parkinsonism, dystonia and akathesia, which have been found to respond to this group of drugs. However, sometimes they are used prophylacticallly to prevent the onset of extrpyramidal symptoms, although data to support their use prophylactically are weak (Gray and Gournay, 2000). While anticholinergic drugs do diminish some side effects, they can cause erectile dysfunction in men and a failure of vaginal lubrication in women (Barnes and McPhillips, 1996).

Iatrogenic sexual dysfunction – clients' perspectives

Research from a client's perspective in Ireland (Schizophrenia Ireland, 2002), as elsewhere (Perreault et al., 2006; Gray et al., 2005), suggested that they are dissatisfied with the information they receive on drugs and would like more

education; in particular, on the side effects of medication that impact on sexual function (Happell et al., 2004; McCann, 2004; Lewis and Scott, 1997). In a UK survey of over 2,000 people who were prescribed medication for mental distress, 39% (780) reported experiencing side effects from the drugs that impacted on sexual function (National Schizophrenia Foundation UK, 2000). In comparison with the other side effects, such as fatigue, weight gain and tremors, the side effects impacting on sexual function were rated as the most troublesome by those experiencing them. Forty-four per cent reported stopping or reducing their medication without input from the health care professionals, with side effects being cited by 41% (820) as the main reason (National Schizophrenia Foundation UK, 2000). Clients (n=9) in Happell et al's (2004) study expressed a high degree of dissatisfaction with the information provided on medication and particularly with information about sexual dysfunction associated with particular drugs. They also expressed dissatisfaction with the failure of health professionals to monitor and evaluate the unwanted effects and were of the view that their experience of iatrogenic sexual dysfunction was often minimised or ignored. In addition, despite having frequent and regular contact with psychiatric nurses, the clients (n=30) in McCann's study, in London, reported that due to embarrassment they had not spoken to a health professional about their experience of side effects, which impacted on their sexual function (McCann, 2004).

Iatrogenic sexual dysfunction – nurses' perspectives

Registered nurses have various roles in relation to medication, including the functions of administration, education and monitoring of both the benefit and side effects of drugs (An Bord Altranais, 2003; Gray and Gournay, 2000). The body of research that examined the role of the nurse in relation to medication management suggested that although nurses acknowledged that education and monitoring of adverse effects were salient features of their role (Coombs et al., 2003), in reality they performed roles in relation to education and monitoring of side effects in an *ad hoc* manner (Happell et al., 2002; Cort et al., 2001; Jordan et al., 1999). In many cases the roles were what Jordan (2002:437) termed 'unoccupied professional territory', as they fell between the professional boundaries of doctors, nurses and pharmacists. Research into the more specific issue of how nurses addressed

iatrogenic sexual dysfunction with clients users was sparse. One study (n=122), however, reported reluctance on behalf of some (16%) community mental health nurses to inform clients about side effects that impacted on sexual function for fear of non-compliance (Cort et al., 2001).

Summary and conclusion

This chapter explored the literature on sexuality in the context of psychiatric nursing, with specific reference to the literature on sexuality and people with mental health problems. Historically, sexuality was viewed either as a cause or symptom of mental illness, thus linking the expression of sexuality to people with mental health problems in a negative manner. The genetic and degenerative theory of inheritance also fuelled ideas that people with mental health problems were hypersexual and a danger to the human race. Within this context, the psychiatric service took on a control and regulatory function in relation to sexual behaviour, segregating and assaulting the body and mind in the guise of therapeutic interventions.

Studies carried out in the USA and other countries, albeit mainly descriptive quantitative studies, supported the view that the patterns of sexuality activity among people with mental health problems were similar to people who did not have a diagnosis of mental illness and reflected a normal sexual desire. Research suggested that individuals with mental health problems experienced a variety of sexuality and relationship difficulties as a result of their mental illness, or secondary to their illness experience. It was noted that people with a diagnosis of severe mental health problems engaged in sexual risk behaviour putting themselves at risk of sexually transmitted diseases and sexual victimisation. The long-term effects of sexual violence on one's expression of sexuality were well documented, as were the sexual difficulties encountered by clients due to prescribed medications. In addition, the presence of mental health problems and suicidal behaviour among gay, lesbian and bisexual people was also confirmed by recent studies. Although limited in number, research that focused on the phenomenon of sexuality from the perspective of people experiencing mental health problems suggested they have an unmet expectation that psychiatric nurses acknowledge the sexual dimension of their

personhood, talk to them about sexual concerns and provide education and support in the area of sexual health care.

Despite the large amount of rhetoric on the importance of sexuality as a dimension of personhood within the health care literature and more specifically within the nursing literature, what was also evident from the review was the meagre amount of research on sexuality within psychiatric nursing. What was available consisted of small local quantitative studies suggesting sexuality as a dimension of the client's life was frequently ignored by psychiatric nurses in assessment discussions. The reliance on quantitative measures, however, did not give insight into how nurses constructed or understood the concept of sexuality. Neither did the research provide a conceptual framework for understanding the processes nurses used to organise their interactions and work so they could ignore the sexual dimension of personhood. Attempting to capture these processes by completing a larger survey design study was considered inappropriate. Hence, it was considered more fitting to explore this topic from an 'emic' perspective, using a Grounded Theory methodology. Therefore, the overall aim of this research was to develop a substantive theory of how psychiatric nurses respond to issues of sexuality in a clinical practice context. The next chapter will discuss the philosophical and theoretical positions that informed this study.

CHAPTER FOUR: PHILOSOPHICAL AND METHOLOGICAL PROPOSITIONS UNDERPINNING THE RESEARCH STUDY

Introduction

In Crotty's (1998) view, when setting out on a research journey, it is important to make explicit not only to the reader, but to oneself, the epistemological, ontological, theoretical and methodological assumptions that have shaped and guided the research process. He believed that setting forth the process in terms of the above four elements constitutes a 'penetrating analysis of the [research] process', as embedded in each element is a set of assumptions that has profound implications for the way research is presented and outcomes interpreted (Crotty, 1998:6). Schwandt (2003) suggested that grappling with ontological and epistemological issues is not about searching for a label that best suits, but confronting choices on how one wishes to live the life of a researcher. Although Glaser's (1978; 1992; 2001; 2005) approach to Grounded Theory is the primary methodology used in the study, grounding the process in epistemology assumed greater importance, given the competing views on Grounded Theory methodology and the debate over whether Grounded Theory stems from an objectivist or constructionist epistemology (Glaser and Strauss, 1967; Glaser, 1992; 2001; 2005; Strauss and Corbin, 1990; Charmaz, 2000).

This chapter begins with an exploration of the philosophical underpinnings of objectivism and constructionism and the implications of these for the practice of research. This is followed by a discussion on the Glaserian approach to Grounded Theory, which informed this study. During this discussion, reference is made to how Glaser differs from other approaches such as those propounded by Strauss and Corbin (1990) and Charmaz (2000). As the differences between the various approaches are dealt with elsewhere (Strauss and Corbin, 1990; Glaser, 1992; Melia, 1996), commentary is mainly confined to issues that help illuminate Glaser's approach. A critique of the various debates around the epistemology that are said to inform Glaser's approach to Grounded Theory follows. The chapter concludes with a statement on the philosophical assumptions that have guided the development of this Grounded Theory study.

Philosophical underpinnings of research paradigms

Research paradigms for human enquiry are frequently denoted by how they address the philosophical questions of ontology and epistemology (Polit et al., 2001). Ontology refers to assumptions about the form and nature of reality. It is concerned with the study of existence itself and differentiates between 'real existence' and 'appearance' (Higgs, 2001:49). Epistemology as a theory of knowledge informs methodology, through consideration of the nature of knowledge, how what exists can be known, and how we can know or validate what we know (D'Cruz, 2001:18). In many cases, within the literature, ontological and epistemological issues were frequently merged. In other situations, writers used terminology in inconsistent and sometimes seemingly contradictory ways, leaving the reader somewhat bewildered. This section explores my understanding of objectivism and constructionism, as a precursor to a subsequent discussion on the debates around the philosophical underpinnings of Grounded Theory.

Objectivism

Naïve realism and critical realism are the major ontological positions that have dominated contemporary discussions on social research (Smith, 1998). Naïve realism asserts that both physical and social reality exist independent of our knowledge, beliefs or descriptions; in other words, reality is independent of mind or consciousness (Crotty, 1998). This ontological position is frequently associated with an objectivist epistemology (Lincoln and Guba, 2000). Objectivism suggests that if meaning exists in objects apart from any consciousness, then we can understand and comprehend the world in its totality. Through the application of agreed canonical procedures to eliminate errors (known as the scientific method), it is possible to produce 'objective,' 'universal' and 'valid' knowledge, which reflects or mirrors the world (Lincoln and Guba, 2000). The empiricist and positivist approaches to research, which are based on these beliefs, emphasise the separate existence of a single and potentially knowable reality independent of ourselves. Implicit in this philosophy is a belief that it is possible to separate the person doing the research from the object of analysis; in other words, the values and beliefs of the researcher do not impact on the research. There is also a belief that social processes can be studied as hard facts and relationships between these facts can be measured

and established as scientific laws, in a detached and value neutral manner. Equally, if objects have intrinsic meaning, then knowledge is stable, fixed and unchangeable. Language is unproblematic, as words are a mirror reflection of things (Smith, 1998). Within positivism, observation and experimental tests are the basis for producing scientific knowledge, and the closed system of enquiry is the model and benchmark for good practice in social scientific research (Smith, 1998). These assumptions and procedures played an important role in generating claims about the ability to produce objective, unbiased, reproducible and universally valid knowledge (Smith, 1998).

Most researchers now accept that positivism in its purest form is untenable and adopt a more post-positivist perspective, which is a modified version of positivism (Lincoln and Guba, 2000). Post-positivists adopt a critical realist position. Critical realists, while also subscribing to the notion of the existence of an objective 'real' external world that can be uncovered by inquiry, are more sceptical than the naïve realists about their ability ever to know fully or apprehend the world (Smith, 1998). In the post-positivist perspective, knowledge is only an approximation. Post-positivists also acknowledge that values, prejudices and preconception can influence science. However, this influence is confined to what has been called the context of discovery (Smith, 1998), a phase of enquiry in which prior values or hunches can motivate researchers to select a topic for enquiry. However, these influences must, in the context of justification, be put to the test through evaluation by the scientific community (Smith, 1998). Like positivism, post-positivism is also concerned with the use of verificational methods that can be tested against procedures, agreed by the institution of science, called validity and reliability (Paley, 2005). In an attempt to capture as much reality as possible, post-positivists rely on multiple methods of data collection, including quantitative and qualitative data (Denzin and Lincoln, 2003).

The post-positivist approach to research, which underpins randomised controlled trials, survey research and some rigorously defined qualitative approaches to research, have been the dominant paradigm in nursing research. The emphasis on these methods within nursing reflects the close association with medicine and may indicate a desire to get academic recognition by emulating what is considered the

scientific method (Cutcliffe and McKenna, 2002). In today's climate of evidence based practice, where randomised controlled trials are considered the highest level of evidence, they are favoured by policy makers and funding agents (Government of Ireland, 2006).

Constructionism

Constructionism is a very broad and diverse perspective that has a strong thread of radical opposition to the traditional objectivist epistemology of empiricism, positivism and post-positivism. Ernest (1995) pointed out that there are as many varieties of constructionism as there are researchers. In the context of this discussion, I will focus on constructionism from two perspectives. Firstly, viewed from the perspective of the individual experience, it is frequently termed cognitive constructionism (Heap, 1995) or constructivism (Crotty, 1998). Secondly, I will address how this differs from the collective activity of meaning-making, termed social constructionism. Making a distinction between constructivism and social constructionism is important, as sometimes writers used social constructionism as an umbrella term for approaches that examine process models of cognition in psychology, or as a term to group together approaches to knowledge on the basis that they were against positivism (Redman et al., 2003). Differentiating between constructivism and social constructionism is also important as constructivism is not as concerned with the hold culture has on us; thus, the critical spirit that is part of social constructionism is not as evident in constructivism (Crotty, 1998).

In contrast to objectivism, cognitive constructionism or constructivism does not subscribe to the view that meaning inheres in the object, waiting for someone to discover it. Neither does it uphold the belief that we can have some kind of unmediated, direct grasp of the world, nor the belief that what we know about the world is a mirror of a world out there (Schwandt, 2003). From a cognitive constructionism perspective, meaning is not passively received or discovered through the senses, but actively constructed by the cognisant person as they engage with the world in a dynamic manner (Ernest, 1995). Although the world and objects in the world may be 'pregnant with potential meaning', meaning only emerges when consciousness engages with the world (Crotty, 1998:43). This view of

meaning-making focuses exclusively on the meaning-making activity of the individual mind, emphasising the role of the individual's cognitive mental operations and judgements in the construction of a meaningful reality (Heap, 1995; Schwandt, 2003). In summarising this view Heap stated:

> 'Cognitive constructionism takes the view that actions, artefacts and events in everyday life depend (to some degree) for their identity, intelligibility, stability and consequences on cognitive representation (plans, schemata, goals, processing rules) and process as enabled and constrained by cognitive architecture' (Heap, 1995:52).

Social constructionism is not in disagreement with cognitive constructionism as it presupposes a cognitive constructionism; however, it denies that we simply, as individuals, engage with objects in the world and make sense of them, at least in the first instance. Social constructionism, arising from the work of Berger and Luckmann (1966) suggests that reality is a function of shared meaning that is constructed, sustained and reproduced through life as we actively engage with each other in community. It is through the daily interactions between people, in the course of social life, that our version of knowledge becomes fabricated and constructed (Stainton-Rogers and Stainton-Rogers, 2001). Therefore, what we regard as truth is neither a product of objective observation of the world, nor a result of cognitive process but the result of social processes and social engagements (Burr, 1998).

According to social constructionists, we are all born into a world of meaning, 'a world already interpreted... [where] a system of intelligibility prevails' (Crotty, 1998:54). Through inhabiting and being inhabited by this world or culture, we acquire and internalise a 'system of significant symbols' that we use within social interaction to construct, sustain and reproduce interpretations of the world (Crotty, 1998:54). Thus, rather than thinking of ourselves as simply constructing meaning, as if it is all our own (cognitive constructionism/constructivism), we are in some ways constructing meanings from inherited understandings that we have acquired through a complex and subtle process of enculturation and internalisation (Berger and Luckmann, 1966). Our cultural heritage can therefore be seen as pre-empting the meaning we apply. Berger and Luckmann (1966), in what is considered the most influential text in social constructionism, *The Social Construction of Reality*,

suggest that reality is constructed through three 'moments': externalisation (whereby cultures, societies and social groups create particular versions of reality), objectification (whereby those constructed realities are made to appear real, naturally occurring, stable, out there and waiting to be discovered), and internalisation (whereby, through socialisation and enculturation, individuals incorporate this socially constructed reality into the world as if it was completely self-evident and taken for granted).

Social constructionism embraces the whole gamut of meaningful reality that includes the natural as well as the social world. For example, the tree may exist as a phenomenal object regardless of whether any consciousness is aware of it; however, it only exists as *a tree,* when consciousness engages with it. In addition, how we see the tree and the meaning we attach to it, such as beauty, strength, shelter or combustible resource, depends on our social and cultural context. Thus, the social in social constructionism is about the mode of meaning-making and not about the kind of object (Crotty, 1998).

Crotty (1998) suggests that constructionism brings objectivism and subjectivism together, in an integrated manner. Meaning or truth can no longer be described as objective – it is not out there, waiting to be discovered. By the same token, neither can it be described as subjective; we do not create meaning from nothing, as we are always working with the world, objects in the world and inherited meaning. Denzin and Lincoln (2003:35), however, disagree with Crotty as they suggest constructionism 'assumes a subjectivist epistemology'. This commentary may be based on the way constructionism is interpreted. Crotty (1998) views constructionism as an epistemology that informs theoretical perspectives and methodologies. Denzin and Lincoln (2003) in contrast, consider it a research paradigm and define subjectivism as individual understanding. The implications of a constructionist epistemology for the practice of research are vast. If we consider that meaning is constructed in interaction with the world, then it is no longer possible to separate the knower from the known, as they both inform one another as they interact. In suggesting this, there is an implication that neither is it possible to separate the social researcher from the world they study, nor for the 'constructions' they produce. In contrast to objectivism, which views knowledge and knowledge

production as disembodied, stable and value free, social constructionism views knowledge as always permeated with values, including the values of the researcher.

Central to constructionism is a belief that what we know about the world does not simply mirror its reality. All we produce are multiple representations and not reproductions of social phenomena. Therefore, what constructionism drives home is that there are multiple interpretations and no 'true' or valid interpretations. All that is available are helpful/unhelpful, liberating/disempowering, fulfilling/rewarding interpretations (Crotty, 1998). From a research perspective, this relativist approach, a source of much criticism of constructionism (Smith, 1998; Schwandt, 2003), has implications and this will be explored later in the chapter.

Social constructionism also highlights that knowledge is always constructed through the lens of our own interpretation and understanding, which is located within the various cultural and institutional discourses we have been exposed to and have internalised. Thus, any knowledge produced needs to be regarded with suspicion and interpreted with caution (Schwandt, 2003), as knowledge (truth) or knowledge production (research) is not apolitical or ahistorical, as suggested by objectivism, but a socio-cultural located activity that is open to constant change and revision. Consequently, there is a need for caution about claims made about 'truth', or claims made about scientific progress.

Constructionism as an epistemology can be said to inform the theoretical perspective of interpretivism (Crotty, 1998). However, my understanding is that although interpretivism and social constructionism share some common philosophical roots, they have evolved in two distinct ways. Interpretivism, although interested in exploring the meaning people attach to their experience and how those meanings are created, negotiated and sustained (Schwandt, 2003), is not as focused on the manner in which social phemomena are constructed, institutionalised and made into tradition (Crotty, 1998). In contrast, whether looking at the social or natural world, social constructionists as researchers are concerned with exploring how descriptive utterances are made to appear stable, neutral and independent of the speaker. They are also concerned with developing a critical understanding of the impact of social practices, discourses and institutions on our

understanding of the world. Thus, intepretivism could be said to lack the critical edge of social constructionism.

Relativism

Once it was accepted that, as a researcher, knowledge about the world is constructed and does not merely represent some external reality, and that multiple perspectives exist, the source of debate moved to relativism; a view that no form of knowledge is more valid than any other. This appeared to be the main criticism levelled against constructionism (Smith, 1998; Schwandt, 2003). If, as constructionism tells us, there is no true or valid knowledge, but multiple realities that are unique and not generalisable, then the question arises firstly as to how one synthesises data from multiple interviews and secondly, how one decides between different knowledge claims. If, as Crotty (1998) suggests, we are truly constructionist, then everyone can maintain whatever theory they prefer, as they are all based on constructions and as such are equally valid. Secondly, if no consensus exists, data should be presented as complete manuscripts, uninterrupted and unchallenged, which could be considered a form of journalism. Such a relativist position, also, calls into question the value of research, as both research-based and non research-based theories are equal. It also suggests that there is no way to make any judgements about the scientific process or its outcomes (Lomborg and Kirkevold, 2003). This leaves research in a 'theoretical black hole' as decisions can be reached idiosyncratically (Rolfe, 2006a:7) and pushes researchers into 'an infinite regress of meaninglessness' (Emden and Sandelowski, 1999:5). To resolve this question, some writers returned to a discussion on realism and its relationship to constructionism (Heap, 1995; Crotty, 1998; Lomborg and Kirkevold, 2003; Rolfe, 2006a).

Constructionism was often spoken of as non-realist or antirealist. Some critics assumed that when constructivists stated that meaning was constructed or when social constructionists stated that there was nothing outside the text or discourse, they were making an ontological claim that rejected an external world (Dickson, 1995). In Schwandt's (2003) view this is confusing epistemological claims with ontological claims. Constructionism confines itself to epistemological claims and

generally does not display any interests whatsoever in an ontology of the real. This lack of emphasis on the ontology of the real does not equate with the complete rejection of an objective world (Rolfe, 2006a). What was untenable in their view was the idea that there existed a 'single' objective truth that described the world, or that we could get unmediated access to that world in a mirror image manner (Rolfe, 2006a). This is different to denying that there is any material base for reality or for shared experiences or understanding. Paley (2005) suggested that the belief that there was no distinction between how the world was experienced and how it was, left no room for mistakes, misconceptions or fallacies and was more a psychosis than an ontology. Saying meaningful reality is constructed does not make it any less real. 'Mental illness' is a socially constructed concept – it exists because professionals have created, in the form of the Diagnostic and Statistical Manual of Mental Disorder (DSM) or the International Classification of Diseases (ICD), rules and criteria that define something as a mental illness (Kutchins and Kirk, 1997). To say, however, that 'mental illness' is a social construct, is not to deny the person's experiences or to say that the person's experience is illusionary. The idea that what we label 'mental illness' is a construction and may change if the powers that be decide to change the rules does not make the person's experience any less real. In other words, to say that 'mental illness' is a social construct that has been created within discourse and is subject to change over time is an epistemological claim, not an ontological one (Hammersley, 1992; Crotty, 1998). Thus, constructionism can also be considered to be informed by realist ontology or a modified realism that emphasises representations rather than reproduction (Rolfe, 2006a). To say that constructionism is informed by realism, is not a return to objectivism, it is simply saying that although the final 'truth' about reality can never be established due to limitations of all human knowledge, the idea of 'truth' does not have to be abandoned completely.

Heap (1995) helped to clarify the issues further in an article on constructionism by differentiating between what he calls 'monist' and 'dualist' researchers. Monists run on 'one metaphysical rail' (Heap, 1995:55). In their perspective, constructionism is not just confined to the topic of study, but characterises the complete research process. For a 'monist', reality is constructed separately by each individual, and any attempt to form collective agreement on the validity of a statement is meaningless,

as all statements are subjective and unique. Thus there are only representational claims, the adequacy of which cannot be raised, as there are no objective features upon which to base a judgement of adequacy. 'Dualist' constructionists, in contrast, distinguish between the person's construction of that reality and an objective reality, and are prepared to judge the adequacy of any claims made against available knowledge. Heap's (1995) typology corresponded with Schwadt's (2003) weak and strong constructionism. Within strong constructionism, there are no frameworks permissible for judging the content, meaning, truth, or reasonableness of claims, as all knowledge is a construction. Thus any framework developed is simply a reflection of the discursive community of researchers that developed it. Weak constructionism, on the other hand, tends to see some underlying objective element to reality that can inform evaluation and judgement.

Rolfe (2006a:14) attempted to resolve the dilemma and stated that ultimately in nursing 'we *have* to make validity judgements about the competing claims of different research paradigms and individual studies'. What we, therefore, need to be concerned about is the criteria we use to judge the validity of knowledge, and we need to recognise that there is no neutral position from which to make a judgement about validity. Whatever criteria used and judgement made are always contingent upon and open to alternative criteria and judgements. The criteria for judging the validity or trustworthiness of a Grounded Theory study will be explored later in the thesis.

Grounded Theory: Background and roots

Glaser (1998:22) suggested that piecing together the roots of Grounded Theory is neither easy nor linear. Grounded Theory as a methodology was developed from the experience of two sociologists, Anselm Strauss and Barney Glaser, when they were studying the experience of dying patients in hospitals in 1967. The principles and practices that were generated when doing this research were subsequently formalised into a methodology.

The Grounded Theory method was shaped and informed by two different schools of thought: the Chicago school of qualitative research and the Columbia school of

quantitative research. Strauss, while studying in Chicago, was trained by Herbert Blumer and Everett Hughes in symbolic interaction and qualitative research methods. Glaser, in comparison, was trained at Columbia University, and was influenced by the work of Lazarsfeld on qualitative maths and quantitative methodologies and Paul Merton's course on theory development. Later, while studying literature at the University of Paris, he was trained in the skill of 'explication de text', which emphasises the importance of 'reading closely line by line to ascertain what exactly the author is saying without imputing what was said, interpreting it or reifying its meaning' (Glaser, 1998:24). Although many writers tend to refer solely to the impact of symbolic interactionism on Grounded Theory (Annells, 1996; Parahoo, 1997; Evans, 2001; McCann and Clarke, 2003c; Streubert-Speziale and Carpenter, 2003), it was from the combination of two different schools of thought and experience that Grounded Theory was born. Glaser's ideas around a concept indicator model of index formation and his training in 'explication de text' was merged with Strauss's symbolic interactionist focus on the study of process, action and meaning.

Grounded Theory as a methodology – Glaser's approach

Grounded Theory is the systematic generation of theory from data and is typified by concurrent activities of data collection, organisation and analysis (Glaser and Strauss, 1967; Glaser, 1998). One of the assumptions underpinning Grounded Theory is that human existence is characterised by what Glaser called a 'latent pattern' of behaviour, of which people are not conscious (Glaser, 1998:117). The goal of Grounded Theory, therefore, is to generate a theory that accounts for that pattern of behaviour and makes the latent process visible to both the reader and the participants, in a way that it is immediately recognisable. In order to accomplish this goal, a Grounded Theory researcher tries to understand problems, action and meaning from the perspective of the participants, and generates an explanatory theory of how participants continually process and resolve their main concern. Emphasis is placed on letting the problem or concern emerge from the participants' perspective as opposed to predefining the problem or 'fitting' the problem into a pre-existing theoretical framework. While all research is grounded or based on data, what Grounded Theory aims to do 'is to relate theory generation to data in a close,

cogent way, so that the data are not forgotten, slighted or forced in the service of an extant theory' (Glaser, 1998:18).

Although often categorised solely as a qualitative method (Annells, 1996; Silverman, 2000; Denzin and Lincoln, 2003), Grounded Theory transcends any one type of data and is a general method that can be used with any form of data collection. Glaser (2003) believed that as a result of many eminent writers propounding on methodology and mixing qualitative data analysis methods and Grounded Theory, the goal of conceptual theory generation was often eroded in favour of conceptual description. Thus, Grounded Theory became, by default, remodelled into qualitative data analysis with all its emphasis on coverage, description, accuracy and member checking (Glaser, 2003). According to Glaser (2003) the goal of Grounded Theory is theoretical completeness, not descriptive coverage. The second problem with categorising it as a qualitative method is that writers such as Smith and Biley (1997) in critiquing Grounded Theory studies, ignored the maxim 'all is data' and raised questions about Grounded Theory studies that used questionnaires as part of their data source. In Glaser's words, 'whether soft or hard, it [data] is just grist for the mill of constant comparison and analyzing' (Glaser, 1992:11).

Grounded Theory analysis differs from traditional qualitative analysis in a number of ways. Firstly, conceptualisation is the core process of Grounded Theory. Although the Grounded Theory comes from data, unlike qualitative research which focuses on producing 'thick descriptions' of data, the grounded theorist does not describe in detail the data from which the theory emerged. While the analyst will use some data to illustrate and support the resulting theory, the focus is not on organising a mass of data, but on organising ideas that emerge from data. In order to make theoretical sense of so much diversity in the data, the analyst conceptually transcends the data and develops ideas on a level of generality higher in conceptual abstraction than the material being analysed (Glaser, 2001). Qualitative data analysis depends on thematic analysis and content analysis, but the germane connections between the themes identified are frequently left undeveloped. In Grounded Theory, these linkages are made explicit. Hence, Grounded Theory does not generate findings in the qualitative data analysis sense; what emerges in

Grounded Theory are abstract patterns called categories and properties, connected into a core category. Thus, 'grounded theories are conceptual communication concerning observation of how persons resolve particular problems in a particular area' (Glaser, 2001:27).

Grounded Theory can be used to generate either substantive or formal theory. Although they differ in levels of generality, they can both be considered as mid range theories in that they fall between a working hypothesis and an all inclusive grand theory (Glaser and Strauss, 1967). Substantive theory focuses on a substantive or empirical area of inquiry such as an aspect of patient care in nursing, whereas formal theory focuses on a conceptual level of enquiry such as 'stigma' (Glaser and Strauss, 1967). Strauss and Corbin (1990) later suggested that a substantive theory evolves from the study of a phenomenon in one particular situational context, whereas with a formal theory the phenomenon is studied in several different types of situations. However, Glaser (1992:99) disagreed that the difference purely related to the number of situations sampled, as one can vary the number of situations sampled and 'still stay on the same substantive area level'. Thus, the difference for Glaser (1992) was more a conceptual level difference as opposed to a sampling difference.

Grounded Theory as a research method – Core characteristics of Glaser's method

Grounded Theory method offers a rigorous, orderly guide for theory development. Although structured and systematic, it is designed to allow the researcher to be free of the structure of more forced methodologies. The goal is not to control what is going on in the data, but to help keep theoretical control over what is emerging (Glaser, 1998). In fact, its real strength lies in its open ended approach to discovery. The data controls the emergent theory and 'the natural social organisation of substantive life is allowed to emerge' (Glaser, 1998:41). The following four techniques lie at the heart of the Grounded Theory method: coding, constant comparative analysis, theoretical sampling and memoing. These techniques are used to guide the analytical process towards the development, refinement and the identification of the interrelationship between concepts (Charmaz, 2000). While

each technique serves a different purpose, its use is guided by the emerging theory (Glaser, 1978).

Coding

Conceptualisation of the data through coding is the foundation of Grounded Theory. The conceptual code is the link between the data and the theory. Coding is the process by which categories and their properties are generated. Glaser (1978) identified two types of codes: substantive codes and theoretical codes. Substantive codes fracture the data and identify ideas emerging from the data. They are used to build the conceptual theory, and result in the formation of categories and properties of the theory. Substantive codes can be 'in vivo', in that they come from the language of the participants, or 'in vitro', constructs by the researcher to reflect the data (Strauss, 1987:33). Both Glaser (2001) and Charmaz (2000) were critical of researchers who import coding concepts from other theories, without them having earned their way into the theory. In other words, grounded theorists cannot 'shop their disciplinary stores for preconceived concepts and dress their data in them' (Charmaz, 2000:511).

Theoretical codes, in contrast, conceptualise how the substantive codes will relate to each other when integrating the theory. In other words, 'they weave the fractured story from concepts back into an organised whole theory' (Glaser, 1998:163). Glaser (2005) offered a number of theoretical coding families that may be used to integrate the theory. These coding schemas are only proposed as a set of lenses or perspectives through which the researcher might view the data. Glaser (1998:165) was adamant that theoretical codes, like substantive codes, must be emergent in the data and earn their way into the theory; in his words, 'they must pattern out to be verified in order to provide grounded integration'. In this context, he was critical of Strauss and Corbin's (1990) over-emphasis on the use of the one coding paradigm, the 6 C's of cause, context, contingencies, consequences, covariances and condition. He was of the opinion that this emphasis led to a destructive forcing of data into a pre-existing framework, which was contrary to the whole Grounded Theory process (Glaser, 1992). Strauss and Corbin (1990) also offered a number of techniques for interrogating the data; however, Glaser (1992:123) in a strong rebuff to both authors, suggested that what they had developed was another methodology,

which he referred to as 'full conceptual description'. He believed that Strauss and Corbin changed the focus of Grounded Theory from the discovery of what is important to the participants, to the researcher's agenda (Glaser, 1992).

There are many conceptual levels in Grounded Theory. The most fundamental conceptual framework is the distinction between category and property. Both categories and properties are concepts that are indicated by the data, but are not the data itself. In other words they 'have a life apart from the evidence that gave rise to them' (Glaser and Strauss, 1967:36). A category is a higher level concept than a property. It stands by itself as a conceptual element of the theory and captures the underlying patterns in the data. A property is a conceptual aspect or element of a category (Glaser, 1998). The core category is the highest level of categorisation. It is the one that constantly reoccurs and relates to all the other categories and their properties. The core category is also the one with the most explanatory power. Through its relationship to other categories, the core category accounts for most of the ongoing behaviour, as well as variations in behaviour in the substantive area being researched (Glaser, 1998).

Constant comparative analysis

Grounded Theory is based on a concept-indicator model, which directs the conceptual coding of indicators or incidents within the data. Constant comparative analysis is an ongoing process that commences after the first pieces of data are collected and only ends with the write up. Initially, the researcher compares the indicator to other indicators and generates a conceptual code or concept that captures the meanings of that indicator. Once a concept is identified, other indicators are compared with a view to identifying similarities, differences or varying conditions. This constant comparison of indicator to indicator, and later of indicator to concept, forces the researcher to confront degrees in consistency of meaning between indicators and concepts. From the comparisons of further indicators to the concept, and concept to concepts, the concept is sharpened to achieve its best fit, while at the same time identifying its properties (Glaser, 1978). In this way, Grounded Theory is a repetitive process, as the researcher is constantly returning to the data to elaborate theoretically, saturate and verify the emerging

interpretations and concepts (Glaser, 1998). This constant interplay back and forth between data and the theory enables the emerging theory to be constantly modified for fit and workability.

As the theory develops, various delimiting features of the constant comparative method help reduce and focus the theory. Delimiting occurs at various levels. Firstly, as the theory emerges, the researcher identifies similarities in concepts and properties and formulates them into a smaller number of higher level concepts, thus reducing the number of concepts for coding. Secondly, as the theory grows, the researcher begins to focus on the core category and variables related to the core. The theory is also delimited through the process of theoretical saturation of a concept. Saturation means that no additional information is being found whereby the researcher can develop properties of a category; the category has earned its way into the theory (Glaser, 1998). Saturation and delimiting is based on the interchangeability of indicators. This means that while 'incidents are empirically different, they indicate the same concept, its properties and/or its hypothetical relation to other categories and their properties' (Glaser, 1998:141).

This understanding of comparative analysis differs from comparative analysis used in other research approaches. Within the quantitative tradition, comparative analysis may mean statistically comparing individuals, groups and organisations to check if the initial evidence is repeatable and correct (Polit et al., 2001). Within the qualitative tradition, comparative analysis has been used to verify, clarify and extend existing theories. It has also been used for the purpose of comparing extracts from qualitative data in order to build a framework for the organisation and description of data such as thematic analysis or content analysis (Burnard, 1991). In each of these situations, theory generation is secondary either to verification or the organisation of data. In the context of Grounded Theory, the purpose of comparative analysis is primarily theory generation. In other words, comparative analysis 'is not used just to prove something as fact but is used to identify the properties and indicators of a category and help theory reduction by delimiting the theory's boundaries of applicability' (Glaser and Strauss, 1967:24).

Theoretical sampling.

Theoretical sampling is another methodological concept that is considered to be a defining property of Grounded Theory and part of the comparative process (Charmaz, 2000). It is a form of non-probability sampling. Glaser (1998:157) suggested that theoretical sampling is both directed by the emerging theory and further directs its emergence and 'is the conscious, grounded deductive aspect of the inductive coding, collecting and analysing'. The basic question in theoretical sampling is where to go next in data collection in order to develop the theory. Glaser (1998) believed that participants, events, sites or other sources of data (for example, documentation) are selected on the basis of theoretical purpose and relevance as opposed to structural circumstances. Analytical interpretations developed from the constant comparative process are used to guide and focus further data collection, which in turn informs, refines and develops the emerging categories and their properties. Therefore, selection criteria are continually tailored to further the development of emerging categories. There is no set sample size or limits set on the number of participants or data sources, just sampling for saturation and completeness, which results in an ideational sample, as opposed to a representative sample (Glaser, 1998). The researcher can only state in retrospect how many individuals, groups or documents, were sampled and from where. The criterion used to guide the researcher on when to stop sampling is theoretical saturation.

Charmaz (2000:519) suggested that theoretical sampling helps 'to define the properties of categories; to identify the context in which they are relevant; to specify the conditions under which they arise, are maintained and vary; and discover their consequences'. The necessity of engaging in theoretical sampling means that the researcher cannot produce a Grounded Theory based on one round of data collection. Instead, theoretical sampling requires that the researcher returns to the field in order to develop and refine the emerging theory. Theoretical sampling, by its nature, keeps data collection of the same issues to a minimum and focuses on the need for data that is relevant to the emergence of new categories and their properties (Glaser and Strauss, 1967).

Participants, groups or events can be selected to either minimise or maximise differences in the data. Minimising differences increases the possibility of collecting similar data on a given category and its properties, thus verifying its existence and establishing a set of conditions under which the category exists. The purpose of maximising difference, by seeking comparative data, is not about 'covering the field in its entirety' but helping to ensure 'theoretical completeness of the category' (Glaser and Strauss, 1967:55). Glaser and Strauss (1967) suggested that researchers should focus first on similarities before moving on to maximise differences. Maximisation of differences is an important process in achieving saturation, as it 'maximises the variety of data bearing on a category and thereby develops as many diverse properties of the category as possible' (Glaser and Strauss, 1967:63).

Memos

Memoing is a central aspect of Grounded Theory methodology and is used to keep track of and preserve conceptual ideas about the emerging theory. Glaser (1998:177) described memos as 'a moment capture', in that they 'are the theorizing write-up of ideas' and meanings about the growing theory at the moment they occur. They are used to record ideas about codes and their theoretical relationships as they emerge during coding, collecting, and theoretically sampling. In addition, during constant comparison, the researcher may experience many non-grounded ideas that come from personal biases, personal experiences, or received preconceptions; thus, memos have a clear function to allow the expression of these distortions so that they will not interfere in the grounding of the theory (Glaser, 1998). Memos can also include questions that the analyst would seek to answer during the course of data collection. Charmaz (2000:517) suggested that memo writing can help the researcher 'to grapple with ideas about data, to set an analytical course, to refine categories, to define relationships among various categories, and to gain a sense of confidence and competence in their ability to analyse data'.

Classifying Grounded Theory – Induction and deduction

The classification of Grounded Theory as an inductive (Parahoo, 1997) or deductive (Carney, 2004) approach to research is an over simplification of the thinking

patterns involved in Grounded Theory. Although Grounded Theory is primarily an inductive methodology, in that it commences with the data and builds a theory based on the systematic analysis of data, rather than using existing theoretical perspectives, to classify it as wholly inductive is to ignore the subtle interaction between induction and deduction as one theoretically samples. Glaser, who acknowledged his dislike of using the word deduction, as it 'smacks of forcing' the data, goes to pains to point out that 'it is not logical, conjectured deduction based on no systematic research' (Glaser, 1998: 43), but a carefully grounded deduction based on an induced category, that directs the researcher on where to go next for data to compare. The researcher starts by coding, conceptualising and generating hypotheses about the relationship between concepts, and then begins to deduce where more data can be found (theoretical sampling) for comparative purposes. Thus, Grounded Theory is both inductive and deductive, with deduction primarily in the service of induction. Strauss and Corbin (1994) suggested that the reason researchers may over-emphasise the inductive part of the methodology is related to the initial presentation of Grounded Theory in *The Discovery of Grounded Theory* Book (Glaser and Strauss, 1967). Because of the rhetorical nature of the text and the (then) authors' wish to emphasise the need for grounded theories, they overemphasised the inductive element.

Grounded Theory epistemology – Objectivism versus constructivism

There is an ongoing debate within the literature on whether Grounded Theory is situated within an objectivist or constructionist epistemology. A number of writers suggested that classical Grounded Theory as associated with Glaser leans toward an objectivist epistemology (Annells, 1996; 1997; Charmaz, 2000; 2001; McCann and Clarke, 2003b). In the seminal text, words such as hypothesis, variable and verification, which are frequently associated with objectivism were used (Glaser and Strauss, 1967). The use of these words, however, does not make the methodology objectivist in its intentions or process, and are more a reflection of the historical and social context in which the text was written.

Charmaz (2001) argued that because grounded theorists offer a 'dispassionate, objective account' of their data, with an absence of both the participants' and

researcher's voices, it is assuming the position of objective observer, and as such is positioned within a realist ontology and an objectivist epistemology. She also suggested that Glaser's methodology fosters the idea that the researcher is merely a conduit for the research process as opposed to an active creator in the process (Charmaz, 2000; 2003). Annells (1997:123) held similar views and stated that Glaser's theory is underpinned by a view that a 'real' reality awaits apprehension (albeit imperfectly)...a reality waiting to be found'. These analyses of Glaser's approach to Grounded Theory are premised on a number of beliefs. Firstly, if one assumes a realist or critical realist position it automatically means an objectivist epistemology, with the position of the researcher being one of objective detachment. Crotty (1998) was critical of writers who automatically inferred that realist ontology meant objectivism, and an incompatibility with a constructionist epistemology. As Crotty (1998:10) pointed out, scholars like Heidegger and Merleau-Ponty frequently invoke a 'world always already there' but they are far from objectivists.

Secondly, Charmaz's (2000; 2003) comment on the absence of participants' voices is to misrepresent the methodology and its aims. The aim of Grounded Theory is not qualitative description of 'voices', but the development of a theory of a concept that has arisen from 'voices', and transcends any one voice in terms of conceptualisation (Glaser, 2002). Grounded Theory names a latent pattern of behaviour from the particularistic accounts, a pattern of which participants often may not be aware. It is not surprising, therefore, that in a response to Charmaz's comments, Glaser suggested that she talks the talk of 'conceptualisation', but walks 'qualitative description' (Glaser, 2002:6).

Charmaz's (2003) comment on the absence of the researcher's voice and the researcher being a conduit appears to be a reference to reflexivity. Hall and Callery (2001) also advocated the use of reflexivity in Grounded Theory. Reflexivity is based on the notion that the researcher is part of the social world they study and as such can have a significant impact on the study process and outcomes. The challenge, therefore, is to engage in a reflexive process in order to make explicit those influences. Charmaz's and Hall and Callery's comments appeared to be based on the assumption that Glaser's methodology ignored the possible impact of the

researcher on the whole enquiry. They also appear to take no account of the role of the constant comparative process in minimising the influence of the researcher on data collection and analysis. Glaser continually acknowledged that the researcher's voice can impact on the data, and challenged the researcher to be conscious of not conjecturing, forcing, or importing ideas and agendas into the research. Consequently, he highlighted the role of memos and personal interviews with self in making explicit one's pre-assumptions, and the subsequent use of that data in the constant comparative process (Glaser, 1998; 2001). If used as outlined, the constant comparative process, theoretical sampling and memoing will ensure that concepts are discarded if they do not fit the data; thus reflexivity is built into the methodology of Grounded Theory. However, Glaser did caution against 'reflexivity paralysis' and turning the study into an auto-ethnography (Glaser, 2001:49), thus derailing the purpose of Grounded Theory, which is to provide a conceptual theory of a latent pattern of behaviour.

Charmaz (2001:249) also suggested that Glaser implied that 'like wondrous gifts waiting to be opened... categories and concepts inhere in the data and may even leap out' at the researcher. Annells reiterated some of this view in the following comment: 'the researcher capable of clearing pre-conceived ideas, focuses on a general interest and the problem for attention is disclosed from the data' (Annells, 1997:123). This portrayal of Grounded Theory appears to ignore the constant interplay back and forth between data and the theory which characterises the constant comparative process and theoretical sampling. It is within the context of the objectivist and constructionist debate that Charmaz (2000) published a method called Constructivist Grounded Theory. In a response to this publication, Glaser rebuked the idea, saying that 'Constructivist Grounded Theory is a misnomer' as 'Grounded Theory uses all data'; thus, constructivist data is just another type of data (Glaser, 2002:9).

Glaser (2001:31) was of the opinion that defining an epistemological basis for Grounded Theory would destroy the emergence at the heart of the technique; thus, he accused those who attempted to box the methodology of engaging in 'rhetorical wrestle'. He was of the view that as a method it can be used with any epistemology and it is up to the researcher, working from the principle 'all is data' to decide how

they wish to operationalise the methodology. In Glaser's words 'Grounded Theory is a general method that can be used on all data in whatever combination' (Glaser, 1998:42). Interestingly, Annells (1997) suggested that Glaser's stance on epistemology is a reflection of his distance from the academic community and his lack of awareness of the contemporary debates and issues influencing qualitative enquiry.

Philosophical and methodological underpinnings of this study

Developing a philosophical and methodological position for this study involved me in many conflicting views. The often contradictory landscape of the literature frequently left me both bewildered and frustrated. Having struggled with the issues of epistemology, the position I adopted for this study is informed by constructionism and the belief that knowledge and meaning about the world is not discovered or created, but constructed by human beings as they engage with the world they are interpreting. Thus, the data produced are constructed from the shared experience of the participants and myself during the interviews. Whilst I subscribe to the idea that there is a plurality of meanings and perspectives, I also accept that there is a world of collective shared understandings. Thus, I do not adopt a relativist position. This is not a return to positivism, but an approach to knowledge that accepts that although there is no direct access to reality, and that data are constructed from the shared experience of the participants and myself, there is a basis for common experiences and collective understandings. It is important to acknowledge that the theory produced, through Glaser's approach to Grounded Theory, is only one interpretation and not a reproduction of the world. Hammersley and Atkinson (1995) however, conclude that although a study may be a construction of the researcher's own making, it is no less valuable as a representation of social phenomena. To say that the theory is an interpretation and representation and therefore fallible, is not to deny that judgements can be made about the soundness, adequacy or probable usefulness of it (Strauss and Corbin, 1994). Therefore, as a researcher, I was concerned with the issue of the validity or trustworthiness of the findings. According to Glaser (1978) the criteria for evaluating the validity of a Grounded Theory study are fit, relevance, workability and modifiability. These criteria will be returned to in the final section of the thesis (chapter eleven), where

issues in relation to the validity or trustworthiness of the emergent theory will be discussed.

Summary and conclusion

This chapter outlined the main epistemological, ontological and methodological propositions that have informed my research journey. In particular, I highlighted the debates around objectivism, constructionism and relativism and discussed how these have impacted on Grounded Theory. I explored the development and methodology of Grounded Theory and in particular Glaser's approach, which is used in this study. Within this exploration, I highlighted what I understood to be the central tenets of a Grounded Theory methodology, and explored how Grounded Theory as a methodology differed from qualitative research. I also set out an argument, suggesting that constructionism was congruent with Glaser's approach to Grounded Theory. Within this chapter I highlighted how Grounded Theory had its own inbuilt system to help the researcher remain open and reflexive in relation to their possible impact on the study. Drawing on the ideas presented in this chapter, the next chapter discusses how the methodology was operationalised in the conduct of this study.

CHAPTER FIVE: OPERATIONALISING GROUNDED THEORY METHODOLOGY

Introduction

This chapter discusses how the philosophical and methodological propositions outlined in the previous chapter were operationalised in the conduct of the study. The chapter begins with a brief description of the aim of the study and the research setting. I then discuss how access and ethical permission to conduct the study was gained. Finally, I explore how data were collected and analysed through the constant comparative process.

Although I present the research process in a linear manner, it must be emphasised that this Grounded Theory enquiry was not a tidy process. Learning Grounded Theory for me was praxis learning (Schreiber, 2001), as it was only in applying the method, reflecting on the process, and applying what I had learned through reflection that I got what Glaser called the 'delayed action learning curve of Grounded Theory' (Glaser, 1998:2). Consequently, I frequently re-visited, revised, re-visioned and reconstructed ideas. Emphasis, therefore, within the chapter, is given to personal reflections on the process of doing Grounded Theory and commenting on how challenges met along the way were navigated.

Aim of the study

Asking a truly accurate research question is impossible before beginning a Grounded Theory study, as the focus of the research problem should emerge from the participants (Glaser, 1992; Streubert-Speziale and Carpenter, 2003). Therefore, this study had a broad aim, which was to develop a substantive theory of how psychiatric nurses respond to issues of sexuality in a clinical practice context.

Although I recognised that predefining exact research objectives in a Grounded Theory study was contradictory, in the context of applying for research funding the following tentative objectives were developed:

(i) to explore how psychiatric nurses conceptualise sexuality in the context of psychiatric nursing practice

(ii) to elicit the mechanisms that psychiatric nurses employ to respond to the sexuality needs of people experiencing mental health problems

(iii) to explore the factors that influence the way psychiatric nurses respond to issues of sexuality in practice

The research setting

The study was conducted in a mental health service in a large city in the Republic of Ireland. The service provided a comprehensive range of adult psychiatric services, including community, inpatient, and day hospital services to a socially and economically varied population of approximately 138,000 (based on the Census of 1996). While it contained many severely disadvantaged localities, it also extended to a number of relatively affluent districts. The service was linked with a number of third level academic institutions for undergraduate and post-graduate nursing and medical education as well as being a site for the education of other professional groups such as family therapists and chaplains.

The philosophy of the care documented was grounded on a Christian tradition that acknowledged the need to respect each person's dignity, rights and civil liberties, while acknowledging and respecting other traditions. Fundamental to the philosophy was a belief that caring implies a partnership and a journeying with people in their search for support, for meaning, for acceptance, and for healing.

Gaining access

Gaining access to the research site was mainly a practical matter. Initially, telephone contact was made with two mental health services, purposefully selected from a particular region in the country. On the advice of the Directors of Nursing in both services, a letter explaining the nature of the study, plus a research proposal was sent to a named person, for their consideration. Following a meeting with the Director of Nursing in one of the sites, permission for access, pending ethical approval, was given. Despite a follow up phone call and information being re-sent, no acknowledgement or correspondence was received from the other service.

Recruitment and sampling

Recruitment of participants

The first step in the recruitment process consisted of the Director of Nursing writing to each nurse working in the clinical area, informing them about the study and requesting permission for their names and contact details to be forwarded to me. The nurses were also informed, by the Director of Nursing, that this did not indicate an agreement to be part of the study. An invitation letter and detailed information leaflet about the study, developed by me, was also included with the letter from the Director of Nursing (see appendix one and two). As an outcome of the request from the Director of Nursing, I received the names and contact details for one hundred and thirty four nurses who were in agreement that I contact them regarding participation in the study.

Contact was initially made either via the telephone or in person. Over the course of data collection, contact was made with 32 nurses: 13 men and 19 women. Two nurses (one man and one woman) said they would consider my request and phone me later to make arrangement for an interview; however, no subsequent communication was received. The remaining 30 nurses were very positive about the study, agreeing immediately to participate, organising a date, time and venue.

Of the 30 who agreed to participate, 27 were interviewed, ten men and seventeen women. Two men cancelled the interviews on two separate occasions, and one woman failed to turn up for the interview. As all three people had my contact details, I was unsure whether their actions were an indication that they did not wish to participate; therefore, I did not make any further contact with these prospective participants.

Developing the theoretical sample

Theoretical sampling, as discussed in the previous chapter, is a defining feature of Grounded Theory, as people, events, or documents are selected based on the emerging theory. At the beginning of data collection, there was no evolving theory to direct data collection; therefore, I entered into the process by purposive sampling as opposed to theoretical sampling. Purposive sampling consisted of choosing

individuals or locations that in my opinion could provide a perspective on the issue under consideration (Cutcliffe, 2000). In this enquiry, it seemed appropriate to talk to nurses working in community settings. This decision was based on the assumption that the clients with whom they were working were over the acute phase of their distress, and living in relationships, so there was an increased likelihood that they would be addressing sexual issues as part of the plan of care. It was also based on the assumption that as these nurses were experienced practitioners, they would have overcome some of the inhibitions around talking about sexual issues that had been reported in the literature.

Following initial coding and analysis of data, it became clear that interviewing nurses in acute hospital settings and psychiatric day hospitals would add to the development of the theory. This was subsequently followed by interviewing nurses working in rehabilitation and community residential settings. The purpose of maximising difference, by seeking comparative data, was not about covering the field in its entirety but about helping to develop as many diverse properties of a category as possible, thus ensuring theoretical completeness (Glaser and Strauss, 1967).

As an outcome of further data analysis and to aid the development of particular aspects of the theory, recently qualified nurses were also interviewed, as were more male nurses and nurses who had worked outside of Ireland. The sampling of nurses based on years of experience or gender was not assumed but based on the emerging theory; thus, 'earning their way' into the theory (Glaser, 2001:33).

Theoretical sampling is not just about sampling people, but is about sampling data to support the emerging concepts and theory. By the time six interviews were completed and analysed, concepts were beginning to form; therefore, in subsequent interviews I asked more theoretically focused questions, to sample specific events and incidents, while still allowing for the emergence of new ideas and concepts. Theoretical sampling of nursing records and organisational policies was also conducted as part of the study.

Due to participants' commitments, I rescheduled a number of interviews; consequently, the interview data were collected over a period of sixteen months. Interviews lasted between 50 minutes and 2 hours. In total, I had 33 hours of taped interviews, which did not include the time I spent with participants before the interview getting to know them or after the interviews in social conversation.

Profile of the participants

All participants were registered psychiatric nurses, 12 with a general nursing qualification. At the time of the interviews, 15 participants had an academic qualification in nursing at the level of diploma or higher and two were pursuing a degree programme. In addition, several participants held diploma qualifications in management, counselling and complementary therapies. At the time of the interviews, the participants were employed at staff nurse or at clinical nurse manager grade and were working in a variety of mental health settings: community residence (7), day centre (2), day hospital (2), admission unit (6) long stay/rehabilitation unit (4), and community health centre (6). Their clinical experience in psychiatric nursing, since qualifying, ranged from less than one year to over twenty years. Nineteen participants had previously worked in psychiatric services other than the research site (appendix three provides a more detailed biographical account of participants).

Data collection methods

Data for the study were collected using a combination of interviews and documentary analysis.

Interview as a data collection method

The interview as a data collection tool has been described as a conversation with a purpose; the purpose being to get a depth of meaning and understanding (Maykut and Morehouse, 1994). However, postmodernist debates have heightened our awareness that meanings are socially constructed, thus the interview is also a site for the construction of meaning (Holstein and Gubrium, 2003). The postmodernist lens has also raised debate around whether the interview produces data that is a

direct mirror reproduction of the person's world or merely a symbolic representation that has been influenced by interaction between the researcher and participant.

Interviews vary from highly structured standardised survey interviews to free-flowing information exchanges (Holstein and Gubrium, 2003). In this study, an unstructured in-depth interview was used at the outset of data collection. In line with Grounded Theory methodology, however, the interviews became progressively more focused as theoretically focused questions were developed and asked (Wimpenny and Gass, 2000; Charmaz, 2003).

Interview process

Some writers suggested that, 'given the "grip" of sex, its potential to embarrass and strong conventions about its "private" nature', it was probably the most difficult research topic to pursue (Stainton-Rogers and Stainton-Rogers, 2001:195). In addition, Wengraf (2001:46) was of the opinion that, in sensitive research, 'rapport talk' needed to be developed before report or 'referent talk' was likely to be of high quality. Rapport talk is social talk, used as a means of getting to know the person; in contrast, report talk or referent talk is talk about the substantive area. Bearing these comments in mind, prior to commencing each interview, I spent time with the participant talking about general subjects from the weather to health policy, to their experience of research. This time was also used as an opportunity for the person to get to know me; therefore, I answered questions about myself, the research study and the consent process. Each interview started when the participant, as requested by me, indicated that they wished the tape recorder to be turned on.

As part of the research proposal for funding, I developed an interview schedule consisting of a list of possible questions for discussion (see appendix four). Following a workshop with Dr. Glaser, and more in-depth reading of Grounded Theory literature, I recognised that using the interview schedule at the beginning of the research was inimical to Grounded Theory methodology. Pre-defining the questions had the potential to pre-frame the problem and force participants to talk

about what I considered were the issues, as opposed to focusing on their concerns. Therefore, the interview schedule as designed was not used.

Since the ultimate aim in a Grounded Theory inquiry, in Glaserian terms, is to identify the participants' core concerns and describe the process they use to ameliorate or resolve those concerns; then, the first goal was to gain an understanding of the basic social problem from the participants' perspective. Although I had identified the area of sexuality for the study and had ideas around what I thought the problem was, I was very conscious of Glaser's (1992) warning that if one is too specific at the outset, it could lead to forcing and, consequently, the real issues become obscured. Hence, as advised by Glaser (1998) I endeavoured to 'instil a spill', by commencing the interviews with a very open and broad statement that permitted participants to talk freely about their issues.

The idea that people construct themselves as they tell their story certainly rang true in this study. Sexuality was something that participants had not given much thought to in the context of professional practice. The interview was, in many cases, the first time they had an in-depth conversation about the subject. Throughout the interviews there was a sense that participants lacked linguistic fluency about sexuality, as they struggled to find words to articulate their ideas. Often participants did not speak in complete sentences and jumped between ideas; commenting on the fact that they were rambling or that they were contradicting themselves. In many cases participants had to be given time to collect their thoughts and formulate responses. In these situations, I had to balance the need to stand back and allow the person to wander and discover their own thoughts and feelings, with my own internal urge to explore emerging categories and properties of categories.

Many participants repeatedly used the phrase *'you know what I mean'*, sometimes assuming that I did, and sometimes using it as an appeal for confirmation that what they said was not extraordinary. On many occasions, rather than glossing over meaning, I responded by saying *'No I am not clear, could you explain to me?'* Thus, the interview was a shared dialogue, rather than a one-way transfer of information from the participant to me. In the beginning, I struggled to get a balance between probing to get an understanding and being perceived as too interrogative.

During the course of the interviews the revisionist nature of experience also became evident, as the participants' narratives were constantly prone to revision and reinterpretation. For example, initially some participants said they had no difficulty talking to clients about sexual issues, but as the interviews progressed and they began to talk and think about their often taken-for-granted assumptions and practices, they started to revise this perception. Thus, by engaging in conversation, rather than adopting a distant, non-involved stance, I got some insight into the processes that participants use to respond to clients' sexuality.

As the study unfolded and categories began to be developed, questions aimed at identifying properties of categories were identified and explored in subsequent interviews. In this way, the emerging concepts determined both the questions asked and the theoretical sample. Although I continued to facilitate open, non-directed discussion at the beginning of all interviews, the interviews gradually became more focused as I took a more directive role in asking questions. In this way, the evolving narrative of the participants and my understanding of that narrative were constructed, and the web of interconnections between the participants' stories began to take shape. At the end of each interview I shared with the participants my construction of the stories I had heard, and looked for other possible constructions that might challenge my emerging theory. In addition, on the advice of Schreiber (2001), I ended the interviews with the following questions: *'Did you get to talk about everything you had planned on talking about'*? and *'Is there anything else I should know about that I didn't ask'*? As part of my own reflexivity and development, I also asked participants to comment on their experience of the interview and my style of interviewing. In most situations these questions did not produce any new data; however, they did reveal the power of the interview as an intervention.

The interview as an intervention

A number of writers commented on the therapeutic potential of allowing people to narrate their story within a research interview (Lee Murray, 2003; Rahm et al., 2006). Narrative theory views reality as a dynamic process and proposes that both the narrator and reality are created and recreated through the narrative (Frid et al.,

2000). In other words, through creating a narrative of something that has previously occurred, the narrator not only creates his or her identity, but also reformulates new meanings and understanding. The narrative, therefore, is not merely a repetition of a rehearsed story, but a creative process that reformulates descriptions and casts new light on that which is familiar (Frid et al., 2000). In this study, some participants, when commenting on the experience of the interview, suggested that talking about their practice was a positive learning experience. Phrases such as *'The interview is good as it has made me more conscious of things'* (13 F), *'It definitely made me think about things*' (15 M) and *'It has definitely given me food for thought'* (24 F) were common sentiments expressed.

Comments also suggested that the interviews were not just dialogues between participants and myself, but acted as personal reflexive dialogues for a number of participants. The opportunity to narrate their story within the interview seemed to facilitate both reflection and revision for some participants. According to Slater (2004:123) revision is evident when people are 'willing to rethink their behaviour, break up their beliefs and create a new paradigm to accommodate new ideas and information'. The following comment suggested that by engaging with the narrative, this participant was beginning to revise her perception of herself and see a need for change:

> *'I am so glad I did this [interview], honestly, because you think of yourself as being a certain way, you think I am a good nurse and I can talk to people about things and then you start talking about something like sexuality and you realise that it never comes into my head. ... I am thinking about so many things now, it has been really good for me' (26 F).*

By talking about their experiences and hearing themselves explain their actions, some participants appeared to begin a process of challenging their thinking and practices. The following comments suggested that some left the interview more introspective about their practice in relation to clients' sexuality.

> *'It [interview] forced me to look at issues that, I suppose, I had let be swept under the carpet and kind of skimmed over, not thought about, because you see people doing things and without realising you do it yourself, so it made me look at things' (14 F).*

> *'This has really made me think, it has really opened an area that I have to review and given me food for thought (pause). Like it's to promote positive*

sexual health and an awareness of sexual health is what I should be doing, rather than trying to introduce prohibition' (16 M).

Tape recording the interviews

Glaser (1998) advised researchers to write detailed field notes instead of tape recording interviews. He was of the opinion that tape recording gave the researcher a false sense of security that everything was captured; thus, blocking the energy for in-depth exploration in the interview, and for ongoing analysis and memoing. In arguing for field notes, he highlighted the potential for tape recording to result in an overwhelming amount of data at the expense of relevance and focus. He also stressed that the researcher was not aiming for descriptive coverage but conceptual abstraction; therefore, did not require the minute detail of every word spoken. For both academic requirement and because of my own limited experience, I tape recorded all but one interview, with the participants' permission. In addition, I wrote a memo immediately after each interview (see appendix five for an example).

Having completed the Grounded Theory, I now have a greater insight into the rationale for Glaser's views on tape recording. In hindsight, tape recording did result in the collection of large quantities of data that were expensive to transcribe and time consuming in terms of checking and cleaning transcripts. In addition, large quantities of similar data were collected and transcribed, which did not substantially add to the theory developed.

Data collection methods – Documentary analysis

Documents in the form of nursing documentation and policy documents were also included in the data collection phase. The decision to search nursing records was taken based on emerging concepts. During the course of the interviews, in one particular aspect of the service, participants commented on the recent introduction of a risk assessment that had a section on sexual risk. The decision to theoretically sample nursing records was, therefore, more about 'enlarging the landscape of the enquiry', to develop properties of a category as opposed to confirming or refuting existing data (Tobin and Begley, 2004:393). As the risk assessment was so recently introduced it was agreed with the clinical nurse manager and Director of Nursing that the best way to access data on the risk assessment was for them to select the

last 20 nursing records of clients who had come to that part of the service. In total, 22 anonymous records were given to me for analysis. In addition, copies of the service philosophy and clinical policies were also provided. This stage of the analysis involved spending approximately 20 hours in the research site analysing nursing documentation and policy documents.

Data analysis: Generating the Grounded Theory

Within the literature, descriptions of data analysis frequently consisted of researchers presenting the process in a seemingly logical, unproblematic manner, involving open coded, compared, categorised, and identified properties. In some cases, people presented their data analysis and code/category reductions in a mathematical, linear diagrammatic format. This emphasis on diagrams and on code reduction procedures is possibly due to the emphasis within the literature on the need to produce a detailed audit or decision trail to establish trustworthiness of the research process (Koch, 1994; Mays and Pope, 2000). My experience of data analysis was a much more messy, circular and fluid process and does not lend itself to a simple mathematical reduction of the numbers of codes. It was characterised more by recycling, renaming (codes, categories), rewriting (interpretations), rereading (data and literature), re-questioning (participants and self) and at times losing faith in both the methodology and my own conceptual ability.

Data analysis commenced immediately after the first interview. To begin the process, verbatim transcripts were made of all the interviews. As I did not personally transcribe the interviews, I checked each transcript for accuracy against the recording. I also used this opportunity to clean the interview transcript of any personal identifiers, such as the name of an organisation, person or training school. Prior to commencing coding, in an attempt to immerse myself in the data, I re-listened to each interview. Using a foot controlled audio machine, I also simultaneously listened to the tape recording as I analysed the data. The concurrent process of listening and analysing enabled me to capture pauses, changes in tone of voice and other verbal nuances that might have impacted on the possible meaning of a statement; thus, the risk of misinterpretation was minimised.

Open coding

Open coding was the first step in the analysis. Grounded Theory does not go with holistic reading of an interview or field notes for the overall conceptual impression; therefore, I commenced open coding, as described by Glaser (1998), by reading line by line and coding for everything possible in the data. In many cases I coded the same piece of information in a number of ways. Having coded four interviews, and despite Glaser's warning that the licence to conceptualise should not go unfettered in an ad hoc or impressionistic manner, I had over 200 codes and memos, many of which held little meaning (see appendix six for the list of open codes). During a subsequent workshop with Glaser I realised I had over fractured the data, in his words 'I had tortured the data' (Glaser 2004, personal communication). My initial approach, on reflection, was the result of a number of errors. Firstly, I had coded and recoded data in every possible way as advised, but omitted the important step on constant comparative analysis in the meaning and naming of a code. Secondly, my approach to coding was driven by an anxiety that I would miss out on something within the data. In other words, I was aiming for theoretical coverage and failed to believe that if an issue was significant in terms of the theory, it would reappear in subsequent interviews. I also failed to take on board the principle of theoretically sampling data, in that I could always revisit previous interviews and theoretically sample them for incidents. Once I made this discovery, using a combination of in vivo and in vitro codes, and the constant comparison of incidents, I began to code at a higher conceptual level. For example, instead of writing a descriptive level code, such as 'medication', I began to code for the action within the incident such as 'hiding sexual side effects' and 'prioritising side effects'.

The early stages of open coding produced a large amount of unrelated concepts, as the initial fracturing of the data involved breaking down descriptions to conceptual fragments (see appendix seven for an example of an early memo from open coding). In this way I was violating the story and ended up with conceptual confusion. The reason for this confusion, according to Glaser, was that no model had yet emerged to organise and integrate the concepts into theory (Glaser, 1998). Glaser (1998:149) cautioned the researcher to resist the urge to reinstate control and to delay putting the story back together, in favour of 'getting theoretical completeness, and

accounting for as much as possible with as few concepts'. Forcing, according to Glaser, often resulted from an inability to tolerate the ambiguity, cognitive confusion and the out of control feeling that the early part of a Grounded Theory study requires and generates in the researcher. Despite my cognitive understanding of Glaser's statement that 'life itself is normative and forcing is a normative projection, a learned preconception, a paradigmatic projection, a cultural organisation' (Glaser, 1998:81), I found this stage of the research process difficult and challenging. I was data collecting, coding and memoing without a clear focus or destination. At one point, due to anxiety and impatience with my inability to see coherence in the categories, I tried to reinstate control by imposing a theoretical code in the form of a typology of behaviour. However, this was abandoned as it did not facilitate the integration of all the categories.

In order to get through this confusion and frustration, I continued to collect and compare data, and develop the categories in greater detail. I was also guided by Glaser's questions: What is this a study of? What categories does this incident indicate? What property of what category does this incident indicate? (Glaser, 1998:123). This model of asking questions, comparing incident to incident, code to code and later category to category, resulted in the development of concepts and their properties. Similarly, through the constant comparative process, concepts and categories were merged and given a higher conceptual code (see appendix eight for an example of a later memo). In some situations codes were excluded; this was not because they were unimportant, but by the very nature of Grounded Theory, a process of selection was required. Consequently, if a code did not contribute to the theory it was omitted. A decision to omit a code only occurred late in the process as the theory was taking shape. However, even if a code was omitted in the early stage, there was always a possibility that it could become important as the theory developed. Thus, it could be reinstated, as decisions were never fixed.

Schreiber and Noerager-Stern (2001) suggested that the researcher doing Grounded Theory may not be aware of the ideas and preconceived notions that they may have about an area of study and should make every effort to uncover and challenge them. This view was emphasised in the writings of both Blumer (1969) and Glaser (2001) who suggested that concepts identified from prior sources must be carefully

scrutinised and only brought into the study if support was found in the data. For example, I identified some concepts from the literature, such as lacking comfort and lacking education; consequently, I was alert to anything in the data that might reinforce or refute these concepts. While these concepts did emerge in the data they only accounted for a small amount of the final theory.

Identifying the core category

In Glaser's (2005), opinion, if a researcher does not conceptualise participants' main concerns it becomes difficult to discover a core category. Frequently, people are not aware of their latent pattern of behaviour; therefore, it takes time for their concerns and the core category to emerge and be conceptualised. In this study, it was through the constant process of fracturing the data, with substantive codes, and the continual asking of questions (such as, 'what is going on in the data?', 'what are the participants' main concerns?', and 'how do they resolve their concerns?') that I conceptualised participants' main concern, as 'the desire to protect their own and clients' vulnerabilities'. Although the main concern emerged early in the analysis, it was only after interviewing fifteen participants that the core category *'Veiling Sexualities'* emerged. As a core category, *'Veiling Sexualities'* met Glaser's (1998) criteria of constantly reoccurring in the data, and being the one with the most explanatory power to integrate all other categories in the theory.

It is hard to describe exactly how the core category emerged. Emergence does not mean that it simply appeared. It was the result of the rigorous processes of constant comparison, theoretical sampling, theoretical sensitivity, memo writing, mapping, sorting and giving myself some mental space to process ideas (Glaser, 1998; 2001). A certain element of the analysis was as a result of what Glaser called preconscious processing (Glaser, 2005 personal communication). For example, at times I would work for three hours at the analysis and abandon it with frustration, only to get conceptual clarity regarding relationships hours later, when I was engaged in non-academic work. When that occurred, I immediately noted the relationships on a piece of paper and checked at some later time to see if my ideas patterned out.

Selective coding

Once the core category was identified, the study was delimited by selectively coding on the core category and related categories. By selective coding, in combination with theoretical sampling, analysis became more focused and the categories were developed and saturated. In addition, code names were modified and changed to achieve the best fit. For example, the subcategory 'voluntary confession' was changed to 'voluntary disclosing by another' and the concept 'mental scripting' was renamed 'mythical self talk'. Although this description suggests sequential steps, in reality open coding and selective coding overlapped.

In hindsight, although I delimited the theory and asked theoretically focused questions about the emerging theory, I continued to allow people a lot of opportunity to talk about their general experiences of talking to clients about sexuality. This decision was more a reflection of my needs: firstly, to give people an opportunity to tell their story in their way; secondly, my obsession with not missing anything; and thirdly, not fully believing the power of Grounded Theory as a methodology. As a consequence, my engagement in data collection was possibly prolonged beyond what was required. I did delimit during my analysis of the transcripts and focused on the emerging categories. However, my failure to keep the later interviews confined to theoretically focused questions did demonstrate Glaser's (1998) argument that collecting similar incidents does nothing to aid the development of a theory as it ignores the interchangeability of indicators.

Theoretical coding

The researcher's main objective is to synthesise emerging categories by creating theoretical links between them, which is called theoretical coding. Theoretical codes are abstract models for the integration of substantive codes (Glaser, 2005). Although Glaser (2005) provided a number of possible theoretical codes, the decision on how to integrate the theory was not based on simply selecting a theoretical code and imposing it. Like everything else in Grounded Theory, a theoretical code must emerge from the data as opposed to being forced onto the data. In this study, once the core category of *'Veiling Sexualities'* emerged, I began to see the interrelationship between the categories and the relationship to the core. It

was also clear that my core category was a basic social process; thus, the theoretical code of process, in combination with causal models and stages, emerged as the way to integrate the theory.

Theoretical saturation

Theoretical saturation is said to be reached when no additional data are being found to develop properties of a category (Glaser and Strauss, 1967). I ceased data collection after the 27th interview, as very few modifications to my theory had been made from the 24th interview onwards. Although I ceased collecting data, I am in agreement with Cutcliffe and McKenna's (2002) view that saturation and 'knowing' is always provisional, tentative, and requires an element of faith. There was always the possibility that, had I continued, the next person might have given me data that indicated another property of a category. In addition, given the revisionist and educational impact of the interview, as discussed, there was the possibility that, had I re-interviewed the participants at some later stage, their practice and perceptions might have changed.

Data analysis: Use of memos, mind maps and computer technology

Memos

Throughout the whole process of the research, memos were written. Memos are what some writers would call a reflexive journal (Lincoln and Guba, 1985; Rolfe, 2006b). Memos were both recorded on the computer and hand written. To aid memo writing and not lose ideas, I carried a note book with me at all times. At the beginning of the research, I searched the literature for a structured approach to memo writing and located guidelines from Strauss and Corbin (1990) and Wengraf (2001). Although these were informative, I took Glaser's (1998) advice not to constrain memo writing by prescriptions and rules, and adopted a totally free approach. Memos were used to record analytic and reflexive insights and process decisions and outcomes.

During the coding and analysing stage, analytic memos were used to capture and track conceptual ideas about the emerging theory. Although I did not use a formula,

I was cognisant of Glaser's (1998) advice and utilised the memos to write about the grounded meaning of codes and not simply to document code titles and lists of properties. I also recorded ideas that emerged from talking to people, other than the participants, about the study area and the emerging theory. The memos were also used to store theoretical questions that needed to be explored in subsequent interviews. In the early part of the study, the memos consisted of just a few lines on the code. As the study progressed and memos were compared, sorted and merged they became more comprehensive and in-depth. After each interview, I also recorded any issue that I considered could affect me making sense of the data and any observations I made, especially if I collected data within a clinical environment. I also documented my own non-grounded ideas about the theory (Glaser, 1998). Once recorded, my conjectured or pet theories were checked with the data. In addition, memos were used to record my learning and as a debriefing tool to document my feelings and frustrations during the course of the research. Process memos were used to record factual accounts of decisions taken, meetings attended and outcomes of decisions and meetings during the course of the study.

Mind maps

As described, memos were written descriptions of codes, concepts and their relationships. Although written memos were central to data analysis, I found them inert in terms of getting an overall visual image of emerging concepts. Consequently, in addition to the memos, I continually mapped out emerging concepts and ideas in flow charts, which ultimately resulted in the creation of a large mind map (6'x 6') on the wall. Mind mapping permitted me to get involved physically in the construction of the theory; I was able to write concepts on coloured post-its and move them around to make connections and relationships. This visual representation, together with the written memos, helped me move from a descriptive level of analysis to a more conceptual level.

Computer technology

At the outset of the research journey, I decided to use NUD*IST 4 (non-numerical, unstructured, data: indexing, searching and theorising), a qualitative text analysis software package as a data analysis aid (Richards, 1998). To learn about its use, I

attended a training programme. Following completion of the training, I had reservations about its potential benefit. My reservation related to the linear way codes were created and later merged which appeared to be not in keeping with my reading of Grounded Theory. However, I used it for the first eight interviews as a data storage and memo storage device. When each code was identified it was entered into NUD*IST and a memo written about that code. After the first four interviews, I found my focus on the technology was hampering my style of working. It hampered my ability to memo quickly, and reduced my freedom to move fluidly between memos on different concepts. Initially I put this down to lack of skill with the technology and my novice status as a Grounded Theorist. After analysing four further interviews, I found the technology very restrictive to my creativity and conceptual ability. Consequently, I decided to memo using a combination of a loose leaf note book, where I could record hand written memos, and Microsoft Word documents. Subsequent to this, NUD*IST was only used as a storage package for coded pieces of information, so that I could quickly retrieve a quote as an exemplar.

Ethical considerations

In health and social care research, ethical concerns are focused on the use of human beings as research subjects. Hyde and Treacy (1999) suggested that human interactions in the research process are often complex, unforeseeable and changeable; hence, there are ethical implications at every stage of the research process. In addition, ethical tensions and obligations may be increased within studies that involve investigating sensitive topics such as sexuality, as there is the potential to invade the person's psyche (Lee, 1993). For some nurses this may be therapeutic; however, for others it may produce pain, distress and emotional upset. This 'double-edged potentiality' of knowledge production poses ethical issues (Sieber and Stanley, 1988:49). In addition, studies of a qualitative nature also give rise to complex ethical issues, as one can not predict beforehand what may surface during the course of the interview, thus, making informed consent a challenge (Parahoo, 1997; Polit et al., 2001). This study was governed by the principles of beneficence, non-maleficence, fidelity, justice, veracity and confidentiality as outlined by the International Council of Nurses (2003). It is within this ethical

framework that the following section describes the ethical issues that arose during the course of the study and outlines how these issues were resolved. For me, however, ethics was also about an embodied ethical self, a way of being, as opposed to simply following prescriptive rules.

Ethical approval to conduct the study

Gelling (1999) suggested that the primary obligation of a research ethics committee is to protect the rights of research participants. Ethical approval to conduct the study was sought from the ethics committee of the University and the local research ethics committee of the service where the study was conducted (see appendix nine and ten for letters of approval). Both committees required a detailed ethics application form to be completed and submitted. When completing the applications, I was conscious that the literature indicated a frequent tendency on behalf of review boards to find fault with protocols that involved socially sensitive research; hence, I was meticulous in answering questions and supporting my proposal with literature (Lee, 1993). In addition to the written application, which sought ethical approval for interviews and documentary analysis, the chairperson of the ethics committee of the service requested that I attend a meeting with the committee members. The purpose of this meeting was to clarify issues and answer questions they had regarding the study. Their questions focused on methodological issues in relation to Grounded Theory and questions in relation to getting consent from participants. Although the committee members were challenging in their questioning, they were far from being what Berg termed 'handcuffs impeding the search for scientific answers to social problems' (Berg, 2001:45). They were very supportive and affirmative of the value of the study. At the end of the interview they also offered to be available for ongoing advice and assistance should I encounter any unforeseen ethical issues during the course of the study. This, I believe, was not just an indication of their commitment to their role as protectors of the rights of the research participants, but also an indication of their commitment to me as a researcher.

Informed consent

Process consent: The doctrine of informed consent, essentially a legal doctrine, was developed out of recognition of a person's right to be treated as an autonomous agent who is capable of self determination (Usher and Arthur, 1998). Informed consent implies that the researcher has made the most honest effort possible to ensure that the potential participants understand the risks and benefits of participating in the study; they are informed about their rights not to participate and are presented with information that is free from overt or covert coercion (Parahoo, 1997; Christians, 2003). In all research, informed consent is a complex issue; however, it was even more complex in this Grounded Theory study as I was not entering the field with a detailed structured interview schedule, and therefore could not predict beforehand what topics would be discussed during the course of the interviews.

The process of gaining consent can be viewed as a static, one-off event or a continuous process that requires negotiation throughout all aspects of the study (Parahoo, 1997). Munhall (1991:260) described the latter as 'process consent' and suggested that the static model is inadequate for qualitative research, due to the changing nature of data collection inherent in qualitative research. Process consent is essentially about entering into a collaborative dialogue with the participants and fostering a consent dialogue throughout the research process (Usher and Arthur, 1998). This requires that, throughout the research process, the researcher constantly uses their 'best skills' of listening, attending, clarifying, making explicit the implicit and genuinely attending to the person before them (Roberts, 2002). As process consent was in keeping with my own philosophy of working, and with the overall research paradigm, I adopted this model of consent from the outset.

Initial contact: As stated in the section on access to the service, all proposed participants were sent written information about the study. The written information sheet contained an explanation of the study, including the aim, purpose, methods and procedures for data collection and the procedure for protecting their identity. Participants were also informed that they had the right to withdraw from the study at any stage without obligation (i.e. without having to offer an explanation). Upon

my first personal contact with the prospective participant, this information was reiterated verbally and the person was given the opportunity to ask questions and seek clarification on any issue before they consented to be interviewed. My aim, during this initial discussion, was to foster an open exchange of information where the person felt free to ask questions, seek clarification and agree or decline to be interviewed without fear of repercussion. I was also conscious that this was my first verbal engagement with the person and, should they consent, it was an opportunity to begin the process of building a rapport. In situations where participants said they had mislaid the original information sheet this was re-sent, with a letter confirming the date, venue and time for the interview (see appendix eleven for letter). At this time, participants were also informed that if they changed their mind they could cancel the interview by voice mail or e-mail or simply not turn up for the interview.

Prior to the interview: Prior to commencing the interview, a detailed explanation about the research process was reiterated and participants were informed that they had the right to withdraw at any stage, decline to answer a question or request to have the tape-recorder turned off without obligation. They were also informed that if they wished to provide an explanation that I would be happy to listen, but at no stage would I try to get them to change their mind. At this stage, participants were again given an opportunity to ask questions and seek clarification on issues before the interview began. They were also reminded that they were free to ask questions during the course of the interview.

Following an explanation of the consent form (see appendix twelve), and sufficient time for the person to read it thoroughly, each participant was asked to sign, giving written consent. Signing the form at this stage indicated that they were consenting to be interviewed and to have the interview tape-recorded. Only one participant declined to have the interview tape-recorded; however, they were happy that I record field notes during the interview. Initially, I was a little concerned about my ability to listen attentively and capture what the person had to say, however, I was amazed at how much of the interview I managed to capture in my field notes. My ability to retain and record the essence of the interview may be due to the fact that I had interviewed a large number of people at this stage and had heard many of the concerns and ideas in previous interviews.

Post interview: Given the nature of the interview process, one can never identify prior to the commencement of the study the issues that may emerge during the course of the interview. Therefore, it could be said that informed consent for using the data can only be given retrospectively. In an attempt to ensure that participants were happy for the contents of the interview to be used in the study, at the end of each interview each person was asked if there was any aspect of the interview that could not be used in the report. None of the participants took up this option. Demographic details were also collected at this stage, using a prepared form (see appendix thirteen).

Confidentiality and anonymity

Christians (2003) suggested that the single most likely source of harm in social research is the disclosure of private information that is considered damaging by participants; consequently, confidentiality and anonymity are generally acknowledged as important ethical dimensions of research. Although, sometimes, both concepts are used as synonyms, they have distinct meanings.

> 'Confidentiality involves the disclosure of personal information and entails the right to privacy; anonymity involves the disclosure of a person's identity and entails the right to remain unidentified' (Baez, 2002:55).

Both concepts are inextricably linked; confidentiality can often be achieved by the use of anonymity. In this study, however, as participants were interviewed, anonymity to the researcher was non-existent; thus, it was important to assure them of a high degree of anonymity in the report, and confidentiality throughout the process. Confidentiality was maintained through the following procedures. Each tape recording and written transcript was given a code number. The name of the person did not appear on the tape recording or written transcript. Initially, consideration was given to attaching a pseudonym to each transcript. Simply assigning a number to participants appeared to be a depersonalising process and contrary to my interactive and interpersonal philosophy; however, as there was a substantial risk that any pseudonym could also be the name of a nurse within the service, I decided to give each transcript a code number. To add a further degree of

confidentiality the code number did not correspond with the sequence of the interview.

Tape recordings and written copies of transcripts (hard copies) were stored in a locked cabinet in my home, where I was the only one with access. The record of consent was also stored in a locked, secure press away from the tapes and written transcripts. All data stored on my personal computer was password protected and stored in accordance with the Data Protection Act (Government of Ireland, 1988). The only other person to have access to the tape recordings was the transcriber who, to the best of my knowledge, was not personally known to the participants and, agreed not to speak about the content of the tape recordings. Tape recordings and discs were delivered to and personally collected from this person. No data were stored on the transcriber's personal computer.

In order to preserve confidentiality, due consideration was given to the location of the interviews. The location and time of each interview was agreed in consultation with participants. In some instances, participants chose to be interviewed away from their work location. In these situations, an alternative venue was secured. In many situations, participants chose to be interviewed in their work location. The participants' choice of work location raised some ethical issues for me in relation to protecting their rights to confidentiality, as I was concerned that my physical presence might indicate that they were contributing to the study. Therefore, if a participant opted to be interviewed in their place of work I explored the implications of their choice vis-à-vis anonymity. It is interesting to note that none of the participants shared my concern. One participant raised an interesting discussion on the rights of the person to be identified and acknowledged for contributing to the study, which made me reflect on the fine line between protecting people's rights and adopting a paternalistic attitude. As the study progressed, it became evident from some comments that participants were discussing the study with each other and telling of their involvement. As a result of knowing this, I informed all subsequent participants that even if they told of their involvement, which they were free to do, I would not discuss their involvement with anybody.

Baez (2002:44), commenting on confidentiality within qualitative research, suggested that confidentiality is rarely watertight, as 'some individuals and institutions are impossible to disguise and, in many contexts, insiders are able to locate a respondent'. Bearing these concerns in mind, transcripts were carefully cleaned for any identifying data such as the name of a training hospital, academic institution or course name, and careful attention was given to ensuring that other information cited in the report, e.g. biographical data, was done in a manner that reduced the risk of participants or the health services involved in the study being identified.

The issue of confidentiality also becomes problematic if a researcher gets access to information about malpractice that they are professionally obliged to disclose (An Bord Altranais, 2000a). In this circumstance, confidentiality becomes a limited confidentiality. On the advice of the University ethics committee, a statement about limited confidentiality was included in the information leaflet given to participants.

Protecting individuals from harm

All research involving human beings entails some human cost and it is the researcher's responsibility to ensure that participants are not harmed; thereby, supporting the ethical principles of beneficence and non-maleficence (Streubert-Speziale and Carpenter, 2003)

Qualitative research is often considered as non-invasive; however, Munhall (1991) rightly suggested that this is a limited perception of the word, as there is an invasion into the person's psyche, with questions often involving personal experience information. In the case of this study, the subject area was identified as a sensitive topic for research (Lee, 1993; Gibson, 1996), with the potential for embarrassment and distress, should participants begin to recall distressing incidents from practice or from their own personal lives. Gibson (1996) pointed out that sensitivity may only become apparent during the interview process; what is sensitive to one person may not be sensitive to another. Therefore, I was mindful that avoidance of harm, in this context, was dependent on the quality of my relationship with the participants; as such, this required that I strike a balance between the rights of the participants,

the risk of exploitation and the wider purposes of the research (Seymour and Ingelton, 1999). From the outset, I was guided by a belief that safeguarding participants was an interpersonal activity that required constant engagement and discussion, with a view to developing a mutually collaborative relationship. In order to commence the process of building a rapport, I spent some time at the beginning of the interview in introductory conversation. Without pre-framing the interview, I took the view that it was important to acknowledge at the outset that the subject area could be considered a sensitive topic. While acknowledging that it was difficult to separate the professional from the personal, and limit what Gibson (1996:66) called 'intrusive threat', I emphasised that my intention was not to probe into private, personal situations or practices; but, my primary interest was in their views and understanding of sexuality in the context of being a psychiatric nurse. Throughout the interview, I endeavored to adopt a collaborative, as opposed to a directive, approach to the interviews and attempted to be sensitive to the participants' emotional needs by: listening attentively to both verbal and nonverbal responses, clarifying responses or probing for further information in an empathetic manner, pacing the interview to suit the person, accepting contributions in a nonjudgmental manner and avoiding imposing my own views. However, no matter how hard one tries to protect participants, there is always an element of revelation and self disclosure in interviews. In one situation, a participant became upset during the interview. When this occurred, I acknowledged the participant's distress, stopped the interview and gave the person time to consider if they wished to continue. In another situation when the person disclosed information about their personal life, I was very conscious of the privileged position I was in and took time at the end of the interview to talk to the person and check if they would prefer that aspect of the interview was not transcribed.

Peeling back what Greenwood (1994:16) called the 'causal onion' generated feelings of professional inadequacy in some participants, as they began to perceive a gap between their espoused theories and their theories in use (Schon, 1991). Consequently, some participants began to appraise themselves negatively and worry about what I might be thinking. They made comments such as, *'You must think I am a terrible nurse', 'I can't believe I said this and that is the way I think',* or *'You must think I am very sexist'*. On these occasions, my approach was one of

understanding, explaining that I did appreciate their openness and willingness to be candid about their practice.

In keeping with the principles of collaboration, I endeavoured, at the end of each interview, to create space and time for participants to talk about their experience of the interview and comment on how I might change my approach in subsequent interviews. In the first two interviews, participants said they could sense my anxiety at the beginning of the interview and this gave them confidence, as one participant stated, *'If you could be anxious, with your experience, I felt it was ok for me to be a little anxious about the interview'.* As the interviews progressed, participants commented on how relaxed they felt during the interviews and reported speaking in a far more honest manner than they had anticipated. One participant commented:

> *'To be honest I am amazed at how open I was, I think that is because of you, had you been different I think I wouldn't have said as much...I didn't feel you were judging me or that, so I found it easy to talk'.*

This comment supports Morgan et al's (2001:1233) assertion that developing rapport is important, as not only does it increase the likelihood of cooperation, but it can strengthen the 'ecological validity of the study'.

Once the interview concluded, I spent time with each participant having some social conversation, as I believed it was the morally right thing to do. The participants were also given a phone number where they could contact me if they wished to discuss any aspect of the interview process after the interview. This offer was not taken up by any of the people interviewed. A personal thank you letter and card, as opposed to a standard thank you letter, was posted to each person following the interview, using the address given for any subsequent contact. A number of participants, who met me after the interviews, approached me to say they appreciated the personalised acknowledgement of their contribution.

In the case of nursing records, the records were anonymous; therefore, I did not have access to personal identifiers belonging to clients, such as names and addresses. However, I did have access to gender and age. When reading nurses' ongoing reports, on occasion the client's first name was cited; however, at no stage did I record this detail in my notes. Once I returned home, my handwritten memos

were transferred into the password protected computer and the handwritten memos shredded.

Summary and conclusion

This chapter focused on describing how the theoretical and methodological propositions that underpin Glaser's approach to Grounded Theory were operationalised in the conduct of this enquiry. Practical issues in relation to access and sampling were discussed, as were the practicalities of collecting and analysing data. Emphasis was placed on detailing the rationale for decisions made and processes used. Throughout the chapter, I endeavoured to capture some of the ethical, methodological and personal challenges I met, and document some of my own learning and reflections on the process. Although many of the processes are described in a linear manner, it was through the concurrent use of theoretical sampling, constant comparative analysis, coding, conceptualising, memoing and sorting memos that the theory '*Veiling Sexualities*' was constructed. The next chapters (six to nine) describe the theory of '*Veiling Sexualities*' and discuss the categories and properties that form the theory.

CHAPTER SIX: 'VEILING SEXUALITIES'

Introduction

The aim of this research was to develop a substantive theory of how psychiatric nurses respond to issues of sexuality in a clinical practice context. Following the principles of grounded theory, as set out in the previous chapters, *'Veiling Sexualities'* emerged as the core category. This chapter begins with a brief discussion on the concept of the *'Veil'* as it relates to the core category *'Veiling Sexualities'*. This is followed by an overview of the complete theory, including a diagrammatic representation of the theory. The chapter concludes with a more in-depth description and exploration of the first subcategory of the theory, which was called *'Weaving the Veil'*.

'Veiling Sexualities': An overview of the theory

Core category

The core category to emerge from the data was conceptualised as *'Veiling Sexualities'*, which describes participants' accounts of how they respond to sexuality as a dimension of clients' lives. Emergence, in this context, does not mean that the core category simply appeared; rather it emerged as the result of the rigorous processes of constant comparison, theoretical sampling, theoretical sensitivity and memo writing (Glaser, 1998; 2001). *'Veiling Sexualities'* met Glaser's (1998) criteria for a core, in that it constantly recurred in the data, and was the one with the most explanatory power to integrate all other categories.

The concept of *'veil'* is not new. Since ancient times it has been associated with different religious practice[27], and has come to be symbolically associated with modesty in relation to women and female sexuality (Jordanova, 1989). In this study the *'veil'* is used in a metaphorical sense, as a verb, noun and adjective. As a verb, it is used to describe participants' reported actions of shading over sexual issues; as a noun, it describes the perceptual filter through which participants viewed sexual

[27]The veil is a term for the head dress worn by women, religious sisters and nuns in the Catholic Church and for a shawl worn by Roman Catholic priests at high mass. The veil is also used to describe a variety of Muslim women's head dress. In some Muslim cultures, the word veil refers to a face-covering known as niqab; in others, to a simple head scarf, known as hijab.

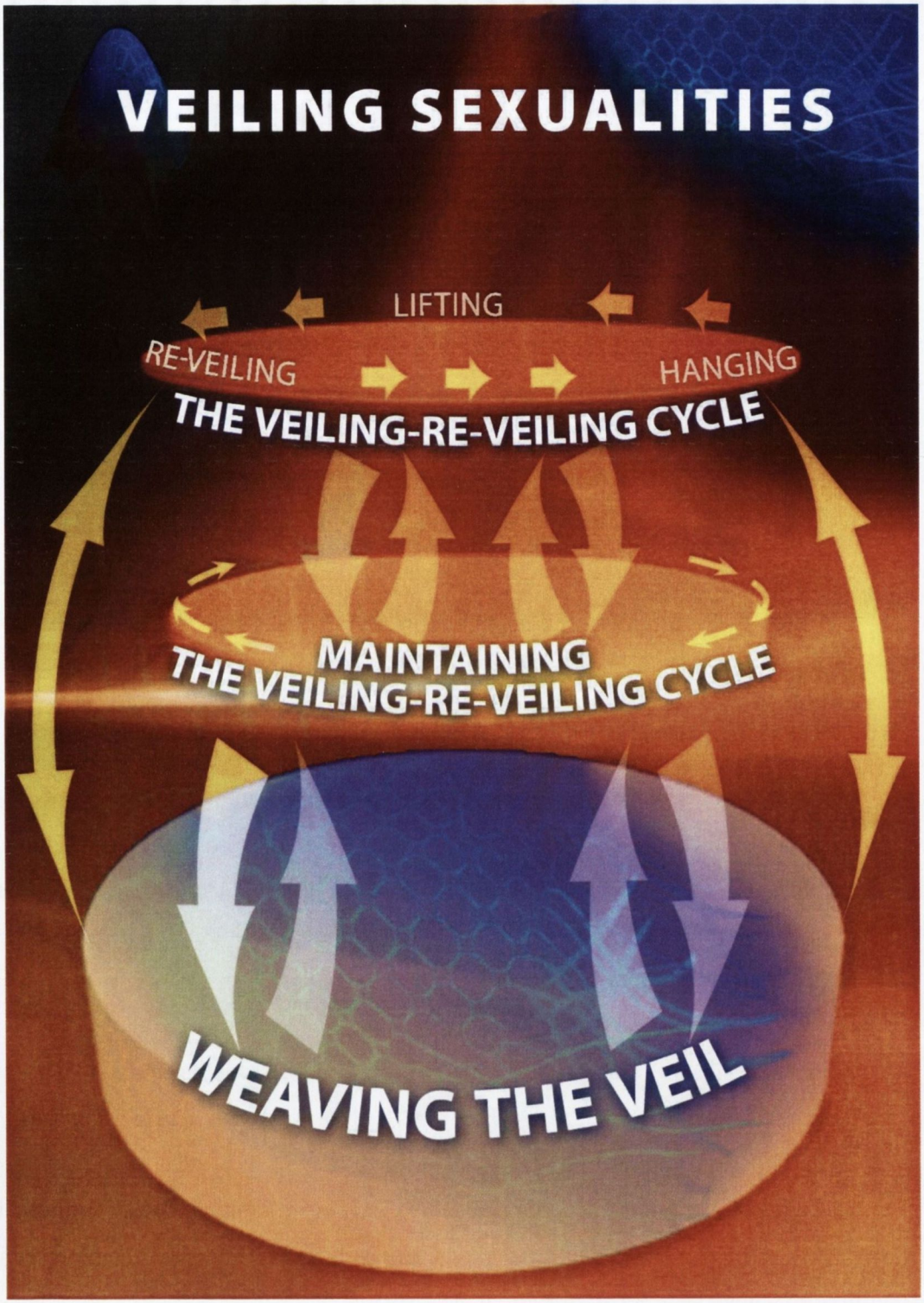
issues and the sexuality of clients; and as an adjective it is used to describe the impact of participants' behaviours on their perception of clients as sexual beings (blurred, dimmed). There are certain aspects of the *'veil'* that make it an appropriate metaphor. The first significant feature is that unlike other materials, the *'veil'* is sufficiently translucent to hint at what lies beneath. In other words, rather that blocking out or completely covering one's awareness or knowledge, it allows for some vision or some knowledge, albeit an obscured perspective. Secondly, by spacing the distance between warp and weft threads, transparency can be increased or decreased. Thirdly, the use of different colours, mixtures and textures of threads, enables different patterns to be woven, allowing for variation, while holding some commonality.

An overview of the core category and the subcategories

Describing the latent pattern of behaviour that participants used, in the social setting, to resolve their key concern is an intricate process. The participants' main concerns about sexuality were related to their feelings of personal and professional vulnerability, and the need to protect the clients and themselves. The participants dealt with these feelings through a process conceptualised as *'Veiling Sexualities'*, which had five subcategories. Three of these subcategories formed a *'Veiling-Re-veiling Cycle'* and consisted of the following categories: *'Hanging the Veil'*, *'Lifting the Veil'* and *'Re-veiling the clients' sexuality'*. The antecedent to the *'Veiling-Re-Veiling Cycle'* was a pattern of thinking created through a process conceptualised as *'Weaving the Veil'*. The *'Veiling-Re-veiling Cycle'* of action was sustained and perpetuated, subsequently, by a number of rationalisations and justifications, conceptualised as *'Maintaining the Veiling-Re-veiling Cycle'*.

Figure 1 is a diagrammatic representation of the theory. This representation provides a visual model of the intricate nature of participants' responses to sexuality in a clinical practice context, and demonstrates the interconnecting relationship between each category. Although presented in the following manner, it is important to note that the relationship between the categories is neither hierarchical nor linear, but iterative and cyclical, as each category shapes and is shaped by the other. In this way, the process is self-perpetuating and self-maintaining.

Figure 1 Diagrammatic representation of the theory 'Veiling Sexualities'



The participants in this study spoke of sexuality as an aspect of the client's life that they did not consider proactively when caring for clients. Although participants acknowledged that the sexual self was an important dimension of their own personhood, participants did not think of clients in the same way, nor did they perceive a need to consider sexuality as a life issue in their work with clients. It was as if there was a perceptual *'veil'* blurring their professional vision of clients as sexual beings. While participants did not completely deny a client's sexuality, there was a continual interplay between keeping 'illicit' sexuality monitored, controlled and concealed from view, while shading over the need to talk openly to clients about sexual concerns. The strands of the *'veil'* through which participants viewed the client's sexuality were *'woven'*, first, through the home and school environment, and later through professional nursing education and practice. Participants spoke of experiencing a repressive discourse around sexuality that emphasised silence. However, what participants experienced were carefully crafted, constructed and directed discourses that were framed and delivered within the paradigms of Christian teaching, natural sciences and the biomedical model. Consequently, in the absence of a discourse that explored sexuality in terms of love, desire, sensuality and essence of self, participants came to view sexuality, primarily, as sexual function, a function surrounded by shame and embarrassment. The absence of a broad discussion on sexuality as a dimension of personhood and positive role modeling on how to talk to clients about sexuality resulted in participants developing, at an unconscious level, a number of habitual strategies or normative forms of responding, which veiled the sexual dimension of the client's personhood, while, concurrently, veiling their own discomfort.

Within the practice environment, these normative forms of responding made up a cycle of behaviour conceptualised as the *'Veiling-Re-veiling Cycle'*. The *'Veiling-Re-veiling Cycle'* consisted of the sub categories *'Hanging the Veil'*, *'Lifting the Veil'* and *'Re-veiling the clients' sexuality'*. Participants *'hung a veil'* around client sexuality using a number of strategies. These strategies had a dual function. Firstly, they enabled the participants to shade over, mentally and verbally, the clients as sexual beings. Secondly, they allowed participants to protect themselves from personal discomfort and professional exposure. In the absence of participants' willingness to acknowledge the sexual dimension of the client's life and to engage

proactively in therapeutic conversation with clients on sexual issues, opening up discussion, or *'Lifting the Veil'* became the role of another. Most frequently it was the client who *'Lifted the Veil'*. When this occurred, the sexual dimension of the client's personhood was revealed clearly to the participants. Once the veil was lifted, participants could no longer ignore, consciously or unconsciously, the sexual dimension of the client's personhood. Participants responded by *'re-veiling'* the client's sexual expression, thus, *'re-veiling'* their own discomfort. Participants were not simply passive agents in the process, but played an active part in the reproduction and weaving of both the veil and the veiling actions, and in socialising and cultivating more junior colleagues into this way of working. Consequently, the *'Veiling-Re-veiling Cycle'* was perpetuated and sustained within practice.

The *'veiling'* and *'re-veiling'* strategies were not used with conscious intent, but were the result of the participants' socialisation into the culture and practice of psychiatric nursing. During the course of the interviews, participants became more conscious that their actions were not congruent with their espoused theories of holistic client centred care. While acknowledging that sexual issues were not adequately addressed, participants justified their action by using a number of rationalisations, which *'Maintained the Veiling-Re-veiling Cycle'*. These rationalisations were conceptualised as *'Mythical Self Talk'*. The participant professional socialisation into the culture of psychiatric nursing was where this pattern of talk was woven.

Through *'Mythical Self Talk'*, participants minimised their responsibility for including sexuality as an aspect of nursing practice, and played down the likely negative effect their veiling actions might have on clients. Many of the rationalisations were constructed in a manner that prevented participants from subjecting their premise to public scrutiny, to test the validity of their claims. Thus, the *'Mythical Self Talk'* was a self maintaining and self reinforcing pattern, which prevented participants from engaging in reflective practice, and from modifying their practice in the light of experience. In this manner, participants' views of sexuality in relation to clients were kept intact and the *'Veiling'* and *'Re-veiling'* strategies were maintained and perpetuated.

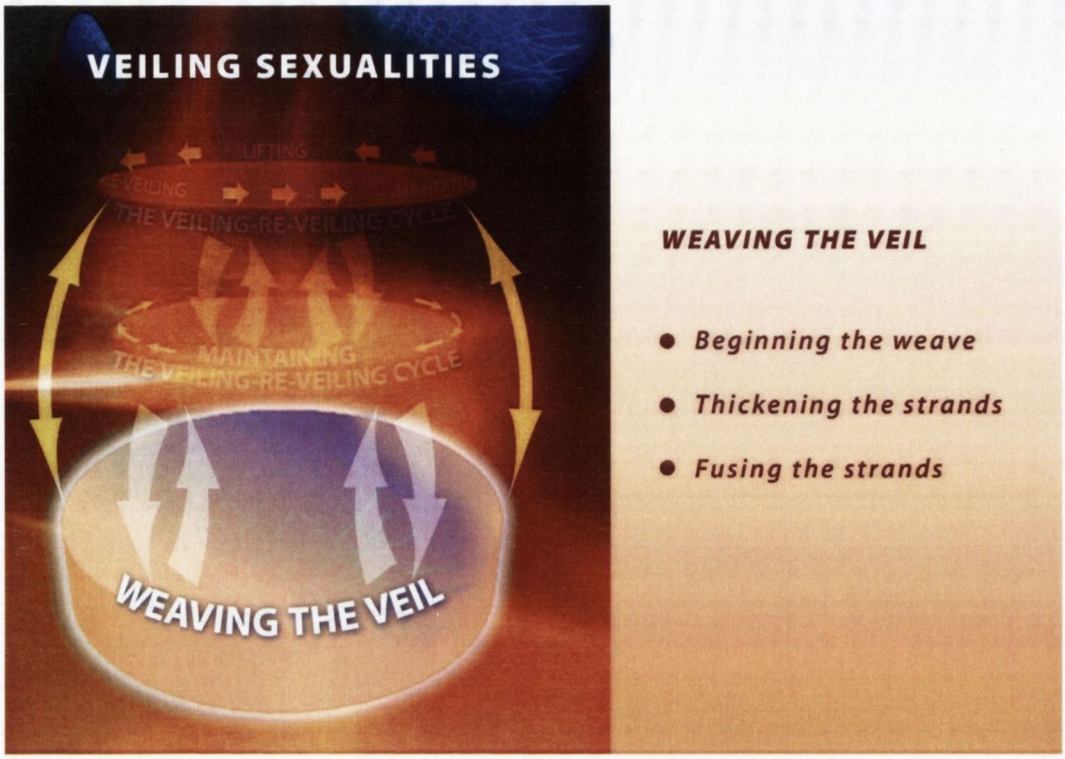
To illustrate the theory further and demonstrate how the theory was constructed, each of the sub categories will be explored in the remainder of this and subsequent chapters (the subcategories and their properties are also summarised in appendix fourteen).

The purpose of grounded theory, as previously discussed, is to transcend the data conceptually and develop ideas on a level of generality, higher in conceptual abstraction than the data being analysed (Glaser, 1998). While some data are used to illustrate and support the categories and their properties, emphasis is not on 'thick' and repeated descriptions of similar data. All quotes used appear in italics. Where part of a quote is omitted, the omission is illustrated by the ellipsis '...'. Where text has been added to clarify meaning of a direct quote, it is enclosed in a square bracket. The gender of the participant appears after the quote, in the form of M = Male or F = Female, together with the interview number. The remainder of this chapter will focus on an in-depth description and exploration of the first of the five categories, conceptualised as *'Weaving the Veil'*.

'Weaving the Veil'

This category refers to participants' socio-cultural and professional socialisation in relation to sexuality. The participants' socialisation provided a particular frame of reference (or perceptual *'veil'*) through which they viewed sexuality in general, and provided a highly particular frame of reference, or *'veil'*, through which they viewed the sexual dimension of the client's personhood. This *'Veil'* was woven through three phases, conceptualised as: *'Beginning the weave'*, *'Thickening the strands'* and *'Fusing the strands'*. There is a temporal ordering to the phases; however, they do not stand in isolation but form an integrated whole, through which messages and rules of communication and action around sexuality were delivered, and the *'veil'* through which participants subsequently viewed sexuality and enacted their care was woven.

Figure 2 Diagrammatic representation of 'Weaving the Veil'



Participants reported that their learning related to sexuality was influenced by a number of sources. These included primary, secondary and professional socialisation in the form of family, school, nurse education programmes as well as experience in nursing practice. Participants spoke of experiencing a repressive discourse that emphasised silence. However, what they experienced was not so much a silence that hid or ignored sexuality, but a subtle network of authorised discourses that constructed sexuality as sex, and created difficulty for the participants to talk openly about sexual issues to clients. Paradoxically, these discourses ensured that the participants were aware of the presence of a 'deviant' or 'pathological' sexuality in the client's life that needed to be controlled and monitored. These carefully crafted, constructed and directed discourses were delivered first through the home and school environment, and later through professional nursing education and practice.

'Beginning the weave'

'Beginning the weave' refers to the process participants experienced during their early years within the family and later through other social institutions such as schools, often referred to as primary and secondary socialisation (Stainton-Rogers and Stainton-Rogers, 2001). Properties of this category are *'acquiring family values'* and *'acquiring structured institutional values'*. Participants did not enter psychiatric nursing out of a vacuum, but came to nursing with views and attitudes that were socially created from the wider culture of family, primary and secondary education. As participants interacted with others, in these contexts, all involved were affected and to varying degrees acquired and modified ideas, attitudes and values around sexuality. Thus, the process of *'Weaving the Veil'*, which later impacted on the participants' clinical practice, commenced long before they came to psychiatric nursing.

'Acquiring family values': The family as the primary communicator of values and beliefs strongly influenced the participants' perception that sexuality was something that should not be openly discussed. For most participants, open discussions around sexuality were absent within the home; consequently, participants read between the lines and developed a construct of sexuality as sex, and issues relating to sexual behaviour as private, personal, delicate and dangerous.

'When I was brought up, it just wasn't a thing you discussed really...so I suppose; you see it as a delicate topic. We were always brought up to not talk...it was just a thing that wasn't discussed' (4 F).

'I suppose we see it as a delicate topic...It just wasn't a thing you discussed really ...there wasn't really any discussion at home' (14 F).

On occasions within the home when sexual function was portrayed in an open manner, for example through the media, anxiety, shame and embarrassment were the associated feelings. Consequently, participants learned embarrassment from others, and to feel uncomfortable around overt expressions of sexuality and discussions on sexual issues.

'When I grew up at home, when the first ads for sanitary towels or something like that came on the telly, my father would be panicking to get at the remote

control...so I think it was the fact that we got a panic reaction... or if there was a love scene on the telly there was a huge panic to get it off the screen...I certainly didn't come from a family that was very open about sex, the sex education I got was ***" there's a blue book on the mantelpiece, if you want to read it work away" ' (8 M).***

As described, sexual education for some participants involved being given or being directed towards a book on sex education, without any follow up discussion. When sexual issues were explicitly spoken about within the family, it appeared that the mother adopted the role of educator. The style of communication was more of a vertical information-giving session, on 'traditional moral values', which defined sex as penetrative vaginal sex that occurred within the confines of marriage, as opposed to an open dialogue on desire, gratification, affection and love. To instigate a discussion with a parent around sexual issues was seen as in some way revealing self as a sexual being; thus, it was perceived safer not to raise any issue for discussion. The following extract is taken from an interview with a recently qualified participant in her early twenties.

'You don't really talk about it at home...like you would have your conversation with your mother and stuff about girly things, but you wouldn't be talking to her about intimate things. It was about periods and things like that and meeting the right person, and behaving yourself... To be honest it was about not to have sex until you are married. That was it really ...it is just an embarrassing subject...my parents are great, but it is all about upbringing and what you grew up in (pause)... God you don't talk about that. I have just always been mortified about talking about the whole area, I think that is where it comes from ...If I went to my mother she would be very open-minded and everything, but you just didn't, like you would be afraid, in case she would think, "Oh my God! (said with emphasis), what do you need to know that for?" ' (26 F).

In the absence of education within the home environment, participants accessed information from other sources such as peers, or as one participant described it *'school yard education' (16 M).*

'Acquiring structured institutional values': Beliefs that sexuality was not a topic for open discussion and that sexuality was about sex were reinforced to a greater or lesser extent within both primary and secondary school education. The older participants, especially the female participants and those educated in schools run by religious orders, spoke of experiencing a discourse that portrayed sexuality as a source of sin. As one participant said: *'basically everything was about sin, dirty, filth, impurity and modesty' (19 F).* This emphasis on purity, self-denial, modesty,

and chastity resulted in the subjugation of a discourse that explored sexuality from the perspective of intimacy, joy, fulfilment or satisfaction. Emphasis was also placed on heterosexual relationships, with no discussion on other forms of sexual expression, such as same sex relationships. If and when sex took place, which was to be within the confines of marriage, sexual obligation for procreation purposes was to take precedence over sexual pleasure. These messages resulted in what many felt was a sexually repressed nation of people who engaged in sexual behaviour, but did not give much consideration to exploring or talking about personal sexual identity, feelings or needs; this gave rise to feelings of shame and guilt around sexual behaviour. These ideas are reflected in the following quotes.

'The church, I think, influenced sexual education and the messages you got in school...you don't have sex until you are married, don't get pregnant and you don't use contraception,...there was a shame about it or it wasn't about enjoying it [sex], it had to be contained,...when I say the church, that was through the school, through being at school and the nuns...you weren't free to speak about it, to talk about your bodies, to talk about what is happening- it was contained. It was very private, so you don't speak the sexual language, or you don't say openly about how you are feeling about your body and what happens between men and women' (25 F).

'The influence of the religious and Catholic Ireland is a big part of it all. It [sex] just didn't happen...sure we were all asexual...we were told that any sexual contact was purely and solely for procreation...you weren't to enjoy it...it was all about guilt... you never learnt to talk about sexual issues, intimacy and that' (16 M).

Although the participants were of the opinion that due to recent scandals about the Church in the media, the influence and authority of the Catholic Church had declined in recent years, they felt that the Church still cast a shadow over Irish society in relation to sexuality. Indeed this influence was evident in the younger, more recently qualified participants' descriptions of sexual education (as previously highlighted by participant number 26). Although the messenger had changed from nuns and priests to the mother, the message was still contained within the context of Catholic moral teaching, emphasising purity and abstinence until marriage. In explaining the role of the Irish mother in sex education, Inglis (1998b), using Bourdieu's concept of capital, suggested that in the absence of economic and social capital, the Irish mother, until recently, aligned herself with the Catholic Church, in order to gain social capital and power. Consequently, even with the decline of direct influence of the Catholic clergy, the discourse that linked sex with sin continued

within the home, as mothers acted as auxiliary forces to the clergy in moral discipline (Hill, 2003).

Although all participants did not experience such an overt discourse around purity, sin and abstinence, it appeared that as this discourse disappeared within the educational system, it was replaced by a discourse crafted within the biological paradigm. This discourse focused on anatomical and reproductive aspects of sexuality. Teachers de-eroticised sex and hid that which they could not speak about behind the technical and neutral language of science. Sexuality became cells, tissues and systems, separated from the more intimate expression of desire, passion, pleasure, sexual satisfaction and love. Consequently, participants were denied the opportunity to acquire a language to speak about sexual intimacy or relationships.

'I can tell you that straight away there was nothing in school. We done biology and we done the human form, and that was about it, lectures and that, we didn't have any sort of classes on sexuality or anything like that, sexual education even. There was nothing, and I am young. I can whole-heartedly tell you that, nothing, just the male reproductive system, the female reproductive system and that was it' (26 F).

'Well we did it [sexual education in secondary school] but it was you know...it was very much function of how children are born and that kind of thing, but there wasn't anything really on it about sex or intercourse, establishing relationships or things like that, so we didn't learn to speak about sexual relationships and intimacy issues, not in an adult way' (22 M).

The focus on didactic models of information transfer exemplified what Freire called the 'banking concept' of education, where knowledge was bestowed by the knowledgeable (teacher as subject) to the unknowing (participant as object) (Freire, 1986). Participants became passive recipients of information transfer, receptacles or containers to be filled by the expert teacher, as opposed to being involved in an 'information exchange' model of education (Lee and Garvin, 2003) . Consequently, they were not facilitated to engage in an exchange, where they might have experienced adult role modelling of open dialogue, without any associated embarrassment and shame. The internalised norm of embarrassment and shame, acquired during home and school life, was carried over into the participants' wider life as many of them spoke of their reluctance to discuss sexual issues with friends and family, even as they matured into adulthood.

'We have difficulty talking about sex ourselves, our sexuality. We have difficulty talking about it ourselves on a day to day basis to friends. There is a kind of embarrassment that goes with it. Perhaps what you would call a sense of shame even' (6 M).

If conversations did occur, it was usually in the context of humour, joking and social banter. However, these interactions did not help deconstruct feelings of embarrassment or enable participants to develop adult models of communication about intimate issues. In many cases, the social banter entrenched the norms of embarrassment and socialised inhibition.

The influence of the Catholic Church within Irish schools and homes is well documented (Inglis, 1998b; 1998a; Scheper-Hughes, 2001; Hill, 2003). Inglis (1998a) suggested that the Church's control was maintained through its ability to censor and restrict both the curriculum and staff[28]. By saturating the formal curriculum with a religious ethos, limiting discussion on sex to the natural sciences and excluding discourses at odds with its beliefs, the Catholic Church maintained control over sex education and limited the development of communicative competence around sexuality. Despite the fact that in 1985, the then Minister for Education, Gemma Hussey, suggested that the Department of Education had a responsibility to introduce sex education into schools, the Relationship and Sexuality Education (RSE) programme was not introduced into primary and secondary schools until 1997. Even then, it was only after much controversy and objection from the Catholic Church[29] and Catholic lobby groups, with some people being of the opinion that it was better to let sleeping dogs lie (Inglis, 1998a). Despite the fact that the RSE programme is more than nine years old, recent research suggested that this programme is taught in a sporadic manner and continues to be strongly influenced by Catholic teachings (Norman et al., 2006).

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[28] The Catholic Church's power over staff is evident in the 1984 judgement of an employment appeals tribunal, which upheld the right of an order of nuns to sack a single teacher, who was living with and had become pregnant by a married man. The tribunal upheld the dismissal mainly on the grounds that her lifestyle was not in keeping with the values of the religious order that ran the school. This judgement also gave rise to a fear among GLB teachers of losing their jobs, should they be 'outed' in a school that has a Catholic ethos.

[29] In response to a statement by the Irish Bishops, that the content of any programme in their schools, would have to reflect the Catholic moral teaching on sexual matters and exclude issues which were inconsistent with the very foundations of Catholic moral thought, the Department of Education and Science, in what appeared to be a compromise, developed national guidelines instead of a full syllabus. This allowed each school to develop its own RSE programme in line with the ethos and core values of the school (Norman *et al.* 2006).

'Thickening the strands'

'Thickening the strands' refers to the professional socialisation participants experienced within formal nurse education programmes. Nurse education in the classroom provided participants with a particular ideology and frame of reference for practice, and represented an important means by which they developed an appreciation of their role in relation to sexuality. Most of the participants in this study could not recall a comprehensive programme or module that addressed sexuality during their pre-registration or post-registration nursing education, despite the fact that many of them had completed a number of post registration educational programmes (see appendix fifteen). Within nurse education, participants were exposed to discourses that focused on *'mechanical-ising'*, *'pathologising'* and *'minimising'* client sexuality. Through these discourses, participants' previous views of sexuality were reinforced, while they simultaneously acquired their professional values around sexuality.

'Mechanical-ising': Similar to their experience in secondary school, participants reported that when sexuality was addressed within nursing curricula, it was framed within the paradigm of the natural sciences. Albeit in a more detailed manner, emphasis was placed on the anatomy and physiology of the reproduction system and on discussing sexuality as a biological mechanical system. In this way, participants acquired a technical language that once again de-eroticised sexual function, but did not acquire a language to talk about sex as pleasure and desire. Acquiring biological knowledge was important to aid understanding of nursing and medical books. However, in the context of practice, this knowledge did not enable participants to incorporate client sexuality within their horizon of nursing practice, as exemplified in the following quotes.

'We did do things on sexual function, physiology and that. But it didn't go into how you then bring this into your practice; in terms of talking to patients...we don't know how to bring it into care...In terms of doing a sexual health assessment, that wasn't talked about, we don't know how to do it, we don't have the expertise to talk,...we need confidence in discussing issues...there was a huge theory practice gap when it came to sexuality...' (22 M).

'We did anatomy and physiology, but I don't remember anyone teaching us on how to speak to a patient about sexual problems, like having difficulty with sex drive or anything like that' (10 F).

The absence of a discussion on the wider context and meaning of sexuality and its relationship to the person's everyday life experience resulted in participants feeling they lacked the language to engage with clients around this aspect of life. It also resulted in participants viewing sexuality within a biological paradigm with an emphasis on sexual problems. Again the absence of role models in the classroom, capable of engaging in adult to adult discussion around sexual needs and desires, left participants feeling uncomfortable, and lacking the confidence to discuss issues in a proactive, competent or confident manner within practice. Participants reported discomfort on a wide number of issues ranging from talking about menstruation, sexual relationships and sexual function, to talking to clients about sexual fantasies. Participants' discomfort was also heightened when it came to talking to clients who were of the opposite gender. Some of these difficulties are reflected in the following comments.

'It is something that I don't really feel comfortable getting into...like taking pride in your appearance...different times of the month for ladies, they are all issues that I would be comfortable with...but sex, erections, orgasms and stuff like that no' (26 F).

'I am fourteen years at this and I still have difficulty, just like, on the assessment form, when you have to assess a female patient. There is a space on it for menstruation, and I just kind of go, "Oh no, I can't ask her this". I suppose it's because I'm uncomfortable, it's quite intimate..., so you try and avoid the subject if you can' (8 M).

'I definitely would never feel comfortable asking a female does she have problems with orgasm or sexual problems like that from drugs. Straight away it is just the intimacy... female patients; I don't think I could ever feel comfortable asking them questions' (18 M).

'Pathologising': Nurse education also exposed participants to another discourse that formed part of the strands of the veil; a discourse that was crafted within the biomedical deviant paradigm or what one participant called *'working with extremes' (15 M)*. Within this discourse diagnostic categories and classification of diseases as identified by the Diagnostic and Statistical Manual of Mental Disorders provided the legitimising framework for discussions on sexuality. People became objects of study and classification; a collection of symptoms or signs that had to be known about so one could observe, detect, control and treat (Foucault, 1989). However,

this discourse provided little guidance on how to communicate or interact with the clients, as highlighted by the following quotes:

'We [students] spent a lot of time on working with paedophiles, what it is, how it is diagnosed, treated' (15 M).

'We [students] did two lectures on it...sexual identity disorders, what they were... but it doesn't help you in practice in terms of talking' (17 F).

'We did a little bit on sexual abuse, like the incidence of it, nothing much that sticks out in my head' (26 F).

'It was touched on – perversion or sexual fetishes. I do remember one tutor talking about it [sexual perversion], but it just seemed so bizarre...it was a skit and a laugh' (25 F).

As an extension of this discourse emphasis was put on sexual health risks with a focus on sexually transmitted diseases.

'It [sexuality] was kind of talked about, the various conditions that one would get with a sexually transmitted disease, condition related' (22 M).

The emphasis on pathological sexuality left participants with a framework that conceptualised sexuality in negative terms. It also left participants with a view that nurses' sole concern was deviant or diseased sexuality that had to be managed within practice as opposed to a dimension of personhood that needed to be embraced, explored and promoted. Social, psychological, political, or economic discourses that may have provided alternative explanations for gender identity disorders, sexual violence or sexually transmitted diseases did not appear to be explored. Neither was there any discussion on the construction of sexual behaviour as a mental illness, nor an exploration of the sexual rights of people experiencing mental distress. Had participants searched nursing books for an alternative discourse, they would have been disappointed. With the exception of Barker's (2003a) *Psychiatric and Mental Health Nursing: The Craft of Caring*, sexuality was frequently omitted as an area for discussion in the psychiatric nursing books recommended for pre-registration education. When sexuality was mentioned, within the books reviewed, it was framed within the traditional biomedical discourse of illness and deviance and discussed in relation to sexual offenses, sexual violence and sexual disorders (Norman and Ryrie, 2004; Keltner et al., 2003; Fontaine, 2003). In this way, authors in the area of psychiatric nursing played their part in

'thickening the strands', by reproducing and maintaining discourses that either desexualised people or presented the sexuality of people who experience mental health problems within a pathological or deviant paradigm.

'Minimising the importance of client sexuality': There were topics within the curriculum which could have been explored in terms of the client's sexual expression: for example, the impact of prescribed drugs on sexual function. It appeared that when drugs were discussed, there was a 'minimisation' of the importance of iatrogenic sexual dysfunction on the client's life. Participants reported that if and when iatrogenic sexual dysfunction was spoken about it was relegated to the end of a list of side effects.

'They [sexual side effects] were quite far down the list, you learnt about the common ones...drowsiness was a big one, drooling, twitching, those ones' (13 F).

'I can't remember it [sexual side effects] being very uppermost, it wasn't something that stuck with me, something that I have to go forward and give this information to the patients, it was absent, it wasn't there' (25 F).

On the rare occasion when iatrogenic sexual dysfunction was mentioned, it was in the context of male impotence. Other aspects of male sexual dysfunction or sexual issues in relation to women (as discussed in chapter 3) appeared to be ignored or, as one participant said:

'The impact [of drugs] on men was briefly mentioned, but I wouldn't be familiar with how they would affect women, we didn't learn that and I did the diploma [pre-registration diploma in Nursing]' (17 F).

The pattern of ignoring drug-induced iatrogenic sexual dysfunction is reflected within the general mental health literature, and more specifically within the nursing literature, where emphasis has been given to side effects such as the extra-pyramidal side effects (Higgins et al., 2005). This practice of ignoring iatrogenic sexual dysfunction also helped reinforce the view that people with mental health problems were either asexual or uninterested in sex, rather than people who have the capacity to participate in full sexual and family relationships (Shakespeare et al., 1996). It also created a mindset that people with mental health problems were in some way different to the rest of humanity, as sexual function and sexual pleasure were optional for them and not a core need.

'Fusing the strands'

The practice environment continued to be a place of learning throughout the participants' careers and was an important part of the socialisation process in relation to sexuality. It was within the practice environment that the strands of the *'veil'* were fused, as participants were exposed continually to both the culture of the organisation or unit, and to role models that reinforced previous frames of reference. It is important to point out that there was a mutual simultaneous shaping of both practice and the participants. While the system acted upon participants and influenced their views and actions, at the same time participants helped shape both the system and new nurses, by recreating and sustaining the discourses internalised. This process of mutual shaping occurred through *'professional comparing'*, *'cultural seepage'* and *'absorbing voices of the past'*.

'Professional comparing': The more recently qualified participants spoke of using a process of *'professional comparing'*, as a way of learning the rules around what was important and acceptable in practice. In professional comparing, participants regularly sought cues from more experienced practitioners on: how to speak to clients, how to open up conversations with clients, how to phrase questions and how to respond in relation to all aspects of care. As one participant said, in relation to observing others, *'That is how you learn' (23 F)*. Participants reported that in relation to talking to clients about sexual issues, they lacked positive and effective role models in practice. Consequently, participants never learnt how to create a context that gave clients permission to be open about sexual issues. Neither did they learn how to introduce the 'sensitive' topic of sexuality into a conversation, or develop the capacity to respond to their own or the client's embarrassment. Instead, participants appeared to be quickly socialised into a model of care that emphasised professional 'silence' and minimised the importance and relevance of sexuality as a dimension of personhood. The following are some of the comments made:

'As a student I didn't see anyone talking to patients about sexual issues. That is not to say that it didn't happen, you know, but I didn't see it. So, you just kind of, you kind of learn from what you see...You would kind of think well maybe it is not as important as other things' (26 F).

'I think if you see other people minimising the issue of sexuality, well, then you think that it is not the done thing to make an issue of this...Like the person who is

being re-admitted and re-admitted, and there is an issue. And because it is not acknowledged as a problem, then you start to think well maybe this isn't a problem. And you start to question your own thinking about it. I think it is about role modeling' (23 F).

Through professional comparing, participants also learnt that expressions of sexuality by clients were not acceptable and had to be monitored and controlled within practice, for fear of accusation of professional negligence. By observing more experienced staff, some participants acquired normative forms of responding, should the client make the sexual dimension of self visible. (These patterns of responding will be explored later in the theory.)

'It wasn't anything I suppose that we were taught, it was kind of more on a ward level...you see what the nursing staff do, I heard them saying that behaviour [two clients kissing] is not acceptable on the ward, you can't be doing that, you need to watch that [behaviour] and things like that, so you get into the way the ward is run' (14 F).

'There is no policy in relation to sexual relationships or inappropriate or appropriate relationships...Like nobody ever sits you down and says this is what should happen...it is a cultural sort of thing, by virtue of practice and being around...It doesn't take a whole lot of input to learn what to do...nobody spells it out, but people pretty much catch onto it very quickly, from watching people, you need to keep an eye, it's [sexual behaviour] not allowed and stamped out and dealt with quickly' (12 M).

The importance participants placed on positive role modelling became evident in their discussions about suicide. The traditional discourse in Irish society around suicide has many parallels with sexuality. Until recently, suicide was both culturally and professionally surrounded by a similar socialised linguistic inhibition. Suicide was linked to a strong discourse within the Catholic Church that prohibited suicide victims from being buried in sanctified grounds and a legal system that criminalised it (Smyth et al., 2003). All of this served to perpetuate it as a taboo subject for open discussion[30]. A number of participants compared their learning about suicide with their learning in relation to sexuality. Although participants reported initially experiencing discomfort talking about suicide, they felt that from observing other people in practice, repeating and practising some of the skills observed, their confidence, comfort and skills had improved over time. This is exemplified in the following participant's account:

[30] Following the passing of the Criminal Law (Suicide) Act in 1993, suicide was decriminalised and suicide prevention firmly entered the public discourse.

'You would have more practice in dealing with patients who might be suicidal, or have thoughts of self-harm...whereas the issues around sexuality, we don't have much experience in dealing with patients. It is not something that you are familiar with. I mean suicide and asking a patient if he has had any thoughts of suicide wasn't always easy...Yeah, it was very difficult. You didn't know what to ask. But the more you talk to patients about it, the more practice you get you become more comfortable in talking about the subject, you know...You learn from the way that other people were dealing with it, other nurses....It was kind of not a list of questions, but you learned that there were kind of important questions to ask the patient. And you kind of knew what those questions were. And you knew if you asked them, I suppose you are covering everything. ...With sexuality it is kind of skimmed over in general. So therefore you don't get to see it being dealt with. So it is difficult' (14 F).

The absence of positive role models in practice in relation to sexuality and the pattern of learning through *'professional comparing'* was an effective means of continuing the cycle of socialised inhibition from one generation of nurses to the next. Consequently, even after years of experience in psychiatric nursing, participants lacked confidence. They shied away from initiating a conversation around sexual issues, and reported, as discussed, varying degrees of discomfort around discussing sexual issues with clients.

'Cultural seepage': In addition to learning through a process of *'professional comparing'*, there was a sense that participants tended to absorb the culture of ignoring the client as a sexual being by a passive process of *'cultural seepage'*. In the absence of an open discussion in formal education, and at organisational or practice level, participants simply took on the culture unknowingly, and were unable to explain how they came to act the way they did. There was a strong sense that *'cultural seepage'* occurred as participants themselves became institutionalised into a particular way of working and adopted unquestioningly the norms of practice. This unquestioning, or what writers such as Schon (1991) and Rolfe et al. (2001) would call an unreflective approach to practice, is evident in the following quote:

'I can't explain to you, I honestly can't explain to you why [sexual needs of clients are not thought about], like there isn't a policy set up to explore the various areas of sexuality, but there isn't a policy not to explore it either. But it's just kind of an area that's not broached upon, but why I can't tell you. It is only since I sat down here that I have given it [sexuality] any consideration. It's like everything, we go along unquestioning an awful lot of the time...it just happens because it always happens. That is the way it is, it was never any different, I am not saying it is right,

but this is the way it is...you have opened up an area that I will have to review. I suppose that's the institution, isn't it. The institution in us all' (16 M).

The process of *'cultural seepage'* was fuelled by a desire to fit in and conform to prevailing practices. Participants spoke of 'adapting' as an easier option to challenging the system. Participants adapted to the Irish culture where sexual issues were not openly discussed and to the culture of psychiatry where diagnostic labels took precedence over client experience. Participants who had returned from working in organisations outside Ireland said:

'I worked in [a hospital outside of Ireland]. Sexual health issues were much more discussed. Patients were provided with contraception on the ward, and there was a nurse who was available to provide contraception and to provide counselling. You know, it was much more of an open experience. Sexuality wasn't a kind of an issue. It wasn't a taboo as it is here, um...But then I slipped back into the ways here, when I came back to Ireland. I did work in [another mental health service in Ireland] previously, and the whole ethos there was the same, so you go with the system' (10 F).

'Like I remember a situation when I came from [another country], I asked about sexual abuse, asked the person about it directly as I was doing in [a country]. The patient had a personality disorder, and because I asked, he [client] started telling me about his experience and giving me all his history and I told the doctors and they were, "don't worry about that, he is a manipulator, he is just messing". So I suppose at that point, I stopped asking about sexual issues directly. So now it is more if it comes up...I suppose you just adapt' (9 M).

In a similar way, more recently qualified participants adapted to the culture to survive and work within the team. The following quote is from a recently qualified participant (less than one year). She is commenting on her difficulty in raising views with the team around giving medication to clients, who did not want to take it because of side effects that affected sexual function.

'It doesn't feel great because it obviously raises a lot of ethical issues. It doesn't feel completely right to give the medication when you know it does that [sexual side effects] and they don't want to take it. But at the same time if you don't give it, you have to stand up and make your point to the medical team and the nursing team and everybody else, why you don't want to give it to her or him at the moment. I suppose, I am a new staff and that kind of confrontation is kind of difficult' (14 F).

As the *'cultural seepage'* occurred, clients gradually became thought of as 'other' and different from the participants in relation to sexuality. They tended to be viewed as 'patients', extensions of their 'illness' and not members of the wider community,

with desires, dreams and ambitions. Although participants talked about the importance of sexual function and relationships in their own personal lives, they tended to desexualise clients mentally, by not consciously thinking of clients as having sexual feelings or needs. This subject-object relationship or 'othering' is highlighted in the following comments:

'I suppose there's the kind of feeling that the patients have no sexual feelings and have no sexuality as such. Sexuality doesn't matter once they are in hospital...they would have no sexual needs' (16 M).

'I just don't think of it as part of their lives really, that's what a lot of it is about... I think with people with serious mental illness like schizophrenia, sometimes we forget about the person...You try not to, but you do see them as a group. The centre of their lives is the illness' (5 F).

'Sometimes you do start to see people as patients. ...They still have desires, they have ambitions, they have dreams that they have never fulfilled. That they are still there in their heart and soul and their mind...but on a day to day you don't think about those needs' (23 F).

Participants felt that this 'othering' was not a conscious, intentional act, but rather a result of their socialisation into a psychiatric culture, where there is very little open discussion about clients as sexual beings. Consequently, as one participant said *'You never intentionally mean to neglect it. You don't even think about these things until you are asked, like it wouldn't come into my head for two seconds'* (26 F). In many situations, participants were of the opinion that it was the presence of the researcher and the interview process that had brought to their consciousness their hitherto unconscious desexualisation of clients, and patterns of responding to clients.

'Absorbing voices of the past': Another aspect of *'fusing the strands'* is '*absorbing voices of the past'*. Even though psychiatric nursing, in Ireland, has modernised itself since the 1960s and 1970s, the older participants were of the opinion that the voices of the past, albeit to a lesser extent, were still influencing current practice and thinking around sexuality. These voices consisted of what Foucault called the 'internal discourse of organisations', in the form of architectural layout of rooms, spaces, and the rule of discipline around behaviour (Foucault, 1976:28). Historically, the assumption that sexuality was a source of danger resulted in men and women being segregated in mental institutions, and subjected to constant

surveillance. This practice of segregating men and women in different wards and different buildings did not change in Ireland until the mid 1980s[31]. One participant's description of attitudes to the sexuality of both the clients and the nurses, where both were considered morally suspect, served to illuminate the historical context from which psychiatric nursing has recently evolved. The following is an abridged version of her account:

'Integration didn't happen until the eighties so up to then, there was only male and female wards. Some of that thinking is still influencing us...there was no preparation or education, you were just told [you were changing wards]. In the beginning, yes, I found it awkward, but you just got used to it. So our history, our history is a big thing.

'Then [prior to integration] we used to take the patients to dancing, down in the main hall, and there would be male and female nurses there, and the patients would dance with one another and anything inappropriate, kissing and their arms around one another or dancing cheek to cheek in slow dances, as true as God, that was all they had to do, then you would have to break it up. That is how we did it. Or the male nurse would come to me and say, "Things are getting out of control or getting out of hand here". So we would escort the patient back to the ward. ...That meant that my patient would lose their liberty for a month, the liberty of going to the dance, liberty of the grounds. That was how strict it was...and it would be a month before she gets it back, and that was the same for the male patients as well...Church was the same. When we would go to Mass on the grounds, males that side, female that side...then we had movies. But the males and the females sat two different sides of the room, there was no sitting together.

'Our dining area was segregated as well, there was the charge nurses up there [points to one side of the room], there was the doctors up there [point to other side of the room], a place for the staff nurses and there was the junior nurses over there, and all the females sat to that side just like at home,...and if you came in late for your dinner and there was only a male seat left, you daren't go to that table for your life, you stood at the doorway until a female got up and left, you did not go to a male seat, that is the truth. You would meet the male nurses up and down, but you wouldn't dream of being caught talking to a male nurse. I had only one relationship with a male nurse and I remember going over one evening for five o'clock tea and I happened to meet this fellah and the old matron was doing her ward rounds in the evening about half four and she caught me talking to him, and she caught me by the ear and said, "Now Nurse, back to work or go to your tea", she pulled me by the ear.

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[31] In 1982, the European Communities (Employment Equality) regulations amended the Employment Equality Act, 1977, to remove all prohibitions on the training and employment of men as midwives and to terminate the exclusion of employment in single-sex institutions and those hitherto excluded on the grounds of privacy or decency. This made it mandatory for the Health Boards of the time to see that a system of integrated nursing was introduced within psychiatry; this eventually occurred over a number of years.

'Now, when integration happened, if there was a male and a female [nurse] on duty together...and it happened that there was a relationship going on [between two nurses], the charge nurse would be informed of it and the charge nurse would bring it to the head's office and the head's office would move that person... the female or the male would be shifted to another ward,...there would be a phone call and either him or her would have to be off the ward...it wouldn't be tolerated...they kept it secret if they could' (19 F).

Similar practices of segregation were documented in the United Kingdom (Nolan, 1993). In his history of mental health nursing, Nolan recounted how both groups were considered untrustworthy, and how the 'superintendent assumed responsibility for the morals of his attendants' (Nolan, 1993:38). However, Nolan appeared to be talking about practices in the early 1900s and not the 1980s as described above. Although, in Ireland, very little is written about the process of integration or the preparation of staff to work with clients of the opposite sex, political commentary at that time suggested that integration was accomplished without adequate educational preparation of nurses (Seanad Éireann, 1986). Consequently, it appeared that, in the absence of an open discussion or education about sexuality and sexual rights of clients, the voices of the past lingered in participants' minds and continued to influence their thinking and practice. These often unspoken attitudes and practices were subsequently passed on to the next generation of practitioners.

Summary of 'Weaving the Veil'

'Weaving the Veil' refers to the socio-cultural and professional socialisation the participants experienced in relation to sexuality. All cultures have rules that regulate the behaviour of their members. To function within a particular culture, people learn these rules and norms through a process of exposure to various discourses. In relation to sexuality, participants spoke of experiencing a repressive discourse that emphasised silence. However, what they experienced was not so much a silence that hid or ignored sexuality, but a subtle network of legitimised discourses that constructed sexuality in particular ways and provided them with a particular frame of reference or *'veil'* that continued to influence their thinking about sexuality and the sexuality of clients. This veil was woven through three stages: conceptualised as *'Beginning the weave', 'Thickening the strands'* and *'Fusing the strands'*. There is a temporal ordering to the phases; however they do not stand in isolation but form an integrated whole.

The weave of discourses experienced by the participants began in primary and secondary socialisation. It was here that participants first *'acquired family values'* and *'structured institutional values'* around sexuality. Sexual education in the home took place in a culture of conservatism, which emphasised sexuality as sex and became linked in the participants' minds with negativity, shame and embarrassment. Although younger participants spoke of more explicit talking on sexual issues within the family, fundamentally the same discourse, reflecting the historical conservatism of Ireland, was evident. Within secondary school the discourse centred on sexuality as a biological mechanical system that divorced sexual function from the more intimate expression of desire, passion, pleasure, sexual satisfaction and love.

The strands of the sexuality veil that participants acquired prior to entering psychiatric nursing tended to remain intact and were not challenged or changed by their professional education. Through the discourse that *'mechanical-ised'* sexuality, these strands were subsequently thickened. In addition, through exposure to discourses that *'pathologised'* and *'minimised the importance of clients' sexuality'*, participants were left with a narrow perspective on sexuality, its relevance to clients and their work as psychiatric nurses. The hidden curriculum communicated powerful messages to participants about the relevance and importance of sexuality to client life. The absence of safe educational spaces and professional role models, capable of engaging in discussions around sexual issues, left participants without the comfort and confidence to discuss sexuality and sexual health care issues with clients. Within the practice environment, participants were exposed to a number of discourses that ultimately culminated in them mentally desexualising clients and becoming desensitised to the sexual needs of clients. The discourses experienced by participants in practice, mainly through other people's behaviour, were very impoverished and akin to a silent pact that some things were best left unspoken. Consequently, through the process of *'professional comparing'*, *'cultural seepage'* and *'absorbing voices from the past'*, participants absorbed and perpetuated a culture that worked on a tacit and unspoken contract that mentally desexualised clients. Through these processes, participants learnt about professional silence and inherited normative forms of responding or 'action schemata'

(Greenwood, 1993:1471) that enabled them to respond should the client make the sexual dimension of themselves visible.

In conclusion, although participants were exposed to a number of discourses, significance did not reside in the number of discourses. What was important was the distribution of discourses in terms of what things were said, what was not said, who was speaking and in what context. Significance also resided in the fact that each discourse reinforced previous cultural and professional views, while simultaneously marginalising social, psychological or political discourses that could have provided alternative perspectives. It was, therefore, the combination of the dominance of some, and the subjugation of other discourses, that helped *'Weave the Veil'*, through which participants subsequently viewed clients' sexuality. Elements of these cultural and professional discourses were reproduced in the types of interactions participants had with clients around sexual issues in the practice environment. Subsequently, through observation of these interactions, the next generation of nurses was socialised into a particular way of working, thus, perpetuating the *'weaving of the veil'*. These patterns of interactions will be explored in the next two chapters, which discuss the subcategories that make up the *'Veiling-Re-veiling Cycle'*, namely: *'Hanging the Veil'*, *'Lifting the Veil'* and *'Re-veiling the clients' sexuality'*.

CHAPTER SEVEN: 'HANGING THE VEIL' AND 'LIFTING THE VEIL'

Introduction

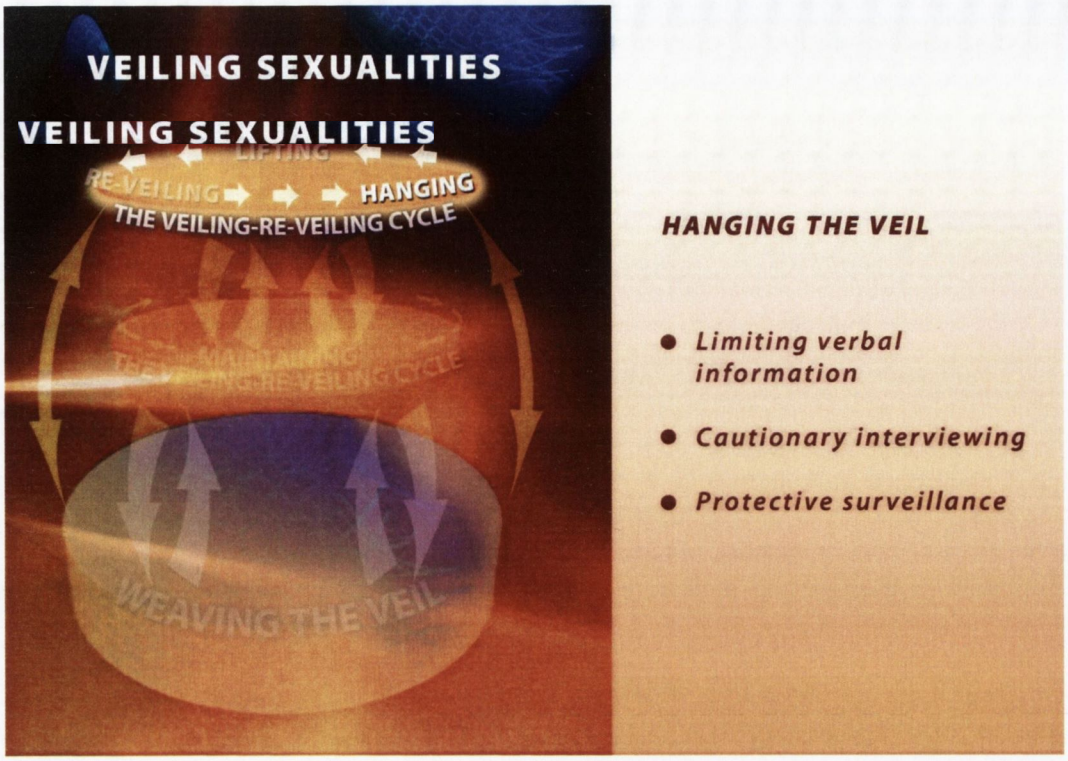
The previous chapter described how the *'veil'*, through which participants viewed the clients' sexuality, was woven. It was through the processes of *'weaving'*, *'thickening'* and *'fusing the strands'* that participants learnt how to view, hear and interpret clients' sexuality. It was also through these processes that participants inherited normative forms of behaviour that enabled them to respond to clients' sexuality in the practice environment. These normative forms of responding or taken for granted practices were conceptualised as a cycle of behaviour, named the *'Veiling-Re-veiling Cycle'*. This cycle consisted of the following three sub-categories: '*Hanging the Veil'*, *'Lifting the Veil'* and *'Re-Veiling'*. This chapter discusses the first two categories that made up the '*Veiling-Re-veiling Cycle'*: *'Hanging the Veil'* and *'Lifting the Veil'*.

'Hanging the Veil'

'Hanging the Veil' refers to strategies that participants used to hang a metaphorical veil over the client in order to keep the client's sexuality verbally and behaviourally contained. By '*hanging a veil'* around the client's sexuality, participants were also able to hang a veil around their discomfort, thus sustaining their professional identity as competent and caring professionals. In this way, the veil had a dual function.

Although the veil did allow for a shading over or coverage of both the client and self, it was sufficiently translucent to hint at what lay beneath. Consequently, participants could not completely deny or ignore the sexual dimension of the client's life. Participants hung the veil using a number of verbal and behavioural strategies; conceptualised as *'limiting verbal information'*, *'cautionary interviewing'*, and *'protective surveillance'*. Each of these three strategies will now be explored together with their properties.

Figure 3 Diagrammatic representation of 'Hanging the Veil'



'Limiting verbal information'

'Limiting verbal information' refers to the way participants avoided verbally disclosing the side effects of prescribed medication that could impact on the person's sexual function, thus drawing a veil of silence around drug-induced iatrogenic sexual dysfunction and, at the same time, veiling their own discomfort. Participants' allegiance to biological approaches to treating mental distress and a desire to avoid personal discomfort strongly influenced their decisions. Participants limited verbal information by working from a *'hierarchy of disclosure'* and *'referring to written information'*.

'Hierarchy of disclosure': As in other studies (Happell et al., 2002; Jordan, 2002), participants espoused the belief that educating clients about adverse effects of medications, and monitoring these effects, was part of their role and in keeping with the rights of clients to make informed decisions. However, in relation to side effects that impacted on sexual function, these positive aspirations were not transferred into practice. In reality, participants limited the information given to clients about

iatrogenic sexual dysfunction by working from what they called a *'hierarchy of prioritisation'* where *'they [sexual effect] are down the bottom of the list' (25 F)* or *'way down the order of priority' (12 M).* For many participants, positioning iatrogenic sexual dysfunctions at the bottom of the hierarchy reflected the 'othering' process previously discussed. As one participant said, *'It's like we expect patients to be kind of non-sexual objects or people' (13F).*

The hierarchy of prioritisation constructed by the participants was not based on research evidence, but reflected participants' perceptions of the relationship between non-compliance and disclosure of iatrogenic sexual dysfunction, the prevalence of side effects, and the participants' comfort level around talking about a particular side effect.

In constructing the hierarchy of disclosure, participants classified side effects as 'safe' and 'unsafe'. Safety of a side effect did not refer to toxicity but referred to the participant's perception of the risk of non-compliance associated with disclosure. In calculating this risk, disclosing iatrogenic sexual dysfunction was considered to carry a considerably high risk of non-compliance. Consequently, in an attempt to control clients' behaviour and ensure compliance, these side effects were relegated to the bottom of the hierarchy and not disclosed. For some participants, the non-disclosure was also motivated by a desire to work in harmony with the medical team, and avoid being blamed for contributing to a client's decision not to take prescribed medication.

'You're certainly not going to turn around and say, "you'll have a problem with expressing your sexuality"; I feel that is the one thing that will put them off taking it, absolutely. It [telling] would be a definite no no, I've seen it...if there's any problem at all in that area and they made the connection between the medication and their sexual functioning the medication is gone, absolutely, out the window' (2 F).

'I think the hesitancy is about nurses overstepping the mark,...you don't activate practice that is going to interfere with the medical practice...I am not saying it is the only thing but it is a factor in that it prevents you ...you don't do something that is going to interfere with compliance' (22 M).

Participants did not appear to consider evidence which suggested the provision of information simply increased clients' understanding of treatments and did not have

any significant impact on compliance (Gray et al., 2002b; Fernandez et al., 2006). Instead, they worked from the assumption, which had assumed mythical status, that there was an inverse relationship between education about iatrogenic sexual dysfunction and compliance – a view shared by some community mental health nurses in the UK (Cort et al., 2001). Similarly, despite evidence suggesting that drug-induced iatrogenic sexual dysfunction is prevalent and can have a significant negative impact on the person's life and self esteem (National Schizophrenia Foundation UK, 2000; Rothschild, 2000; Montejo et al., 2001; Wallace, 2001; Smith et al., 2002), participants did not recognise the implications of their non-disclosure. This lack of awareness was possibly reinforced by the lack of education on this topic, and the infrequency of role modelling of discussions with clients in practice. Consequently, emphasis was placed on what participants considered, from visual observations of clients, to be the most common side effects. The following are indicative of comments:

'You tell them the common ones...like you see patients sedated and falling, I see people drooling but you don't really think about the ones you don't see' (13 F).

'I would list the common side effects - you tell about dizziness, blurred vision, dry mouth, constipation, stomach upset...I list side effects I would come across very often, the ones I learnt' (11 F).

Talking about iatrogenic sexual function was considered a subject that had the potential to engender a high degree of personal discomfort and embarrassment. Therefore, to maintain personal comfort, participants also avoided telling clients.

'I don't tell to be honest, again it is one of those things, I've said my views would be liberal, but still to be talking to someone about the [sexual side effects], it does make you feel slightly uncomfortable, so you try and avoid the subject' (8 M).

'We are comfortable talking about dry mouth, we are not comfortable when we are talking about dry vaginas. Let's face it, we are not comfortable, so we are not going to talk to them' (24 F).

'Referring to written information': Some participants did give clients written information about the side effects of drugs and invited them to disclose if they experienced any of the side effects identified. Providing written information is to be welcomed, given that 65.8% (310) of service users with enduring mental illness in an Irish survey (n=471) reported receiving no written information on the drugs

prescribed (Schizophrenia Ireland, 2002). However, referring clients to written information mirrored some participants' experiences of their own sexual education, when they were given a book to read, without follow up discussion. The tactic of referring to written information projected an illusion of information-giving and education, while at the same time *'veiling'* the participants' personal discomfort. By placing the onus on the client to make the connection between sexual dysfunction and prescribed medication and voluntarily disclose difficulties, participants were able to avoid having to engage proactively in direct discussion about what they considered an uncomfortable subject.

'The booklet is there and you don't have to bring it up (laughs) and they know that they can come to you then, if they have one [iatrogenic sexual dysfunction]' (26 F).

'I would give them the leaflet...but to be honest I think a lot of the patients here don't understand the leaflet, their level [of literacy] wouldn't be very good' (11 F).

'You go, "Read this leaflet and if you have any problems come back to me"...I suppose that presumes that they still have the courage to come to you and openly talk to you about it' (18 M).

The latter two comments also highlighted the degree to which participants continued consistently with the practice of referring to written information, even though they doubted in their own minds the clients' ability to interpret such information, and their confidence to disclose sexual difficulties voluntarily. Similarly, this unreflective and unquestioning approach to clients' sexuality was evident in the manner that participants, although aware that sexual effects could be distressing for clients and would not like to suffer the side effects personally, were willing to allow it to happen to clients. As one participant said:

'It can be a great problem for some, very distressing... but it [telling clients] would be just way down the order of priority, they wouldn't take the drug, not that I blame them, I wouldn't take it' (12 M).

In summary, by *'limiting verbal information'* through the use of a *'hierarchy of disclosure'* and *'referring to written information'* participants drew a veil of silence around drug-induced iatrogenic sexual dysfunction and, at the same time, veiled their own discomfort.

'Cautionary interviewing'

A holistic assessment of the client is a central task for psychiatric nurses and is important for individual care planning and service provision (Simons and Petch, 2002). According to McCann (2000) if mental health nurses want to be truly responsive to people with mental health problems and their carers, they need to include sexuality as a dimension of that holistic assessment, and need to ask about sexual and relationship issues. Although participants talked about holistic care, they avoided proactively initiating or engaging in a discussion with clients around sexuality by speaking through a metaphorical 'veil' in assessment discussions. The metaphorical veil that participants spoke through was named *'cautionary interviewing'*. *'Cautionary interviewing'* has the following properties: *'routine questioning', 'avoiding taboo questions', 'vague questioning', 'passive waiting for disclosure'* and *'skipping over'*.

'Routine questioning': Through professional comparing and socialisation into the professional discourse of psychiatry, participants learnt a routine set of questions to ask clients during assessment interviews. As one participant said:

'There is a practiced line of questioning that you develop an expertise in, you feel comfortable with, you know you are going to be able to deal with the consequence of the answer, and you stay with that...safe questions' (22 M).

Although participants talked of using a nursing model or conceptual framework to guide their assessment, the questioning process described tended to be significantly infused with the belief system of the biomedical model. Emphasis within this model was on viewing mental distress as 'illness' and identifying symptoms as opposed to creating a context for clients to tell their story, in whatever way they choose. In keeping with the biomedical model, questions were limited to the classical questions around symptoms such as thought process, content, mood, behaviour, and what participants considered was the presenting problem. The following are reflective of the comments made that highlight the routine type of questions asked:

'I ask people about their appetite, I ask them about their energy levels, I ask them about their sleep, I ask them about all the stuff, the delusion or all that kind of stuff, if they're psychotic thinking, cognitively impaired...it's just it's [sexuality] not

something you ask and I mean I was never trained to ask it I suppose, and I don't' (5 F).

'A lot of it is around how people are presenting, their mood, their behaviour, the focus is on that...the presenting problem...it's [sexuality] not something I think about' (25 F).

Questions or statements relating to the sexual dimension of the person in terms of developing intimate and sexual relationships or their experience of intimate and sexual relationships was not proactively included in either the initial nursing assessment or subsequent nursing assessments or discussions with clients.

The *'routine questions'* asked were perceived as necessary to help participants perform their role, which was to treat 'illness'. Questions relating to sexuality did not have the same degree of legitimacy. As one participant said:

'... the questions [routine] are necessary, so you can care for the person...I mean they [questions about sexual relationships, sexual experiences or sexual health] are not necessary. Okay, yes, it is an activity of daily living, but it is not necessary, you can care for people without addressing it' (22 M).

The emphasis on accessing information in order to treat 'illness' is also evident in the following comment:

'I think peoples' sleep is so important... it tells you whether people are depressed, whether they are elated, whether they are psychotic, whereas I suppose it doesn't occur to me that their sex life, relationships tells me so much about them (said with a sense of shock)' (5 F).

By confining themselves to a *routine questioning* technique, participants were able to control the interaction, and control the possible outcomes, in terms of what clients told them. In this way, participants minimised the likely consequences to self in terms of exposure of personal discomfort or competency deficits.

'Avoiding taboo questions': Designating a topic as taboo was a product of perspective. When a topic was appraised as sexually laden with meaning or extremely intimate, participants would not, because of personal discomfort, initiate a conversation on this topic. Questions in relation to sexual activity, sexual orientation, sexual violence and iatrogenic sexual dysfunction fell into this category

and were consciously avoided by participants. Even in situations where participants recognised that clients were experiencing some difficulties around sexual identity and orientation they were reluctant to ask questions or explore issues, as highlighted by this participant.

'It is something that is difficult to ask like whether they have any issues...I have nursed a couple of young lads who I felt were struggling with their sexual identity and I felt uncomfortable asking them anything; it is something we as nurses are scared of, so you don't ask' (15 M).

Participants expressed a high degree of discomfort around the area of sexual violence; consequently, they avoided any questions in relation to sexual experiences, whether positive or negative:

'I wouldn't ask, (pause) no, I wouldn't feel one hundred percent comfortable asking about sexual abuse – again, you are only going to ask questions that you feel comfortable with' (22 M).

'People who have been abused who have been sexually abused I would be more cautious as well... just the whole sensitivity around that issue,...being abused can cause such issues for people over their life, you know so that one would be kind of an area that I wouldn't ask questions about' (23 F).

There did not appear to be an alert consciousness of the need to break the cycle of silence, fear, stigma and shame, by creating a context that encouraged people to tell of their experiences of sexual violence. Participants were also not conscious of the way their actions could either reinforce a belief that the client's experience was too bad or too unpleasant to discuss with anyone, or be experienced as a further collusion with society's denial of the prevalence or impact of sexual abuse.

Participants did ask some direct questions of clients which could be considered related to sexuality. However, these questions were not linked, in the participants' cognitive schema, with sexuality, sexual expression or the 'erotic'. Consequently, they did not evoke the same element of discomfort and were not perceived as transgressing social taboos. For example, participants asked female clients about contraceptive medication. The purpose of this question was not to explore sexual relationships or sexual health, but to acquire facts deemed important for medication management. Commenting on asking about contraception, participants said:

'We have a physical section [on the assessment form] so we get information there, if somebody is on the pill they will bring it in to us, and we will dispense it from the drug trolley so they can continue the contraception while in hospital, but we don't delve into things beyond that' (10 F).

'When we're doing the initial assessment we would ask people are they on any medication and they almost always think it's psychiatric medication and I'd say, "Are you on the contraceptive pill"...it is just another question...because they are on other medication that might interact with the pill' (1 F).

Similarly, participants did enquire if clients were in relationships. However, the focus was not on the significance or meaning of the information to the client's sexuality and sexual health, but on acquiring facts about next of kin or civic status, in order to complete some administrative duty. Subsequent, follow up, or exploratory questions on the nature of the relationships or the impact of the current crisis on the relationship were not addressed. Inherent in many of these questions about relationship was a heterosexist bias that assumed heterosexuality:

'You say "are you married Mary or Jack"' (14 F).

'We would ask their marital status, but it is just for our knowledge are they married, single, separated' (12 M).

'Vague questioning': In light of the discomfort participants reported around asking direct, focused questions about what they considered to be taboo subjects, they veiled what could not be openly spoken about by using a *'vague questioning'* style. Vague questioning enabled participants to *'walk the very fine line between intrusion and what needs to be addressed' (24 F).* Vague questioning consisted of the use of questions that lacked a degree of precision. Given the imprecise nature of the questions, they were open to different interpretations by clients, thus enabling participants to project themselves as unintrusive. However, in the absence of follow up questions, this vague questioning style left clients without a context or permission to discuss sexual or intimacy concerns. The following are reflective of the style of questions participants used to ask about sexual related issues:

'You might ask, "Are you in a relationship?" and "How is it going?", but you would never ask if it was sexual' (13 F).

'I wouldn't give specifics. I was saying like "How are you feeling like, is there anything different, like, to when before you started the meds?", that is what I would say...I am pussyfooting around the subject' (15 M).

'Passive waiting for disclosure': Participants reported that they passively waited for the client to give them some verbal indication of a problem in relation to the sexual dimension of their personhood. Statements such as *'unless they bring it up' (14 F), 'unless they come to me' (19 F), 'if they don't say anything, I don't' (15 M)* and *'I wouldn't encourage it' (11 F)* permeated their descriptions. This passive waiting and '*only talking if the patient says something that provokes you to talk' (9 M),* contrasted with the more proactive, guiding, interactional style that participants took with other aspects of the person's life, such as suicide, where participants gave permission and set a context for clients to disclose suicidal intent and talk about their feelings.

Passive waiting related to all aspects of sexuality, including iatrogenic sexual dysfunction, sexual violence and relationship issues and was considered '*a way of protecting yourself' (15 M)* from the perceived consequence of transgressing social or professional taboos. By placing the onus on the client and in the absence of any triggers from the participants that might indicate willingness to listen to or explore sexual concerns, participants were enabled to maintain some degree of control, as they could choose whether to pick up or ignore cues or statement given by clients. Even though participants had some awareness that clients may not have had the confidence, comfort and linguistic skills to initiate a conversation about sexual issues, they continued with this passive approach, as suggested by this participant:

'I suppose a kind of knock on effect really isn't it, if we don't talk about it, they don't talk about it, like if they are having problems they don't feel that they can say it to us, because they think it isn't an issue that is appropriate to be talking to this person [nurse] about. I suppose if we don't speak about it now, how are they going to come to us?' (26 F).

'Skipping over': Participants reported that when it came to sexuality, *'if you are doing an assessment and it is on the documentation, everyone just skips over it, it is just left blank, not really broached' (17 F).* In some part of the service a risk assessment document was in use, which had a category for sexual risk. In the nursing records reviewed, thirteen (59%) of the twenty-two records indicated that

the risk assessment was completed and, contrary to the participants' verbal reports, nurses were not skipping over the assessment of sexual risk. However, in the course of the interviews, participants indicated that the risk assessment was completed by referring to past nursing or medical records and not through discussion with the clients. By skipping over the client voice in the assessment, participants were able to veil their discomfort while projecting an illusion that a comprehensive sexual health risk assessment had been completed. This practice of skipping over was also reported in relation to other forms of assessment documentation. One participant, commenting on the introduction of a rehabilitation assessment tool, said:

'We brought in an assessment tool for rehabilitation...on it there was a section on sexuality...in over a hundred of them that I looked at, it was not applicable, or not relevant, that is what was documented...so that's the story' (3 F).

In summary, '*cautionary interviewing'* referred to the strategies that participants used to avoid including any direct reference to sexual or relationships needs in their discussions with clients. By using the strategies of '*routine questioning', 'avoiding taboo questions', 'vague questioning', 'passive waiting for disclosure'* and *'skipping over',* participants maintained a veil of silence around sexual issues while concurrently veiling their discomfort.

'Protective surveillance'

Although participants on the whole tended to veil over the sexual dimension of the clients' personhood, paradoxically, they did have some conscious awareness of clients as sexual beings. However, sexuality, in this context, was viewed as something that was 'illicit' and 'dangerous'. Participants had a heightened fear that clients, while in residential care, would engage in a heterosexual relationship; therefore, in order to protect the 'vulnerable' client and protect themselves from an accusation of professional negligence, participants hung a protective veil over clients through a process conceptualised as '*Protective surveillance'. 'Protective surveillance'* had the following properties: *'keeping a close eye', 'tuning into the warning signs', 'alerting others', 'peer monitoring', 'limiting freedom of movement', 'keeping in the dark', 'paternalistic protection', 'biased protection', 'limited protection'* and *'professional protection'.*

'Keeping a close eye': 'Keeping a close eye' was the primary method used to prevent clients from engaging in sexual "wrongdoing", such as a heterosexual encounter. Participants spoke of *'keeping a close eye' (15 M)* or *'keeping a watchful eye at all times' (12 M)* to ensure that *'nothing inappropriate was going on' (19 F).* Keeping a close eye was akin to diffuse observation, where everyone in the team had a responsibility for observing clients. This form of observation was done in the context of the general level of every day, routine observation that was used for all clients to maintain their safety, whether in hospital or community housing. Keeping a close eye reflected a physical proximity rather than an emotional proximity. The focus was on observation rather than therapeutic engagement with clients to assess competence, consensual ability or knowledge of safe sexual practices.

'Tuning into the warning signs': Tuning into what participants called the 'warning signs' was an important dimension of the visual surveillance process. Participants were continually on the lookout for signs that a heterosexual relationship, with the potential for a sexual encounter, was developing between two clients, for example: looking for an increased level of interaction between clients, such as spending extra time chatting together, going places together, limiting interaction with other clients, touching each other or behaving in any way that participants interpreted as sexual. This constant tuning into the warning signs enabled participants to intervene immediately, reducing the chances of a consensual or non-consensual sexual encounter occurring. In describing what was being observed, participants said:

'They mightn't even have touched off each other, they might be just spending more time with each other than the rest of the group, you see people pairing off, ...you see a male and a female, two young ones especially, nearly every day, the day is spent sitting with each other at the dinner table or they are in activities and groups and they are not really concerned about what is going on, they just want to have the chats...you are observing who they are engaging with, how they are interacting, if they are interacting with anybody, so when you are doing that you are going to identify that these two are getting a bit too cushy' (10 F).

'You would be watching for the relationships to develop.... you could see relationships flourishing...people would gather together in different groups or different cliques and they would socialise together, be watching TV, playing some games of pool or going on an outing together, asking to go to the shop together' (12 M).

'Alerting others': In situations when participants considered there was a risk of a sexual encounter, they verbally alerted other nurses so that their surveillance could be increased. Although participants likened the alerting of other nurses to telling about suicide risk, unlike a situation where clients were considered a suicide risk, there was no formal written plan of care in relation to this aspect of the person's life.

'Staff are reminded and obviously made aware of it [risk of two clients having a relationship]... they just make an extra check for the two you are concerned about. It is the same if somebody comes in and they are an extra risk, a suicide risk, you are going to tell and make an extra little check in on them' (10 F).

'There are things passed on... you know, "You want to watch that", "Keep an eye on that" and "Make sure she doesn't be doing that in the course of the shift"' (18 M).

'Peer monitoring': On occasions, other clients became part of the 'surveillance' network and reported suspicious behaviour to participants. As one participant explained, *'You would have other patients and they would tell tales and say there are two patients in the toilets down there together, so you go and investigate' (16 M).* This peer monitoring of fellow clients resonated with Goffman's discussion on clients 'squelching on their friends', in the hope of improving their own status within the institution (Goffman, 1961:265).

'Limiting freedom of movement': Participants endeavored to prevent sexual encounters by *'limiting freedom of movement'* of clients. In situations where participants were concerned about two clients of the opposite sex, those clients were restricted from leaving the ward together or going to any area that was considered 'backstage space' (Goffman, 1959). Backstage space was any space that was not frequented by nurses. This approach is reflected in the following comment:

'This gentleman developed a relationship with this girl on the ward... there was a constant concern about it, especially if they were on their own. We would allow them to sit beside each other and talk where we could see them. If they wandered off to (names part of the ward that is not frequently frequented by nurses), we would say, "Come on now, you need to be in a space where we can see you at all times"' (10 F).

'Keeping in the dark': Although there was an unwritten policy that prohibited clients from engaging in any sexual relationships within wards or community

residences, and prohibited clients from going into rooms of the opposite sex, clients were not automatically told these rules. Written information leaflets that identified other 'rules' in relation to alcohol or illicit drugs, were given to clients on admission to the service; however, information about sexual behaviour was not included. Neither was there information about the rule governing not going into bedrooms of the opposite gender. As a consequence, clients learnt the rules by a process of transgression or, as one participant described it, *'Unless you put your nose out of joint, you [patients] are never told... if you are seen, you are ticked off then...that is it basically, you have to offend' (12 M).*

Even in situations where participants requested clients to remain visible, they did not openly speak about their concern to the client. This covert approach to dealing with concerns around sexuality is reflected in this comment about a client and a visitor who had the screens pulled around a bed:

'I have had that where the screen has been pulled around the bed and I have said, "I am sorry I have to have the screens pulled back" and they said "but why", and I said "I am just saying while you are in here, I need to have the screens pulled back, and I need to be able to observe you at all times"... if they were in a single room and there was somebody going in, a visitor that you were concerned about and that you had an inkling about, you would ask for the door to be kept open, you would always put it off by saying, "we need to observe, we need to be able to see patients all the time when we pass up the corridors", you wouldn't say what you were thinking'(27 F).

'Paternalistic protection': Participants justified their surveillance by appealing to the principle of beneficence and their duty to care for clients who were considered vulnerable. This duty to care was more a *'paternalistic protection'* where the emphasis was on caring for clients as opposed to caring with clients. Participants continually spoke of their duty to care using the paternalistic language of *'caring for' (10 F), 'looking after' (19 F)* and *'my/our role' (12 M),* which resonated with Beauchamp and Childress's (1989) description of paternalism: an attempt to address the needs of the individual in the same way as a parent does with children. When clients were spoken about with the prevailing medical paradigm of illness, they were constructed as vulnerable, irrational beings, who by virtue of their mental health status lacked the requisite social judgements and had a reduced capacity to make effective decisions in relation to sexual relationships. Thus, participants were

of the opinion that they had a duty to override client autonomy and protect them from the possible negative consequences of poor decision making:

'Patients in hospital are very vulnerable; they have diminished capacity to consent to sexual relationships as in the case of a manic patient they can be sexually disinhibited. Some patients are very naïve and innocent so you need to protect them; some have no insight, other patients can use them for money, sexual favours. As a nurse you have a duty to care for patients who are vulnerable, there is an onus on you to step in and protect the person' (6 M).

'People here are vulnerable, they are here [community house] to be protected, they need to be looked after...there is nobody here I would consider a consenting adult' (19 F).

It could be argued that the absence of competence to make a decision could be in keeping with the principle of beneficence and a justification for a weak paternalism (Beauchamp and Childress, 1989). However, because an assessment of competence, consensual ability or knowledge of safe sexual practices was not completed, all clients were automatically presumed to be incapable of effective decision-making.

'Biased protection': When hanging the veil of protection, participants worked from a heterosexist norm that tended to define sexual relationships in terms of vaginal penetrative sex. Consequently, the veil of protection was strongly biased towards heterosexual relationships. Participants did not seem to give much consideration to the possibility of same sex relationships or the protection of men within a heterosexual relationship.

Greater emphasis was put on the need to hang the protective veil around women. Using a combination of explanations that both reversed and conformed to traditional social norms, participants explained that women were more vulnerable than men on a number of counts. Women when mentally unwell were considered to be more sexually promiscuous and predatory than men. Women were viewed as more willing to seek out a sexual partner actively and to solicit sexual relationships without discrimination. Men, in contrast, were considered to isolate themselves and to become withdrawn or preoccupied with delusional thoughts.

'Generally female patients are more sexually inappropriate...throwing themselves at males' (10 F).

'My experience has been that chiefly female patients that are manic are more likely to be promiscuous; the males that I have known that are manic tend to get involved in religious delusions, it tends to be more a psychotic aspect to their mania' (9 M).

Participants' thinking also conformed to traditional stereotype that engaging in sexual behaviour was more emotionally significant for women. Thus, women who engaged in sexual relationships while mentally unwell were considered to be more prone to feelings of shame and guilt. These feelings were considered to have a negative effect on their mental health. Consequently, participants emphasised the need to protect women's 'dignity' by protecting them from regret and embarrassment. The need to protect men from shame or regret did not appear to be an issue:

'It's dreadful for them [women] afterwards to be left with that memory and it can actually lead them straight into a major depression afterwards, and I think it's their dignity, I think at the end of the day it is so demeaning for them to remember that, to be left with that' (2 F).

'We are more protective of females definitely ...you would have ladies especially who are unwell and very vulnerable, and they would do things that they would really, really regret' (15 M).

Women's vulnerability was also linked to their reproductive capacity. Although some participants talked about protecting women from sexually transmitted diseases, similar to participants in other studies their primary concern was pregnancy (Buckley and Wiechers, 1999; Cole et al., 2003). Despite the mortality and morbidity risks associated with unsafe sexual practices, participants tended to ignore or minimise these and spoke of risk using the traditional discourse of fear of pregnancy. Embedded in some of the comments was the view that women, because of their mental health problem, would not be capable of caring for the child. These views are summed up in the following quotes:

'You are really just protecting the female from an unwanted pregnancy, it is the female that is the focus and pregnancy is the issue...There is nothing done about sexually transmitted disease risk to the male, or indeed the female, it is always let's think about the female and the risk, but it is only with the pregnancy risk' (12 M).

'Like we have a woman who does sexual favours for men in exchange for alcohol and you are concerned about her, you know, meeting complete strangers, getting

pregnant and there are no ladies here at the moment who would be able to handle a baby, that would be a disaster' (13 F).

Paradoxically, although men were considered to become more sexual passive, when mentally unwell, they were considered to be 'naturally' less likely to decline a heterosexual invitation. This gender assumption was then translated into a professional assumption that it was unlikely that men could be sexually exploited by women, and an overlooking of men's capacity to consent to sexual relationships:

'It is just that men are seen that they will always consent, that is the view...we would view it that the man will avail of the offer, willingly take part...there is never a sense that a man is not able to say no' (15 M).

'Limited protection': The paradox within this veil of protection was that it only afforded a *'limited protection'* to clients. Although participants talked of their professional and legal responsibility to protect all clients, and more specifically the female clients, from possible danger or the consequence of uniformed actions, their zone of concern and accountability extended to what they knew about and could see. Their boundary of concern was defined by the physical structure of the service they worked in. What clients did outside the physical structure of the service was considered to be none of the participants' business. The protective veil, therefore, was more of an imposed, short-term, controlling veil to stop sexual relationships within the service, as opposed to a sexual health promotion veil where emphasis was on promoting positive sexual health through education and collaborative dialogue with clients. This is best represented by the following exchange:

Participant: *'What they do when they go outside is their business...if they want to have a sexual relationship outside that is fine...you can go down the road and go to the park and go anywhere you like, don't do it on our property, don't do it in here'.*

Interviewer: *How does that sit with what you are saying about a duty to protect?*

Participant: *'When they are outside we don't know what they are at anyway, so it makes no difference, unless a Garda [police officer] knocks on the door and says there is two of them down in the park ...they are inappropriately acting, then that would concern us but you can't control what they do outside' (19 F).*

'Professional protection': The limited protection described above was related to participants' concern with *'professional protection'* and personal consequences to self. The protective surveillance was motivated by participants' desire to reduce the

risk of an accusation of professional negligence, with the resultant consequence to their professional career. Pregnancy appeared to represent the objective evidence of professional negligence, and participants feared having to report and explain to members of the team and the client's family what had occurred. These concerns are summed up in the following:

'What they do outside the hospital is their business, but when people come in that is different, she might get pregnant and I don't want to be writing a report saying so and so got pregnant on my watch' (6 M).

'I would be afraid that I would have to account to that person's family, friend or who ever is their advocate ...So if you heard that oh they had sex you would be thinking, oh Jesus, ...the first question isn't did both parties consent did they want to do that, it is about Oh Jesus what if she is pregnant and it is on my watch, that is the attitude really' (12 M).

'You have allowed those two people to have a relationship and the children aren't going to be cared for properly and it is going to affect their mental state, then you would be asked a lot of question as to why I allowed it to happen, the medical and nursing team as well as the Assistant Director of Nursing would ask a lot of questions, it would become a bigger issue than just at ward level...you would get into trouble, so I am not going to let it happen' (14 F).

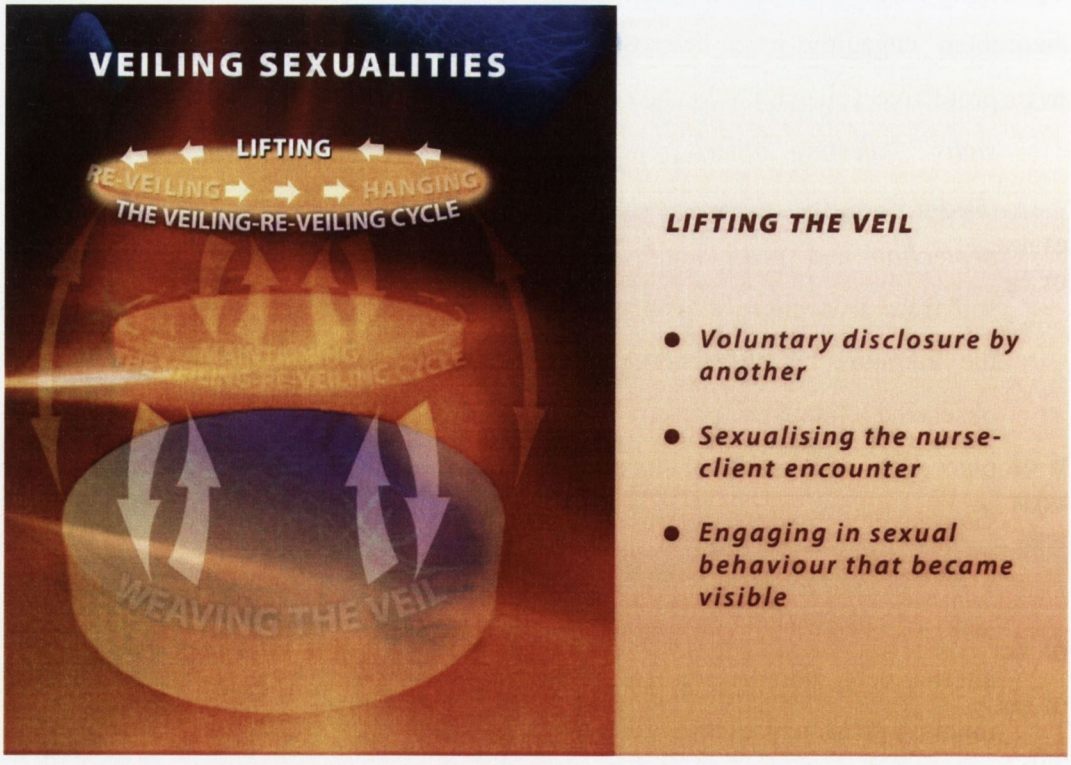
In summary, *'Protective surveillance'* referred to the manner in which participants hung a veil over clients, particularly female clients, in order to reduce the risk of them engaging in a heterosexual relationship while in residential care. This protective veil which consisted of *'keeping a close eye', 'tuning into the warning signs', 'alerting others', 'peer monitoring', 'limiting freedom of movement', 'keeping in the dark', 'paternalistic protection', 'biased protection', 'limited protection'* and *'professional protection'*, was motivated by a desire to protect the self from an accusation of professional negligence. Interestingly, in the context of the literature on observation and special observation in mental health nursing, observing clients to prevent sexual relationships is not discussed. Emphasis is placed on observation of those at risk of suicide, self harm (Bowers et al., 2000; Gournay and Bowers, 2000; Cutcliffe and Barker, 2002) or violence and aggression (MacKay et al., 2005). This absence of discussion may be a reflection of the general lack of discussion on sexuality and people with mental health problems; alternatively, the practice of '*protective surveillance'* for this purpose may be unique to Irish psychiatric nurses.

The next section of this chapter will discuss the second sub-category in the *'Veiling-Re-veiling Cycle'*, which is conceptualised as *'Lifting the Veil'*.

'Lifting the Veil'

As previously stated, participants had some conscious awareness of the clients as sexual beings, *vis-à-vis* the risk of clients engaging in a sexual relationship; however, it was only through the veil being lifted that the sexual dimension of the clients' personhood became clearly visible. Since participants were disinclined either to acknowledge openly the sexual dimension of clients' personhood or to start a therapeutic conversation with clients on sexual issues, lifting the socially and professionally constructed veil became the role of 'another'. This 'another' was most frequently the client. *'Lifting the Veil'* occurred through three processes conceptualised as: *'voluntary disclosing by another*; *'sexualising the nurse-client encounter'*; and *'engaging in sexual behaviour that became visible'*. Each of the three processes will now be explored together with their properties.

Figure 4 Diagrammatic representation of 'Lifting the Veil'



'Voluntary disclosing by another'

'Voluntary disclosing' is the process by which 'another' verbally lifted the veil, thus indicating to the participants that there was a sexually related dimension to the client's life that required acknowledgement. Voluntary disclosure had the following properties: *'chance happenings'* and *'gendered biased disclosure'*.

'Chance happenings': Although participants indicated that on a rare occasion a member of the multidisciplinary team, such as a medical practitioner or occupational therapist, did inform them about a sexual concern of the client, most frequently, it was the client who voluntarily disclosed information. What made the disclosure voluntary was that the client's expression of concern or need arose unprompted. Participants were not consciously creating a context or inviting clients to disclose issues. Consequently, there was a fortuitous nature to the participants' awareness, with participants becoming aware of clients' needs more through '*chance happenings*' as opposed to conscious intervention. Participants spoke of hearing about concerns '*by accident' (5 F)* or *'stumbling across it [client problem]' (12 M).* Inherent in the subtext of some participants' responses was a sense of having to be forced to acknowledge the sexual dimension of clients' lives, as they appeared unwilling to lift the veil voluntarily:

'We wouldn't discuss it until [laughs], until you can't avoid it any more...it's only if it becomes blatantly obvious, they ask about an issue or it emerges as an issue, when it is not something that they can hide and it becomes visible' (2 F).

'In my experience if there isn't a problem we tend to leave it alone, unless there is an obvious screaming problem, [pause] and I think I still operate like that, if I have to I will address it' (24 F).

In these *'chance happenings'* clients sometimes disclosed an illness experience of a sexual nature, an experience of sexual violence, or an experience of iatrogenic sexual dysfunction. Illness experiences of a sexual nature were associated with what participants described as psychosis, delusions or hallucinations that had a sexual tone:

'How it comes up would be in relation to psychosis, some of their delusions would be around sex' (1 F)

'One chap, he was having voices and the voice was telling him that he was gay, ...they [voices] were all around his sexuality...that's the kind of thing that comes up in relation to sexuality' (10 F).

On other occasions, disclosures by clients were connected to experiences of sexual violence, such as sexual abuse:

'I have actually got a patient who I was seeing for a few years in the community, it took her two years before she told me there were abuse issues...after a few years of building up a relationship and trust she eventually told me there were abuse issues...but I didn't ask' (5 F).

In the light of participants' reluctance to ask clients about either positive or negative sexual experiences, or create a context for disclosure, voluntary disclosures of sexual violence appeared to be a rare occurrence. The latter quote also illustrates how, in the absence of sensitive inquiries, it could take clients years to disclose sexual violence. In the meantime, clients may be left without focussed emotional support.

The most common disclosure from clients was related to their experience of iatrogenic sexual function. Although not frequent, these disclosures had a fortuitous nature, as participants were not actively enquiring about iatrogenic sexual dysfunction. They were also fortuitous as, in the absence of education and information, clients had made the connection between their changed sexual experience and the drugs prescribed.

'I mean we were just lucky that he came and said it [that he was experiencing sexual dysfunction], he could have just stopped taking those tablets which is, I suspect, what happens' (24 F).

'I have at the moment a lovely man and we were working together for about a year almost, and it just – bump – came into the conversation, he had difficulty masturbating and he mentioned that...I had to, I had to take a deep breath and say okay don't panic here, now, you know what I mean' (4 F).

'Gendered biased disclosure': Despite the wealth of evidence suggesting that neuroleptic and antidepressant drugs can have a negative impact on both men and women's sexual function (Teusch et al., 1995; Peuskens et al., 1998; Milner et al., 1999; Fortier et al., 2000) there appeared to be a *'gendered bias'* in relation to who disclosed iatrogenic sexual dysfunction. Although literature suggested that women

generally engage in more health help-seeking behaviour than men (Hyde et al., 2004), both male and female participants continually reported that it was rare for a female client to seek advice for sexual dysfunction. In contrast, participants reported that, in recent years, some men had made reports of iatrogenic sexual dysfunction. If a female client complained of a side effect, which related to sexuality, it was most frequently related to the impact of weight gain on body image:

'No woman will ever come in and say I want my medication changed because my sex drive is gone, I would never have experienced it, but in recent time I would have heard it frequently from men' (3 F).

'A young girl who had been on [names an antidepressant drug] and she had problems with her sex drive after going on it...that's the only time I can think of a woman ever coming along to tell us she had a problem, with women it's [sexual side effects] not spoken about...it's more a male thing' (5 F).

The low rate of reporting by women would accord with findings of other studies on help-seeking behaviour in relation to sexual dysfunction (Moreira et al., 2005; Papaharitou et al., 2005). In the first large, multi-country survey, Moreira et al. (2005) using the Global Study of Sexual Attitudes and Behaviours Questionnaire (GSSAB), reported low help-seeking behaviour in both men and women. Although low help-seeking behaviour for sexual problems was reported in both groups, there was a lower frequency of women (1-8%) seeking professional help as opposed to men (2-12%). The most common reasons cited by both groups for not seeking help were: being uncomfortable, not thinking it was a medical issue, hoping that the problem would go away, and thinking that nothing could be done (Moreira et al., 2005). In a general population study of women experiencing sexual dysfunction in Greece, Papaharitou *et al.* (2005) reported that, due to a variety of interpersonal factors such as embarrassment, ignorance and misinformation, women were reluctant to seek help with sexual dysfunction.

Participants in this study tended to account for the low reporting of women by appealing to sexual essentialism. Sexual essentialism is the belief in the 'deep, unchanging, inner character of sexuality, such that its biological basis is uncontaminated by cultural influences' (Beasley, 2005:136-137). In contrast to their previous explanations, which suggested that when women become mentally unwell

they move from passive to active sexual beings, in this context female clients were constructed as sexually passive and concerned with their 'biologically given' parenting and homemaker role. In keeping with this sexually passive view, women were considered to be more willing to forfeit sexual pleasure as by 'nature' they were less concerned, than men, with sexual desire, pleasure and sexual arousal. Men, in contrast, were by 'nature' more focused on sex, more concerned with sexual performance, and less willing to live without sexual pleasure. These views are reflected in the following comments:

'It's a huge thing on their [men's] confidence...I think we women, (lowers voice) we're a bit different, how we express it...Whereas men...for them it's a real macho thing, it's their manhood almost' (1 F).

'It's not high on the agenda for them [women], as it would be for men. Through my experiences it wouldn't be high on their agenda, all kind of other things like diet, children or the house, you know the housekeeping or the money, they would be more high on the agenda, it is more of a man thing' (4 F).

'Like being potent is a big thing for males, it is a kind of a thing of power and just being sexual and masculine ...with women I think it is kind of more passive possibly' (15 M).

Although participants were aware of the overall low rate of disclosures and the gendered bias in disclosure, this did not increase the likelihood that either female or male participants would ask about iatrogenic sexual dysfunction. Participants continued to wait passively for clients to *'lift the veil'*.

'Sexualising the nurse-client encounter'

'Sexualising the nurse-client encounter' was the second way that clients lifted the veil and revealed the sexual dimension of personhood. There were unwritten and unspoken professional expectations or norms that clients treated the participants, and nursing encounters, in an asexual way. However, on occasions, both female and male clients transgressed these taken for granted norms and lifted the sexuality veil by engaging in behaviour that was conceptualised as *'sexualising the nurse-client encounter'*. The sexual behaviour directed towards the participants almost invariably involved clients of the opposite sex. Although infrequent, both male and female participants did recount incidents of same-sex sexualised behaviour. In these situations the sexual orientation of the clients was described as gay or lesbian.

'Sexualising the nurse-client encounter' had the following properties: *'sexual gesturing'; 'sensitive sensing'; 'calculating the risk';* and *'feeling vulnerable'.*

'Sexual gesturing': Clients sexualised the nurse-client encounter using the following strategies: verbal comments or questions, written gestures and physical gestures. Verbal comments extended from subtle, sexually suggestive remarks about participants' physical body shape or appearance to overt requests for sexual contact. Suggestive remarks ranged from, *'You look very attractive today' (14 F), 'You have beautiful eyes' (18 M), 'Your bum looks nice in those trousers',* or *'You have a lovely figure' (13 F)* to, *'Asking you about your sex life' (15 M)* or saying, *'I would like to drag you into bed' (12 M).* Although not frequent, some clients did make overt requests for sexual contact, such as recounted by this participant:

'There was also a patient here and he had a thing about me, and he started telling people he wanted to have sex with me... and he said he got an erection and I was mortified, every time he saw me the fellah would repeat it over and over and over again, "I fancy you, I fancy you, I want to have sex with you", and it was really upsetting me because I just wanted it to stop' (13 F).

Female participants also recounted situations where male clients talked about sexual hallucinations in a manner which led them to believe that their professional interaction was being used as a source of sexual stimulation:

'I have had it a few times with male patients, telling you about their voices, one man he said the voices were telling him that he wanted to stick his penis up me and touch my breasts... I felt he was getting some kind of sexual gratification out of it, out of telling me, I could be wrong, but that is how I felt' (21 F).

'He would talk about voices that he was hearing and what the voices were telling him to do, in a real sexual nature and very vivid pictures he would be describing to me, that he had to masturbate because the devil was in him...I did think to myself, he is just getting a satisfaction out of telling me things like that... to get some sort of pleasure' (17 F).

One male participant recounted his feelings regarding receiving two letters to his home from a female client which he felt had a sexual undertone:

'At the time I certainly felt that maybe there was more to come, maybe there wasn't (pause), again I will use the word inappropriate ...I felt first of all that my little bit of space between home and work had been violated...I felt that I had been kind of

invaded ...I also felt there was more to it, it was kind of a precursor to something greater, maybe an infatuation. Again maybe that was my paranoia but that certainly was part of the feeling' (16 M).

Physical sexual gestures ranged from physically touching the participants, such as *'touching you up in a sexual way, giving you a tap on the arse or trying to grab your breasts' (13 F)* to *'stroking your arm and trying to kiss you' (22 M).* Although male participants did mention what they called 'inappropriate touch' from female clients, being touched in a sexual way by clients of the opposite or same gender appeared to occur more frequently to female participants. Both male and female participants also recounted incidents of male clients exposing their genitalia in a sexually suggestive manner:

'When I am doing the injections, they [men] have to pull down their pants, and in the past some of them would say, "Get a load of this", they shake their willy [penis] at you, and say hold that (penis) for me...instead of seeing you as a nurse, they see you as a young women' (4 F).

'I have had one gentleman, he took his penis out and asked me for a hand job [to masturbate him], he was chronically psychotic and he had kind of homosexual tendencies (pause) and he had been abused as a child ...I said look that is not on at all, look you can't be asking anyone for a hand job' (15 M)

'Sensitive sensing': Because of the subtleties of some behaviour, interpreting and defining behaviour as sexual was not always clear-cut for participants. The knowledge used by participants to define behaviour as sexual, was so imbedded in practice that it was often taken for granted and difficult to articulate or as one participant said, *'It is difficult to define the borderline, where it is not invasive but it is not quite appropriate' (10 F).* Consequently, they resorted to phrases like *'you just know' (17 F)* or *'you just sense it' (14 F).* When asked to elaborate it became clear that it was not the behaviour *per se* that defined a situation as sexual, but the participants' personal interpretation. In constructing behaviour as sexual, participants used a process conceptualised as *'sensitive sensing'*. Here no one indicator was used, but a combination of personal feelings, cognitive appraisal of a variety of contextual variables, the client's past history, and experiential knowledge. It was this combination that helped participants have an intuitive sense, or grasp, of the situation.

'Sensitive sensing' was like a temperature reading, but in this case participants were firstly taking a reading of their own personal feeling of discomfort. Participants frequently used comments such as:

'You get an uneasy feeling, like the hairs on the back of your neck and stuff like that' (21 F).

'You get a feeling if it makes you really uncomfortable... you just kind of sense that it doesn't sound or feel right' (17 F).

'There is a feeling that it's not right' (16 M).

'It's like that intuition you get when you're under physical threat' (7 M).

This reading of personal discomfort, or pre-verbal intuitive sense, was then combined with a number of contextual variables to get a more complete picture. Breasts, buttocks and face were ascribed with more sexual meaning than other parts of the body. Therefore, participants considered touching or commenting on these body parts as highly sexual. Other indictors included the frequency of the behaviour, whether the behaviour was particularised and focused on an individual nurse, or whether the behaviour was focused on a particular gender. The manner in which the comment or gesture was made, and gender difference between the client and participant, were also used to help define whether a gesture was sexual. These variables are reflected in the following comments:

'It depends on the content and if it is a constant thing, it depends on the person as well and how the remark is said, how long it went on for,...like that guy talking about my bottom, I saw that as a bit sexual, whereas the guy saying my hair was nice I didn't see that as sexual, it was a once off...but I heard a patient [male] saying to another nurse, 'that top is lovely and tight it shows you off well", I saw that as inappropriate and sexual' (13 F).

'You know a constant sort of a flow of comments and over-familiarity, heavy and repeated comments, basically inappropriate...a flirtatiousness, comments on your dress, your behaviour, your presentation...that looks all right on you and that's grand on you..., that sort of stuff...if it is coming from a middle aged person or an older lady, it is sort of safe ground...but if it is with a younger person you would be conscious' (12 M).

'You sense it might be meant in a different way, their body language, their tone of voice, how well you know the person, are they well or unwell...it's a bit too far' (14 F).

The client's past history was another important contextual variable. Participants were quicker to define the incident as sexual if colleagues had informed them that a client had a history of engaging in sexualised behaviour:

'Past history is a big thing, if they have done it before' (18 M).

'If it is a once off thing it might be a comment that came out the wrong way, but if it is someone that has done it before that is different' (13 F).

Experiential knowledge gained from past experiences of situations in practice was also used. Participants likened this knowledge to an 'intuitive' sense one acquires from being exposed to, or by being personally involved in, similar situations. Participants also considered that this type of knowledge was different to book or theoretical knowledge as it could only be learnt in practice.

'When you are dealing with situations on a regular basis you get more adept at reading the situation..., as an eighteen/nineteen year old, I wouldn't have picked up on things as quickly, I think experience helps' (21 F).

'It's instinctive, and over the years you learn to read the signs' (16 M).

'It is that intuition that you get after so many years of experience ...that's something you can't learn out of a book' (7 M).

'Calculating the risk': Once behaviour was defined as sexual or 'inappropriate', participants appraised each incident to determine any personal and professional risk to themselves. *'Calculating the risk'* involved positioning the behaviour on a continuum from 'benign to malevolent' or 'mad-to-bad'. Sexualised gestures that participants perceived were unmotivated by any personal gain, but the result of impaired judgments or insight due to illness, were viewed through a more benign lens. Where participants judged that the client was seeking some personal gain or exerting power over the participant, these were classified at the malevolent end of the continuum. Similarly, the term 'bad' was used to denote awareness and conscious intent for personal gain, with 'mad' being used to denote lack of insight due to illness:

'You do rationalise it and say it is part of the illness, but sometimes it is somebody that is bad rather than mad, it is not a psychosis or confusion, they are not suffering from mania' (27 F).

'If there was no badness behind it, that they were not well, ...they were not trying to take advantage of me, or trying to make me feel uncomfortable, trying to use me for their own satisfaction...that's different from the person who knows what they are doing, they are just doing it out of badness, as in to make me feel uncomfortable, to get some gratification out of it for themselves' (17 F).

Categorising sexual behaviour into illness and power related behaviour was also part of the implicit system of rules governing nurse-client exchanges in Lawler's (1991) Australian qualitative study. She suggested that nurses were better able to cope with sexual behaviour from clients when it was perceived to be the result of impaired judgement or illness, but would not tolerate behaviour if it was seen as exploiting the care giving situation.

'Feeling vulnerable': Not surprisingly, if behaviour was considered malevolent or 'bad', participants reported *'feeling vulnerable'* and had greater levels of fear and concern for their safety. Feelings of vulnerability were related to the gender of the client, with participants feeling more vulnerable with clients of the opposite sex. When a male client engaged in sexualised behaviour, female participants were concerned with bodily and physical safety, as one participant commented, *'I was quite afraid, terrified actually, when I think about it [client who was making comments] afraid of what he might do to me' (F 23).* In contrast, male participants were concerned with their reputation and professional safety. Male participants' concern over reputation and professional safety was strongly related to their fear of being the subject of an erroneous or vexatious allegation of sexual impropriety from female clients. Participants believed that even if the accusation was subsequently found to be erroneous, the suspicion among colleagues would continue, which ultimately would destroy their reputation and professional career. As one participant said:

'As a male nurse you are vulnerable, because females [patients] may make an allegation of sexual misconduct, then you are gone out the door, you know, you are guilty until proven innocent not like in a court. I have a family and I can't afford that to happen, my career destroyed, I have seen it happen, any question, doesn't even have to be a written complaint and you are out that door, until it is investigated, so you see you have to be careful with female patients' (6 M).

The degree of fear experienced by male participants is summed up in the following statement:

'I would be more prepared to put my physical self on the line, I would be more prepared to take a punch, I would rather be seriously assaulted than be accused of inappropriate sexual relations with a client' (12 M)

Similarly, other studies involving qualified nurses, student nurses and physical therapists, have reported incidents of 'unwanted sexual attention', 'deliberate touching', 'sexual propositions', 'unwanted discussions of sexual matters', 'rude jokes' and 'exposure of genitals' (Lawler, 1991; Kettl et al., 1993; Finnis and Robbins, 1994; Dan et al., 1995; de Mayo, 1997; Madison and Minichiello, 2000; Nijman et al., 2005). These behaviours have also been identified, in the nursing literature, as a form of sexual aggression (Jordheim, 1986), sexual seduction (Whitley, 1978), sexual abuse (Celik and Bayraktar, 2004) and sexual harassment (Kettl et al., 1993; Finnis and Robbins, 1994; Madison and Minichiello, 2000; Nijman et al., 2005). Many of the behaviours described by the participants could also be considered to meet the criteria for sexual harassment as defined in the Employment Equality Act 1998 (Government of Ireland, 1998). In essence they were unwelcome and undesirable verbal, physical and written sexual contact that interfered with the person's ability to carry out their role. However, in contrast to the papers cited, and yet similar to the nurses in Lawler's (1991) Australian study, participants in this study did not to use the words 'harassment', 'aggression' 'abuse' or 'seduction' to describe their experiences. Instead, they used the binary positions of 'appropriate and inappropriate' or 'mad and bad'. This could possibly be related to participants' acceptance of the behaviour as an inherent part of mental health care; therefore, it was not considered a form of sexual harassment. It could also be that the language of 'inappropriateness' was a euphemism or 'veil' for something that the participants could not speak about, in an open direct manner.

'Engaging in sexual behaviour that became visible'

Engaging in sexual behaviour was considered 'not appropriate' in the health care environment. Hence, the third way that clients lifted the veil, thus revealing themselves as sexual beings, was by engaging in some form of sexual behaviour that became visible to the participants. Despite the 'no sex policy' and the *'protective surveillance'*, similar to studies in the US and UK (Civic et al., 1993; Buckley and Hyde, 1997; Dobal and Torkelson, 2004; Warner et al., 2004)

participants reported incidents of seeing clients engaging in sexual behaviour. The sexual behaviour witnessed ranged from sexual intercourse, self or mutual masturbation, oral sex, kissing and caressing, to what participants described as sexually provocative behaviour. Sexual behaviour was considered provocative when it appeared to be intentionally directed at another client, such as the description given by the following participant:

'She was touching her breasts, she was putting her hands in between her legs and moving her legs up and down more or less, with her skirt up to here, [indicates to his mid thigh], there was a lot of her skin showing I suppose, this is very sexist, ...but the main thing that makes her specifically provocative is that she only does it in specific areas, and there is two specific people, specifically people that respond to it, like the elated patients' (18 M).

In the absence of organisational guidelines or multidisciplinary consensus on what sexual behaviour was 'appropriate' and in what context behaviour was 'inappropriate', it appeared that decisions were based on personal beliefs and value system. Self masturbation was permitted (in theory) if done in private. However, when there was a clash of value systems, such behaviour was classified as 'inappropriate' and resulted in clients receiving mixed messages, as the following accounts suggested:

'Somebody [a female nurse] was doing a round...a male patient was on his bed with the curtains pulled and was masturbating and he was chastised for it, which I would feel is wholly wrong, ahm, given any of the literature or research no matter where you would read it, be it official or unofficial, any kind of acts that involves sexual release is good for stress...there was nobody else involved, there was nobody else in the room at the time, he was doing it in, what I would view as, a very private area, and my opinion when something like that has happened let him belt away' (8 M).

'You go around in the mornings to the males...their hands down their pyjamas,...I would just close the curtain and walk away and leave it...whereas some people, I have worked with people who would say, (raises voice) "What is going on there, come on, up, up, out" and I have seen that happen' (25 F).

Even when professionals were accepting of male clients' masturbating, professional opinions about the appropriate location for such activity were also conflicting. Some participants advised the clients to use their bedroom space, whereas others considered the bedroom not appropriate and advised the use of the bathroom.

'I certainly would have discussed masturbation with a number of male, male clients ...Rather than say masturbation in the toilets, if they had a room of their own or you know or whatever. Have a reasonably kind of I suppose setting where it was relatively private that's what I would try and encourage them to do' (16 M).

'It wouldn't really be considered appropriate to be masturbating in the bedroom, because anybody could walk in so perhaps the toilet would be a better place' (22 M).

Masturbation by male clients, if done in privacy, tended to be more acceptable than female clients masturbating. Again, personal prejudices came to the fore as this participant explained:

'I think masturbation is much more acceptable for men than for women, we sort of expect it from men, whereas from women there is a few more eyebrows raised about it, even though you shouldn't be [thinking that], women are entitled to, but I think from that way they are different, I think we do have different standards' (24 F).

The above quotations support Buckley and Wiechers' (1999) opinion that lack of discussion, guidelines and multidisciplinary consensus, leaves staff confused, forcing them to make decisions based on personal beliefs and moral judgements, which can adversely affect clients as they have to adjust to staff members' attitudes on a continual basis. It also means that clients who are being cared for by staff who have more liberal attitudes have a greater chance of expressing their sexuality without repression (Trudel and Desjardins, 1992).

Witnessing sexual behavior tended to provoke a mixture of emotions in the participants, ranging from feelings of embarrassment to annoyance. The embarrassment appeared to be related to the participants' expectation that clients should be asexual; consequently they were shocked and embarrassed when their mental scripts were challenged:

'I was a bit embarrassed, I didn't expect to come across it, [two clients kissing in a bathroom], it's not what you expect to come across in your workplace...it's like we expect patients to be non-sexual objects or people' (26 F).

'I was going around just checking the rooms...he was masturbating and I was just mortified...I was just mortified, you don't expect things like that' (13 F).

There was also a perception that clients who engaged in sexual relationships should try to conceal their behaviour from the participants or experience shame and

embarrassment on discovery. Clients who did not conform to the norm of shame on discovery, and visibly display embarrassment, were considered to be indifferent to the rules of the service and to be challenging participants' authority. Consequently, participants' own embarrassment was followed by feelings of annoyance, as suggested by the following comments:

'They made no effort to conceal it [two clients engaging in a sexual relationship], no effort to be discreet and that would annoy you' (12 M).

'They didn't have any shock reaction to people walking in on them [two clients in bed together] and that made it annoying' (8 M).

'I was a bit cross that was my reaction. They were two older people, older than fifty you know, I was cross, it [two clients in bed together] was inappropriate, this is a hospital, it can't be happening in here and they had been told that' (25 F).

Participants did not appear to consider that the '*protective surveillance'* by mental health staff and the absence of any private 'backstage space' (Goffman, 1959), made concealing sexual behaviour a near impossibility for clients. In view of the fact that clients continually lived with the reality of being discovered, lack of embarrassment on their behalf could also be considered as an adaptive response.

Summary of 'Hanging the Veil' and 'Lifting the Veil'

In this chapter the first two categories of the '*Veiling Re-veiling Cycle'* were presented. *'Hanging the Veil'* referred to the processes participants used to shade over, mentally and verbally, the clients as sexual beings, thus protecting themselves from personal discomfort and professional exposure. *'Lifting the Veil'* referred to the processes clients used to lift the veil, revealing the sexual dimension of their personhood.

Participants hung a veil over the clients' sexuality and their own discomfort through the processes conceptualised as *'limiting verbal information'*, *'cautionary interviewing'* and *'protective surveillance'*. Participants firstly drew a veil of silence around drug induced iatrogenic sexual dysfunction through *'limiting verbal information'*. In so doing, participants also drew a veil over their own discomfort in relation to discussing sexual issues. By speaking through a metaphorical 'veil', conceptualised as *'cautionary interviewing'*, and using the strategies of '*routine*

questioning', *'avoiding taboo questions'*, *'vague questioning'*, *'passive waiting for disclosure'* and *'skipping over'* participants avoided proactively initiating or engaging in a discussion with clients around sexuality. In this way, participants maintained a veil of silence around sexual issues while concurrently controlling their own feeling of discomfort and avoiding the perceived risk associated with transgressing a social and professional taboo. *'Protective surveillance'* referred to the process participants used to hang a protective veil around clients, particularly female clients, in order to prevent clients engaging in sexual relationships while in residential care within the service. This *'protective surveillance'* was structured within the traditional heterosexist's norms that emphasised sexuality as penetrative sex and positioned women as more vulnerable than their male counterparts. Emphasis was, therefore, placed on a controlling, biased and limited veil of protection as opposed to a veil that emphasised dialogue and sexual health promotion. The primary motivation for the *'protective surveillance'* appeared to be the need to protect the participants from an allegation of professional negligence.

As participants were disinclined to acknowledge voluntarily the sexual dimension of clients or proactively engage in therapeutic conversation with clients on sexual issues, clients were forced to *'Lift the Veil'* and reveal themselves as sexual beings. Consequently, participants heard about clients' concerns more through chance and fortune than therapeutic intent. *'Lifting the Veil'* occurred through the three processes of *'voluntary disclosing by another'*, *'sexualising the nurse-client encounter'*, and *'engaging in sexual behaviour that became visible'*. When one of these processes occurred, participants could no longer either consciously or unconsciously deny the sexual dimension of the client's personhood. *'Voluntary disclosing'* was the process through which clients verbally lifted the veil, indicating to the participants that there was a sexually related dimension to their life that required acknowledgement. In many cases, clients' disclosures related to an illness experience that had a sexual tone or an experience of iatrogenic sexual dysfunction. Although not a frequent occurrence, clients sometimes disclosed experiences of sexual violence.

There were unwritten and unspoken professional expectations that clients treated participants, and nursing encounters, in an asexual way. Therefore, the second way

that clients lifted the veil was through *'Sexualising the nurse-client encounter'*. Clients sexualised the nurse encounter through the use of verbal, written and physical gestures. Due to the subjective nature of experience, deciding when a gesture had a sexual undertone was not straightforward. In interpreting an incident as sexual, participants used a process of *'sensitive sensing'* that combined an appraisal of personal feelings and contextual variables with experience, in order to get an intuitive grasp of the situation. Once defined as sexual, participants *'calculated the risk'* to the professional self, using a continuum from either benign to malevolent or 'mad-bad'. Incidents that were classified on the 'malevolent' or 'bad' end of the continuum resulted in participants *'feeling vulnerable'*. There was a gender difference in these feelings of vulnerability, as female participants were concerned with bodily safety, whereas male participants were concerned for reputational safety.

The third way clients lifted the socially and professionally constructed veil was by *'engaging in sexual behaviour that became visible'*. Despite the 'no sex policy' and the *'protective surveillance'*, similar to findings in other studies, some clients did engage in sexual behaviour within the care environment. Participants reported incidents of sexual behaviour, ranging from caressing to sexual intercourse. In the absence of organisational guidelines defining what sexual behaviour was permitted, participants were using their own value system as the bench marker for practice, resulting in mixed messages to the clients.

The next chapter will discuss the subcategory *'Re-veiling the clients' sexuality'*, which is the third stage in the *'Veiling-Re-veiling Cycle'*.

CHAPTER EIGHT: 'RE-VEILING THE CLIENTS' SEXUALITY'

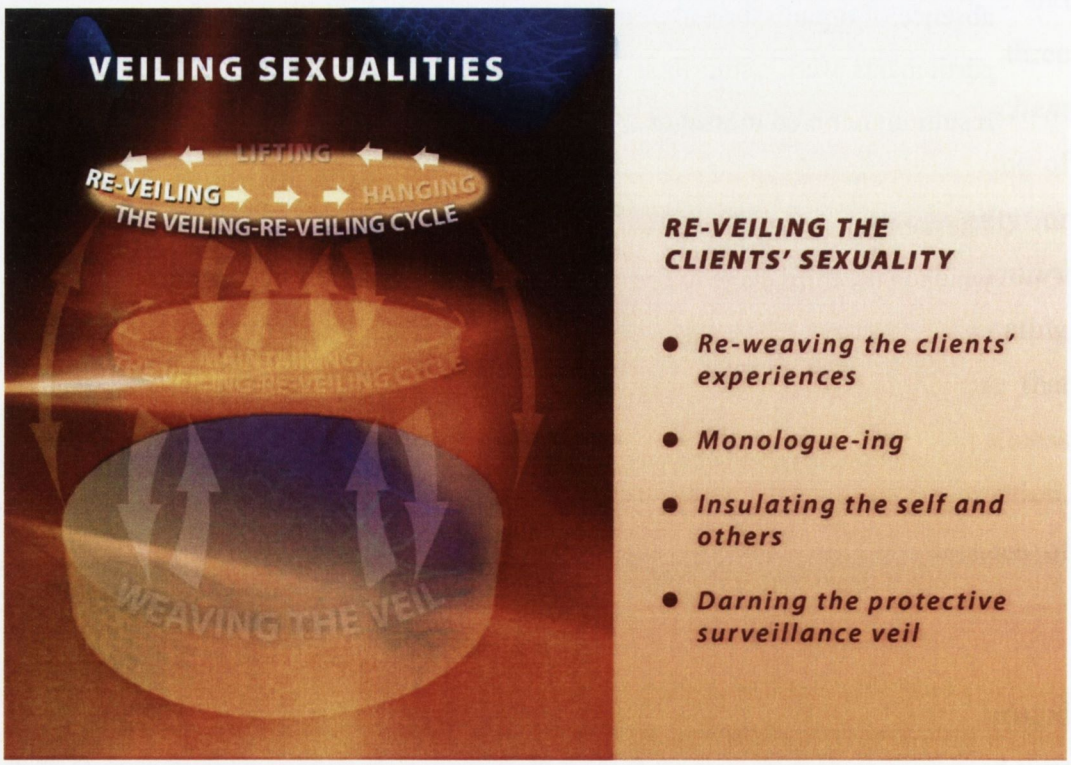
Introduction

This chapter discusses the fourth category conceptualised as *'Re-veiling the Clients' Sexuality'*. This category describes the strategies participants used to respond to clients, who *'lifted the veil'*, revealing the sexual dimension of their personhood.

'Re-Veiling the Clients' Sexuality'

Once the veil was lifted, participants could no longer ignore, consciously or unconsciously, the sexual dimension of the clients' personhood. In the absence of professional discussion on how to respond in a therapeutic manner, to sustain their professional identity as competent practitioners and to minimise perceived risk to the professional self, participants *'re-veiled'* both the clients' sexual expressions and themselves. The strategies used by participants are conceptualised as: *'re-weaving the client's experience'; 'monologue-ing'; 'insulating the self and others'* and *'darning the protective surveillance veil'*.

Figure 5 Diagrammatic representation of 'Re-Veiling the Clients' Sexuality'



It is important to note that these processes were associated with a strong motivation to care and help clients. Similar to the strategies described in *'Hanging the Veil'*, these strategies were routine responses and were derived through the process of socialisation into the culture and practice of psychiatric nursing. Although conceptualised as individual processes, it was the integrated and concurrent use of all the strategies that re-veiled the clients' sexual identity and sustained the participants' identity as competent professionals.

'Re-weaving the clients' experiences'

'Re-weaving the clients' experiences' refers to the way participants constructed the clients' experiences and behaviour from a perspective other than the clients'; thereby, veiling the clients' interpretations. Participants re-wove the clients' experiences using the *'narrative of pathology'* and the *'narrative of deviance'*. What both narratives had in common was that firstly, in the absence of any shared discussion with the client, the participants assumed the role of sole-author and defined the meaning of the experience. Secondly, the participants' perspective took precedence, as clients were not asked to validate assumptions. Thirdly, re-weaving behaviour was never a value-free, neutral act, as the very act of re-weaving produced an effect; thus, participants' subsequent responses to clients were based on this re-woven narrative.

'Narrative of pathology': A number of participants spoke of clients talking about 'hallucinations' or 'delusions' that had a sexual dimension. When this occurred, participants aligned themselves with the prevailing psychiatric medical discourse and used the medical model as the lens through which nursing care was constructed. The ideology underpinning the psychiatric medical discourse is a belief that delusions and hallucinations are a symptom of illness, not grounded in any reality, and a result of a faulty material body (biochemical changes in the brain) that can only be treated with pharmacology (Pilgrim and Rogers, 1999).

In keeping with this disembodied paradigm, participants re-wove the clients' sexual stories as symptoms of 'illness'. Participants were of the belief that discussion about

sexual delusions would risk reinforcing the 'false belief', thus they avoided any discussion of content. By judging the content of sexual delusions or hallucinations as irrelevant to the past history of the client or their current experience, the link between 'symptoms' and psychosocial history was missed, such as the link between the content of hallucinations and sexual abuse (Read and Argyle, 1999). Similarly, when the person had 'recovered', in that they were not verbally talking about sexual delusions or hallucinations, participants perceived that any subsequent discussion held the possibility of reawakening or exacerbating the person's distress. Consequently, emphasis was placed on medication as the primary method of treatment. Talking of a young man who was hearing a voice telling him he was gay, one participant said:

'He was treated for schizophrenia and the voices were treated in the same way as if it was a voice telling him to kill himself, treated with drugs, you know, this was the way his psychosis reared its head...he didn't like any of the gentlemen staff coming near him, you know he would say, "You are coming too close", now you wouldn't engage with that except the person he was directing it at would say, "No, I am calling you for a certain reason, I am calling you for your medication"' (10 F).

Another participant commented:

'If there was a psychosis or delusion that was all about sexual performance, we wouldn't talk about it, it's talked about in terms of medication. Now with medication that [the delusion] eases off considerably, but it's not talked about then either, you see if you talk about it, is it bringing it all back up?, so therefore it becomes an issue that is not talked about' (1 F).

Although some participants had a degree of awareness of a possible relationship between the clients' thoughts and current or past lives, and viewed the clients' situations in a more embodied manner, the primacy of the medical paradigm and the narrative of pathology prevailed. This is exemplified in the following quote:

'I was working in the acute ward at the time, and this patient and she was very, very elated and she was in a gay relationship and she had a coffee bean ring and she was talking in a very sexual way about the clitoris and that, but she kept referring to the ring and I remember at the time feeling very uncomfortable, because she was quite overwhelming really...But I think it [her sexual talk] was more identified as a symptom of illness... thinking about her now it was possibly related to her life experience (pause), thinking about the handling of that situation we moved away from it, that's what we do. We are not really getting to the meaning behind things. We think of illness and symptoms, you know and some of them [thoughts] are...just a reflection on people's experiences' (23 F).

On the rare occasions when female clients complained of sexual dysfunction, possibly due to drugs, there appeared to be a tendency to pathologise the complaint as a symptom of 'illness', as opposed to exploring it with the client:

'This lady was manic...sometimes they are disinhibited and they can say anything. She said she had no interest in it [sex] at all since she started the drugs, and she was with fellahs regularly and she couldn't make any good of it. At the time her treatment of her mania would be the priority with nursing..., we would have been about getting her mania under control first ...when she got better she never mentioned it, it's more a disinhibited thing' (27 F).

This tendency to pathologise women's sexual discussion was also reflected in the way participants did not initiate a discussion on the sexual issue even when the person's mental health was deemed to have 'recovered'. Paradoxically, the subsequent silence of the clients, about their sexual concerns, simply reinforced the participants' belief that the initial complaints were a symptom of illness. This is reflected in the following quote, by another participant:

'S*he can kind of go manic at times and with that she would want to talk about sexual difficulties...but realistically when somebody's mood tends to fluctuate you are more interested in stabilising it...it is just that when her mood is elated that she gets very upset ...when her mood is stable she doesn't seem to see it as that much of an issue, she tends not to talk about it, so it's not mentioned' (14 F).*

Participants did not appear to consider that the initial dismissal of the women's complaints might have communicated to them that sexual concerns were not a priority or that they were a taboo subject for discussion. Neither did participants appear to consider how the pathologising of women's sexual concerns constructed and reconstructed female sexuality as passive and non-pleasure centred. These omissions reinforced the view that when women openly expressed an interest in sexual pleasure it was in some way pathological.

'Narrative of deviance': In situations where clients lifted the veil by *'sexualising the nurse-client encounter'* or by *'engaging in sexual behaviour that became visible'*, participants interpreted this behaviour as a breaking of rules, pushing boundaries and challenging authority or the system. Participants, thus, re-wove the client behaviour as deviant and used a binary discourse of 'appropriate' and

'inappropriate' to interpret behaviour. Within this binary discourse, there could only be two types of behaviour, their existence resting on the notion that one was professionally and institutionally permissible and the other was unacceptable. As one participant said:

'We have grown up on it in psychiatry, there is appropriate and inappropriate behaviour and if we say it is inappropriate behaviour, it covers all, we know what to do, stop it [behaviour]...we do, we throw out these clichés and usually we just stop it in the moment' (24 F).

Labelling behaviour as 'inappropriate' or 'not acceptable' transformed the way in which participants responded to and treated the people concerned. Once labelled as 'inappropriate', the label became an end unto itself and the professional interpretation was once again privileged over the development of a shared understanding. 'Inappropriate behaviour' became 'a thing that happened' and had to be stopped rather than a process that needed to be understood, explored and responded to in a collaborative manner.

'Monologue-ing'

The second strategy that participants used to re-veil the clients' sexuality and their own discomfort was through a process conceptualised as *'Monologue-ing'*. Participants often described meetings with clients where they 'talked at' rather than 'talked with' the person. Such 'power positions' were classified as 'monologue-ing'. Guilfoyle (2003) suggested that for a dialogue to occur there must be a true commitment to engaging in joint discussion and willingness to hear both parties' perspectives, with a view to collaborative decision making. In the context of this study, what made the interaction a 'monologue' as opposed to a dialogue was the disinclination on behalf of a participant to enter the world of the client and explore the client's experience with a view to developing a shared understanding. Instead, participants entered the interaction with meanings and desired outcomes already constructed, and 'spoke up' their 'professional' interpretation of the clients' situations. Participants used two types of monologues, which I have conceptualised as *'compliance monologue-ing'* and *'suppressive monologue-ing'*.

'Compliance monologue-ing'

Where clients complained of side effects of drugs that had a negative impact on sexual function, participants tended to respond by 'compliance monologue-ing'. What made the interaction a compliance monologue was firstly, participants' tendency to enter the interaction with a predefined outcome, which was to ensure compliance with the drug treatment, thus limiting the possibility of mutual decision making; secondly, a tendency to 'speak up' their professional interpretation of the client's situation; and thirdly, a disinclination on their behalf to enter the world of the client and hear the impact of sexual dysfunction on the person's sense of self. 'Compliance monologue-ing' had the following properties: *'speaking up the positive'; 'ignoring power differentials';* and *'pseudo-advocating'.*

'Speaking up the positive': Although participants spoke of providing clients with balanced information, the manner in which they presented information to clients indicated an allegiance to the pharmacological model. There appeared to be a normative tendency to 'speak up' the positive aspects of continuing medication. In many situations, participants presented clients with what could be considered 'Hobson's choice', which consisted of a choice between mental illness and healthy sexual function. It was as if healthy sexual function and mental health were mutually exclusive. To support the argument for medication, participants tended to highlight the disorganised chaos of pre-medication life, and emphasise past incidences of hospitalisation or the possibility of future 'unwellness'. The following are reflective of comments made by participants that demonstrate these points:

'I would try and reason with them as best I could, ...I would say, "Well the down side of this is, if you become active [sexually], then you become very unwell, and your stays in hospital are going to be longer and your stretches at home are going to be shorter", so like you have to lay out the pros and cons, whether you think it is worth it to be sexually active and to be unwell all your life, so they would have to make that decision' (19 F).

'It is very difficult you know, you try and say, "Well this is the option, like it is well and good having a mott [girlfriend] for a weekend, but look at where you have ended up", and that is the only advice I can give like, they certainly won't have a girlfriend if they are sitting in the ward hallucinating, and that is very crude but it is the truth, you know what I mean, or if they are barking mad, thinking they are Superman or something, they are not going to have a girlfriend then either and you

just hope that after a while some of these side effects will even themselves out, after a while, as your body gets used to them' (15 M).

In some cases, despite the fact that research suggested that spontaneous resolution of iatrogenic induced sexual dysfunctions rarely occurred (Rothschild, 2000), some participants, as the last quote suggested, did intimate that with time the client's body may adjust to the drugs and spontaneous resolution of iatrogenic sexual dysfunction may occur. Exploring the person's experience in terms of the impact of sexual dysfunction on one's sense of self and personhood was an avenue into which the participants or other members of the team seemed not to enter:

'Well I certainly never heard anybody say that they talked to patients about what the effects were like on them and I worked on an acute unit for four and a half years' (24 F).

'Ignoring power differentials': Although participants did speak of giving clients choice, and continually acknowledged that it was their decision whether to continue with medication or not, the choice presented to clients was, as said, a choice between sexual function and mental health. The possible impact of the inherent power differential within the relationship on the client's ability to choose an alternative course of action, other than drugs, or disagree with the nurse's interpretation of the situation, was not considered. Making an informed decision not to take any medication and pursue alternative types of therapy did not seem to be an option that was presented to clients:

'You do give them choice, one person in particular and he came to me and said, "I have erection problems" and this is because of his medication,...obviously he can't masturbate, it is a difficulty for him...the medication wasn't changed because the benefits were weighed up and that was the answer to it..., he is better on the medication, he is mentally more stable, it was put back to him and I said, "Do you want to have proper sexual function or would you want to be mentally well enough that you are not going to try and kill yourself?",...so he said, "No I will keep on the medication, I will put up with it"' (18 M).

'Pseudo-advocating': In situations where participants perceived that their intervention was not working, they referred the client to the medical practitioner or made representation on behalf of the client to the medical practitioner. The participants' motivation in referring or representing the client continued to be a desire for compliance; thus, there was an element of *'pseudo-advocating'*, as the participants' intention was not, truly, to represent the clients views, but to achieve

the predefined outcome of compliance with some form of medication. In the words of these participants, *'It is so they at least take something' (1 F)* and, *'Encourage the person to remain compliant with some dose...rather than losing them completely' (2 F).* The subsequent response of the medical practitioner tended to vary. In some situations, clients' medication was changed; however, in other situations, particularly if the client was in long term care or had a long term mental health problem, the complaint was ignored and the medical practitioner became part of the *'compliance monologue'*:

'Some doctors would look at it in a positive light and would try and adjust the medication to facilitate, and others would kind of leave it, it would just be kind of poo-pooed. Explain to them, well it's kind of swings and roundabouts' (26 F).

'It would depend on the consultant looking after the patient and on how they viewed kind of, whether this was a basic right or not. (pause) Sometimes their needs are met... Other times it's not, um (pause), they would say, " it's just a side affect of the medication and the medication is necessary to kind of keep you mentally well and you have to forfeit the other" ' (16 M).

For a dialogue to occur there needs to be a commitment to that dialogue and a willingness to engage in joint discussion, and hear both parties' perspectives. By adopting the compliance monologue, participants positioned themselves as both the knowledgeable expert and objective observer of the clients' situations, standing outside and unaffected by the clients' situations or stories. Thus, the participants' role became one of compliance advocate, acting on clients and directing them towards an outcome that was both predefined by the professional and deemed to be in the best interest of the client. By adopting the 'professional as expert' model of care, participants not only veiled their own discomfort, but they veiled the voice of the clients in terms of the impact of sexual dysfunction on the self.

'Suppressive monologue-ing'

'Suppressive monologue-ing' refers to the pattern of interaction participants adopted with clients who engaged in sexual behaviour that was labelled 'inappropriate'. In *'suppressive monologue-ing'*, participants entered the interaction with the meaning of the clients' behaviour pre-authored as 'sexually inappropriate'. Consequently, their desired outcome was to stop subsequent behaviour by admonishing clients, as opposed to entering into a dialogue to explore the possible meaning behind the behaviour and gaining an understanding from the clients' perspectives. *'Suppressive*

monologue-ing' had the following properties *'communicating the label', 'laying down the law', 'speaking up the negative', 'pseudo-collaborating', 'instilling fear',* and *'ignoring resistance'.*

'Communicating the label': Once behaviour was labelled as 'sexually inappropriate', the participants' initial response was to communicate the label of inappropriateness to the client. Communicating the label of inappropriateness was used in situations where clients lifted the veil by *'sexualising the nurse-client encounter'* or by *'engaging in sexual behaviour that became visible'.* In either of these situations, communication was one-way and mimicked a parent-child interaction, of 'scolding' the client, or as one participant said, *'It is always punitive, stop that and don't be doing that' (24 F).* Although the participants emphasised that their intention was not to be confrontational, the focus was on communicating their disapproval to the client. The word 'inappropriate', which permeated all participants' comments, was considered a catchall phrase that could be used without further explanation. The following are reflective of the comments made:

'What I would be saying to them [clients kissing] is, "You need to behave in an appropriate manner, behave appropriately", ...there is that word again appropriate, what ever it means (laughs)' (16 M).

'You try to be sensitive [female client commenting on nurse], and without being confrontational say, "it's not appropriate", those famous words. Not appropriate is a kind of a word that can be used without causing offence, because you are saying it so many times about everything else' (22 M).

'You just make a general statement saying you know, "That is not appropriate, it is not an appropriate thing to say [client who comments on her physical appearance]"' (14 F).

'When I am doing the injections and some of them [male clients] would say, "Get a load of this" [point to genital area]...I would say "that's not appropriate, that's not on"' (4 F).

By labelling the behaviour as 'inappropriate' and subsequently communicating that to the client, participants did not have to think or speak about sexual issues. Despite the obvious sexual nature of the client's request in the next scenario, the participant went about completing the clinical task without reflecting on the possible meaning behind the behaviour. For this participant, thinking about the sexual nature of the

client or the sexual nature of care would, in her perspective, negatively impact on her practice. Thus, over the years, the client's sexuality became eroded and lost in the ritual of labelling behaviour as 'sexually inappropriate':

Participant: *'We have a patient in the service, he has schizophrenia, I suppose one of those people that are treatment resistant, you know and they haven't found anything that works and that [impotence] was a big problem for him, and one day, I will always remember doing the depos [intramuscular injection]...he asked me could I hold it [penis] before I gave the depo, so I said, "I can't do that, you know I can't do that, that's inappropriate, so just turn around there, so I can give you the depo", and that was that'.*

Researcher: *'What do you think his request was about?'*

Participant: *'I'm not really sure maybe it was to see could he get an erection... I don't think about it...I'm so used to doing...but it is a very personal thing and depending on your point of view, it could be a very sexual thing but obviously I don't think it is (laughs), I wouldn't be able to do the job if I did, so ...I suppose it's just familiarity as they say breeds contempt, you just get used to something and you don't think much about it, you just tell them it is inappropriate' (5 F).*

By communicating the label of inappropriateness to clients, participants closed down the interaction and limited further discussion, as little room was left for clients to disagree or propose alternative meanings.

'Laying down the law': In situations where the 'inappropriate' behaviour involved two clients engaging in sexual behaviour, the monologue was more extensive and included what participants termed 'laying down the law'. This meant informing clients about the rules of the service while maintaining a disapproving tone of voice. Commenting on two clients who were engaging in sexual behaviour, one participant said:

'It's basically laying down the rules, it is not acceptable, it is more a slap on the hand,...like what you are doing, it is not going to be accepted here, and that was that, it wasn't addressed anything further, it was the same with him, this is not appropriate, this isn't going to happen here' (10 F).

Commenting on an incident where two clients were found lying on a bed together:

'I said...nobody in your room that is the rule, no residents in the room...I said it can't be happening...you can't be in another resident's room' (18 M).

'Speaking up the negative': Laying down the law was frequently followed by a message that emphasised the reasons why relationships between clients should discontinue. To support their view, participants frequently spoke up the negative aspects of the situation such as the clients' level of unwellness, their inability to make competent decisions or the negative effect of the relationship on recovery. In this way, the monologue continued as a monologue of sickness or inability to make 'good' decisions. The clients' views of the relationships did not appear to be considered, neither was there discussion on whether the client thought that the relationship was interfering with their recovery:

'You say, "You are both here for being looked after for mental health problems and you need to give yourself time to feel well... you are on medication that can relax you and make you feel more approachable and less anxious or hesitant and so therefore are you making decisions in the clear light of day?"' (22 M).

'We would always say to patients... "It is great if you have friendships on the ward and if you get on well with people that is fine, but your main priority when you are in hospital is to get well and while you might feel well enough to have a relationship, we don't feel that you are ...while you are in hospital keep a 'can' on it, just don't bother", that's what we are saying' (15 M).

'The staff on the ward would reinforce that yeah it is ok to have a boyfriend, but you need to understand that it is not appropriate while on the ward, you need to concentrate on getting better and when you leave, there is no problem' (10 F).

'Pseudo-collaborating': Initially it appeared that participants were attempting to explore the clients' feelings and emotions, with a view to a more in-depth discussion on the meaning of the relationship or the positive and negative aspects of continuing with the relationship. However, as participants entered the interaction with the decision on outcome predefined, the purpose of the interaction was merely to tell the client that the relationship was not to progress. Thus, there was a degree of clandestine control or pseudo-collaborating within the monologue:

'I would give them the spiel about how do you feel about this [relationship], and then you say, "Well, we feel you are not well at the minute and when you go home if you want to continue the relationship that is brilliant, but just not when you are in hospital", that's how you do it and then you keep an eye and you would lay down the rules, the person is unwell' (15 M).

'You would step in and make sure nothing happened, have a chat around what is happening, around relationships in general, how they see the relationship and why

it is not appropriate, that their mental health is not the best at the minute, and that we don't think it is appropriate' (17 F).

'Instilling fear': In some cases the monologue included the use of fear tactics, where the participant pointed out to the client that a repetition of the sexual behaviour could result in some personal cost to the client. Fear tactics sometimes included comments on the risk of sexually transmitted diseases or other illnesses:

'The way that I would get around it is talking about venereal disease, exposing themselves to that, what about cervical cancer, they say you're more likely to get it if you have too many partners, don't they; and that's how I would deal with it' (5 F).

Inherent in this description is an assumption that merely providing information will change behaviour and produce the desired outcome. There is also an assumption that fear is an effective model for sexual health education. This model of information transfer reflected the participants' own experience of sex education, where information was passed in a didactic manner, with the expectation that they would follow the dictates of their seniors in a passive, unquestioning manner. In keeping with this top down, vertical model of interaction, participants used other fear tactics such as comments on the possibility of involvement of the Gardai (police officers) or comments on the possible risk of being moved to another part of the service:

'I said like this person has every right to contact the Gardai if they want and that [touching another client] sort of thing was sexual harassment...That was the kind of way I did it' (26 F).

'We would just say you can't be doing that, that can't happen...if it [relationship] was to go any further you will be moved' (11 F).

The nursing records also provided evidence of the use of fear tactics. The following is a written entry in the nursing notes of a young male client:

'Female patient reported that he asked her for a wank [to masturbate him], but says he was only messing. I told [names client] that the comment was inappropriate, told if it reoccurred he would be transferred to [names another part of the service], later spoken to by the ward manager about behaviour. Patient said he apologised to the other patient concerned' (Nursing record).

There did not appear to be an awareness that laying down the law and admonishing the client to behave better, even if said with kindly tones or sugared words, was a poor substitute for the willingness to listen, explore and understand the possible meanings behind the client's behaviour, with a view to collaborative working (Mace and Margison, 1997).

'Ignoring resistance': While the suppressive monologue tended to preclude the possibility of alternative meanings being generated, a review of the nursing records indicated that on some occasions, clients did attempt to resist the professional interpretation and imposition of meaning, however, with limited effect. The extract below, taken from the nursing record of one client, not only exemplifies the client's resistance to the monologue (entry 8) but also serves to highlight the entrenchment of the participants to the already established 'professional' meaning, that labelled behaviour as 'sexually inappropriate'.

The following is an abridged version of the nursing record of a forty-five year old man, who was being cared for in part of the service for what was recorded as 'a paranoid schizophrenic breakdown'. The entries related to a ten-week period of the client's life. Each entry represents a different day. The name of the client has been changed and direct quotes from the nursing record are included in inverted commas. The first reference to 'sexually inappropriate behaviour' was made one week after the client come to the service. Subsequent to this, a number of different nurses, both male and female, recorded incidents of what they called 'inappropriate', 'sexually inappropriate' or 'over familiar' behaviour. In some cases, the record did not give any exact detail about the behaviour or what the client said to make the nurse interpret it as sexually inappropriate. Although a risk assessment was included in the nursing record for this client, the sexual part of the risk assessment was not completed:

Entry 1 *'At times content of his conversation was sexually inappropriate this was explained to Jonathon as boundaries needed'.*
Entry 2 *'Female pt informed me that Jonathon put his hand on hers without permission and was verbally abusive to her, spoke to him, as he expressed no regret sent to (names another part of the service), called a visiting priest a child abuser as he left'.*

Entry 3 *'Tends to be over familiar with staff and patients alike, was inappropriate in conversation, which had a sexual content, same discussed with Jonathon and boundaries were set'.*
Entry 4 *'Asking after female staff that are on duty, spoke to staff and mentioned that he was sexually abused in (names a residence where the client lived prior to coming to the service), but did not elaborate'.*
Entry 5 *'Inappropriate behaviour was observed this evening when he asked a female client to marry him'.*
Entry 6 *'Over familiar, when making his bed thanked me for making bed and said I love you, told him that making bed part of my role and there was no need to be so grateful'.*
Entry 7 *'Asked nurse on a date during trip out, explained the inappropriateness of such a question and about appropriate behaviour towards staff on the ward'.*
Entry 8 *'Staff approached by female patient, says that patient following her looking for kisses and staring at her mother and sister, spoke to Jonathon and explained that it was unacceptable, patient became annoyed and said "it is ok for you, you can go out at night, there is nothing wrong with me, it is you nurses that need to respect me", explained that behaviour was inappropriate' The nursing record recorded a second entry the same day by another nurse who wrote, 'Spoke to the client to tell him that his behaviour was inappropriate'.*
Entry 9 *'Asked female staff about her boyfriend and private life, spoken to about being over familiar with female nurses'.*
Entry 10 *'Inappropriate towards female nurse on night duty, spoken to by ward manager but didn't want to talk, later spoken to by the team about his behaviour being inappropriate'.*
Entry 11 *'Inappropriately ardent towards female nurse'.*
Entry 12 *'Noted to be intrusive on occasions with other clients, eg. asking questions of a too personal a nature, explained that this was inappropriate'.*
Entry 13 *'Female client informed nurses that Jonathon asked her how to make babies, and put his hand on hers, spoken to and boundaries set. He admits that this was inappropriate'.*

What is evident from this record is how the *'suppressive monologue'* enabled participants to respond in a manner that did not require engagement with the client's emotions or meaning and blocked the client's efforts to create an alternative story.

In summary, as there was a high degree of uncertainty and unpredictability about engaging in collaborative dialogue with clients around sexual behaviour, the *'suppressive monologue-ing'* freed participants from having to discuss intimacy needs, sexual desire and wants. It also freed participants from having to explore the possible relationship between sexualised behaviour and previous sexual experiences. In this way participants were able to 're-veil' their own discomfort. Although participants did emphasise that they talked to clients about behaviour, it was in the context of reinforcing the participants' wishes. By so doing, although

projecting a veneer of equality and empowerment, they constrained the clients' responsive potential and veiled the clients' stories by preventing the generation of 'not-yet said or heard meanings' (Guilfoyle, 2003:332).

'Insulating the self and others'

The third method that participants used to *'re-veil the clients' sexual expression'* and their own vulnerability was through the use of a variety of verbal and behavioural strategies conceptualised as '*insulating the self and others'*. The motivation for these strategies was to veil and protect the self or colleagues from any possible personal or professional negative consequences that could result from a client's sexuality encroaching upon the relationship. *'Insulating the self and others'* occurred through the use of a number of strategies called *'erecting professional boundaries', 'deflecting the conversation', 'physically avoiding clients', 'transferring care', 'increasing personal visibility', 'putting on record'* and *'tipping off'*.

'Erecting professional boundaries': In situations where the client asked questions that were perceived to be of a personal or sexual nature, participants erected professional boundaries, reminding clients that the relationship was of a 'professional' nature. Although participants tried to respond in a friendly, non-confrontational tone, in order as to reduce the risk of offending the clients, there was a cautiousness and defensiveness in the response. Responses were shaped by a kind of 'therapeutic correctness' (O'Shea, 2000:9), whereby participants made reference to professional prohibition against personal disclosure and intimacy in the relationship:

'You just say, "I can't answer that question because you don't need to know it, it is not very professional of me to give out information about my personal life"' (14 F).

'You would get a few that would ask you about your sex life or have you a girlfriend and with them, I just go, "Ah sure I am not here to talk to you about that, I can't really discuss that with you"' (15 M).

'There are boundaries...what I would tell the students is that if they are being very inquisitive about where you were last night, are you living together, I said, "You can gently distract them and say well actually we are told we really shouldn't discuss that kind of thing"' (27 F).

Some writers suggested that self disclosure is an important dimension of therapeutic relationships as it promotes trust and genuineness and demonstrates to clients how to undertake self disclosure effectively, thus encouraging reciprocity from the client (Ashmore and Banks, 2001; McCann and Baker, 2001). Clients in Jackson and Stevenson's (2000:379) study also expressed a wish for professionals to be able to move away from the 'professional me' to the 'ordinary me' domain and share personal information with them. However, in the context of this study, and similar to nurses in Scanlon's (2006) research, participants tended to stay in the 'professional me' domain as they viewed self disclosure as creating personal and professional vulnerability. This is best exemplified in the following quote:

'The more information we give away...the more vulnerable we are...people can become unwell and they can say things when they are unwell, they can throw it back on you...the more information they have about you the more they can do things to you, if they knew where I lived they could go and knock on my door, when they are as high as a kite' (18 M).

Consequently, participants worked within the 'professional me' domain (Jackson and Stevenson, 2000), allowing clients little insight into the private self and concealing the self by erecting professional boundaries.

'Deflecting the conversation': Participants also limited their involvement in interactions and insulated themselves from personal discomfort by deflecting the line of conversation. Humour was a strategy frequently used by participants to deflect the conversation away from comments that were perceived to have a sexual undertone. Deflecting a conversation, through the use of humour, was perceived to be less offensive to the client than responding with the suppressive monologue, especially when participants perceived the question or comment to be more like social banter than a malevolent intent to embarrass or control:

'We laugh it off, make a joke of it, somebody might say something like asking you out and we might say something like, "Ah I would cost you too much money or what ever", we make some kind of joke about it' (24 F).

'I would kind of joke it off, if they said have you a boyfriend or are you living with him, I would say, "Oh I have myself and the dog and that is enough", I would say kind of things like that, I would laugh it off, I just wouldn't give out that information' (11 F).

Humour was also used within the team to insulate the professional self and deflect the real issue that needed to be spoken about.

'Sometimes things are kind of laughed about and jokes are made, like if somebody was particularly camp it might be mentioned [in the team] in a slagging kind of way...It's about avoiding the issue as well, definitely if they are uncomfortable about it definitely... when that gentleman was masturbating that girl, you know his erection was visible, like that was said in a report, you know, "His anti-psychotics weren't affecting him", and it was a joke at the time' (15 M).

Participants also avoided uncomfortable conversations by steering the conversation to topics or areas of care that they felt more comfortable talking about, thus avoiding any discussion on the sexually related issue. The idea of steering the conversation to safer ground is captured in the following comment:

'He brought up an awful lot of sexual fantasies and he was talking about two particular women and discussing his fantasy...and I could feel myself going hmmm now how appropriate is this, is he looking for a reaction...I felt a little uncomfortable,...later when I visited him [in his home] I kept it kind of controlled, he would say things like, "Oh my fantasies are coming back" and I would say, "Oh you have fantasies, are they the same ones as before", so I kind of knew what the baseline of the same was, so we were talking about them but not talking about them if that makes sense... I would say I more or less kind of skirted around the issue,...I felt more comfortable focusing in on vocational areas and his mood and things like appetite, sleep, things like that, so you move it [conversation] to things like that' (4 F).

'Physically avoiding clients': In situations where the sexualised behaviour was persistent, and where verbal strategies did not appear to be working, the targeted person disengaged from care by physically removing themselves from being around the client, thus minimising opportunities for the behaviour to continue. When this occurred, verbal interaction with that client was reduced, as participants only spoke to the client on what they called a 'superficial level', which meant exchanging greetings:

'I kind of take a step back from them which kind of affects other things as well, it can affect your relationship with them...like with that man that made the comments to me [about appearance] I was inclined to step back, not be around him, and I wouldn't have got to know him as well as other patients because of that... you just say hello' (14 F).

'If you knew someone was at risk of doing that [making a sexual comment], and telling them that it was not appropriate didn't work, you would let the girls [female nurses] do the engagements with them, you know, just interact on a superficial kind of intervention' (15 M).

Although rare, there were some accounts of incidents where female clients had previously made a sexual allegation against a male nurse, which was investigated and found to be erroneous. As a consequence of this, all male nurses insulated themselves by avoiding these clients, leaving the care of the client to female colleagues. The strength of male participants' fears and avoidance is expressed in the following comments.

'She says, male community nurses when giving her a depo injection, used to touch her in various positions when she was getting her depo, she mentioned four different male nurses, and I am telling you, I am not giving that woman, that girl a depo ever and I never have and I never will, a female nurse looks after her' (18 M).

'We make sure that no male is on their own with her [client with a history of making an accusation] for five minutes...they will not say to her it is time to have a bath or shower, anything to do with her body and it is the females who give out the medication, and her injection, she is such a dangerous person...they keep well out of her way...it is a way of protection' (19 F).

'Transferring care': In practice areas where participants carried an individual case load, or were allocated clients using a key nurse or primary nurse system, participants disengaged by transferring care and making an official arrangement for the carer to be changed. This frequently involved making arrangements for a nurse of the same gender as the client to take over the care:

'If I believe that the person is misinterpreting or that the person is thinking that there's something else going on, I will stand completely back and I will say listen maybe it would be better if we had a different nurse looking after you...I would keep myself covered' (7 M).

'If I felt it was just to get off on the fact that they were talking about sex, then I put a stop to that, and redirected it to the male nurse and asked them to speak to them ...so you kind of transfer them' (10 F).

'Increasing personal visibility': Increasing personal visibility was another strategy that participants used to insulate themselves and others, when caring for clients of the opposite sex that they perceived may pose a risk to their personal or professional safety. In an attempt to increase personal visibility, participants modified the care

environment by leaving doors of the interviewing rooms open, by interviewing clients in a room or location with increased visibility, by requesting a chaperone, or by senior staff shadowing a more junior nurse. Ironically, participants were aware that these strategies would not prevent clients making accusations of sexual impropriety or making subsequent unwanted sexual comments, however, participants believed that they did afford them some protection in terms of reducing the risk of unwanted sexualised encounters. In the case of male participants, the perception was that the strategies would help them to have evidence to support a repudiation of an erroneous allegation of sexual impropriety.

Leaving the door open or interviewing in a room with windows was a strategy used by both male and female participants; however, male participants, because of their fear of an erroneous accusation of sexual impropriety, were much more conscious of remaining visible. In situations where participants were concerned about visiting clients in their home, in order to increase visibility, they sometimes requested clients to come to a venue such as the community clinic. The following are reflective of the comments made:

'I would never have a female in the office with the door closed, I would do it with the lads, with a female never...it is not worth it, it is not worth it for my own safety to close the door and bring a female patient into the room' (18 M).

'I would happily have a chat like in the day room on a one to one with a girl, but I would never be in a room with shut doors with just myself and a lady patient, No, never' (15 M).

'If I had to have a chat with someone that I felt was going to be saying things, commenting on me, I would have it in an office where there is windows all around, rather than coming in to a quiet room like this' (10 F).

'Some people I won't see in their houses, some men, because, if my gut tells me, I don't go there. I ask them to come to the clinic' (5 F).

In situations where clients were perceived to have previously sexualised the nurse encounter in a malevolent manner, participants also increased their personal visibility by seeking a colleague to chaperone them when caring for a client of the opposite sex. The purpose of the chaperone was to provide surveillance for the participant. When female participants requested a chaperone, they were not

concerned about the gender of the chaperone; however, male participants tended to request the presence of a female chaperone:

'I didn't feel that comfortable around him so I would have another person in the room with me, male, female, it doesn't matter' (13 F).

'If I am worried, I would ask for a chaperone, one of the girls to join me' (7 M).

'If a female patient wanted to talk to me and I was worried, I would have someone with me, another nurse, a female, if not in the same room, within earshot, coming in and out' (6 M).

More senior participants also helped to insulate junior colleagues from unwanted sexualised encounters by shadowing. Shadowing differed from chaperoning, as in this context the person was not present as a result of a request, but was present in the background vicinity, listening and watching the client's behaviour. Shadowing also gave the person the opportunity to intervene should the junior colleague not know how to react to sexualised behaviour:

'*There is one gentleman on the ward that I would keep an eye on him ...in terms of the young student nurses...the female students that I would be concerned with... because sometimes they'll not say anything about it... "I don't want you touching me there"...by them not putting firm limits on him, it kind of gives him the wrong message that it is okay...he just needs the firm boundaries there at all times really,...so you keep around them [students] and watching' (10 F).*

'Putting on record': Participants did not record all sexualised behaviour in the clients' nursing records. The perceived risk, at some later time, of being called to account, strongly determined what participants documented about sexual behaviour of clients. Thus, putting on record was about protecting themselves, particularly against legal repercussions. When participants perceived professional risk to be low, there was a greater chance that they would not document incidents, thus incidents of benign sexualised behaviour by clients were not always documented. In situations where behaviour was perceived to carry a high risk to the participant, such as in cases where sexualised behaviour was perceived as malevolent, or the behaviour involved another client, the participants documented the behaviour in the clients' nursing records. The motivation for this documentation was to *'put on record'* their professional response, in order to provide evidence of actions, should they be subsequently called to account:

'There was a fellah and a girl in the bed, not having sex, but there was very intimate body contact going on...I wrote a report and I felt was it necessary, yes, I am writing a report about this because if it did go further or there was any allegations that he had taken advantage or there was any allegations so it was right to write a report' (25 F).

A participant commenting on his reporting of a letter he received from a client said:

'I suppose the fear of accusations and allegations being made further down the line and I suppose with a view to transparency and openness was why I kind of declared my hand, I said it to the ward manager...and we kind of spoke to the girl and it was ironed out, recorded it...But, yeah, (pause) I felt that I needed to be a hundred percent above board to distance myself from the thing. I didn't want the problem to escalate' (16 M).

'Tipping off': Tipping off was the final process participants used to insulate and protect colleagues from a perceived risk. In the absence of a unified organisational approach to communicating about sexual issues or behaviour, verbal communication within the nursing team about sexually related issues occurred in an ad hoc and informal manner. When participants considered that a client posed a personal and professional risk to colleagues, they informally alerted each other to be cautious and careful around that client. Based on this tipping off, participants were then in a position to utilise other insulating strategies if required. This informal tipping off is captured in the following accounts:

'We got a patient referred who had a history of making an accusation, I was told watch your career, be careful, don't what ever you do be on your own, No, no, (said with a change of tone in voice to emphasis) the report wasn't written, it was a kind of just telling you to be careful, kind of informal...it is make it up as you go along, no organisational approach, nothing written down...nothing like that, just a handover verbal report – be careful' (20 M).

'The males would be sort of made aware of this person's history, be careful, they have made allegations...but it wouldn't formulate an overall care plan, it would be reported informally in the team to each other' (12 M).

Paradoxically, the insulating behaviours described did enable the participants to get on with their day to day work, and afforded them some protection from perceived personal and professional risks. However, like a double edged sword, these behaviours also resulted in participants disengaging emotionally and physically

from clients. Consequently, many issues were sidestepped and never discussed within the team or with the individual client.

'Darning the protective surveillance veil'

'Darning the protective surveillance veil' was the fourth strategy participants used to *'re-veil the clients' sexuality'*, while simultaneously protecting themselves from allegations of professional negligence. When clients lifted the veil and engaged in sexual behaviour that became visible, participants attempted to reduce the possibility of further sexual behaviour by 'darning' what could be considered a weakness in the original *'protective surveillance'* veil. In an attempt to darn this weakness, participants became more vigilant and increased the *'protective surveillance'* as described in the category *'Hanging the Veil'* (chapter seven). In conjunction with *'increasing protective surveillance'*, participants also used a strategy conceptualised as *'separating from the person of desire'*.

'Separating from the person of desire': Clients were separated from their persons of desire by engaging them in activities, so they had minimal time together, or by moving them to different wards or discharging them. One participant summed up this approach in the following comment:

'"The devil makes work for idle hands", so keep them involved in day activities, involved in groups, and if that doesn't work you find them a bed in another ward, or their discharge could happen quicker' (6 M).

Whether the client was separated by activities or location depended on how serious the team considered the situation, and the likelihood of the relationship becoming a sexual relationship. In situations where participants were of the opinion that the relationship would continue as a sexual relationship, then separation by location was the preferred option. In mixed sex wards separation by location meant transfer to another ward. If wards or bed areas were already segregated, then the clients were prohibited from visiting each other:

'If there was no guarantee that it [relationship] wouldn't reoccur, then the people would be separated, like we had a situation there recently and the man was removed, the following morning he was transferred to another ward, basically we took a stand on it and that was how it was dealt with' (12 M).

'What we did was we spoke to him and told him not to come down near her again and she was kept up around our area, the female area, the female bed area, she wasn't allowed up his side' (27 F).

Separation by location was not only an effective mechanism of controlling the behaviour of the clients concerned, but it was also a very public statement of professional control, as the outcome of this action was visible to all other clients. For participants working in the community, hospitalisation was viewed as a way of separating people and a source of protection. Commenting on clients who were considered to be at risk because of sexual behaviour, in the community, participants said:

'You need to get in there and tackle that fairly quickly with medication obviously and an admission into hospital. I mean if someone was out in the community and behaving like [sexually disinhibited] they are seriously at risk' (2 F).

'We operate on a very defensive practice...so the first line of defense is hospital incarceration get them off the streets, and I think nobody says it but I think that is the message' (24 F).

By increasing protective surveillance and separating the people concerned, participants maintained the veil of control over the client sexual expression, and protected themselves from the possible allegation of professional negligence. While these strategies may need to occur, to protect a client who is vulnerable to sexual exploitation, what appeared to be absent was firstly, an individualised assessment of clients' risk, competence and capacity to consent and secondly, an empowering educational discourse that involved clients. While recognising the fluctuating nature of the capacity to consent and the lack of objective tools to measure consent, simply adopting a 'policing' or 'separating' approach could be considered as violating rights, especially for clients in long term residential care. The real key to the safety and wellbeing of the clients and staff, as well as the facility as a whole, is, according to some writers, the development of frameworks and guidelines on sexuality and sexual relationships that guide staff in their daily work with individual clients (Trudel and Desjardins, 1992; Torkelson and Dobal, 1999; Buckley and Robben, 2000; Warner et al., 2004).

Summary of 'Re-veiling the Clients' Sexuality'

'Re-veiling the Clients' Sexuality' is the third and final stage in the *'Veiling-Re-veiling Cycle'*. It is the process by which participants metaphorically re-veiled the clients' sexuality and themselves in response to the clients' attempts to lift the veil and reveal themselves as sexual beings. By *'re-weaving the clients' experiences'; 'monologue-ing'; 'insulating the self and others'* and *'darning the protective surveillance veil'*, participants kept the clients' sexuality contained and veiled, thus preventing it from encroaching in a therapeutic manner into the nurse-client relationship. In so doing, participants also maintained their professional identity as competent practitioners and minimised perceived personal and professional risks.

Most incidents can hold therapeutic potential, depending on how the professional understands and responds to the situation; however, it appeared that when clients lifted the veil and revealed the sexual dimension of their personhood, the therapeutic potential of situations was lost. The professional reconstruction or *'re-weaving of clients' experiences'* by either the narrative of pathology or the narrative of deviance, acted as a powerful means of removing sexuality as an immediate concern, thus distancing the clients' feelings from the self. By privileging these narratives as better than, rather than different from other perspectives, the clients' experiences and perspectives were perceived as illegitimate areas for exploration and discussion; thus, subsequent action on behalf of the participants, with the exception of drug administration, was deemed unnecessary. Consequently, the clients' lived experiences and interpretations were subjugated, and the discourse of pathology and pharmacology took precedence. In addition, the attachment to the prevailing medical paradigm that judged the content of hallucinations to be irrelevant, resulted in the links between 'symptoms' and psychosocial history being missed.

In contrast to a dialogue, which is characterised by an egalitarian rather than an authoritative stance to communication (Guilfoyle, 2003), participants responded to clients' sexual concerns and sexual behaviour using a professional as expert model of interaction. Participants were disinclined to enter the world of the client and explore the clients' experience with a view to developing a shared understanding.

Consequently, both the *'compliance monologue'* and *'suppressive monologue'* ensured that the space to explore sexual issues in a dialogic manner was closed off, and the voice of the client was marginalised, silenced and unheard. Similarly, through *'insulating themselves and others'* and *'darning the weakness in the protective surveillance veil'*, participants not only maintained the veil of control over the clients' sexual expressions, but they maintained control over relationships by disengaging emotionally and physically from clients. These re-veiling strategies left little room for clients to challenge the professional interpretations and propose alternative stories; thus, the existing power structures were shored up.

It is important to note, firstly, that the strategies, or behaviours used by the participants in practice to *'hang the veil'* and, subsequently, to *'re-veil the clients' sexuality'* were associated with a strong motivation to care for and assist clients effectively. Secondly, having learnt these patterns of behaviour through their socialisation into the practice of psychiatric nursing, participants did not use them with conscious intent, but in an unconscious and fluid manner. Consequently, participants were not consciously aware that they were using these strategies to avoid discussions on sexual issues and to protect themselves from embarrassment and fears. Neither were participants aware of how their actions might be impacting on clients. Thus, there was a 'skilled incompetence' that gave rise to a 'skilled unawareness' (Argyris, 1999:57-58). However, in the course of the interviews, participants began to develop a conscious awareness of the behaviours described in the *'Veiling'* and *'Re-veiling'* categories. In an attempt to explain the motivation for these behaviours participants engaged in a pattern of self talk, which acted as 'grist' to the *'Veiling-Re-veiling Cycle'*.

The next chapter will discuss this pattern of talk, which formed the subcategory *'Maintaining the Veiling-Re-Veiling cycle'*, which is the final category of the theory.

CHAPTER NINE: 'MAINTAINING THE VEILING - RE-VEILING CYCLE'

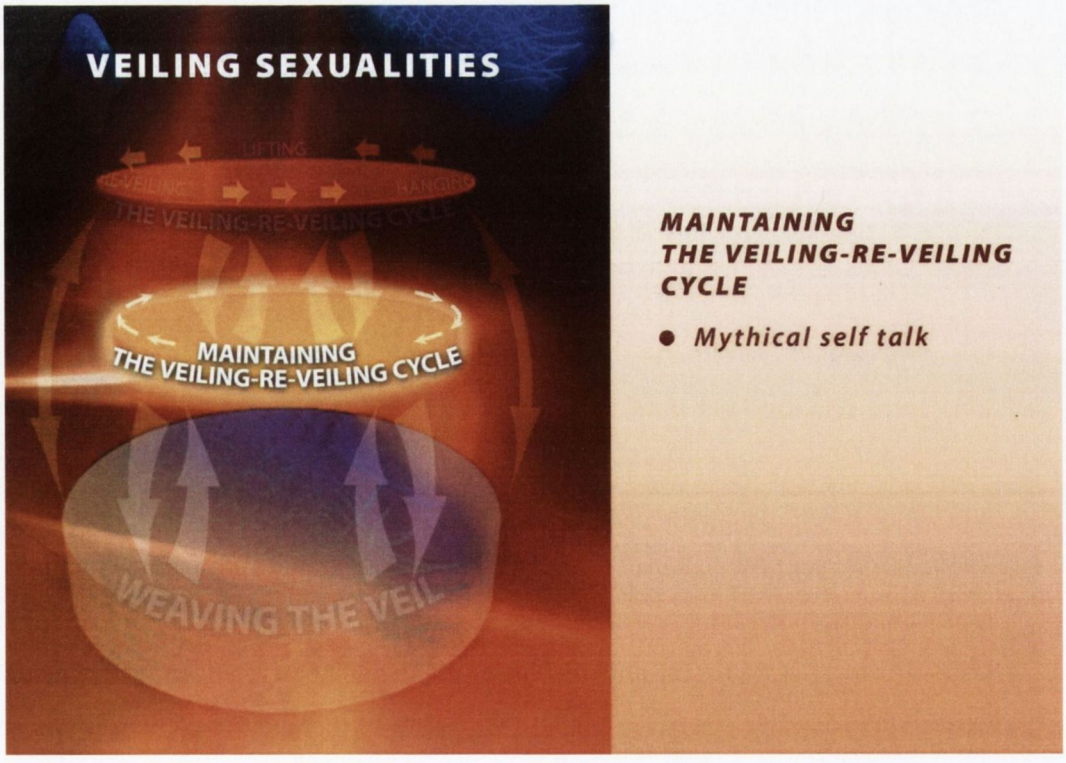
Introduction

This chapter commences with a description of the fifth and final category of the theory. This category was conceptualised as *'Maintaining the Veiling-Re-Veiling Cycle'* and consisted of the explanations that participants used to explain their actions described in the *'Veiling-Re-veiling Cycle'*. The final part of this chapter also includes a summary statement of the research problem and the findings.

'Maintaining the Veiling-Re-veiling Cycle'

The category *'Maintaining the Veiling-Re-Veiling Cycle'* referred to the stories offered by participants as explanations for the pattern of behaviour described in *'Veiling-Re-veiling Sexualities Cycle'*.

Figure 6 Diagrammatic representation of 'Maintaining the Veiling-Re-veiling Cycle'



During the course of the interviews, participants began to recognise that their patterns of behaviour were not congruent with their espoused theory of holistic and client-centred care. This awareness resulted in participants offering a number of remedial explanations or mental scripts, conceptualised as *'Mythical Self Talk'*.

Myths, although thought of as 'untrue' or without foundation, paradoxically are both 'true' and 'false'. They are 'true' in that they represent the world of the teller, and are the theories or beliefs that guide participants' actions. However, they are also mythical and 'false', as they are not grounded in 'objective' evidence, and reflect common professional fictions and generalisations. The participants' professional socialisation into the culture of psychiatric nursing was the breeding ground for development of this pattern of talk. One participant crystallised the idea of *'Mythical Self Talk'* in the following comment:

'Oh lord God! When you think about sexuality in terms of talking to someone, I call it a sieve, because you have all this stuff in your head that you should or you shouldn't do, and it's [sexuality] kind of filtered through that...your own thoughts ...there are just so many things there that just filters it out, and then it gets down to nothing, and the issue isn't addressed at all' (26 F).

Participants filtered and justified their actions through the following patterns of talk: *'dividing practice', 'appealing to higher goals', 'comparing to self', 'hesitating to fuel ideas', 'minimising clients' ability', 'arbitrarily assuming', 'fearing consequences to self', 'blaming resources'* and *'transferring responsibility'*.

'Dividing practice'

Dividing practice referred to the way participants separated the building of trusting, long term relationships with clients from the task of proactive engagement with clients on sexual issues. Building a relationship with a client to facilitate autonomy and control over disclosure of information is central to all therapeutic work (Peplau, 1952; Barker and Buchanan-Barker, 2005). When Peplau (1952) conceptualised the nurse-client relationships as developing through the phases of orientation, identification, exploitation and resolution, she did not create an artificial divide between developing a relationship and engaging in therapeutic conversations about problems or concerns. For her, developing the relationship and therapeutic

conversation occurred concurrently in an iterative process. However, within this study, building a relationship or developing sufficient clinical rapport was considered by participants to be something that needed to precede therapeutic conversation on sexual issues, in a linear manner. This view is similar to that communicated by writers who translated Peplau's (1952) original phases into introduction, working, and termination phase, and in so doing identified a discrete working phase (Usher and Arthur, 1997; Fontaine, 2003). Hence, based on a perceptual division between building a relationship and engaging in therapeutic work, participants justified themselves by emphasising that prior to talking to clients about sexuality there was a *'need to know them [clients] very well' (18 M),* a *'need to build a rapport with someone' (15 M),* and a need to *'have a long-standing relationship with them [clients] to develop trust' (2 F).*

Implicit within participants' comments was an assumption that, once the relationship developed, this alone would foster voluntary disclosure by clients, thus freeing the participants from any responsibility to create an enabling context for discussions or move from their passive waiting stance. Embedded within the need to build a relationship was an opt-out clause, as participants could always use the self talk, of not having achieved sufficient rapport or trust, to excuse themselves from having to raise a discussion on sexuality. Therefore, even after long periods of engagement with clients, participants never voluntarily raised issues or gave permission to clients to talk about issues. To support and justify the need to build a relationship, participants appealed to examples of situations where clients needed a long period of time 'to suss out the nurse', before asking for help on sexual matters:

'Like, the man who we talked about that came to me about relating to women and girlfriends...He felt more comfortable because I had worked with him for a long time and had achieved things and he could trust me, and he could talk to me about his problem relating to females. If we hadn't that relationship he wouldn't have told me' (18 M).

'I just thought my god I've been seeing him one to one for about maybe eight months and it took him that length of time to come up and say it [impotence]. And I thought...maybe should I have brought it up, you know the way you bring questions for yourself and then I thought, "NO. (emphasised no) The time was right possibly for him because he was sussing me out"' (4 F).

What is problematic about the participants' justification was the abdication of responsibility to introduce sexuality or sexual health into the discussion, and actively create a context for disclosure. They did not appear to consider that the process of building a relationship, and the task of engaging in a therapeutic conversation about sexual issues, was something that needed to occur in a concurrent and interrelated process, rather than in a sequential manner. Neither did they consider that the initial phase of the relationship was the time to communicate therapeutic expectations and legitimise sexuality as a topic for discussion, by introducing it as a possible area for future discussion (Tsai, 2004). Thus, clients were left to *'lift the veil'* and provide a cue to participants, in the hope that they would hear and respond. Alternatively, they followed the participants' example of 'silence' and did not disclose issues for fear of a negative response.

'Appealing to higher goals'

Participants also justified themselves by appealing to higher goals. By drawing on the principle of beneficence (Rumbold, 2000), participants reasoned that their *'veiling'* and *'re-veiling'* actions were necessary to achieve more positive therapeutic intentions. These therapeutic intentions related to: *'protecting clients' sensitivities'*, *'protecting the intactness of the nurse-client relationship'*, and *'protecting clients' mental health'*. Inbuilt within each intention was a negative consequence, should the participant act in an alternative manner. Consequently, participants could never open their assumptions to testing without evoking the perceived negative response. In this way participants became trapped in their own rationalisation without recognising the paradox within their '*appeal to higher goals'*.

'Protecting clients' sensitivities': Similarly to nurses and midwives in other studies (Kautz et al., 1990; Tsai, 2004; Stenson et al., 2005), participants considered that sexuality was a private and intimate aspect of the person's life. Consequently, they justified their reluctance to start a therapeutic conversation with clients on sexuality, sexual function or sexual violence on the grounds that this would cause the client embarrassment, upset or offence, and would not to be congruent with the client's expectation of the nurse's role. In this manner, participants justified their lack of

action by appealing to the higher goal of protecting the client's sensitivity. This is exemplified in the following comments:

'Some people would be very offended by that [talking about sexual health issues]' (13 F).

'You think ...if I brought up issues with them it might embarrass them' (23 F).

'I wouldn't ask [about sexual abuse], that is because it has been such an upsetting time for them and they may not want to talk about it' (27 F).

By fearing the negative response of embarrassment or offense, participants never subjected their rationalisation to testing by clients. This rationalisation also ignored the evidence that suggested clients have difficulty initiating a conversation or seeking help with sexual concerns due to embarrassment and shame (McCann, 2004), and think it more appropriate for professionals to raise a discussion on sexuality and sexual health with them (Crawford and Shaw, 1998; McCann, 2004).

'Protecting the intactness of the nurse-client relationship': Participants also appealed to the higher goal of maintaining the nurse-client relationship intact. Participants viewed the nurse-client relationship as central to the work of the psychiatric nurse and very sensitive to disruption or damage. Opening up a therapeutic conversation about sexuality was seen as having the potential to threaten the relationship and the willingness of the client to tell other information. In this way participants justified their reluctance to start talking about sexuality:

'You could close down an interview very quickly, if you ask somebody personal questions...and it can have an adverse effect on the whole relationship' (15 M).

'Asking them intimate questions...it mightn't set you off in the best footing' (17 F).

'That [sexuality] could be something that they are extremely uncomfortable talking about...I think you could close up the whole interview' (8 M).

'I feel if I said something about their sexual relationships, about sex they would freeze up...and they will tell you nothing' (1 F).

Participants did not appear to consider the possible impact, on the client-nurse relationship, of their *'veiling'* and *'re-veiling'* actions, which revealed them as unwilling to acknowledge the sexual dimension of the client's life.

'Protecting clients' mental health': As discussed previously, participants withheld information about iatrogenic sexual dysfunction and were reluctant to enquire from clients about experiences of iatrogenic sexual dysfunction. Participants rationalised this behaviour by appealing to the higher goal of protecting the clients' mental health. To talk about or ask about iatrogenic sexual dysfunction was perceived as risking the integrity of the drug regime and therefore risking deterioration in the person's mental health. By drawing on the principle of beneficence, participants represented their failure to educate or enquire as necessary. In the participants' perspective, enhancing compliance with medication was equated with enhancing mental health; thus, their actions were justified as therapeutic in intent and outcome. These views are reflected in the following comments:

'There is a kind of a protective withholding of certain information...we are trying to avoid making it a problem, to ensure some sort of compliance with the treatment. And I suppose it is unethical up to a point to give someone that and not tell them everything, but the way we look at it, is that you are trying to get the best effect out of the medication and if things aren't going right, then we start explaining, we back-pedal, use a bit of hindsight to explain and tell them' (8 M).

'Because if you did [tell about sexual side effects], the possibility is, they may stop taking that drug and become unwell... So in order for them to be well and be maintained in the community, they need to continue these drugs... So therefore you don't ask or tell them. Because the name of the game here is to keep them well... mentally well' (19 F).

Assalian et al. (2000), referring to the vulnerability-stress-coping-competency model of the course of schizophrenia, suggested that withholding information from clients may inadvertently contribute to their ill health. The vulnerability-stress-coping-competency model, posits that people with a diagnosis of schizophrenia experience everyday psychosexual events as more stressful that the general population (Assalian et al., 2000). Thus, the experience of sexual dysfunction, in the absence of an explanation as to the cause of such dysfunction, could be a stress factor leading to deterioration in the person's mental health. Paradoxically, in this context, participants may be contributing to ill health as opposed to promoting mental health. In addition, the dichotomous position of either compliance or education, and the argument of protecting the client's mental health, located the professional as 'paternalistic expert' and served to negate the possibility of, and need for, collaborative discussion with clients. It also negated the need to recognise

the client as having a right to make an informed choice about treatment approaches, thus minimising their autonomy and agency.

'Hesitating to fuel ideas'

Participants also justified their actions on the grounds of 'client suggestibility'. Participants were of the opinion that if they asked clients questions or engaged in discussion about sexual issues, they might 'fuel ideas' in the clients' minds – ideas that would not be congruent with the participants' aims of care. Not telling or enquiring about iatrogenic sexual dysfunction was justified on the grounds that clients would subsequently 'imagine' the side effects, and use this as a reason for not taking the drugs. Some participants commenting on drugs said:

'If you tell them...I will guarantee you one hundred percent that they will come back and tell us about it [iatrogenic sexual dysfunction], they will blame the medication' (27 F).

'I wouldn't enquire...if I brought that up [sexual side effects] I would be putting a seed in their head that this could be a problem' (2 F).

'I would never tell anyone...people will come back to you going I have got this, I have got this and they would be histrionic, so if you tell them things they will come back with a list of things they have' (15 M).

By not telling or enquiring about iatrogenic sexual dysfunction participants perpetuated the illusion that they could control clients' behaviour and did not seem to contemplate the fact that service users often stop taking or reduce medication because of iatrogenic sexual dysfunction without input from health care professionals (National Schizophrenia Foundation UK, 2000). Deegan (1999) also suggested that this failure to educate or inquire about sexual dysfunction frequently resulted in clients blaming themselves for their sexual dysfunction, feeling too ashamed to talk or disclose the facts to health care professionals, or becoming fearful of engaging in intimate relationships.

In keeping with this theme of 'fuelling ideas', participants were of the opinion that asking clients about experiences of sexual violence might suggest to the client that this had occurred in their lives. Commenting on why they were reluctant to open a discussion on sexual violence participants said:

'I mean if someone said to me, "Were you sexually abused?", I would say, "Jesus Christ what do you mean, how dare you ask me that", because I wasn't. What made you think I was? Because I [client] am going to presume that the nurses think that I was' (27 F).

'By asking [about sexual abuse] you could be making the situation worse, trigger something off, something in their heads...and if it hasn't happened, what will they think...then you've got a whole deluge of problems on you hands, deal with the small problems first and it may come up later and deal with it then' (8 M).

Participants did not appear to consider that revealing a history of abuse may be the first step in dealing with a psychological burden that has been kept secret for years, nor contemplate the impact of stigma, self-hatred and shame on the person's ability to voluntarily disclose (Gallop et al., 1995b; Ray, 2001; McGee et al., 2002). This lack of alert consciousness and focused questioning on sexual violence have also been reported in other papers (Gibbson, 1996; Long and Smyth, 1998). Commenting on what he called 'suppressed awareness' of sexual abuse, Gibbson suggested that helping professions are like the victims of abuse, who protect themselves from the pain and terror by splitting off all memories of sexual traumas (Gibbson, 1996:1755). Similarly, in what could be described as a parallel process, the participants in this study dissociated from the pain of the sexual trauma in the lives of the people they met, by their rationalisation. In view of the research that consistently indicated that people with mental health problems who are asked directly about abuse experiences disclose higher rates of sexual abuse, in comparison to people who are left to volunteer the information during ongoing clinical encounters (Briere and Zaidi, 1989; Read and Fraser, 1998), Doob (1992) suggested that the unwillingness on the part of nurses to raise issues of abuse with clients was tantamount to re-abuse, by omission.

In suggesting a reason for nurses' 'dignified silence' in relation to sexual violence, Long and Smyth hypothesised that it was due to nurses' socialisation into Freud's theory of sexual abuse (Long and Smyth, 1998:130). As a consequence, female children were viewed as tempting the older adult, and sexual abuse was confined to the realm of fantasy. While this may be one possible explanation, the dissociation and denial by the participants in this study is likely more reflective of their lack of skill and confidence on how to ask questions and subsequently respond to clients who have experienced sexual violence, in the absence of comprehensive services

for abuse victims. It may also be a reflection of the wider culture of denial that was evident with Irish society and more particularly the Catholic Church until recently (Murphy et al., 2005).

Although participants spoke about clients' vulnerability to sexual exploitation, pregnancy and sexually transmitted diseases, they were also reluctant to educate clients about aspects of sexual health. Participants justified this on the grounds that education might encourage or release a desire, or heighten sexual activity in a way that would not be in keeping with the focus of practice, which was control of sexual expression. This is exemplified in the following quote from a participant, who was working with people with long term mental health problems in a residential setting:

'We are not going to bring it [sexual health education] up, because it might just encourage them, you know it might put thoughts into their heads about sexual relationships and they might not have thought about having a sexual relationship, we are here to discourage people from having a sexual relationship' (13 F).

This view is similar to views reported in other studies. Staff in some studies were of the opinion that people with mental health problems were incapable of handling their sexuality responsibly. Therefore, they justified their failure to discuss sexual issues or educate clients about condom use on the grounds that it might encourage sexual promiscuity, sexual disinhibition, or increase or cause sexual 'acting out' (Wasow, 1980; Goisman et al., 1991; Hajagos et al., 1998; Purdie, 1996; Davidhizar et al., 1991; Sadow and Corman, 1983).

These views also hold similarities to the wider arguments put forward during the 1970s campaign to have laws banning contraception appealed[32] and more recently in campaigns against the introduction of the Relationship and Sexuality Education programme into primary and secondary schools. As previously discussed (chapter six), Catholic lobby groups, clergy and individuals, fearing that either the introduction of contraception or frank discussions on sexuality might awaken the

[32] Although Mary Robinson began her campaign to the Oireachtas in 1971 to have the laws banning contraception repealed, the Health Act allowing for the sale of contraception did not happen until 1979, and then only after heated debate with the Catholic Church. The then Bishop of Kerry, Kevin McNamara, was of the opinion that making contraception available to unmarried people would have serious consequences, as in other states contraception legislation had led to the moral corruption of the youth, an increased spread of sexually transmitted diseases, increased marital infidelity and the acceptance of pre-marital sex as the social norm (Ingles 1998b).

dormant sexual appetites of the Irish people, argued against the introduction of both (Inglis, 1998a; Scheper-Hughes, 2001).

'Minimising clients' cognitive ability'

Minimising clients' cognitive ability related to the way participants justified their actions by playing down the clients' cognitive capacity to engage, understand and process educational information. Participants used this rationalisation for a number of issues, including education about relationships, safe sexual practices, and iatrogenic sexual dysfunction. This is summed up in the following comments:

'You think that you are non-judgmental of people, ...but you think maybe some people are not able for certain things...if I brought up that [sexual health issue] with them, they wouldn't be able to answer or they wouldn't know what I was talking about... there is a bias there, or sort of judgments' (23 F).

'Well I will tell you for starters you can talk until the cows come home about educating them as regards sexuality, because number one they are not going to listen, and number two they are not going to sit down long enough for you to get talking about it, and they are going to dismiss it, and it is going to be in one ear and out the other...because that is the nature of the patient here there is only so much they can take in their mind,...they are cocooned in their own little world' (19 F).

Anecdotal accounts in the literature suggest that these views are not just confined to the participants in this study. Welch and Clements (1996) commented that many people, with what they termed 'chronic' mental health problems, lacked the skills necessary to attend, process and transform information into behaviour. However, findings from studies that have explored the impact of sexual health education programmes (discussed in chapter 3), provided evidence of both the feasibility and efficacy of sexual health education for people experiencing 'severe' mental health problems (Kelly et al., 1997; Weinhardt et al., 1998; Kalichman et al., 1995; Otto-Salaj et al., 2001; Carey et al., 2004). These studies also challenged the view that many people with mental health problems lacked the skills necessary to attend, process and transform information into behaviour.

'Arbitrarily assuming'

Arbitrarily assuming referred to the way participants made assumptions about clients' confidence to disclose concerns. Participants assumed arbitrarily that clients

had the confidence and comfort to disclose sexual concerns voluntarily. Participants did not appear to consider that clients might have experienced the same socialised inhibition as themselves, and that this might be inhibiting them from expressing such concerns:

'I would say that if they [women, who are experiencing sexual side effects of drugs] had a problem or had any difficulty they would say it' (27 F).

'You expect them to make the connection [between the drugs and sexual side effects] and you expect them to come to you, that is the truth, most people would be pretty quick to figure out if they are not functioning properly in a sexual sense and they will put two and two together' (15 M).

This assumption that all clients have the assertiveness skills to disclose sexual concerns voluntarily is contradicted by the findings of McCann's (2004) study. Clients in McCann's study reported a reticence in telling health professionals about sexual concerns due to embarrassment (McCann, 2004). The latter comment above, also assumed that clients would make the connection between sexual dysfunction and the drug prescribed, thus ignoring the difficulty clients may experience in making such connections, in the absence of adequate information (Jordan, 2002).

'Comparing to self'

As previously discussed, in *'Hanging the veil'*, participants tended to treat clients as 'other'. However, when they spoke about their reluctance to talk to clients about sexuality and sexual needs they resorted to *'comparing to self'*. Using themselves as a benchmark of comparison, participants were of the opinion that if they were uncomfortable, in a health care context, talking about their own sexuality or sexual relationships then this must be the same for clients. This rationalisation was used for a variety of issues ranging from asking about sexual partners to sexual violence and is captured in the following comment:

'I would find it very private and personal... I wouldn't be too quick to discuss any issue or anything like that, and for that reason I suppose I am putting myself in their shoes...If I was a service user, I wouldn't like someone to start asking a whole heap of questions about my sexuality and do I have a boyfriend and all that' (11 F).

By privileging their own perspective, participants not only projected their own discomfort onto clients and used their own personal wishes as a basis for the goals

of client care, but they also diminished the autonomy and agency of clients by deciding for the clients without negotiation. Again embedded within this rationalisation was the belief that to ask would engender disapproval from the client. Consequently, it was not possible for participants to test their hypothesis, as to do so risked causing the inferred negative effect.

'Fearing consequences to self'

Throughout the interviews, participants spoke of the 'fear of consequences to self' should they initiate any discussion on clients' sexuality. This included: *'fearing exposure of a competency deficit', 'fearing exposure of self as a sexual being',* and *'fearing derision from others'.*

'Fearing exposure of a competency deficit': Participants did acknowledge that, in other areas of practice, if they did not know something, they would tell clients and seek the information required. However, the same principle did not appear to apply to sexuality and sexual health. Participants believed that clients saw them as experts, and rather than expose their lack of knowledge and receive a negative evaluation from the client, they opted to ignore the sexual dimension of the person's life. In this way, participants maintained a presentation of themselves as knowledgeable and competent practitioners:

'I'm afraid I'd be asked something or I might have to talk about something that I mightn't know an awful lot about or I mightn't feel comfortable talking about. I don't want to give people the wrong advice either, because people look to you because you are the nurse as some kind of expert but of course I'm not, I don't know anything about bisexuality, I don't know much about homosexuality and then there's the whole thing of paedophilia and that has so many criminal connotations and someone starts talking about that, well you could end up having to report... it is a difficult one to deal with' (5 F).

'Sex, erections, orgasms all that sort of stuff, it is hard to get the words to be able to [talk about it] and you want to sound like, to reassure this person that I know what I am talking about here and I am going to be able to help you, but with a situation like that and you are like oh my god the words won't come out, and the person doesn't have much faith in your ability then and that is what I would be afraid of' (25 F).

'Fearing exposure of self as a sexual being': Some participants feared that if they opened up a conversation on sexuality, clients would expect reciprocation; they would have to expose something about themselves as sexual beings. Therefore, in order to avoid the discomfort associated with this, participants opted to maintain a boundary between self and sexuality:

'I think it's something that is very personal and then [if you raise it] you might have to share some of your own stuff and I wouldn't necessarily feel comfortable with that' (5 F).

'If we ask them about their sex life, they are going to want to ask us something about sex, and then you are really going "I want to know personal things about you, but you are certainly not going to know anything about me"... It's about keeping a distance' (22 M).

'Fearing derision from others': Participants worked within what they considered were the norms for practice. Proactively talking to clients about sexuality or sexual issues was not part of that norm. Stepping outside that norm was perceived as risking professional derision or being labeled a maverick. Thus, participants opted for what they considered was the safest solution – professional conformity and conservatism – as one participant said:

'There isn't a culture within the team of talking about this, within the nursing, medical or management team...asking people about sexuality and sexual experiences is not considered to be the norm on an interview with a patient, and therefore if the nurse engages in that... you are going to appear to be a maverick you know, what are you doing, why are you asking people these questions' (22 M).

Fear of being laughed at or thought of as different were reasons put forward by other participants:

'I do think we should be thinking about things, but if I was to go this morning and make a suggestion to nursing management, that we should consider the sexual rights of long stay patients... maybe it is my paranoia but I think it would be met with howls of derision' (16 M).

'It just isn't encouraged [talking about sexuality], you know...if you were to say she is really upset today or she is really hurting or maybe she is talking about her sexual relationships, and I don't think it has been looked at, will you have a chat? They'd say, "What are you saying (tone dismissive), what are you going on about, what it this about?" or, "For God's sake, I am not talking to her about that", so you fit in, you slot in' (25 F).

Lee (1993) suggested that researching a taboo subject, such as sexuality, carried a risk of stigma by association. In the context of nursing practice, it appeared that showing an interest in sexuality, in an environment that tended to ignore clients as sexual beings, also carried a risk of being stigmatised and labelled as being 'different' and 'over-interested'.

'Blaming resources'

Similar to nurses in Guthrie's (1999) qualitative study, participants were of the opinion that due to competing demands they frequently lacked time to talk to clients about sexual issues. Blaming a lack of time came into play, mainly, when participants talked about their hesitancy to explore issues around iatrogenic sexual dysfunction:

'You don't have the time, to be honest; if you were to go through every medication that a patient is being put on, you just don't have the time...things like being unable to masturbate or vaginal dryness or things like that, it's difficult to make room for it [education], I know we should, but it's time' (10 F).

Such claims could be seen as very reasonable, as lack of time to talk to clients has been reported in other studies (O'Donovan and Gijbels, 2006). However, lack of time may simply be another way of avoiding the issue, and a projection of participants' own discomfort onto environmental factors. As Barker et al. (1999) pointed out, the less time nurses spend with clients the more remote they are from intimate knowing.

Participants also blamed the nursing documentation. The lack of reference to sexuality in the nursing documentation was viewed as a reason why participants ignored the sexual dimension of the client's life:

'If it was part of our assessment, it might just be a reminder to ask more questions in that area' (23 F).

'You don't approach it with anybody, because it is not a standard care plan, not part of our documentation' (18 M).

'It is because traditionally is not been part of our assessment documentation' (23 F).

However, as previously discussed, and similar to findings in other studies, even when aspects of care relating to sexuality, such as sexual abuse (Read and Fraser, 1998), contraception, sexually transmitted diseases (Dorsay and Forchuk, 1994), or the general heading sexuality (Mulhearn, 1989) were included in documentation, there was no guarantee that mental health professionals would discuss these issues with clients.

'Transferring responsibility'

Although participants verbally acknowledged that sexuality was, 'theoretically' an important dimension of client care, they also excused and justified themselves by transferring the responsibility for this aspect of client care onto another member of the team. Transferring responsibility was based on a belief that, because of the stage of their illness, clients were not, at that particular time, suitable for education:

'I suppose if I was to look at people that are in the community, that go to day centres and day hospitals, they are highly functioning, I think that [sexual health education] would be very good for that kind of an area. It's more relevant there than here [rehabilitation unit]; the area does make a difference, day centres and acute as opposed to here' (11 F).

'I think it is harder for here [acute unit] because we have people of different levels of wellness. You would have to gauge what one could take in...It [discussions on sexual health] is something that should be done in the community...that is where it is an issue' (10 F).

In relation to the side effects of medication, participants transferred the responsibility onto the medical team, or onto the community pharmacist. This transfer of responsibility was based on the belief that the participant either did not prescribe medication or, in the case of community nurses, did not dispense medication. Consequently, it was considered the role of the doctor or the community pharmacist to inform clients of the side effects of prescribed medication, including those affecting sexual function:

'That is more the doctor's thing to go through the side effects with them' (15 M).

'I am a nurse, I am not prescribing, it is not our decision really, it's the doctors that should be telling really...my role is to represent the client to the doctor if they tell me' (17 F).

'We're not physically handing them out; it's their pharmacist's role' (4 F).

Participants seemed not to take cognisance of their various roles in medication, other than administration, such as educating clients about medication and monitoring both the benefit and side effects of drugs (An Bord Altranais, 2003).

Summary of 'Maintaining the Veiling-Re-Veiling Cycle'

'Maintaining the Veiling-Re-Veiling Cycle' was the final category of the theory. It consisted of rationalisations, justifications or excuses offered by participants for the pattern of behaviour described in the *'Veiling-Re-veiling Cycle'*. These rationalisations were developed as a result of the participants' professional socialisation into the culture of psychiatric nursing. While acknowledging that sexual issues were not adequately addressed, participants reasoned and justified their actions through a process conceptualised as *'Mythical Self Talk'*. *'Mythical Self Talk'* consisted of *'dividing practice'*, *'appealing to higher goals'*, *'hesitating to fuel ideas'*, *'minimising clients' cognitive ability'*, *'arbitrarily assuming'*, *'comparing to self'*, *'fearing consequences to self'*, *'blaming resources'* and *'transferring responsibility'*. In using these justifications, participants attempted to minimise their responsibility for including sexuality as a dimension of practice, and played down the likely negative effects their actions might have had on clients. The apparent absence of self-reflexivity resulted in participants accepting unquestioningly their prejudiced view of sexuality in relation to clients and failing to see the degree to which the *'Mythical Self Talk'* was 'grist' perpetuating and maintaining the *'Veiling-Re-veiling Cycle'*.

The pattern of *'Mythical Self Talk'* was also a self-perpetuating and self-reinforcing pattern. The rationalisations used by the participants were constructed in such a manner that they simultaneously prevented the participants from subjecting their beliefs to public scrutiny to test the validity of their claims. The rationalisations were based on un-discussable issues with clients, that if discussed would result in a negative outcome, either to the client or self. Therefore, being un-discussable, and

having negative consequences if discussed, these issues could not possibly be laid open to public scrutiny from clients or others. In addition, the un-discussability of the un-discussable was never opened up for critical scrutiny at organisational or team level. Thus, the perceived notions, as described in *'Mythical Self Talk'*, blinded the participants to alternative perspectives as they became 'imprisoned in the world of their own constructions' (Crotty, 1998:59).

Prior to discussing the findings in greater depth, in the next chapter, the remainder of this chapter will provide the reader with a brief summary of the statement of problem and the emergent theory.

Summary statement of the research problem and the emergent theory

Although some research, as described in chapter three, had been carried out to explore the difficulties experienced by nurses in addressing sexuality issues with clients, this research was mainly small scale, survey design studies, involving nurses working in contexts other than mental health, and with clients who were not experiencing mental health problems. The outcomes of these studies frequently resulted in a list of possible reasons for nurses' failures to address issues of sexuality with clients. The few studies that involved psychiatric nurses suggested that they did not talk to clients about sexual issues, including sexual orientation, impact of drugs on sexual function, or experiences of sexual violence. While these issues did re-emerge within this study, the previous studies did not provide in-depth understanding or illumination of the practice of psychiatric nurses. Neither did the studies provide a theory or conceptual framework that described and made explicit psychiatric nurses' behaviour and motivation for behaviour, or integrated possible cause-effect relationships. To understand any aspect of psychiatric nursing practice, it is important to make explicit any taken for granted assumptions and practices. Without this understanding, effective practices cannot be taught and ineffective practices can not be changed and modified. This research, therefore, set out to develop a substantive theory of how psychiatric nurses respond to issues of sexuality in a practice context.

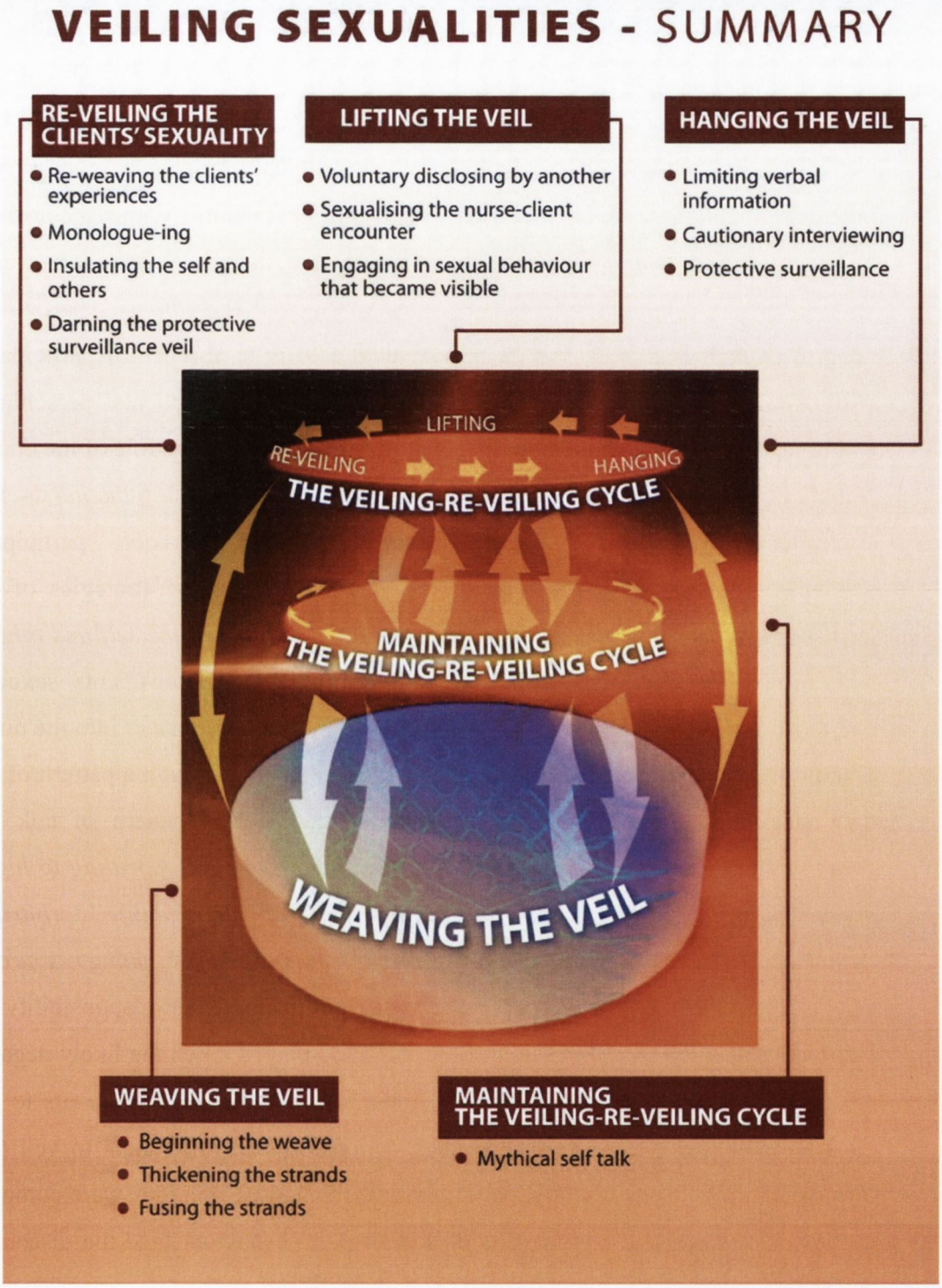
The study was informed by a constructivist epistemology and the principles of Grounded Theory as described by Glaser (1978; 1992; 2001; 2003; 2005). Data were gathered in one mental health service in an urban area in the Republic of Ireland. Participants consisted of twenty-seven nurses who were working in a variety of clinical areas within the service. Data were collected through interviews and documentary analysis, and analysed using the concurrent processes of constant comparative analysis, data collection, theoretical sampling and memoing.

Describing how participants respond to issues of sexuality in a practice context is a complex process. The process, as it emerged from my analysis, suggested it could best be described using the core category, conceptualised as *'Veiling Sexualities'*. As the core category, *'Veiling Sexualities'* provided the most explanatory power; it described the latent pattern of behaviour participants used in the social setting to resolve their key problem, and accounted for all the other categories and codes. Participants' main concern in relation to sexuality was related to their desire to protect their own and clients vulnerabilities. To do this, participants developed a number of strategies that simultaneously veiled the sexual dimension of the clients' personhood and their own discomforts.

The process of *'Veiling Sexualities'* (described in chapters six to nine), comprised of five categories, conceptualised as *'Weaving the Veil'*, *'Hanging the Veil'*, *'Lifting the Veil'*, *'Re-veiling the clients' sexuality'* and *'Maintaining the Veiling-Re-Veiling Cycle'*. Three of the categories (weaving the veil, hanging the veil and lifting the veil) formed a *'Veiling–Re-veiling Cycle'*. The relationship between the categories was neither hierarchical nor linear, but an iterative cyclical process as categories shaped and influenced each other. In this way, the process of *'Veiling Sexualities'* was maintaining and perpetuated.

Figure 7 provides a diagrammatic representation of the overall theory together with the categories and subcategories that make up the theory of *'Veiling Sexualities'*.

Figure 7 Diagrammatic representation of the theory 'Veiling Sexualities' with subcategories



The strategies that participants developed to *'veil'* clients' sexualities were *'woven'*, *'thickened'* and *'fused'*, as a consequence of exposure to, and engagement with various sexual discourses, during primary, secondary, and professional socialisation. These discourses provided participants with a view of sexuality that emphasised taboo, privatisation, sin, pathology, deviance and control. Absent were social, political, cultural, interpersonal, or rights-based discourses that could have provided participants with the knowledge and clinical competence necessary to include sexuality in an open, constructive and confident manner within the horizons of psychiatric nursing. Consequently, by using the strategies of *'limiting verbal information'*, *'cautionary interviewing'*, and *'protective surveillance'*, participants hung a metaphorical veil over clients' sexualities. In the absence of participants' willingness to acknowledge openly the sexual dimension of clients' personhood, lifting the socially and professionally constructed veil became the role of the clients. When clients lifted the veil, by *'voluntary disclosing'*, *'sexualising the nurse-client encounter'*, or by *'engaging in sexual behaviour that became visible'*, participants responded by *'re-veiling the clients' sexuality'*. By using the strategies of *'re-weaving the clients' experience'*, *'monologue-ing'*, *'insulating the self and others'*, and *'darning the protective surveillance veil'* participants kept the clients' sexuality contained and prevented it from encroaching in a therapeutic manner into the nurse-client relationship. Participants rationalised their behaviour though a pattern of talk that maintained the *'Veiling-Re-veiling cycle'* intact. This pattern of talk was conceptualised as *'mythical self talk'*. By *'dividing practice'*, *'appealing to higher goals'*, *'hesitating to fuel ideas'*, *'minimising clients' cognitive ability'*, *'arbitrarily assuming'*, *'comparing to self'*, *'fearing consequences to self'*, *'blaming resources'*, and *'transferring responsibility'*, participants minimised their responsibility for including sexuality as a dimension of practice, and played down the likely negative effects of their actions on clients. The strategies used by the participants to veil clients' sexualities and to rationalise their actions, also enabled them to veil their own discomforts. Consequently, participants were unaware that they were complicit in the construction and reconstruction of the veiling behaviour, and the discourses and rationalisations that maintained the behaviour intact.

The findings, as interpreted in the theory of *'Veiling Sexualities'*, generates some valuable insights into the strategies that psychiatric nurses use to address issues of

sexuality in practice, and provides enlightenment into how these strategies were developed. The findings also shed some light on the process of thinking that motivated participants to use the *'veiling'* and *'re-veiling'* strategies, as well as the processes that maintained their use. The theory also highlights how the categories identified were in constant interaction with one another, producing, reproducing and maintaining the participants' patterns of behaviour and thinking in a circular manner. In identifying practices that have become naturalised and taken for granted, the study provides a new way to consider how psychiatric nurses respond to sexuality, thus adding to the body of knowledge and the development of psychiatric nursing. The findings also provide guidance for future education and research in this underdeveloped and under researched area of practice.

The next chapter will discuss the emergent theory in greater detail.

CHAPTER TEN: DISCUSSION OF THE FINDINGS

Introduction

Previous chapters have included some discussion of the emergent theory in relation to existing literature; however, this was limited to commentary on the way the theory might confirm or refute previous research or extant theoretical or philosophical positions. This chapter aims to provide an in-depth exploration of the findings at they relate to the wider literature. This chapter discusses issues that required more in-depth exploration. These represent, firstly, issues that embraced all the categories and, secondly, issues that have significant implications for the practice of psychiatric nursing and nursing education, not only in relation to sexuality but for the whole realm of psychiatric nursing. Consequently, this chapter will explore the subject areas of therapeutic relationships, the psychiatric narrative, power, heterosexism, gender, protection and education.

'Veiling Sexualities': Antithesis to the ideals of therapeutic relationship

Since Hildegard Peplau's *Interpersonal Relations in Nursing* was published in 1952, and Joyce Travelbee's *Interpersonal Aspects of Nursing* in 1966, the concept of the therapeutic nurse-client relationship and therapeutic alliance has emerged as central to the practice of psychiatric nursing and an important variable in the health outcomes for clients. Welch (2005) noted that hardly a single textbook fails to mention the therapeutic relationship and its key role in psychiatric nursing. A therapeutic nurse-client relationship is considered to be one that is person-centred, and respects the totality of the individual's experience, uniqueness and dignity (Hanson and Taylor, 2000; Hess, 2003; Barker and Buchanan-Barker, 2005). It is also marked by a willingness to engage in what Gadow calls a 'relational narrative' (Gadow, 1996:9), or a willingness to engage in a dialogue that is neither general nor personal, but a co-composed and co-analysed interpretation of the good being sought. The aim of this is not to find one voice, 'but to express contradictions, discuss them… (and) open new perspectives' (Seikkula, 1995:25). Others suggest that therapeutic relationships are anchored by a therapeutic stance of 'bearing witness' to clients' experiences, by 'being with', 'engaging with' and 'caring with'

clients (Barker et al., 1999; Cody, 2001; Wilkin, 2003; Naef, 2006). Therapeutic relationships are also characterised by a sensitivity to power differentials within relationships, with a commitment to promoting the client's right to self determination (Hess, 2003). The theory *'Veiling Sexualities'* challenged the degree to which the participants consistently worked within the ideals of therapeutic relationships as envisaged by these writers, and supported findings from other client-focused studies, which suggested there was a considerable degree of dissonance between the ideals underpinning therapeutic relationships and the reality of psychiatric nursing practice (Goodwin et al., 1999; Latvala et al., 2000; Forchuk and Reynolds, 2001; Moyle, 2003).

Person-centred relationships are predicated on the value of personhood (McCormack, 2003). Central to this is a valuing of the uniqueness of the individual with a commitment to having a deep understanding and respect for the person, as a psychological, social, spiritual, physical and sexual being (McCann, 2004; Barker and Buchanan-Barker, 2005). The theory *'Veiling Sexualities'* suggested that two forms of discursive practice shaped and dominated participants' understandings and practices in relation to sexuality; firstly, practices that tended to shade over the existence of people's sexuality, thus rendering it partially invisible and, secondly, practices that portrayed sexuality as something that was dangerous to both the client and the nurse, and therefore needed to be controlled. These practices, which transformed the personhood of clients into patients, illnesses, objects and 'other', with a collective identity, not only discounted the clients' humanity but minimised the shared humanity that existed between the clients and the participants. By so doing, participants perpetuated practices that marginalised, discriminated and socially excluded clients as 'sexual citizens' (Richardson, 2000:75) and engaged in practices that were antithetical to the principle of person-centred care.

A core element of a therapeutic relationship is the facilitation of clients to tell their stories with a view to enabling them to re-author the story of their lives and commence the voyage to recovery (Barker and Buchanan-Barker, 2005). The therapeutic and emancipating value of engaging with clients in facilitating the telling of stories and talking frankly about feelings and experiences, has also been iterated and reiterated by clients in a number of studies (Jackson and Stevenson,

2000; Forchuk and Reynolds, 2001; Shattell et al., 2006; Cutcliffe et al., 2006). Central to facilitating clients to tell their story is the ability to live on the edge of 'not knowing' (Wilkin, 2003:26), tolerating the anxiety and feelings of discomfort this creates within, while at the same time creating a context for telling, through 'natural curiosity' and the asking of 'interesting questions' (Stevenson, 2003:100). The adoption of a 'not knowing' stance facilitates the collaborative emergence of new meanings and perspectives. In other words, meaning emerges 'not from the intention of individual speakers, but *between* speakers, from within the conversation itself' (Guilfoyle, 2003:333). However, findings from this study suggest that participants were unable to engage in the uncertainty and unpredictability of collaborative dialogue around sexual issues. Participants were reluctant to move away from their *'cautionary interviewing'* style and fixed pattern of questioning that excluded areas with which they felt uncomfortable, assuming that clients would disclose, unprompted, any sexual concerns. The use of a *'cautionary interviewing'* style did allow clients some protection as they were not forced into an unwanted disclosure. However, the assumption that clients would 'confess' without the nurse creating a context for the discussion of sexual concerns, resulted in clients being in the onerous position of having to lift the socially and professionally constructed 'veil' and risk an unpredictable response from the professional. As a result, many stories of sexual violence, relationship difficulties, drug induced sexual dysfunction and concerns around sexual identity possibly went unheard, unsupported or mistreated, with clients left isolated, confused and distressed (Deegan, 1999). Equally many positive sexual stories of love, friendships, passion, and desire that could have acted as points of hope, inspiration and refuge went unrecognised and unacknowledged.

Even when clients disclosed information, asked for advice or engaged in sexual behaviour that revealed the sexual dimension of their personhood, the *'monologue'* stance adopted by participants limited opportunities for exploration of meaning from clients' perspectives. Similarly, by *'reweaving the client's story'*, using the narrative of deviance or pathology, participants colonised their distress and 'submerged the person's story in a sea of professional theorising' (Barker and Buchanan-Barker, 2005:7). Instead of new meanings being generated from a synthesis of voices within conversation, fixed meanings already inherent in the

participants' store of expert knowledge were reproduced. By colonising the clients' distress and limiting opportunities for clients to tell their own story, rather than empowering clients to engage in a personal voyage of discovery and recovery, participants engaged in what Barker called 'the most common form of disempowerment – the failure to afford proper hearing to their [clients] personal story of the experience' (Barker, 2003b:99).

Writers on therapeutic relationships and therapeutic nursing highlighted the importance and therapeutic value of nurses moving from the stance of objective observer to the position of emotional connectedness with the clients (Jackson and Stevenson, 2000; Freshwater, 2002; Barker and Buchanan-Barker, 2005). Central to this connectedness is the ability to be in the world with the clients and become oblivious to any sense of otherness. In other words, the nurse 'suspends the separateness of the self and crosses the threshold of subject-object dichotomy' (Rowan and Jacobs, 2002:76). In this *'I-Thou'* moment (Buber, 1958), collaborative healing takes place. However, the theory *'Veiling Sexualities'* suggests that participants' concern with personal and professional protection limited their ability to progress from an *'I-It'* relationship to an *'I-Thou'* moment. Few would argue against the need for nurses to be conscious of personal safety, or for nurses to avoid becoming so enmeshed in the clients' experiences that they can not distinguish their own emotions from those of the clients; however, the distancing of the self through the use of the *'veiling'* and *'re-veiling'* strategies described in the theory, reduced the possibility of participants meeting clients at the relational depth of an *'I-Thou'* moment. This is not to suggest that the participants in the study did not attempt to engage with clients or were not empathetic; however, in relation to sexuality, it appeared to be a 'limited liability' engagement with instrumental type empathy (Rowan and Jacobs, 2002:24). Participants were present to clients in a role, as opposed to the intersubjective, interpersonal 'being with' presence described by writers such as Barker and Buchanan-Barker (2005) or the 'embodied engagement' envisaged by Hess (2003). In other words, participants may have had physical contact and a verbal exchange with clients; they may have heard what the client said and felt affection for the person; however, they seemed to remain outside clients' experiences and disconnected from their vulnerability and suffering. The challenge of living in the tension created by the legal discourse, which formally emphasises

client protection, and the professional discourse, which formally and informally emphasises self-protection, appeared to result in a mode of being more focused on contact and observation than connection and emotional engagement. Consequently, and paradoxically, while attempting to protect clients from embarrassment, distress and poor decision making, participants were infringing clients' rights to information, freedom, and corrupting the ideals of the therapeutic relationship. Similarly, while attempting to protect themselves from self disclosure and allegations of professional negligence, participants were also leaving themselves open to allegations of minimal therapeutic engagement and a reluctance to 'bear witness' to the lived reality of the person (Cody, 2001:289).

Therapeutic relationships are, in general, also characterised by an egalitarian model of communication, where nurses are consciously alert to the inherent power differential that is pervasive within the relationship (McAllister et al., 2004). Power differentials within relationships arise from social, professional and institutional forces that position nurses differently from clients, with greater speaking entitlements. Power also arises from 'expert' knowledge and its imposition on the client's experience (Guilfoyle, 2003). Consequently, nurses are urged to finely-tune their self reflective skills and become critically aware of their preconceptions about cause, treatment or outcome that might seep into the therapeutic encounter (Freshwater, 2002). They are also advised actively to encourage clients to challenge professional interpretations and articulate their preferences for care (Barker and Buchanan-Barker, 2005). In this way, the outcome is a care plan based on balanced information, mutually agreed and negotiated, as opposed to an adherence to a one-way authoritarian instruction. However, the theory *'Veiling Sexualities'* suggested that although participants talked about engaging in a discussion with clients, they frequently ignored the power differential within the relationship. Examples of this behaviour include entering interactions with outcomes predefined, and not wholeheartedly making room for the other person in the interaction by creating a context or invitational space for clients to disagree with professional interpretations and suggestions. This was not done with malicious intent, but was possibly born out of participants' experiences of professional discourses, which authorised nurses to act on behalf of clients, positioned professional interpretations of the person's

experience central, and provided uncritical and unreflected certainty 'about the good' of expert knowledge (Hess, 2003:139).

'Veiling Sexualities': A foregrounding of the psychiatric narrative

The construction of mental distress as a psychiatric illness or a problem of living that has been medicalised and colonised by mental health professionals has been the subject of much debate in the psychiatric literature and nursing literature (Szasz, 1961; Foucault, 1989; Barker, 1999; Barker and Stevenson, 2000). Forchuk (2001:39), in reference to this debate, likened psychiatric/mental health nursing to a 'house divided', between the 'biological' and 'therapeutic relationships' camps. Writers who advocate the therapeutic relationship camp suggest that the human experience should be the primary focus of psychiatric nursing (Barker et al., 1999; Forchuk and Reynolds, 2001; Barker and Buchanan-Barker, 2005; Cameron et al., 2005). As previously described, within this view, all clients are seen as possessing their own life story, which is located at the heart of the caring process. The focus within the biological or the psychiatric camp is on the classification and elimination of symptomatic behaviours and experiences, through the use of medication or other interventions. Within this view, mental distress is seen as illness, with treatment remaining within the expertise of the medical profession, which knows what is best for the client. In keeping with this view, there is an expectation that clients conform to Parsons' (1951) idea of the sick role: they seek help and, in an unquestioning manner, accept and conform to the advice of the medical professional, whether it be the doctor or the doctor's representative – in this case the psychiatric nurse.

The *'Veiling Sexualities'* theory supports Barker's assertion that psychiatric nursing 'still stands in the shadow of psychiatric medicine' (Barker, 2003b:96). Although participants espoused a view of distress as a problem in living, it is suggested that their 'theory in use' was more in keeping with the grand narrative of the 'biological' or psychiatric camp. In other words, the theory that actually guided their practice was more reflective of a belief suggesting that all distress could be explained through a psychiatric medical lens and that, although it is good to talk to clients about their experiences, the most effective 'treatment' was medication and the most

effective intervention on the nurse's behalf was to ensure compliance with a medication regime.

The shadow cast by psychiatric medicine was, firstly, reflected in the *'cautionary interviewing'* style of the participants. Participants entered assessment discussions with an agenda of looking for pathology or symptoms of 'illness'. This routine and problem orientation approach to clients, which considered clients as repositories of information, and sexuality as not important or relevant to the care of clients, ensured that both the participant and the clients remained wedded to the psychiatric illness narrative. Despite participants' espoused beliefs that mental distress is a problem of living, their perception of their role in relation to medication also suggested they strongly adhered to the 'biological' view of distress and the therapeutic power of medication. In keeping with the illness view of distress, participants tended to view recovery as the absence of symptoms and their role in the promotion of recovery as the promotion of medication compliance, irrespective of clients' rights to informed choice or a fulfilling sexual life. This paternalistic and compliance-orientated view, was revealed in the manner in which participants uncritically *'limited verbal information'* about iatrogenic sexual dysfunction and responded to clients who did ask questions or complain with a *'compliance monologue'*. These behaviours appeared to be underpinned by an expectation that clients would simply conform to the 'sick role' and follow professional instructions by adhering to a medication regime, irrespective of personal burden. The presentation of a choice between either mental health or sexual function, was also consistent with the biomedical model and its ethos of reductionism. The emphasis on the possibility of future relapse perpetuated the erroneous view that relapse was always an inevitable consequence of non-adherence to medication and that medication was beneficial to all clients. Consequently, evidence that suggested 'compliant' people relapse, that many people recover with no drug treatment and many more people recover given the appropriate emotional and social support, faded into the background (Barker and Buchanan-Barker, 2003).

Participants' descriptions of their reactions to what was considered 'psychotic' behaviour also reproduced the grand narrative of biomedicine. Emphasis appeared to be placed on describing clients' experiences as symptoms of an illness. Their

allegiance to the 'illness' narrative, which judged the content of 'sexual hallucinations' or 'sexual delusions' as irrelevant, resulted in no discernable dialogue taking place between the 'expression of mental illness' (i.e. delusions and hallucinations) and the impact or meaning of these from a human point of view. Consequently, the meaning of these experiences from the clients' perspective, and possible links between these experiences and past psychosocial sexual history were pushed to the background, missed, or possibly 'treated' with medication. Supporting Gibbson's contention that the experience of victims of sexual abuse within the mental health services often reflected a 'repetition of the victimisation experience, with further disempowerment, a label and medication' (Gibbson, 1996:1759-1760).

Participants also used the psychiatric discourse of deviance and boundary violation to codify sexual behaviours of clients. The tendency to view behaviour that sexualised the nurse-client encounter as deviance and merely an attempt, on the client's behalf, to exercise power over the nurse in a hierarchical manner, resulted in other possible explanations for the behaviour being pushed to the background. For example, if one considers the negative effects a diagnosis, and subsequent treatment, can have on a person's sense of sexual attractiveness, sexual identity and gender role performance, it is reasonable to theorise that some of the sexualised behaviour participants experienced as boundary violations, could have been a search, on behalf of the clients, for validation of themselves as attractive, desirable, sexual beings. (Assey and Herbert, 1983). Viewed through this recovery and validation lens, behaviour is no longer about power or oppositional defiance, but a part of a self-assessment exercise, which commences with a subjective appraisal and then moves to a more objective search and confirmation from another person that one is sexually attractive. Consequently, the focus of care moves from strategies (such as the *'suppressive monologue-ing'* and *'insulating strategies'*) that are solely aimed at closing down conversation, to strategies that open up dialogue with clients. Care also becomes more focused on acceptance of clients as they struggle to re-evaluate their sexual selves, with a view to exploring the possible meaning of the boundary violations and impact of mental health problems on the clients' sexual selves and identities. This is not to suggest that nurses do not have a right to a safe working environment free from sexual harassment and innuendo, or

do not have the right to use *'insulating strategies'* or assertive communication skills in the form of a *'suppressive monologue'*. What is at issue is how the *'narrative of deviance'* potentially demonised all clients, thus limiting alternative perspectives that may have given rise to alternative actions and outcomes.

The participants' allegiance to the illness and deviance narratives no doubt reflected their educational experience, where emphasis appeared to be on what Foucault (1976) calls the medicalisation of mental distress and where sexuality was either pathologised or problematised. It was also reflective of their experience in practice where participants, through the processes of *'professional comparing'* and *'cultural seepage'*, learnt to fit in and conform to the prevailing culture of the Irish mental health service, which currently is weighed towards the biological model of illness and treatment (Mental Health Commission (Irl), 2005; Government of Ireland, 2006). Up until 1984, psychiatric nursing, in the Republic Ireland, was largely a hospital based activity. With the publication of the report 'Planning for the Future' (Department of Health, 1984) the mental health services began to develop a comprehensive community-oriented service. Despite the move from the institutions and a change in language to include the rhetoric of recovery, inclusion and social issues, care continued to be based on a biological model of illness, and the view of clients remained wedded to the older idea of 'patient'. Although pockets of alternative approaches developed in an *ad hoc* and fragmented manner, the expert group on mental health stressed the need to move beyond the current biological and illness focused mental health services to a more 'biopsychosocial model' of practice. They were of the opinion that 'the artificial separation of biological from psychological and social factors has been a formidable obstacle to a true understanding of mental health... [and resulted in] ...lost opportunities for the provision of psychological and social interventions for people' (Government of Ireland, 2006:18). In this context and in the absence of other models of care, it is easy to see how the participants accepted the bio-medical model, as to reject this model would leave participants with no other alternative models of care. The power of the psychiatrist within the psychiatric service also renders psychiatric nurses' voices inaudible should they wish to argue or proffer an alternative approach to care. This critique of participants' practices is not to suggest that the narrative of psychiatric medicine and illness is to be ignored or has nothing to contribute to

clients and families. Speed (2006) highlighted how clients in the Republic of Ireland used the language of patient, consumer and survivors to describe themselves. Although the concept of 'patient' has the potential to objectify the client as a repository of pathology, he suggested that it can 'absolve' the "patient" of any blame or sanction for their situation' (Speed, 2006:37). Therefore, what is at issue is not an 'either/or' oppositional choice between the therapeutic relationships or psychiatric/biological camp, but the manner in which participants' allegiance to the grand narrative of psychiatry and diagnosis, led to only one reading of clients' distressing experiences. Consequently, other possible meanings or interpretations of distress were subjugated, and pushed to the background, and limited space was created for counter meanings or alternative models of care to emerge.

Veiling Sexualities': A dynamic network of power relationships

The role of the psychiatric services in the regulation and control of people's behaviour has been the subject of continuing discussion within the literature (Barker and Stevenson, 2000). Discussions of power-related issues have focused on the power of the total institution to control and mortify the self (Goffman, 1961), the role of the mental health professionals in denying people the right to individual liberty, the administration of treatments against their will (Szasz, 1994; 2002), and the subtle and coercive power within the rhetoric of democratic principles that underpin therapy (Baron, 1987). This section discusses the link between the theory of *'Veiling Sexualities'* and power using a Foucauldian perspective. Foucault describes a form of power – 'biopower' – which operates through social institutions and everyday practices. For Foucault, power is not a property or possession of a dominant class, state or sovereign, but a strategy – a ubiquitous and productive force in society that is embedded in all social relations and revealed in the course of interaction (Smart, 2002; Hyde et al., 2004). In other words, power acts upon individuals, who in turn, act upon others. In this way, power is relational. While power may produce self-regulating subjects or compliant, docile bodies, it also creates its own opposition; thus, it is both a repressive and productive force (Foucault, 2001). This understanding of power moves away from the traditional, one-sided, hierarchical view of power to one that focuses on power as a fluid network that circulates through bodies (Holmes and Gastaldo, 2002).

According to Foucault, power does not function just on the basis of law, but also through the use of a number of disciplinary techniques. Through the use of what Foucault called 'normalising judgements', participants in this study defined standards of normality for sexual behaviour and then applied mechanisms to exclude, reject or correct whatever did not meet that standard (Foucault, 1991:177). Similar to Foucault's disciplinary technique of the panopticon[33] and 'clinical gaze', participants through *'protective surveillance'* maintained close observation of clients' actions (Foucault, 1991). In this way, any sexual behaviour that deviated from the predefined norm was either prevented or became the subject of sanctions. Participants also exercised control by using their speaking rights to determine the direction and content of interactions. Through the use of *'cautionary interviewing'*, participants ruled in topics that could be spoken about, while ruling out others, thus ensuring that sexual issues did not encroach into the nurse–client interaction or relationship in a therapeutic manner.

The need for clients to be informed is not just a key issue in consent, but it is central to one's sense of control, as information is power. The strategies of *'limiting verbal information'* to clients about iatrogenic sexual dysfunction, could be considered an attempt to control clients' choice and options. For choice to be informed, it must be based on adequate balanced information on the purpose, likely benefits and risks of the treatment, including the likelihood of its success and any alternative options (Laugharne and Brown, 1998; Usher and Arthur, 1998). By withholding information, participants not only attempted to shape and control clients' actions through a knowledge/power game, but also became agents of the system as opposed to client advocates. Similarly, by limiting and framing interpretations, within the 'expert' psychiatric discourse of illness, and through the use of *'monologues'*, participants reproduced authoritative positions and practices. As Guilfoyle highlighted, monologues by nature are characterised by 'the addressor's failure to adopt the role of *addressee'* and by a lack of recognition of clients' agency and voice in decision making (Guilfoyle, 2003:332). Although participants used a

[33] Based on Jeremy Bentham's work on prisons in the 18th century, Foucault referred to the panopticon as an architectural layout that permitted one guard to see every inmate, while preventing the inmate from seeing the guard watching.

number of the legal and professional arguments as an ideological referent to support their actions, it is suggested that the *'veiling'* and *'re-veiling'* strategies used by participants, amount to coercive helping practices or subtle technologies of power, which exercised control over people in the guise of protecting and maintaining their mental health (Foucault, 1991).

Foucault (2001) also highlighted the relationship between discourses and the creation of subjectivities or identities. By codifying behaviour within a medical discourse, and through the use of authoritative statements to emphasis clients' status as mentally ill and dependent on medication, participants were complicit in the construction of clients' identities as 'mentally ill'. In addition, the presentation of a choice between mental health and sexual function, suggested that, unlike the rest of humanity, sexual function for clients was an optional luxury with which one could dispense. This discounting of clients as sexual beings, together with the other *'veiling'* and *'re-veiling'* strategies, also contributed to the construction of and maintenance of clients' identities as asexual 'docile bodies' (Foucault, 1991:135).

This is not to suggest that clients were powerless and destined to be subjugated by nurses. According to Foucault, where there is power there is resistance. To be targeted by a professional discourse is, according to Foucault, a necessary condition to generate resistance, or an oppositional discourse (Hyde et al., 2004). As clients were not passive agents of the organisation, an individual nurse or the 'label', the clients' presentations of self in a sexualised way could be considered an attempt to create a counterforce or counter-reaction and subvert the discursive practices of the psychiatric system. In Foucauldian terms, *'Lifting the veil'* is an active attempt by clients to reassert their sexual identities and subvert the professional discourse that constructed them as asexual, docile bodies and considered their intimacy and sexual needs and desires to be optional (Foucault, 1976). Viewed from this perspective, discussion around how to respond to sexual behaviour moves beyond a focus on controlling the individual client who is labeled deviant, to an exploration of how mental health practitioners contribute to the de-sexualisation of clients. It also challenges professionals, including policy makers, managers, educators, and individual clinicians to develop strategies that acknowledge clients as sexual beings. This requires mental health professionals to shift from a focus on personal and

professional protection, to a therapeutic stance, characterised by a willingness to engage with clients as sexual citizens.

The participants in this study did not simply exercise power over clients in a vacuum. They were themselves a product of 'power'; written on by various institutions such as family, schools, church, nursing education and practices. In Foucault's analyses, knowledge is an important technique of power, with the intimate connection being expressed as one: 'power/knowledge' (Foucault, 2001). Through the schooling and internalisation of the various discourses described in the category *'Weaving the Veil'*, participants came to view their role as psychiatric nurses through a particular knowledge lens. Firstly, they came to view expert biomedical knowledge of mental illness as holding greater truth, and being higher in the hierarchy, than knowledge accrued by clients through their experiences. Secondly, in the absence of alternative discourses that might have challenged the dominant psychiatric discourse, participants came to view their role as being responsible for others, as opposed to responsible to self and others. Thirdly, through their experience of an educational system (classroom and practice) that minimised the sexual needs and sexual rights of clients, participants became socialised into particular ways of thinking and behaving. In a similar manner to the way participants disciplined and controlled clients, they also disciplined and controlled their own and others' actions. Through self-monitoring and scrutiny of each others' practices, in a circular manner they socialised the next generation of nurses into conformity, or compliant 'docile bodies'; thus, perpetuating the *'veiling'* and *'re-veiling'* strategies and allegiance to the organisation as opposed to the clients (Foucault, 1976).

When viewed through a Foucauldian lens, the findings of this study challenge much of the rhetoric, which suggested that nurses were in the best position to advocate on behalf of clients (Mallik, 1997). They also shed light on Pol's (2003) assertion that it is difficult for nurses to act to improve client autonomy, as to do so puts them in opposition to themselves and the system of which they are part. To act against a system, first requires that one has an objection to that system. Given the manner in which the participants in this study were socialised and their identities as psychiatric nurses constructed, it is understandable why participants aligned themselves with

and became agents of the system. In the absence of a space to think aloud and reveal, to themselves or others, their assumptions about sexuality and the sexuality of clients, participants were not consciously aware of their assumptions and how these assumptions were impacting on their practice. Neither were they consciously aware of the manner in which they were complying with the requirements and imperatives of the organisation, as opposed to acting with and on behalf of clients. Indeed, a parallel could be drawn between the participants in this study and Inglis' (1998a) hypothesis of Irish mothers. As discussed (chapter six), Inglis suggested that in the absence of social or economic capital, until recently, the Irish mother aligned herself with the Catholic Church, in an attempt to acquire status (Inglis, 1998a). Similarly, it could be said that in the absence of professional capital, in an attempt to achieve position and status within the community of mental health work, participants unconsciously aligned themselves with the powerful psychiatric institution.

'Veiling Sexualities': An institutionalisation of the heterosexual norm

The dominance or institutionalisation of heterosexuality as the desired social norm has been commented on frequently within the literature (Wilton, 2000; Hyde et al., 2004; Beasley, 2005). Wilton (2000) suggested that the normalising of heterosexuality as the desired social norm has the effect of calling into question all other sexual behaviour, as sexual behaviour that does not conform to that norm is considered deviant. The participants in this study did not exist in isolation and were not immune to the heterosexual norm held within Irish society. Although the participants did not express overt negative attitudes towards lesbian/gay/bisexual or transsexual people (LGBT), the theory of *'Veiling Sexualities'* raises questions around how participants unknowingly brought heterosexist attitudes into their encounters with clients.

The institutionalisation of heterosexuality was reflected within the participants' practice in a number of ways. Firstly, the participants' questioning style showed a tendency to work from a heterosexist norm, with questions biased towards heterosexual relationships. The dominance of heterosexuality, as normative sexuality, was also reflected in the participants' concern with 'illicit' heterosexual

relationships, and their concern with protecting women from pregnancy. The entire focus of the *'protective surveillance'* was based on biological difference, with little conscious awareness or discussion on the need to protect clients from making poor decisions around same sex relationships or the risk to clients of sexual violence from people of the same sex. As sexual relationships appeared to be constructed in terms of the traditional heterosexual relationships, organisational rules emphasised limiting the opportunities for members of the opposite sex to be together unobserved, and prohibiting clients from entering rooms of the opposite sex. Yet these same rules allowed complete freedom to people of the same sex.

The institutionalisation of heterosexuality and the heterosexist assumption adopted by the participants has the potential to reinforce the invisibility of LGBT people within society and more specifically within the mental health service. Consequently, if alternative sexualities are to be heard, people must struggle to reveal themselves in a culture that, in some ways, is unaware of their existence. There is also the possibility that the heterosexism or subtle neglect of LGBT issues (Wilton, 2000), forced clients to lie about their sexuality for fear of negative, insensitive, discriminatory responses (Golding, 1997; McFarlane, 1998; King and McKeown, 2003).

The automatic assumption of heterosexuality no doubt reflected the dominant belief system within Irish society, where LGBT relationships have, until recently, been ignored, silenced and/or criminalised[34] (Inglis, 1998a). It also reflected participant socialisation into psychiatric nursing education where the sexualities of LGBT people were not discussed, except within a medical/pathological discourse. Consequently, in the absence of other discourses on LGBT issues within professional education, participants tended to construct LGBT sexualities as

[34] Homosexual acts between consenting adults, of 17 years or more, was not decriminalised until 1993. Upon Ireland's entry to the European Union in 1973, the state was bound by the EU Convention on the Protection of Human Rights and Freedoms (1950). This allowed Senator David Norris, a rights campaigner and member of the Oireachtas (Irish parliament), to take a case in the European Court of Human Rights on the grounds that the various Irish anti-homosexual laws were an infringement against his right to privacy which was guaranteed under section 8:1 of the EU convention. Senator Norris won this case in 1988 and in so doing forced the Irish Government to introduce the Criminal Law (Sexual Offences) Act (1993) and remove the existing laws that were criminalising homosexuality.

uncomfortable subjects that were outside their expertise, and reported unwillingness to engage with issues surrounding LGBT sexualities.

'Veiling Sexualities': A reproduction of masculine and feminine gendered stereotypes

Although I did not commence the data collection or analysis with a gendered lens, issues in relation to the construction of gender stereotypes which participants did not consider as problematic, emerged during the course of the interviews. By adopting gendered stereotypes, participants not only, reproduced and perpetuated these gender stereotypes within professional practice, but also created many blind spots in their approach to care which require further discussion.

Understandings of masculinity and femininity are 'cultural scripts' that associate men and women with different attributes (Miers, 2002:71). Within wider society, these scripts consider men to be more rational, sexually active, less emotional and the person who initiates a sexual relationship (Showalter, 1985). Women, in contrast, are constructed as Madonna type figures: pure, sexually passive, emotional, nurturing and responsive to the male agenda (Showalter, 1985; Chesler, 2005). In relation to this study there appeared to be a combination of conforming to the gender norms present in wider society, and a reversing of gender norms.

The trend of reversing gender norms was reflected in the way clients were considered to move on the passive/active sexual continuum, when mentally unwell. Women moved from being sexually passive to active and men from sexually active to passive. Women were considered to be more sexually promiscuous, predatory, and more willing actively to seek out a sexual partner and to solicit sexual intercourse without discrimination. Men, in contrast, when 'ill' were constructed as sexually passive, as they were considered to isolate themselves and to be more withdrawn. This phenomenon of reversing gender norms and constructing women as the 'temptresses' has been reported elsewhere. Mental health professionals, in Krumm et al's (2006) focused group study, in Germany, tended to describe female clients as more active, sexually aggressive and externally orientated. Male clients, in contrast, were described as passive, quiet, modest or isolated. A literature search,

for a possible reason for this perceived change in women's sexual behaviour and gender roles, did not provide an answer. In the few studies that explored gender differences in sexual risk behaviour among people with mental health problems, men reported higher incidences of multiple sexual partners than women (Kelly et al., 1992; Menon and Pomerantz, 1997), with the exception of Kalichman et al's (1994) study where rates were approximately the same. Research evidence, therefore, does not appear to substantiate, or provide an explanation, for participants' perception that women become more sexually promiscuous and predatory when mentally unwell.

A possible reason for the reversing of gender norms within a mental health context may be found in feminist literature. Over the years, a number of feminists have critiqued psychiatric care in relation to female clients (Showalter, 1985; Busfield, 1996; Chesler, 2005). From a historical point of view these feminist writers argued that, within a patriarchal society, women who revolted against the traditional modernist view of femininity, which portrayed women as passive, dependent and maternal, were at a greater risk of being labelled as mentally ill and admitted to a psychiatric hospital. Once admitted to a psychiatric institution, women were subjected to much more surveillance and control than men. Following this line of argument, therefore, it is reasonable to suggest that participants' perception of women being more 'sexually promiscuous' is linked to a societal gender expectation that viewed women as sexually passive and men as more sexually active. Within the confines of the mental health service, women's behaviour was subjected to an increased protective surveillance and policing; consequently, any deviation from the 'expected' norm of being sexually passive, responsive to male sexuality and focused on long-term mating patterns became instantly visible. Thus, once women 'acted out' behaviour that did not conform to this gendered stereotype, they were labeled deviant, disturbed or promiscuous, as they were not conforming to the gendered stereotype. In contrast, sexual behaviour by men, which was not subjected to the same degree of surveillance, remained professionally unnoticed and considered a normal part of the landscape of male sexuality. In other words, in keeping with the biological essentialist view of male sexuality, men by 'nature' are always interested in sex. Indeed, the classic study by Broverman et al. (1970) illustrated how dominant notions of masculinity and femininity were internalised by

mental health professionals and formed part of the diagnostic framework. In a more recent study among psychologists, Crosby and Spock (2004) demonstrated that when behaviours (or 'symptoms') were inconsistent with the person's gender and the corresponding feminine or masculine sex-role stereotype, behaviours were deemed pathological. Crabtree's (2004) ethnographic study in Malaysia also found that suspicion of sexual promiscuity in women commonly led to forced admission to psychiatric hospital, as sexual promiscuity in women was seen as a revealing sign of mental illness.

The protection of all clients is part of the nurse's role, but the surveillance and policing of women was greater than men and based on entirely different criteria. This served to perpetuate the gendered stereotypes of women as vulnerable, irrational, emotional and in need of protection from themselves. Women who deviated from the passive sexual stereotype and initiated a sexual relationship were considered mentally unwell and by definition incapable of making good decisions; hence, they needed protection from themselves and from the professionals' fear of pregnancy. Engaging in a sexual relationship was also considered to have greater emotional significance for women; this had resonance with the evolutionary theories that viewed women as having evolved to be more emotional because of their need to engage in long-term mating patterns and the mothering nurturing role (Symons, 1979; Buss, 1998). Thus, in a circular manner, participants used the professional discourse of 'care and protection' to support the discourse of greater control, restrictions and surveillance on women, supporting some writers' assertions that the sexuality of women clients has long been seen as a commodity to be controlled by mental health staff (Showalter, 1985; Busfield, 1996; Crabtree, 2004).

In contrast to the protective surveillance afforded to women, participants appeared to minimise the need to protect male clients, as they were seen as better able to protect themselves, thus reinforcing the gendered idea that men can look after themselves. This view of masculinity may have left many men unsupported and shameful of seeking help for negative sexual experiences. These gendered views of protection, which emphasise the need to protect women, also give weight to Mendel's (1995) assertion that the helping professions have moved from being

blind to sexual violence to having a one-eyed, gendered, biased perspective of sexual violence.

Paradoxically, when participants spoke of the difference between male and female clients in the reporting of iatrogenic sexual dysfunction, they tended to conform to the gendered norms of wider society. The participants' comments were reflective of modernist theories of sexuality that emphasised the essentialist notion of men needing sex, and perpetuated a sexist image of women as being closer to nature and reproduction than men and lacking in a discourse of desire (Stainton-Rogers and Stainton-Rogers, 2001). In this context, female clients were constructed as sexually passive and concerned with their 'biologically given' parenting and homemaker role. In keeping with this sexually passive view, women were considered to be more willing to forfeit sexual pleasure, as by 'nature' they were less concerned than men with sexual desire and sexual arousal. Men, in contrast, were always (by 'nature') interested and focused on sexual gratification, with the erect penis being viewed as the primary focus of male sexual expression. The emphasis on biological gender difference is also reflected in Freud's theory of sexuality, where primacy is given to male sexuality and the importance of the male sex drive (Appignanesi and Forrester, 1992).

Although participants may have neither agreed nor disagreed with these stereotypes, they were complicit in the reconstruction of societal norms of masculinity and femininity. They were also complicit in reproducing the professional discourse that pathologised women's sexuality. By rationalising women's non-reporting of iatrogenic sexual dysfunction as due to their lack of concern about sexual pleasure, and the subsequent pathologising of the few women who did complain of sexual dysfunction, participants recreated and sustained the discourses that positioned women as sexually passive and treated women's interest in sexual pleasure as pathological. When participants hung the protective *'veil'* over women, they simultaneously reproduced, rendered legitimate and sustained the institutional arrangement whereby women's sexuality was subjected to increased surveillance and control, and where men were considered safe from sexual victimisation. The polarisation of vulnerability based on gender served to keep the world view of male and female sexuality intact and reproduced the traditional view of male sexuality as

'active', whereas women are passive and victims. The emphasis on the emotional context of sexual relationships for women, and the lack of attention to the emotional impact of negative or failed sexual relationships on men's mental health, reinforced the gendered stereotype that men are not concerned with the emotional significance of sexual relationships and are only concerned with physical pleasure.

Similarly, the view that men are able to defend themselves, not only reinforced the traditional views of masculinity (strong, macho), but may have contributed to the isolation and distress of men who have been sexually abused. The assumption of men's ability to protect themselves may heighten men's feelings of guilt, shame and belief that they were in some way personally responsible for the assault (Rentoul and Appleboom, 1997). The belief that women contributed to sexual assaults or rape has been refuted (Beasley, 2005); however, the view that male clients are able to protect themselves could, if left unchallenged, result in a similar blaming of men for a personal lack of judgment.

The concern over protecting women is reflected in the current debate on gender sensitive care, and single versus mixed sex wards (Kohen, 1999; 2001; Department of Health (UK), 2002; The Women's Health Council, 2005; Krumm et al., 2006). In the ongoing debate about the advantages and disadvantages of mixed sex accommodation versus segregation, Krumm et al. (2006) suggested that two opposing paradigms could be distinguished. Mixed sex wards are seen as favourable to the well-being of clients and in keeping with the principles of normalisation. On the other hand, the protection paradigm views separation and segregation as a way of protecting vulnerable female clients. Following both the normalisation and protection paradigms creates a dilemma for staff; therefore, some people are currently advocating segregation as the solution (Kohen, 1999; 2001). Without undermining the need to protect all clients from sexual coercion and assault, it is questionable whether gender-specific needs can be addressed by single sex wards or women-only rooms. Providing a gender sensitive service is more complex than simple segregation, as gender needs are much more multifaceted and are part of all aspects of care (The Women's Health Council, 2005). In the context of this study, it appeared that gendered sensitive care was compromised due to participants working from gender-based stereotypes.

The influence of participants' primary, secondary and professional socialisation, where the *'veil'* (emphasising the sexual passivity of women and the predatory nature of men) was unknowingly woven, may account for these sexist stereotypes. It is also likely that the stereotypes have been enabled further by nurse education, in its failure to introduce alternative discourses such as feminist or queer theory that might have deconstructed the sexists' assumptions and the taken for granted categories that were part of society and the folklore of psychiatric nursing.

'Veiling Sexualities': A strategy for personal and professional protection

Throughout the theory, a dominant theme that emerged, albeit at a subconscious level, was the need for participants to protect themselves from personal and professional exposure and project the image of competent professional to both the clients and others. This need appeared to arise from a position that constituted clients' sexuality as being both a risk (danger) and at risk (vulnerable). The theory suggested that in an attempt to feel safe and prevent sexuality encroaching into the nurse-client relationship, participants enacted a number of *'veiling'* and *'re-veiling'* strategies. The idea of developing and using strategies for self-protection is not new. Reference has been made to self-protection within sociology (Goffman, 1959), psychology (Festinger, 1957) and nursing (Menzies, 1970; Lawler, 1991; Evans, 2002; Inoue et al., 2006). This section will discuss the theory developed in the context of this literature.

The *'veiling'* and *'re-veiling'* strategies used by the participants could be likened to Menzies' (1970) defensive techniques, and Goffman's (1959) impression management strategies. Menzies (1970), in what is considered a seminal piece of work, proposed that nurses develop defensive techniques, to survive within health care organisations. She argued that where human connectedness towards caring is difficult, and when nurses lack organisational support to care in deeply personal ways, they attempt to 'externalise and give substance in objective reality to their characteristic psychic defense mechanisms' (Menzies, 1970:47). In other words they develop, at an unconscious level, defensive techniques to avoid or minimise personal anxiety, through collusive interaction and agreement with members of the

organisation. In the context of this study, engaging with clients in an open and emotionally connected manner on the subject of sexuality appeared too challenging for participants. Therefore, in the absence of a perceived competence in this area of practice, participants learned, through interaction with psychiatric colleagues, 'defensive techniques' to survive within the practice environment (Menzies, 1970). By using these techniques, participants drew a protective veil around themselves which enabled them to negotiate difficult social contexts, maintain orderly interaction and manage their personal and professional fears in relation to the subject of sexuality.

In line with Goffman's grand theory on dramaturgical self-presentation and performance, the strategies used by the participants could also be considered an attempt to project and sustain an image of competent professionalism before clients (Goffman, 1959). Goffman (1959) suggested that people attempt to project a desired image of the self, by managing the impressions other people formulate. In other words, to protect and project a particular image of the self, people learn, through socialisation, a series of performances that are considered socially appropriate. Therefore, it is proposed, in the absence of communicative competence around sexuality, participants were reluctant to lift the veil and live on the edge of not knowing, as this increased the risk of presenting the self in a manner that did not accord with expectations of what constituted a 'competent practitioner'. Participants perceived that should they get the interaction wrong, they carried, at best, the risk of engendering personal or client embarrassment and, at worst, they risked upsetting the nurse-client relationship and, consequently, other members of the team. Therefore, in an effort to reduce the risk of social disapproval or negative evaluation from clients and other professionals, participants used the *'veiling'* and *'re-veiling'* strategies as 'impression management' strategies (Goffman, 1959). By using these strategies, participants were able to continue to project an image of themselves as competent professionals and go about their daily work without risking exposure of their vulnerability, lack of knowledge or confidence, or being seen as incompetent.

The *'mythical self talk'* used by the participants could also be considered an impression management strategy. As suggested in the previous chapter, the *'veiling'* and *'re-veiling'* strategies were developed to the level of 'skilled incompetence',

which gave rise to a 'skilled unawareness' among participants (Argyris, 1999:57-58). In other words, the strategies were used in an unconscious, reactive manner; however, as the participants began, through the research interview, to develop a conscious awareness of their actions, they engaged in '*mythical self talk*' or a series of rationalisations to explain their behaviour. Festinger (1957) postulated that when individuals are presented with evidence contrary to their world view or contrary to the way they behave, they experience 'cognitive dissonance' or an 'unpleasant state of tension'. According to Festinger, individuals will try to relieve this dissonance or tension in one of two ways: by increasing the number of consistent cognitions through rationalisation, thereby abating the dissonance; or by changing their attitudes or behaviour, thus excising the inconsistent belief or action from their world view (Festinger, 1957). In the courses of the interviews, participants' espoused beliefs in mental distress as a 'problem in living' and verbally advocated holistic client-centred care underpinned by the principals of right to sexual expression, informed consent and partnership in decision making; however, their behaviour suggested they were working from a different theory in practice. Therefore, it is suggested that as the participants began to recognise the dichotomy between their espoused theory and their actions, they experienced a state of tension or anxiety. To relieve this tension, and protect themselves, they attempted to increase the number of consistent cognitions and resolve their anxiety through the *'mythical self talk'*. By so doing they were also projecting an image of the self as a caring professional, who only deviated, in the best interest of the client, from their espoused theory.

Lawler's (1991) ethnographic study, in Australia, highlighted the ways in which general nurses managed their embarrassment and negotiated the socially delicate aspects of invading bodily space when caring for the physical body by developing what she called rules and contextors. To confer a protective and private social atmosphere on the situation, nurses created a system of rules to which they expected clients to conform. The rules included the 'compliance rule', 'the dependency rule' 'the modesty rule' and 'the protection rule'. In effect, patients were 'expected to let the nurses have control and comply with the nurses' requests, to be appropriately modest, and for their part, nurses acknowledged a need for protection of patients' (Lawler, 1991:148). To ensure adherence to these rules and structure situations as

nursing practice, nurses used a number of 'contextors' (Lawler, 1991:151). These consisted of the wearing of a uniform, the adoption of a professional matter-of-fact manner, minimising the size severity of an event or comment, asking relatives and visitors to leave, and discourse privatisations. Similar to the participants in this study, these rules and contextors were not formally taught but learnt through socialisation and personal experience in nursing.

Evans (2002), in a qualitative descriptive study of male nurses working in a variety of Canadian health care settings, identified six strategies used by participants to protect themselves from being wrongfully accused of 'inappropriate touch' by female clients. These included: taking time to build trust, maintaining formality, wearing a white uniform, working in teams with female colleagues, delegating intimate care to a female colleague, and modifying procedures to minimise client exposure (Evans, 2002:444). In addition to transferring care to a female staff member and using a chaperone, Inoue et al. (2006), in a similar study, described how Australian male nurses also used the suppression of personal feelings, the focusing on care as a procedure, humour, and leaving curtains open to protect themselves when providing intimate physical care to women. In studies that explored strategies used to respond to sexual harassment, Dan et al. (1995) found that female nurses in the US most commonly responded by physically avoiding the person or ignoring verbal comments. Similarly, passive strategies of ignoring the behaviour and leaving the scene were reported by Bronner et al.(2003), in their survey of nurses in Israel.

In the one study that specifically addressed sexual issues, Roach (2004) developed a grounded theory of how nursing home staff, in Australia and Sweden, dealt with the affectionate and sexual behaviour of residents. Using a core category conceptualised as 'Guarding Discomfort', Roach described how participants either opposed or facilitated residents' sexual expression (Roach, 2004:375). Participants who opposed sexual expression 'stood guard' against experiencing personal discomfort by restricting and controlling sexual expression through the use of strategies such as: moving, threatening and punishing residents. Participants who acted in this manner justified their actions on moral, religious and cultural grounds. Participants who facilitated sexual expression 'guarded the guards' to ensure that

they did not succeed. Through 'proactive protection', which involved educating staff, residents, and families, along with the development of policies and the provision of privacy, staff in this category promoted sexual expression among residents (Roach, 2004:377). Roach suggested that nursing homes in Sweden fitted the more permissive end of the continuum, promoting sexual expression among the residents.

All of these studies reported the uses of some of the behavioural strategies identified by the participants in this study. However, many of the interactional strategies described in the theory of *'Veiling Sexualities'* have not been explicated previously within the literature. Neither have the strategies, identified within the theory, been integrated into a substantive theory about nursing and sexuality and more specifically about psychiatric nursing and sexuality. This may be due to previous studies either focusing on strategies used in the provision of physically intimate care, or on the narrow focus of sexual harassment. Consequently, these studies did not illuminate the provision of emotionally focused care around sexual issues which can be equally intimate. Therefore, I propose that the theory of *'Veiling Sexualities'* not only builds on previous studies but adds to the body of literature in nursing and psychiatric nursing by providing a more focused and comprehensive insight into the behavioural and interactional strategies used by psychiatric nurses to manage the perceived sensitive and intimate subject of sexuality. In addition, this study has provided new challenges and insights into the multifaceted nature of protection and the intricate and complex interrelationships between the strategies used for personal and professional protection and participants' experience of various sexual discourses.

'Veiling Sexualities': A 'lack' of education or a critical relationship to particular discourses

A number of studies have identified the 'lack' or 'absence' of education on sexuality as a key contributor to nurses' difficulties in talking to clients about sexual issues. In studies that explored aspects of educational preparation of nurses in relation to sexuality, there was widespread dissatisfaction among nurses with the educational preparation received. The vast majority of nurses stated that they lacked

or did not receive education in this area of practice (Conine et al., 1980; Shuman and Bohachick, 1987; Matocha and Waterhouse, 1993; Long, 1998). As an outcome of this survey type research, authors made a linear cause-effect relationship between the 'absence' of education and participants' reported reluctance to talk to clients about sexual concerns. Consequently, based on this relationship, they made a recommendation for the inclusion of sexuality within the formal curricula. In so doing, these researchers took an uncritical and narrow view of education, ignoring the impact of the various discourses on sexuality that nurses are exposed to through sources such as family, church and the informal curriculum within nursing. These researchers also tended to position nurses as passive agents in the education process, taking no account of how nurses co-create discourses within practice and, consequently, sustain poor practices in relation to sexuality. Not discounting the importance of this research or the relevance of the recommendation to include sexuality with curricula, the theory *'Veiling Sexualities'* suggests that issues are a little more complex and circular. The theory, firstly, challenges the simplicity of the 'lack of' or 'absence of' education hypothesis and secondly it challenges the passivity of nurses in the education process.

An analysis of participants' accounts in this study suggested that the difficulty could best be described as 'absence/presence'. It was both the presence and exposure to certain carefully crafted and constructed discourses, and the absence of others, that was the issue. By privileging discourses within the biological, medical and theological paradigm, the *status quo* was maintained and other discourses, which could have provided an alternative view, were subjugated and marginalised. For example, in the process of becoming a 'psychiatric nurse' the participants in this study followed the various discourses of sexuality that were taught to them formally and informally through family, school, church and nurse education. Consequently, they came to view sexuality as sex shrouded in shame, and the sexuality of clients as either not relevant to their care, or as illness or deviance that needed to be contained or controlled. The fact that these views were often unconscious attests to the power and dominance of these discourses within Irish society and the psychiatric profession.

The privileging of biological and medical discourses within the nursing curriculum is partially a reflection of the manner in which religious and nursing discourses were interlinked, formally, within church-controlled hospitals, and informally in many state-run hospitals. In discussing the interrelationship between nursing schools and the Catholic Church, Robins (2000) noted the discussions that took place in 1955 and 1956 between An Bord Altranais and the Catholic hierarchy, over the content of the ethics and psychology lectures provided for nurses. Although some members of An Bord Altranais were angered by the interference of the 'ecclesiastical authorities', they eventually acquiesced to the views of the hierarchy and agreed, firstly, with the draft syllabus for the teaching of ethics and psychology submitted by Monsignor Horan (Robins, 2000:34). They also agreed that lecturers in the subjects would be appointed by each hospital, only after approval by the local bishop and thirdly, that An Bord Altranais would not carry out an examination in either ethics or psychology. It was not until the 1985 Nurses Act (Government of Ireland, 1985) that An Bord Altranais was finally permitted to provide guidance to the nursing profession in all matters relating to ethical conduct and behaviour (Robins, 2000). Despite this, until the transfer of nursing into the higher education sector in 2002, the practice of employing a priest, approved by the local bishop to teach ethics, did not change in many hospitals. By restricting the type of discourse on sex, within the curriculum, the Catholic Church no doubt played a part in nurse educators reproducing the dominant values within Irish society.

The indirect influence of the church may also account for the tardiness of An Bord Altranais in responding to the World Health Organisation's (WHO) statement about the need to educate health care professionals in the area of sexuality. Although the WHO identified the need for education as far back as 1975 (World Health Organisation, 1975), notably, the word 'sexuality' did not appear in the syllabus for the education and training of psychiatric nurses until 1986 (An Bord Altranais, 1986). However, the term 'sexuality' was omitted from the psychiatric nursing section in the subsequent Requirements and Standards for Nurse Registration and Education of programmes for psychiatric nurses (An Bord Altranais, 2000b; 2005), although it does remain a requirement for learning disability nursing (An Bord Altranais, 2000b; 2005). In view of this, it appears that the governing body for

psychiatric nurse education is also complicit in perpetuating the view that people with mental health problems are 'other' and asexual.

Previous research into education also tended to position nurses as passive agents in the education process, as if nurses themselves were simply devoid of agency and were 'acted upon' by education, or in the case of sexuality, 'not acted upon'. The findings from this study suggest that, far from being passive agents, participants were complicit in the construction and reconstruction of behaviour and discourses within practice which maintained and perpetuated ways of thinking and behaving in relation to sexuality. Gadamer (1994) suggested that, although we are all captured in tradition, and cannot make ourselves free, we can act critically, by reflecting on things taken for granted, including 'prejudices'. The apparent absence of reflexivity in relation to self, relationships, values and theories resulted in participants accepting unquestioningly their prejudiced view of sexuality and actions in relation to clients. It also resulted in participants failing to see the degree to which they were complicit in the construction and reconstruction of behaviour, and the discourses that maintained and perpetuated the veiling behaviours. Neither were they conscious of the possible negative consequences their actions had on clients. In so doing, not only did the participants maintain their own views and behaviour intact, but in a circular manner they perpetuated these behaviours, views and discourses though the socialisation of novice nurses.

One of the most surprising findings of this study is the apparent lack of impact, on psychiatric nursing, of the radical modernisation process that has occurred in the rest of Irish society in relation to sexuality, in the past 10-15 years. This modernisation process is reflected in the fall in devotional and religious practices[35], the increased number of births outside marriage[36], the falling figures for religious vocations, the deregulation of contraception, the decriminalising of homosexual acts, and the legalising of divorce. Modernisation is also evident in the perceived openness around discussing sexual matters; it is now commonplace to hear, read

[35] National surveys show that the number of people attending church, receiving Holy Communion, and confessing their sins are declining (Mac Greil, 1991; Hornsby-Smith &Whelan, 1994).

[36] By the end of the twentieth century the number of births outside marriage had risen from 2.6% of all births in the Republic in 1970, to 22.5% in 1995 and 31% in 1999. Significantly, a large number of these births are to cohabiting couples who have chosen parenthood but not marriage (Rundle et al., 2004).

and see sexual matters discussed in the mass media (Murphy-Lawless et al., 2005). Messages within soap operas on television, advertisements, music and magazines, many of which come from outside Ireland, advocate an alternative discourse to the emphasis on sin, shame and embarrassment. As a result of this free discussion, previously prohibited topics are increasingly tolerated and a more open discourse has commenced, emphasising and legitimatising self expression, eroticism, desire, pleasure, and sexual fulfilment (Hornsby-Smith and Whelan, 1994). Each day new debates emerge in relation to sexuality, such as the sexual rights of people with disability, marriage of gay couples, and the artificial insemination of lesbian women. While one may be tempted to believe that these changes would be reflected in attitudes towards the sexuality of people who experience mental health problems, the theory on *'Veiling Sexualities'* suggests otherwise. The open and more radical approach to the discussion of sexuality evident in liberal Irish society does not appear to be paralleled in nurse education or professional practice, suggesting that the culture of psychiatry and psychiatric nursing has remained a somewhat closed system, immune to the wider changes happening in Irish society.

Summary and conclusion

Within this chapter I discussed the theory of *'Veiling Sexualities'* in relation to a wider body of literature. Although some research had been carried out to explore the difficulties experienced by nurses in addressing sexuality issues with clients, this was the first study to bring together the different elements of psychiatric nurses' practice in relation to sexuality and conceptualise how each element was connected and related. Writing this chapter presented two major challenges: firstly, to move beyond a dualist position that located the strategies used by the participants as either good or bad, to a position that located strategies within a context. It would have been easy to position the issues raised by the findings of this study at the level of the individual nurse. However, to do this would have ignored the wider contextual factors that influence and have influenced the participants and psychiatric nursing in Ireland. My second challenge was to present a critical commentary on the strategies identified that was discomforting rather than destructive, while at the same time not paralleling the participants' protection of the self.

The discussion focused on key issues that embraced all the categories and, also, issues that had significant implications for the practice of psychiatric nursing and nursing education such as: therapeutic relationships, the biomedical narrative, power, heterosexism, gender, protection and education. Within the discussion, attention focused on the dissonance between the ideals underpinning therapeutic relationships and the reality of practice as described by the participants. It appeared that in relation to sexuality, participants were reluctant to move away from a detached, objective observer stance that centred on controlling interactions and client behaviour to a collaborative model of engagement and dialogue. The findings also suggested that despite the recent governmental policy directives towards stronger collaboration and increased service user involvement, the prevailing psychiatric nursing culture of practice and education appears to be steeped in a discourse of treatment and care, control and compliance and professional expertise. This critique of the participants' allegiance to the psychiatric medical discourse was not meant to suggest that one had to adopt an oppositional choice between discourses, but to highlight the manner in which the psychiatric medical discourse that underpinned participants' *'veiling'* and *'re-veiling'* strategies, stripped away and submerged the possibility of other discourses coming to the fore.

Discussion also focused on how the theory of *'Veiling Sexualities'* was related to Foucault's theory of power. In this context, it was suggested that the participants did not simply exercise control over clients' sexuality in a linear, hierarchical manner, but that they themselves were subjects of 'bio-power', having been written on by various institutions and discourses. Neither were clients passive agents in the process. By *'Lifting the Veil'* and revealing themselves as sexual beings, clients attempted to undo the discursive practices of the professionals which desexualised them, and to create a counterforce or counter-reaction to the construction of them as asexual, docile bodies. The discussion also highlighted the manner in which participants recreated a heterosexual bias and were complicit in the construction of gender stereotypes within practice. Consequently, many blind spots were created in the participants' approach to care.

The penultimate section in the chapter explored the relationship between the theory and literature on personal and professional protection. The *'veiling'* and *'re-veiling'* strategies used by the participants were linked to studies and theories in the area of nursing, psychology and sociology. Although some similarities were found between the strategies used by the participants in this study and previous research, it was suggested that many of the communication or interactional protection behaviours described in the theory of *'Veiling Sexualities'* had not been previously explicated within the literature; neither had they been integrated into a substantive theory about psychiatric nursing and sexuality.

The theory was also positioned in the context of previous literature on education and sexuality. It was suggested that the theory, firstly, challenged the previous 'deficit hypothesis', dominant within the literature on education. It was suggested that an 'absence/presence' was more reflective of the difficulties within education. In other words, it was both the presence of certain carefully crafted and constructed discourses, and the absence of others, that was the issue. It was also suggested that, far from being passive agents in the educational process, participants were actively involved in constructing practices and discourses that kept the sexuality of clients *'veiled,'* thus forming and shaping the next generation of nurses to behave in similar ways.

Finally, we must return to the question of whether or not the research has fulfilled its aim. The aim of this study was to develop a substantive theory of how psychiatric nurses respond to issues of sexuality in a clinical practice context. The theory *'Veiling Sexualities'* does answer this question and offers some insights into the strategies that psychiatric nurses used to address issues of sexuality in practice, albeit in an Irish context and in one service. The theory questions the often held assumption that psychiatric nurses respond to clients' sexuality by inaction, in other words 'do nothing'. In questioning this assumption, the theory *'Veiling Sexualities'* shook loose those practices used by nurses that have become naturalised, taken for granted and previously hidden. It also shone some light on the process of thinking that motivated participants to use the *'veiling'* and *'re-veiling'* strategies as well as the processes that created a need for participants to behave in the manner they did, and the processes that perpetuated and maintained the veiling behaviours intact.

This study, therefore, makes a unique theoretical contribution, because it is the first time a theory has been developed accounting for how psychiatric nurses respond to issues of sexuality in a clinical practice context.

The next, and final chapter in the thesis, will address the limitations of the study, identify recommendations and consider issues of trustworthiness.

CHAPTER ELEVEN: LIMITATIONS, IMPLICATIONS AND TRUSTWORTHINESS OF THE STUDY

Introduction

This chapter, the final chapter in the thesis, firstly identifies the limitations of the study. This is followed by a discussion of the implications of the theory of *'Veiling Sexualities'* for education, practice, management and research. Using Glaser's (1998:17) criteria of fit, relevance, workability and modifiability, the chapter then concludes with a discussion of the trustworthiness of the study.

Contextual issues

While the theory of *'Veiling Sexualities'* makes overt the participants' latent pattern of behaviour, the implications and recommendations need to be read in the context of the following contextual issues.

- The study focused on psychiatric nurses; hence the theory generated is limited to psychiatric nurses working in a mental health service.

- The study took a retrospective view of the participants' accounts and relied on recollection of actual practice. Therefore, in the context of remembering incidents from practice, participants may have been influenced by recall bias.

- The findings are reported behaviours and, in the absence of direct observation of participants in practice, it is possible that the participants behaved differently in the real world of practice, or indeed that their accounts of the way clients behave are also different in reality.

- The study is confined to participants working in one service; therefore, it is possible that the actions reported and the theory generated are a reflection of the culture of that service and do not have application or fit for nurses working in other services within Ireland or mental health nurses working in

other cultures. However, some of the findings are reflected in other studies undertaken outside Ireland and the large number of participants who worked in other services prior to coming to the research site did not report any differences in their behaviour.

- The findings are the result of one narrative that arose from a particular view of sexuality and the sexuality of people experiencing mental distress. Therefore, it is possible that people who have been socialised differently in relation to sexuality and the sexuality of clients behave differently.

- The impact of the researcher on the participants' narratives also needs to be considered, as participants, in an attempt to project themselves in a favourable or unfavourable light, may have been under-critical or over-critical in reporting their behaviour.

- Finally, deciding when theoretical saturation is reached is a matter of personal judgement. Although I considered that my theory was saturated after twenty-seven interviews, there is a possibility that, had I continued with further interviews, I may have encountered a participant with an alternative story to the one described within the theory.

Implications and recommendations

Based on a review of the literature, this is the first study that attempted to explore how psychiatric nurses respond to issues of sexuality within practice. The emergent theory, which was conceptualised as *'Veiling Sexualities'*, has a number of implications for education, practice, management and research. These implications and recommendations for action will be discussed in this section.

Implications and recommendations for education and educators

The findings of this study revealed many important aspects of participants' views in relation to sexuality that have implications for nurse educators at undergraduate and postgraduate level. The findings as presented in the theory *'Veiling Sexualities'*

revealed a complex circular relationship between the sexual discourses participants were exposed to during the formal and informal curricula (classroom and practice) and participants' subsequent actions in practice. The theory suggested that the current deficit hypothesis, dominant within the literature, was insufficient to explain the impact of education on nurses' reluctance to engage proactively with clients on issues around sexuality. Hence, the concept of 'absence/presence' was proposed. In other words, it was the absence of some discourses and the presence of others that was the issue. In addition, the theory highlighted the manner in which nurses are actively involved in the construction and re-construction of nursing practices that keep the sexuality of clients *'veiled'*. The theory also highlighted how the gendered assumptions of the participants resulted in the ideals of a gender sensitive mental health services being compromised. In previous research on sexuality, authors tended to propose strategies that put emphasis on 'up-skilling' of the individual nurse in communication skills, such as questioning and listening skills. Evidence from this study suggested that this simple add-on approach to curriculum development by including more microskills, although important, is limited. Indeed, the findings suggest that this behaviourist approach to the teaching of communication skills will not equip nurses to meet clients at a relational depth or equip them with the knowledge, skills and attitudes necessary to address issues of sexuality in an open, confident and competent manner.

These findings, therefore, challenge educators involved in curriculum development at all levels of psychiatric nursing to rethink the fundamental philosophy that is shaping psychiatric nursing curricula. Educators are not just challenged to develop ways of heightening students' awareness of the need to include sexuality within the horizon of nursing practice, but they are also challenged to develop curricula that are not as foregrounded in the biomedical narrative of illness. In other words, if nurses are to be facilitated to critique the ideological, structural and historical influences that have ignored or pathologised clients' sexuality and develop a more empowering discourse on sexuality and sexual health with clients, educators are challenged to foreground sexuality within nursing curricula at all levels and within all relevant modules and incorporate more critical discourses about 'mental illness', sexuality and recovery. This is not to suggest that the current focus on psychiatric illness or reproductive biology should be discontinued within curricula. However, if

nurses are to move from the current emphasis on paternalistic expertise to a more rights-based, recovery focused model of care, there is a need to foreground other perspectives to balance the current one-lens illness perspective. In the light of the findings, the following recommendations for educators involved in the development and delivery of curricula are put forward.

It is recommended that:

1. Sexuality be actively acknowledged and foregrounded within nursing curricula at all levels and within all relevant modules and that the following issues are included in all courses:
   - More critical social, psychological, political, economic and rights-based discourses that deconstruct and challenge the current emphasis on the psychiatric or disease-oriented discourse on sexuality.
   - An exploration of how gender and gendered behaviour are created and recreated though performance and how gender stereotyping influences nursing practice.
   - An exploration of factors that have shaped people's understanding and behaviour in relation to sexuality and the sexuality of people with mental health problems.
   - Education on the impact of prescribed drugs on sexuality to be included in all sessions on medication.
   - Aspects of the political dimension of drug prescribing and the wider context of the multinational pharmaceutical industry, including discussion on the subtext of compliance and its link with the medical model and pharmaceutical pressures.

2. Educators review curricula to ensure that:
   - The heterosexist norm of society is not mirrored within educational processes and practices.
   - Nurses receive education and training on how to explore and respond to the issue of sexual violence in a competent and compassionate manner.

- Particular attention is given to challenging assumptions that abuse is less relevant to male clients or that asking about abuse may traumatise the person.
- The knowledge, skills and attitudes necessary for nurses to respond in a more therapeutic manner to clients who sexualise the nurse-client encounter are included.

3. Educators review their teaching approaches to ensure that:
   - They move beyond the modernist and behaviourist approach, characterised by the teaching of micro-communication skills, and create educational opportunities for nurses to develop the higher level skills required to move away from the position of objective observer and meet clients at relational depth, such as: creating context for disclosure, asking interesting questions, managing the power differential within relationships, balancing paternalism with advocacy and living with informed uncertainty.
   - In the absence of effective role modelling in practice, teaching strategies are used that provide students with opportunities to practise talking about sexual issues to people of the same and opposite gender.
   - Teaching methodologies are used to firstly, develop nurses' reflexive awareness of the *'veiling'* and *'re-veiling'* strategies they use within practice and secondly, bring to their conscious awareness the counterproductive defensive reasoning underpinning their *'mythical self talk'*.

4. In-service education programmes on sexuality be developed for nurses who are qualified, as not all nurses will pursue postgraduate higher educational programmes.

5. An Bord Altranais include sexuality as one of the criteria for the approval of undergraduate curricula for psychiatric nurses.

Implications and recommendations for management and the culture of organisations

Given the manner in which nurses are formed and shaped within the practice environment, focusing solely on education within the classroom is likely to have

little immediate or long-term impact. Organisations must be developed so that nurses are able to respond to clients without major organisational constraints. In this context, organisation means the culture and philosophy of the service. Managers play an important role in setting the organisational culture and leading change in this area of practice by communicating a clear message of the relevance and importance of clients' sexuality and rights. If the predominant management ethos is one that values the control of clients' sexuality through surveillance and medication as opposed to dialogue, autonomy, participation and education, then a culture that ignores the wider issues in relation to the sexual dimension of the clients' lives is likely to be fostered. Individual practitioners need space to think aloud about the sexual issues that occur in practice. This can be created through the introduction of a model of clinical supervision for nurses whereby staff will be enabled to engage in the self, theoretical and relational reflection necessary to relate with clients in an intimate and therapeutic manner. Clinical supervision will also help offset the likelihood of poor practices becoming habitual or developed to the level of skilled unawareness that was evident in this study. The professional and personal awareness required to respond to clients' sexuality in an open and empowering manner is not a once-off event, but a life-long professional journey; therefore the following recommendations are made for management.

It is recommended that managers:

1. Commence discussions on the subject of sexuality and develop clear multidisciplinary policies and processes for addressing issues of sexuality in a dialogic manner with clients, families and team members.

2. Establish mechanisms for staff to communicate concerns around sexual behaviour in an open manner.

3. Review current policies, practices and processes to ensure that they do not reflect the heterosexist norms of society or that care is not based on sexual stereotypes.

4. Include sexuality as an aspect of audit.

5. Promote in-service education on sexuality and sexually related issues.

6. Create a space for practitioners to think aloud about the sexual issues that occur in practice, through the introduction of a model of clinical supervision for nursing staff.

Implications and recommendations for nurses working in clinical practice

The theory of *'Veiling Sexualities'* has a number of implications for nursing practice. The theory suggests that currently nurses are using, albeit at an unconscious level, a variety of *'veiling'* and *'re-veiling'* strategies to shade over, cover and control clients' sexual expression. Consequently, clients are not receiving optimal care and are left without focused emotional support or education in the area of sexuality. If nurses are to be responsive to the current emphasis on the philosophy of recovery and client involvement in care, there is a need for some fundamental changes in their nursing practice. While acknowledging that without education little will change, the following recommendations are made for nurses working in clinical practice.

It is recommended that nurses:

1. Move away from the current emphasis on medical and illness discourses to explain the person's distress and embrace the clients' lived experiences and personal theories of illness.

2. Genuinely involve clients in a dialogue about their experiences and desires for care, so that care is based on a mutually agreed plan, rather than one-way, authoritative instruction.

3. Work from the premise that clients are competent to make a decision, unless proven otherwise, and respect and support decisions even if in conflict with professional perspectives.

4. Consider the sexual dimension of the person in their nursing assessment and everyday interactions with clients and their families and be more proactive in giving clients permission to talk about sexual issues.

5. Be more proactive in engaging with and asking clients about sexual experiences with a view to providing more focused and appropriate emotional support for clients who have experienced sexual violence.

6. Be more proactive in giving clients information on the side effects of drugs that impact on sexual function, and assess clients' experiences of these side effects.

7. Move away from the current reactive and compliance model of education on prescribed drugs to a rights-based model, where education is given as a basic human right as opposed to supporting a professional agenda of compliance.

8. Commence the process of sexual health education at individual level and group level with clients on issues such as: relationship development, impact of stigma of mental health problems on relationship development, impact of drugs on sexual function and safe sexual practices.

9. Avoid the use of heterosexual language in their interview style.

10. Seek and attend in-service educational programmes on sexuality.

Implications and recommendations for research

Overall, the literature review carried out for this study suggested that there was a dearth of research in the area of sexuality as it relates to clients who experience mental health problems and psychiatric nurses. What was available tended to be localised audits of nursing and medical documentation or survey design studies that included a few questions on sexuality. While this study has commenced the process of research in this important area of nursing practice, the findings suggest a number

of areas in need of future investigation, both from the clients' and psychiatric nurses' perspectives. For example, it was beyond the scope of this study to explore the impact of the *'veiling'* and *'re-veiling'* strategies on clients, or if the gender of the nurse or if a perceived acceptability of sexual dysfunction in one's own life influenced participants' willingness to give clients drugs that impacted negatively on sexual expression. Although the theory of *'Veiling Sexualities'* provides an understanding of the strategies used by nurses to manage their own discomfort, there are a number of issues that require exploration in greater detail; therefore, the following recommendations are made for research.

It is recommended that:

1. A study is undertaken from the clients' perspective to explore the impact of the *'veiling'* and *'re-veiling'* strategies on their experiences of care and recovery – for example, the impact of the *'veiling'* and *'re-veiling'* strategies on: the nurse-client interaction, the clients' willingness to disclose information, the clients' perception of self as a sexual being and the impact of the strategies on clients' overall care experience.

2. In view of the findings and the current plans to provide nurses with prescribing powers, further research is needed to explore nurses' practices in relation to medication management. It is recommended that particular emphasis be placed on exploring the giving of information to clients on side effects that impact on sexuality, the monitoring of these side effects, and the role of visual observation in the assessment of the side effects of drugs.

3. A study be undertaken to explore in greater detail clients' experiences of drug-induced iatrogenic sexual dysfunction and the strategies they use to cope with these effects.

4. Given the incidence of drug-induced iatrogenic sexual dysfunction reported in the literature and the limited number of clients who reported iatrogenic sexual dysfunction to the participants in this study, further studies be undertaken to identify why this is the case.

5. A more focused study, possibly in a questionnaire format, be undertaken to measure if gender or perceived acceptability of sexual dysfunction in one's own life influences willingness to administer drugs and willingness to provide information to clients about iatrogenic sexual dysfunction.

6. Further research be carried out to explore, in greater depth, the issue of sexualised behaviour by clients in a mental health context, with specific emphasis on the meaning of such behaviour from both the nurse and client perspective.

7. A study be undertaken to explore the impact of sexual behaviour on the quality of therapeutic relationships and care given to clients. Research studies are also required to quantify the frequency of sexualised behaviour and identify if there are particular variables associated with sexual behaviour, such as: age, gender, diagnosis, location of behaviour, age of nurse, duration of knowing the client, and ratio of male to female staff on units. Understanding the motivation, rationale and context for sexualised behaviour may lead to more effective strategies for responding to such behaviour within practice.

8. Further research be undertaken to explore, in a more in-depth manner, the differences between male and female nurses' experiences and responses to sexualised behaviour be undertaken, including a more in-depth exploration of the effects of such behaviour on the psychological, social and professional well-being of nurses.

9. In view of the limited research on the experiences of male nurses in relation to sexualised behaviour and the fear expressed by male nurses in this study about an erroneous allegation of sexual inappropriate behaviour, further research into the specific concerns of male nurses needs to be undertaken.

10. In view of the findings that suggest nursing care is influenced by gendered stereotypes, there is a need for further studies to explore gendered stereotyping. Particular emphasis should be placed on exploring the impact

of gendered stereotyping and the care offered to the following clients: clients who have been sexually abused, and clients with a diagnosis of personality disorder, depression, manic depression, or eating disorder, as these diagnoses are frequently associated with gendered assumptions.

11. Given the dearth of knowledge surrounding the experiences of certain groups of peoples of the Irish mental health services, further research be carried out to explore GLBT people and people who have experienced sexual abuse experiences of the mental health services.

12. In addition to the need for research studies in the areas identified, there is potential to build on and develop the substantive theory of *'Veiling Sexualities'* in a number of ways. The theory has the potential to be developed further by theoretically sampling nurses in other psychiatric services and nurses who voluntarily and proactively *'lift the veil'*, such as nurses working in Sexually Transmitted Diseases Clinics, or nurses working as Clinical Nurse Specialists or Advanced Nurse Practitioners in the area of sexual health care. In addition, with further theoretical sampling, the theory could be developed to formal level theory, by exploring how psychiatric nurses and nurses in other branches of nursing *'veil'* and *'un-veil'* other taboo topics, such as suicide and death.

13. Along with the above recommendations, much remains to be learned about the most appropriate and most effective educational strategies for developing competence in this area of practice. Therefore, it is suggested that research also needs to be carried out into the impact of curricular changes on nurses' practice and subsequent outcomes for clients.

The final section of this chapter will explore issues of trustworthiness in relation to the emergent theory *'Veiling Sexualities'*.

Demonstrating trustworthiness of the study

Establishing what counts as rigor or trustworthiness in qualitative research has troubled researchers for the last quarter of a century (Peck and Secker, 1999; Sandelowski and Barroso, 2002; Rolfe, 2006b). Despite all the debate there are many unanswered questions, debatable issues and dichotomies on this matter (Cutcliffe and McKenna, 2004). This section highlights some of these debates and discusses the steps taken in this study to ensure that the theory was arrived at by rigorous methods and thus might be considered trustworthy.

Trustworthiness in qualitative inquiry

In response to what has become termed the 'crisis of representation' (Sandelowski, 2006:10) and the view that all criteria are social constructions (Morse et al., 2002), debates have centred on whether it is possible or even desirable to establish a consensus on criteria for assessing quality in qualitative studies. These debates are entangled within the wider modernist and postmodernist epistemological and ontological discourses and reflect the multitude of terms used. Rigour, standards, criteria, principles, guidelines, quality, goodness and trustworthiness are used interchangeably within the literature with little consensus on their meaning (Emden and Sandelowski, 1999). This vast array of terminology, doubtlessly led Morse et al. (2002) to describe the literature on validity as being muddled to the point of being unrecognisable.

Views on what constitutes criteria for trustworthiness, the qualitative version of rigour, range from positions that reject the notion of criteria altogether, to the identification of criteria specifically for qualitative research, to the retention of concepts drawn from quantitative research (Spencer et al., 2003). Morse et al. (2002) believe that to ignore the criteria of validity and reliability is to reject science, and to cast qualitative research adrift from the scientific community, fostering the notion that qualitative research lacks rigour and, by default, confining it to a form of fictional journalism. Other writers, while agreeing on the need for a grand narrative, are of the opinion that to import criteria developed for another research paradigm is to favour that paradigm. For example, positivism and interpretivism are epistemologically divergent (Leininger, 1994; Lincoln, 1995;

Emden and Sandelowski, 1998; 1999). Consequently, writers have been creative in proposing an array of alternative criteria considered more congruent with the epistemology and aims of interpretative enquiry, such as those in table two.

Table 2. Criteria for judging qualitative research

Credibility Dependability Transferability Confirmability (Lincoln and Guba, 1985; Lincoln, 1995)	Credibility Dependability Transferability Confirmability Ethical authenticity Educative authenticity Catalytic authenticity Tactical authenticity (Sandelowski, 1986; 1993; 2006)	Credibility Fittingness Auditability Confirmability Creativity Artfullness Interpretative validity (Burns and Grove, 1993)	Descriptive vividness Methodological congruence Analytical preciseness Theoretical connectedness Heuristic relevance (Leininger, 1994)	Credibility Confirmability Meaning–in context Recurring patterning Saturation Transferability (Morse et al., 2002)

In a review of the literature, Spencer et al. (2003) located 29 frameworks for the assessment of quality. Many of these build on Lincoln and Guba's (1985) original criteria of credibility, dependability, transferability, confirmability. As an outcome of their work, various techniques have been developed to enhance credibility and diminish threats to trustworthiness, such as: peer debriefing, audit or decision trails, member checking and triangulation (Koch, 1994; Begley, 1996; Cutcliffe and McKenna, 2004; Tobin and Begley, 2004). This method of adding more criteria and strategies is akin to Smith's (1990) open-ended list, where criteria evolve in a dialogic manner, in response to changing conceptions of both science and knowledge development.

By contrast, Heshusius (1990) suggested that if something is good you should 'know' it, and it is a mark of naïvety, regression and a return to positivism to depend on any list of criteria to decide on trustworthiness, as no criterion can be independent of the community that produced it. This view is akin to Sandelowski and Barroso's (2002) and Rolfe's (2006b) arguments against epistemic criteria for evaluation; instead, they advocated that research should be judged against aesthetic and rhetorical considerations, which are revealed in the report itself. Thus Rolfe

(2006b:309) suggested that it behoved the researcher to leave a 'super audit' trail of the actual course of the research, rather than an idealised view of what occurred. This audit trail should recount the rationale underpinning decisions taken and include an ongoing self-critique and self-appraisal. Other authors have stressed the inter-relationship between trustworthiness as an intellectual academic pursuit and an ethical way of being (Emden and Sandelowski, 1998; Davis and Dodd, 2002). To further compound the debate, different criteria have been put forward by Glaser (1978) and Strauss and Corbin (1998) in relation to trustworthiness or rigour within a Grounded Theory study.

Demonstrating trustworthiness in this Grounded Theory inquiry

Although these debates help reveal the contradictions within research reports, they do not, as Parson (1995) suggested, help the researcher decide the criteria to determine the quality of the study, or offer an answer on trustworthiness or rigour. Given the expanding array of criteria and Hammersley and Atkinson's (1995:69) assertion that 'there is no bedrock of truths beyond all doubt, which can be used as the basis for assessment', I took Koch's (1996) advice to select or develop the most appropriate criteria for the study. In this study, I used Glaser's (1978; 1998) criteria of fit, workability, modifiability and relevance. These fitted the methodology and are similar to criteria identified by other writers. Selecting Glaser's criteria is not to dismiss Rolfe's (2006a) suggestion of an audit trail, as I endeavoured in chapter five to describe the rationale for decisions made, including an ongoing critique of my own involvement.

Fit

According to Glaser (1998), 'fit' refers to whether or not the categories and concepts generated adequately express the patterns in the data that they purport to conceptualise. Fit might correspond to the concept of credibility and interpretative validity (Lincoln and Guba, 1985; Morse et al., 2002). Grounded Theory, by virtue of its methodology, will possess fit, if concepts and categories are carefully derived from the data and not from a prior theory of the world (Glaser, 1998). Within this study, decisions about 'fit' were made throughout the research process. The ability

to generate a concept that 'fits' is, firstly, dependent on 'interpretive validity' and the ability to reduce 'interpretive differences' (Sandelowski, 2006:11). Negotiating and reducing interpretive differences required entering into a dialogue that facilitated the clarification of ideas and perspectives, rather than adopting a distant and neutral stance.

Once coding of data commenced, the aim was to get the best concept that fitted and authentically reflected the data, as opposed to developing concepts by conjecture or importing 'received concepts' from the literature. As Glaser (1998:31) said, 'no theoretical capitalism is tolerated'. Although concepts such as 'monologue' and 'compliance' are discussed in the literature, 'compliance monologue-ing' was not a received concept but one derived from the data. Once concepts were identified, they were modified, sharpened and verified throughout the data collection and analysis phase of the study. Words that best fitted the data were selected. Similarly, categories, properties and their relationships were checked repeatedly, using the constant comparative process and theoretically sampling to see if they patterned out in both new data and in previously collected data. This self-correcting process ensured that pet ideas and assumptions were not imposed. Smith and Biley (1997) suggested that triangulation is one way of testing the 'truth value', accuracy or validity of the findings in Grounded Theory studies and suggested the use of different data collection tools, different data sources and theoretical triangulation. In so doing, they presented triangulation as if it was a new dimension to Grounded Theory, and failed to see that the constant comparative process, which involves the constant and repeated checking of concepts against data from different sources and in the later part against literature, to see if concepts pattern out, is a core part of Grounded Theory methodology.

This process of checking the emerging theory, just described, differs from member checking as advocated by Lincoln and Guba (1985) and is sometimes confused within Grounded Theory writings (Dey, 1999; McCann and Clarke, 2003a). Post theory development member checking is frequently used in qualitative enquiry as a means of establishing confirmability or verification of findings (Morse et al., 2002). Traditional qualitative methods often involve the collection of all data prior to data analysis; hence, researchers are left with no option but to member check post theory

development. Morse et al. (2002) suggested that post theory evaluation is a serious threat to the validity of studies, as issues may not be found until it is too late. Within Grounded Theory methodology, verification is subsumed within the concurrent steps of data collection and constant comparative analysis. It is the incremental development of the theory, however, that is verified with the data and participants, and not the overall theory, a point that is confused when discussed by Dey (1999).

A number of writers talk about the importance of reflexivity in relation to rigour (Hall and Callery, 2001; Davis and Dodd, 2002; Rolfe, 2006b). Reflexivity involves the researcher's awareness of biases and assumptions that may impact on the study (Hall and Callery, 2001). In relation to reflexivity, a balance is necessary between turning the research into an auto-ethnographic study, where the focus of the research is more on the researcher than the participants and the substantive area, and ignoring the status of the researcher as instrument. Within this study, I endeavoured to use the methods of Grounded Theory that facilitate reflexivity. Although Glaser (1998) does not speak of reflexivity *per se,* he has offered advice on how to minimise what he calls conjectured theory. It has been argued that engaging in mental self-purification to eliminate personal bias is an impossibility (Paley, 2005). Therefore, I aimed to mimimise personal bias and check that my conjectures were supported by the data. As described previously (Chapter 5), I used memos to record my own ideas and assumptions. Within these memos I was free to allow my conjectured ideas take flight. Once they were on paper, I was then in a position to use them as another source of data and compare them against data collected in the interviews. This helped to ensure that concepts developed were not figments of imagination but derived from the data.

The second strategy I used was peer debriefing. The role of a peer de-briefer is to ask probing questions to help search for alternative perspectives and explanations (Baxter and Eyles, 1997). I approached an academic colleague who worked in another university and had a background in psychotherapy to take on the role. Prior to commencing data collection, and at various points throughout the study, this person interviewed me and asked probing questions about my presuppositions and unconscious assumptions. I found this helpful on a number of grounds. It helped identify my ungrounded assumptions prior to commencing the study and throughout

the study, thus, stopping the creative mind from being a conjecturing mind (Glaser, 1998). I also found it helpful to talk about aspects of the emerging theory, as it helped hone my thinking and analysis.

Once the theory was developed, I presented it to nurses both within psychiatric nursing and outside the discipline. The purpose of presenting the theory was not to verify the overall theory, but to check for relevance and receive feedback that would improve my thinking on concepts and categories. To return with the theory for verification was considered philosophically inconsistent with my views on constructionism and my ideas of Grounded Theory. Firstly, constructivism, as discussed (Chapter 4), posits 'multiple realities' and that the data produced in the course of the interviews are time and context bound. Having grappled with these issues, I thought that seeking verification of the theory would be ironic, as it suggested that there was some alternative interpretation that had a greater claim on an objective reality and truth than the theory conceptualised. This is not to suggest that there could be no alternative interpretation, or that another researcher would not have conceptualised the theory in another way. However, the only possible outcome I could have received would have been merely an alternative, rather than a greater claim to an objective truth. Secondly, the aim of Grounded Theory is to transcend the data and present a theory that explains a latent pattern of behaviour. To accomplish this, data were conceptualised, synthesised and abstracted from and across individual participants. Thus the theory does not describe any one individual, but an overall approach comprising all the participants' accounts. There is no reason, therefore, for people to recognise themselves in the complete theory, although they may identify with the explanatory power of the theory. Morse and Singleton (2001) are also of the opinion that it is impossible for participants to validate a theory if results have been synthesised and conceptualised.

Although the study was informed by the epistemology of constructionism, in that meaning was jointly constructed within the interviews, it is important to point out that the participants did not engage in the conceptualisation stage of data analysis. Neither did they decide how the theory was going to be integrated, in terms of theoretical coding. This did not mean that participants' views were ignored, or that the concepts or categories were creatively conjectured. As discussed, all aspects of

the emerging theory were checked through the iterative process of theoretical sampling of people, issues, documents and the constant comparative process. Although the theory of *'Veiling Sexualities'* had fit with the data, it was still my interpretation and representation of the nurses' conversations and was by no means the only way that the data could have been interpreted and conceptualised. However, this does not make the theory any less valuable as a representation of social phenomena (Hammersley and Atkinson, 1995).

Workability

The concept of workability means that the concepts and the way they are related sufficiently account for how the main concern of participants in a substantive area is continually resolved. In the words of Glaser (1978:4), 'does the theory explain relevant behaviour in the substantive area, predict what will happen and interpret what is happening in the area of enquiry'. I do believe that the context of the theory of *'Veiling Sexualities'* offers one interpretation of what is happening in the practice of the nurses interviewed; however, I also acknowledge Emden and Sandelwski's (1999:5) 'criterion of uncertainty', that all research outcomes are tentative and there is no way of showing otherwise.

Modifiability

Modifiability is Glaser's third criterion. As Glaser (1998) suggests, the theory is not being verified as in verification studies, and thus it is never right or wrong. Even if new data emerge, they do not disprove the theory, but rather provide an analytic challenge to modify the theory (Glaser, 1998). For example, should new data emerge that identify strategies that nurses proactively use to explore sexual issues with clients, the concept of *'Veiling Sexualities'* would be capable of being modified in the light of these data.

Relevance

Relevance relates to whether the theory developed is useful to the people in the substantive field, and is akin to Morse et al's (1998) idea of pragmatic utility. For a theory to have relevance it must give people theoretical control of the phenomenon,

by providing them with understanding and insight into the substantive area (Glaser, 1998). This means that it must be innovative enough to enable people to see what had previously been covert knowledge or embedded practice. A Grounded Theory is meant to identify a main concern and explain the latent patterns of behaviour that people use to resolve that concern. Relevance is evident if the perspectives of the participants are listened to and the preconceptions of the researchers avoided (Glaser, 1998). Once the theory was developed, I presented it, as stated, for comment to nurses both in psychiatric nursing and outside the discipline. In response to the various presentations at conferences and in one-to-one consultation, nurses said that they could relate to the theory. My initial reaction was that I had 'discovered' the obvious, and some old nagging doubts about the value of the theory returned. However, as I listened to and explored people's responses, I realised that I had given people a workable model from which to understand and question embedded nursing practices. Frank (2004) argues that many people experience a gap between what they know and can articulate. This gap is often a source of powerlessness, as 'what cannot be said cannot be acted on' (Frank, 2004:437). In the case of this study, the theory *'Veiling Sexualities'* provided nurses with a model, which helped them to see a wider picture and revealed often unquestioned and unspoken practices. In revealing the collective unspoken, the theory was also revealing what these practices concealed at the individual level. I am not suggesting that the theory is a direct mirror representation of practice or the complete world of psychiatric nursing, but, as a theory, it enables people to get, as Glaser (1998) suggests, some conceptual control of their own actions, thus commencing the process of incremental change.

I also consider that this theory has practical relevance, as it gives complex issues an articulated form and creates a wider discourse within the profession of psychiatric nursing on the sexual right of clients. Plummer (2003:33) suggested that since the late twentieth century, 'many desires have found a voice' in the form of 'coming out', 'sexual survival', and 'recovery' stories. However, one sexual story that has been given limited voice is the story of people experiencing mental health problems, and the psychiatric nurse. Plummer (2003) also postulated that sexual story telling is a political process. For sexual stories to 'find their time', there is a sequence of story telling that moves from imagining, to articulating, to inventing

identities (becoming a story teller), to creating a community of support or reception who will hear the story, and finally to creating a culture of public problems where the story enters an array of public discourse and becomes a 'political spectacle'. In the political context of nursing and health care, research stories are heard with greater clarity than individual commentary. It is hoped that this theory is the beginning of a process of helping people with mental health problems and their carers find a voice and a time for their sexual stories to be told and heard.

Summary and conclusion

This chapter, the final chapter in the thesis, identified the limitations of the study and discussed the implications of the emergent theory for research, education, nursing practice and management. The chapter also discussed the steps taken to promote trustworthiness within the study. In Glaser's view (1998:17), if a theory holds up to the criteria of fit, relevance, workability and modifiability, and if the researcher has been sufficiently rigorous, then the theory should 'conceptually empower' people with a greater understanding of their world. It is hoped that the theory *'Veiling Sexualities'* will enable nurses, educators, and managers to develop a greater understanding of their behaviour and begin the process of undoing the 'code of silent omission' (Zerubavel, 2006:28). In this way, the presence of sexuality in all nurse-client encounters will be acknowledged, and the sexual rights of people experiencing mental distress will become part of the discourse of psychiatric nurses and all people involved in the delivery of mental health services.

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APPENDICES

Appendix One: Invitation letter to participants

Address
Date

My name is Agnes Higgins and I am currently a student in the School of Nursing and Midwifery in Trinity College Dublin. I am a psychiatric nurse undertaking a research study as part of a higher degree. My research supervisors are Professor Philip Barker and Dr Cecily Begley. I am writing to you to invite you to consider being a participant in this research study. Due to an interest in the area of sexuality, my research study is focusing on the meaning of sexuality in the context of psychiatric nursing care. The purpose of the study is to help develop a greater understanding of how psychiatric nurses interpret sexuality and respond to health care needs in this area of practice. I have attached an information sheet, which will explain the study in more detail.

If you agree to take part in the study it will involve an interview with me at a time of your choosing. I will also arrange a venue and time that suits you. Participation is voluntary and you may withdraw from the study at any stage without obligation to anyone.

I should be very grateful if you would consider being part of the study. If you choose not to participate I thank you for taking the time to read this letter.

Thanking you
Yours sincerely,

Agnes Higgins

Appendix Two: Information leaflet for participants

TITLE OF STUDY: An exploration of sexuality in a psychiatric context from the perspective of the psychiatric nurse and people with mental health problems.

WHAT IS THE STUDY ABOUT?

The focus of the study is on exploring how psychiatric nurses respond to issues of sexuality and intimacy with people with mental health problems. The study will involve interviewing psychiatric nurses and service users from psychiatric services in Ireland. It is important that you realise that the interview is **not** about your **private, personal situation** or **practices** but rather about your understanding of sexuality from the perspective of being a psychiatric nurse.

WHAT WILL YOUR PARTICIPATION INVOLVE?

If you are selected as one of the participants you will be asked to participate in an interview. The interview will consist of you speaking to me about your views on sexuality in the context of psychiatric nursing and your role as a psychiatric nurse. It is important that you realise that the interview is **not** about your **private, personal situation** or **practices** but rather about your understanding of sexuality from the perspective of being a psychiatric nurse. During the interview my role is to listen to your story. I will ask some open-ended questions, which you are free to answer in whatever way you choose. There are no right or wrong answers. My objective is to hear your views and opinions.

HOW OFTEN AND HOW LONG WILL YOU BE INTERVIEWED FOR?

The interview may last between 30 and 60 minutes and will be held at a time and location convenient to you and of your choosing. The interviews will be tape-recorded as it would not be possible for me to remember or write all your contribution during the interview. It is my intention to interview you once, but I should be grateful if you would give me permission to return for a second discussion should I deem it necessary as the research study unfolds.

WHAT WILL HAPPEN TO THE INFORMATION ONCE COLLECTED?

Once the interview is over, the information on the tape will be transcribed onto paper so I can read it and begin the process of looking at the information for common meanings between participants. The tape recording and any subsequent printed transcripts of the interviews will be stored in a locked press. Any information transferred to a computer will be password protected. The only people who will have access to the tape-recordings are, my research supervisor, myself and the person who types up the tape recordings, whom will assure me of confidentiality. At no stage will your name appear on the interview tape or the transcript. Each tape recording and printed transcript will be given a number for identification purposes. I am the only person who will know who the number corresponds to and I will not divulge this to anyone.

ARE THERE ANY CONSEQUENCES IF I CHOOSE TO BE PART OF THE STUDY OR I WANT TO OPT OUT PARTWAY THROUGH THE STUDY?

There is no obligation on you to participate in the study. If you choose to participate you are free to withdraw your consent at any time without obligation to

anyone. This means you can opt out before, during or after the interview. I am aware that talking about sexuality may be a sensitive issue and that you may become embarrassed, hence you can refuse to answer any question, turn the tape off, or request to stop the interview at any time.

If you wish to drop out of the study you can tell me in person at any time during the interview, or let me know by letter, email or phone. I will give you my email and phone number at the time of the interview.

WILL PEOPLE KNOW I TOOK PART IN THE STUDY?
I will not be informing anyone that you participated in the study. Information that might identify you will not be used in any presentation or publication resulting from the study. If you wish to talk to people about the study you are free to do so.

WILL EVERYTHING I SAY BE TREATED IN CONFIDENCE?
If during the interview you tell me something that gives me cause for concern as a nurse, then I am obligated to pass on this information. Should this happen, I will tell you of my intention but I must point out that I do not need your consent to pass on the information. It is a rare possibility that this may happen, but should it happen complete confidentiality with the specific issue cannot be assured. This is a requirement for all registered nurses.

WILL I BENEFIT DIRECTLY FROM PARTICIPATING?
The purpose of the research is to produce information that may, in future, influence how nurses understand the issue of sexuality and address the issues of sexuality with people who have experienced a mental health problem. Therefore, you will not receive any direct personal benefit. No expenses will be incurred by you, as I will be interviewing you at a time and location convenient to you.

IS THE STUDY BEING FUNDED?
The study is being funded by the Health Research Board and I am undertaking the study as part of a higher degree.

You are under no obligation to participate in this study and deciding not to participate will make no difference to your employment.

Thank you for taking time to read this leaflet, and for considering taking part in this study.

Yours sincerely,

_____

Agnes Higgins
Research Fellow
Health Research Board

Appendix Three: Biographical details of participants

Gender	Female	17
	Male	10
Current role	CNM 1	2
	CNM 2	6
	CNM 3	2
	Staff Nurse	11
	Community Psychiatric Nurse	6
Work context at time of interview	Community residence	7
	Day centre	2
	Day hospital	2
	Acute admission unit	6
	Long stay/rehabilitation unit	4
	Community health centre	6
Experience in psychiatric nursing since qualification	0-5 years	9
	5-10 years	4
	10-15 years	6
	15-20 years	3
	> 20 years	5
Completed psychiatric nurse training	Within service	11
	Other service within Ireland	12
	Outside Ireland	4
Worked in psychiatric service	Research site only	8
	Other than the research site	19
Of the 19 people who worked in services other than the research site	Within Ireland only	12
	Within and outside Ireland	4
	Outside Ireland only	3
Professional qualifications	RPN only	16
	RPN and RGN	11
Academic qualifications other that their RPN	Diploma in Nursing	8
	Primary degree in Nursing	5
	Graduate/Postgraduate diploma	1
	Masters in Nursing	1
	Currently undertaking a degree	2

Appendix Four: Proposed interview guide

Purpose of the study

Identify, describe and provide a theoretical analysis of how psychiatric nurses respond to issues of sexuality in practice.

Central research question

How do psychiatric nurses respond to issues of sexuality in practice?

Objectives

- To explore how psychiatric nurses conceptualise sexuality in the context of psychiatric nursing practice
- To elicit the mechanisms that psychiatric nurses employ to respond to the sexuality needs of people with mental illness
- To explore the factors which influence the way psychiatric nurses respond to issues of sexuality in practice

Theoretical questions

- How do psychiatric nurses conceptualise sexuality in the context of psychiatric nursing practice?
    - What does sexuality mean? (physical, psychological, social, spiritual; normal, abnormal; acceptable, unacceptable)
    - How does sexuality relate to psychiatric nursing and people with mental health problems?
    - Do psychiatric nurses have a continuum of acceptable sexual behavior?

- What are the sexuality and intimacy issues that nurses encounter with patients?
    - Who is involved?
    - How did you respond?
    - What was the outcome?
    - Would you respond this way always?

- Under what conditions will psychiatric nurses address issues of sexuality with patients?
    - How does the nurse learn that that an issue is of concern to a patient?
    - How are the issues raised (who raises issues, what strategies are used, do nurses include sexuality in patient assessment, wait for patient, where is it discussed, what is the context [care plan], early after meeting the person or later)?
    - Are there any enhancing factors talking to patients and if so what are they?

- Are there any inhibiting factors to talking to patients and if so what are they? (barriers, eg. patient (age, gender, illness), self, culture of the organisation)
- How is the issue avoided? What is the consequence to patient care?

- What interventions do psychiatric nurses employ to respond to the sexuality needs of people with mental illness?

    - Do psychiatric nurse treat issues of sexuality differently from other health care issues?
    - Do nurses have an education programme on sexual health, relationships, side effects of drugs,?
    - Do nurses involve the multidisciplinary team, refer patients? Talk to family, spouse?
    - Do nurses document issues of sexuality in care plans?
    - Are there rules by which patients must live? If they break the rules how is it dealt with?

- What are psychiatric nurses' main concerns around sexuality and people with mental health problems?

Appendix Five: Example of a post interview memo

Post interview memo Code number

This was the second time arranging an interview with this person. When I arrived to do the interview, the person, due to competing demands at work, was not there so rearranged the date and time, via the phone. She had left a contact number for me. The issue of protecting people's confidentiality is an issue, but at this stage I remind them when we make arrangements, that if they are interviewed in work people will know they are involved. In fact, they don't seem to care, they are telling each other. I am beginning to relax a bit about this and have come to the conclusion that once I point it out to them, I can't do any more. In fact it is more about my paternalism, than anything else.

Arrived in service to do interview, a little early, met at the door by a nurse who I had previously interviewed, she had a great welcome for me and thanked me for the card and note, I felt good that I had taken time to give it the personal touch. Initially thought of having a standard letter of thanks, but then thought that a personal response to the person I met was more appropriate given the way I work and the fact that they share such personal information with me, you really get a sense of knowing the person, knowing about their personal circumstances-some people tell you about where they are from, whether they are in a relationship, educating their children about sex, the impact of their own education or lack of, not only on their practice but on their professional lives.

Invited for a cup of tea, had tea with the nurse and we talked about nursing assessment forms, she gave me the assessment forms they use. Said they have no training in using this assessment, self taught, and said that other when patients are transferred to the service the assessment forms are not completed correctly as people don't know how to fill them out or calculate the score. Had a quick look – not much there in relation to sexuality. Now beginning to use a model of nursing. Asked about who was supervising me. She was excited that Prof Barker was one of my supervisors, as she is reading one of his books for a course. I was conscious that this information was on the information leaflet; it begs a question about how well people read the information leaflet about the study.

Interviewee arrived after about 10 minutes. It was only through conversation that I discovered the person is on night duty and came in on her off time, discovered this at the end of the interview and felt bad for having kept her so long.

Very forthcoming in the interview, needed very little prompting. I had to ask for clarification on some issues, kept my focused theoretical questions until the end. She seemed anxious that she wouldn't be answering correctly, reassured her that I was interested in her views and opinions that there were no right or wrong answers.

This seem to be an issue for some people – that what they might have to say wouldn't be useful to me, and that they would have wasted my time, also a sense that if you are doing it for a PhD they should speak in what they term 'academic language', which when I ask what that means, the typical answer is 'you know, big words, theory, like what you read in some journals'. This response gets me thinking that not only have we put people off reading the journals and implementing research because they can't interpret what people write, but there is a danger that they will not participate in research, especially interviews, if they think that there is a 'different language' required.

Spent over 2 hours talking to this woman, spoke very openly and candid, many of the same issues in relation to waiting coming up. At the end of the interview she spoke of the impact of her education and upbringing on her relationship, sexual life and her subsequent marriage and life. I felt humbled and really sad at times. I was thinking of my own life and how satisfying my relationship is. I was also thinking how her education may have impacted on her relationship, I was conscious to let her talk as opposed to bringing it back to her nursing career. In fact there isn't a separation as people bring these experiences into practice, for her sexuality and sex life is private, and is no business of health professional so she treats clients in the same way, if they have an issue and they tell she will help.

When the interview was over we sat and chatted about her life. I shared some information with her about my life, as she asked if I was married and had children. I was very conscious that a lot of private information was on the tape about her and that she may want it erased or not used in the study, so I asked her about it, she said 'no problem, if it helps you use it'. She then used this phrase, 'If you have nothing to hide, you hide nothing; I live my life as an open book'. I was really struck by that, that she wasn't hiding her experience of pain, her emotions around what happened in her life, she had come to terms with it, it wasn't that she didn't feel these things any more but she wasn't hiding them. This interview set me thinking about the whole idea of the objective detached person – I am getting so close to these people. I feel privileged by the way they share things with me. What is interesting to think about is the way they tell me things during our meeting, yet say that clients need to know nurses for a long time before they would talk about intimate issues.

When we finished, a member of the household staff had two plates of food prepared for us, and she joined us for coffee, she was asking about the study and the interviewee explained. In some way I feel part of the place, and for the first time start to think about the impact of the study if what is written up is perceived to be reflecting negatively on the staff and the organisation. At one level I feel I will be telling it as I perceive it from what I was told, but worry about presenting it in a non-judgemental way. Need to talk to supervisor about concerns, about not blaming or pointing a finger at staff, as the issues are wider than the individual nurses and need to be positioned in context.

Appendix Six: Example of open codes developed

Q.S.R. NUD.IST Power version, revision 4.0.
PROJECT: Sexuality Nudist, User Agnes

(F) //Free Nodes
(F 1) //Free Nodes/question
(F 2) //Free Nodes/defining sexuality
(F 3) //Free Nodes/partners
(F 4) //Free Nodes/problems
(F 5) //Free Nodes/medication
(F 6) //Free Nodes/physical
(F 7) //Free Nodes/sex act
(F 8) //Free Nodes/Psychosis
(F 9) //Free Nodes/not talked about
(F 10) //Free Nodes/sexual delusion
(F 11) //Free Nodes/pre and post illness
(F 12) //Free Nodes/Culture
(F 13) //Free Nodes/Forced discussion
(F 14) //Free Nodes/nurse patient relationship
(F 15) //Free Nodes/overstepping the mark
(F 16) //Free Nodes/phone as a tool
(F 17) //Free Nodes/nature of relationship
(F 18) //Free Nodes/patient freezes
(F 19) //Free Nodes/talking facilitates talking
(F 20) //Free Nodes/experience
(F 21) //Free Nodes/live life
(F 22) //Free Nodes/mature
(F 23) //Free Nodes/self aware
(F 24) //Free Nodes/religious thing
(F 25) //Free Nodes/ a need
(F 26) //Free Nodes/ a taboo
(F 27) //Free Nodes/Nursing competence
(F 28) //Free Nodes/Assessment
(F 29) //Free Nodes/part of a list
(F 30) //Free Nodes/requires a lead into
(F 31) //Free Nodes/Special friend
(F 32) //Free Nodes/Euphemisms
(F 33) //Free Nodes/listen for cues
(F 34) //Free Nodes/Gays more open
(F 35) //Free Nodes/time
(F 36) //Free Nodes/Sex is communication
(F 37) //Free Nodes/trust
(F 38) //Free Nodes/trigger questions
(F 39) //Free Nodes/First interview
(F 40) //Free Nodes/Nursing intervention
(F 41) //Free Nodes/referral of patient
(F 42) //Free Nodes/Gender stereotyping
(F 43) //Free Nodes/blunt questioning
(F 44) //Free Nodes/Competence deficit
(F 45) //Free Nodes/service user raises issue

(F 46) //Free Nodes/drug related sex problems
(F 47) //Free Nodes/physical appearance
(F 48) //Free Nodes/drug information leaflet
(F 49) //Free Nodes/drug compliance
(F 50) //Free Nodes/difficult for patient to talk
(F 51) //Free Nodes/Service users home a safe place
(F 52) //Free Nodes/Family
(F 53) //Free Nodes/gender difference in sexual expression
(F 54) //Free Nodes/Needing permission
(F 55) //Free Nodes/Education
(F 56) //Free Nodes/Sequencing talk
(F 57) //Free Nodes/visible v's invisible sexuality
(F 58) //Free Nodes/Ageism
(F 59) //Free Nodes/Reflection
(F 60) //Free Nodes/Safe sex
(F 61) //Free Nodes/Gay stereotyping
(F 62) //Free Nodes/selective education
(F 63) //Free Nodes/women passive
(F 64) //Free Nodes/impact of socio economic group
(F 65) //Free Nodes/clinical supervision
(F 66) //Free Nodes/talking to team
(F 67) //Free Nodes/doctors perspectives differ
(F 68) //Free Nodes/sexual abuse
(F 69) //Free Nodes/drug a means of control
(F 70) //Free Nodes/sexual disinhibition
(F 71) //Free Nodes/hospitalisation as a means of control
(F 72) //Free Nodes/personality of the nurse
(F 73) //Free Nodes/Perceived risk
(F 74) //Free Nodes/nurse raises the issue
(F 75) //Free Nodes/contraception
(F 76) //Free Nodes/not being able to solve problem
(F 77) //Free Nodes/women financially dependent
(F 78) //Free Nodes/age
(F 79) //Free Nodes/gender of the nurse
(F 80) //Free Nodes/formal v's informal assessment
(F 81) //Free Nodes/clarifying hunches
(F 82) //Free Nodes/challenging contradictions
(F 83) //Free Nodes/financial assistance
(F 84) //Free Nodes/sexual health education programme
(F 85) //Free Nodes/client is service user
(F 86) //Free Nodes/language of service user
(F 87) //Free Nodes/clarifying language
(F 88) //Free Nodes/gender of nurse
(F 89) //Free Nodes/gender of patient
(F 90) //Free Nodes/A more sexual world
(F 91) //Free Nodes/feeling unskilled
(F 92) //Free Nodes/composing oneself
(F 93) //Free Nodes/feeling confident
(F 94) //Free Nodes/protecting the self
(F 95) //Free Nodes/physical context of conversation

(F 96) //Free Nodes/discerning patients agenda
(F 97) //Free Nodes/acknowledging distress
(F 98) //Free Nodes/less than honest
(F 99) //Free Nodes/preparing self
(F 100) //Free Nodes/pornography
(F 101) //Free Nodes/maintaining control
(F 102) //Free Nodes/skirting around the issue
(F 103) //Free Nodes/feeling uncomfortable
(F 104) //Free Nodes/Experiencing the taboo
(F 105) //Free Nodes/drawing the line
(F 106) //Free Nodes/confronting behaviour
(F 107) //Free Nodes/sussing out the scene
(F 108) //Free Nodes/protecting the patient
(F 109) //Free Nodes/questioning nurses' sexuality
(F 110) //Free Nodes/challenging boundaries
(F 111) //Free Nodes/not knowing the person
(F 112) //Free Nodes/knowing it's appropriate
(F 113) //Free Nodes/feeling comfortable
(F 114) //Free Nodes/feeling unsafe
(F 115) //Free Nodes/appropriate time
(F 116) //Free Nodes/patient not ready
(F 117) //Free Nodes/enquiring about side effects
(F 118) //Free Nodes/indirect questioning
(F 119) //Free Nodes/gentle questioning
(F 120) //Free Nodes/rationalising own behaviour
(F 121) //Free Nodes/lacking time
(F 122) //Free Nodes/giving permission to phone nurse
(F 123) //Free Nodes/education deficit
(F 124) //Free Nodes/assessing patient readiness
(F 125) //Free Nodes/stressing confidentiality
(F 126) //Free Nodes/gaining trust
(F 127) //Free Nodes/negotiating ground rules
(F 128) //Free Nodes/managing the legal issues
(F 129) //Free Nodes/direct questioning
(F 130) //Free Nodes/emerges accidentally
(F 131) //Free Nodes/responding to doctors request
(F 132) //Free Nodes/needing to be careful
(F 133) //Free Nodes/Responding to intuition
(F 134) //Free Nodes/getting to know the patient
(F 135) //Free Nodes/presenting choice
(F 136) //Free Nodes/attempting to get a balance
(F 137) //Free Nodes/becoming immune
(F 138) //Free Nodes/clashing value systems
(F 139) //Free Nodes/patients or people
(F 140) //Free Nodes/a very personal thing
(F 141) //Free Nodes/a right
(F 142) //Free Nodes/limiting sexual expression in hospital
(F 143) //Free Nodes/managing tensions
(F 144) //Free Nodes/protecting the public
(F 145) //Free Nodes/changing social context

(F 146) //Free Nodes/chastising the patient
(F 147) //Free Nodes/differing value system of nurses
(F 148) //Free Nodes/constructing inappropriate behaviour
(F 149) //Free Nodes/Protecting the vulnerable client
(F 150) //Free Nodes/Breaking the rules
(F 151) //Free Nodes/mixed wards
(F 152) //Free Nodes/Protecting the vulnerability of the nurse patient relationship
(F 153) //Free Nodes/Responding to inappropriate behaviour
(F 154) //Free Nodes/Menstruation
(F 155) //Free Nodes/protecting the vulnerability of the treatment regime
(F 156) //Free Nodes/promiscuous behaviour
(F 157) //Free Nodes/nursing different from therapy
(F 158) //Free Nodes/adapting to the culture
(F 159) //Free Nodes/Reflecting on practice
(F 160) //Free Nodes/global questioning
(F 161) //Free Nodes/feeling embarrassed
(F 162) //Free Nodes/accepting the client
(F 163) //Free Nodes/unconditional acceptance
(F 164) //Free Nodes/being an Irish male
(F 165) //Free Nodes/exposure to other cultures
(F 166) //Free Nodes/education in school
(F 167) //Free Nodes/anti male
(F 168) //Free Nodes/Impact of single parent family
(F 169) //Free Nodes/integrated wards
(F 170) //Free Nodes/letting patient define the problem
(F 171) //Free Nodes/acknowledging failings
(F 172) //Free Nodes/tailoring the assessment
(F 173) //Free Nodes/following the patients lead
(F 174) //Free Nodes/service versus patient needs
(F 175) //Free Nodes/hypomanic patient
(F 176) //Free Nodes/sex on the ward
(F 177) //Free Nodes/fearing allegation of sexually inappropriate behaviour
(F 178) //Free Nodes/rape
(F 179) //Free Nodes/personhood of the nurse
(F 180) //Free Nodes/personality disorder
(F 181) //Free Nodes/learning to read signs of danger
(F 182) //Free Nodes/vulnerable to misinterpretation
(F 183) //Free Nodes/impact of travel
(F 184) //Free Nodes/institutional arrogance
(F 185) //Free Nodes/cognitive philosophy of therapy
(F 186) //Free Nodes/fearing repercussions
(F 187) //Free Nodes/requesting to change carer
(F 188) //Free Nodes/Catholic church
(F 189) //Free Nodes/influence of peer
(F 190) //Free Nodes/hospital ethos
(F 191) //Free Nodes/reluctant to use probing questions.
(F 192) //Free Nodes/doctors ask
(F 193) //Free Nodes/professional divide

(F 194) //Free Nodes/education in nursing
(F 195) //Free Nodes/benign neglect
(F 196) //Free Nodes/personality disorders
(F 197) //Free Nodes/Maintaining the professional persona
(F 198) //Free Nodes/constructing maleness
(F 199) //Free Nodes/fearing being seen as being gay
(F 200) //Free Nodes/manic patient
(F 201) //Free Nodes/nurses expectation of care
(F 202) //Free Nodes/talked about in supervision
(F 203) //Free Nodes/legal issues
(F 204) //Free Nodes/researchers interviewing style
(F 205) //Free Nodes/Becoming visible
(F 206) //Free Nodes/Responding to sexual accusation
(F 207) //Free Nodes/Protecting against allegation of sexually inappropriate behaviour
(F 208) //Free Nodes/Consequence of accusation
(F 209) //Free Nodes/Positioning the source of an accusation
(F 210) //Free Nodes/Prioritising other problems
(F 211) //Free Nodes/Impact of the environment
(F 212) //Free Nodes/Organisational rules
(F 213) //Free Nodes/Segregation of the sexes
(F 214) //Free Nodes/protecting the privacy of patients
(F 215) //Free Nodes/constructing the vulnerable client
(F 216) //Free Nodes/Sexual encounter on the ward
(F 217) //Free Nodes/reprimanding the client
(F 218) //Free Nodes/reading the signs of a possible sexual encounter
(F 219) //Free Nodes/ascertaining sexual intent
(F 220) //Free Nodes/informing clients of rules
(F 221) //Free Nodes/protecting the vulnerable female student
(F 222) //Free Nodes/changing carer
(F 223) //Free Nodes/managing competency deficit

Appendix Seven: Example of an early memo on the concept of forced discussion

Concept: Forced discussion

1st interview (7th October 2004)

The person used the words 'how it comes up' as if there is not an element of choice, one is forced to see it, recognise sexuality as an issue. There is a sense from this person, that the client is the person who raises the issue first, eg. uses the phone to ask about sexual side effects, again later in the interview she mentions that the service user coming to the clinic for an injection raises the issue. This must take a lot of confidence on the part of the service user.

2nd interview (11th October 2004)

Again there is a sense that the nurse waits for the client to raise the issue, uses the phrases 'men mostly have come forward', they themselves would bring it [sexuality] into the discussion, the phrase 'come forward', and 'bring it forward' is very like the 'how it comes up' of the 1st interview. In this context the client asked about a side effect to a drug.

3rd interview (15th October 2004)

This nurse says she will not discuss sexuality issues until the issue is very 'blatantly' obvious, until you can't avoid the cues any more. Again there is a sense of the nurse only responding when clients make an issue or ask a question. Says she will address the issue when it 'becomes visible', when the service user can't hide issue any longer. From the three interviews, it appears that sexuality becomes visible when the service user asks a question about sexual function, or volunteers information and concerns about relationships, abuse. Sexuality also becomes visible when behaviour is perceived by the nurse to be out of the norm, eg. client touches the nurse? What they call sexual disinhibition. Does ask about contraception, asks about what medication or contraceptive device she is using. Need to explore in subsequent interviews: What makes sexuality visible? There is also a sense that nurses are waiting for clients as opposed to being proactive. Start checking this out in subsequent interviews.

There is a link between this memo and the one titled 'not talked about', consider sorting and merging these.

Appendix Eight: Example of a later memo, after sorting early memos

Concept 'policing sexual expression'

Nurses consider that clients are their professional responsibility once they come in to care. For some nurses this responsibility is more akin to a paternalistic responsibility as opposed to a joint relationship. There are focusing on caring for and responsibility for as opposed to caring with and responsible with. Nurses are very conscious that they have a duty to care for clients and prevent any client from being sexually exploited while under their care. This duty of care gives rise to a number of concerns or consequences for themselves and the client; for the nurse in relation to being accused of 'negligence', fear of pregnancy, protecting patients from regret. Hence, in order to protect the client and consequently protect themselves from being accused of negligence they operate out of a model of care that limits and controls sexual expression of any kind. Their focus is on creating an environment that limits clients' opportunities to engage in sexual relationships or develop relationships while in hospital or residential care. The idea of creating or not creating an environment is constructed within the discourse of 'safety for client'.

None of this is written and there has been no general discussion at organisational or team level, with a lack of organisational guidelines or policy. The approach is a more informal process than formal, sexual risk assessments are not completed in a formal manner, hence category of risk is not identified, no formal care plan documented for patients who are at risk, nor is there any education. Main focus of the nurse is on preventing sexual relationships occurring, in order that they are not seen to be negligent. All service users treated the same whether in acute care service, rehabilitation or community residence, there is a blanket policy of no sexual behaviour within the residence, this is seen as about equity, but it also prevents the nurse having to make an individual assessment of capacity to consent or engage with the ethical and legal issues surrounding sexual behaviour; nurses don't have to engage with what the knowledge or understanding of the client is or get involved in individual patient education.

Nurses see their duty to care as extending to what they can see, with their boundary of concern being defined by the physical structure of the ward, community residence. What patients do outside that is considered their own business or what they do inside as long as the nurses don't know; hence, their focus is on policing sexual behaviour to prevent it occurring, as opposed to promoting positive sexual health, which might encompass sexual health education including skills development. Their approach is one of immediacy as opposed to long-term protection. They tend to enact that protection in a limited what to way they can see or have been told about. Focus is on the desire to keep the ward running smoothly. and on the visual, what can be seen or noticed.

Concept 'policing sexual expression' continued

Concept of boundary breaching, behaviour about boundary pushing, relationship development within hospital is seen as interfering with the recovery process. Nurses use the explanation that they must be able to see clients for their own safety as a reason why they can't be out of sight, sense that client must be visible at all times, which is not possible but it is used as an explanation as to why people can't be in room together, saves the nurse from having to tell the client the real reason, saves the nurse having to verbally check out his/her assumption (visual surveillance). Nurses construct sexual behaviour as inappropriate and once labelled the meaning behind the behaviour is not explored from the client's perspective; the nurses' meaning is what takes precedence, thus the voice off he client is lost within the duality of appropriate/inappropriate behaviour.

'Policing' may not be the right word, so could consider the title 'Protecting the vulnerable' or think about the word 'curtailing relationships', and 'surveillance'.

Appendix Nine: Copy of letter confirming ethical approval from the University

THE UNIVERSITY OF DUBLIN TRINITY COLLEGE
FACULTY OF HEALTH SCIENCES
School of Nursing & Midwifery Studies
Trinity Centre for Health Sciences, St. James's Hospital, James's Street, Dublin 8.
Tel: + 353 1 6082692/2777/3704 Fax: + 353 1 4732984

13th December 2002

Ms Agnes Higgins
School of Nursing and Midwifery Studies
Trinity Centre for Health Sciences
St James's Hospital
Dublin 8

Re: Application for Research Ethics Committee approval

Dear Agnes

Further to your recent application to the School of Nursing and Midwifery Studies Research Ethics Committee, I am writing to inform you that the committee considered your application at their meeting on the 10th December 2002.

The issues being dealt with in this application were very "delicate and "sensitive" and it was felt by the committee that overall these issues were handled very well.
The committee has approved your application and have made the following comments in relation to your study:

- The statement regarding withdrawal from the research at any time should be included on the information sheet.
- Clarification is required on how the confidentiality of the data will be protected during transcription.
- The title of the study needs to be clarified i.e. is it the patient's perception of the nurses facilitating and acknowledging "sexuality issues".

On behalf of the committee, I wish you the best of luck in what is a very interesting and valuable study.

Yours sincerely,

Catherine McCabe
Chairperson
Research Ethics Committee

Appendix Ten: Copy of letter confirming ethical approval from the Health Service

To maintain anonymity the name of the health service and the chairperson has been removed.

9 June 2003

Ms Anges Higgins
Lecturer/Course Co-ordinator
School of Nursing & Midwifery Studies
c/o Trinity Centre for Health Sciences
St James Hospital
James's Street
Dublin 8

Dear Agnes

An Exploration of Sexuality in a Psychiatric Context from the Perspective of the Psychiatric Nurse and People with Mental Health Problems

Thank you for attending at the Ethics Committee meeting this morning at which your application for the above study was considered further. I am pleased to confirm that any concerns, which the committee has had, have been fully satisfied by your responses to the meeting. Accordingly the committee is pleased to approve this study.

We wish you every success in your study.

Yours sincerely

Chairperson
Ethics Committee

Appendix Eleven: Letter to participants confirming interview arrangements

Date.....

Dear

Thank you for agreeing to be interviewed as part of the research study I am conducting. Enclosed please find a copy of the information leaflet. I look forward to meeting you at (Venue) on the (Time/Date).

As I mentioned on the telephone, if the time becomes inconvenient or having re-read the information leaflet you do not wish to be interviewed, please do not hesitate to ring me at (Phone Number) or email me at (Email address).

Thanking you.
Yours sincerely

Agnes Higgins
Research Fellow
Health Research Board.

Appendix Twelve: Consent form

Research title: An exploration of sexuality in a psychiatric context from the perspective of the psychiatric nurse.

Principal researcher: Agnes Higgins RPN, BNS, MSc

Prior to interview

Date..... **Time**

This is to certify that I ....., give my consent to be included in the above study.

I confirm that I have read the information leaflet and received an explanation on the nature, purpose, duration and effects of my involvement in the study.

I understand that my participation is voluntary and that I am free to withdraw from the study at any stage if I so wish, without giving an explanation.

I have been informed that my employment will not be compromised if I decide not to participate in the study or withdraw my consent at any stage during the study.

I give permission to be interviewed and the interview to be tape-recorded.

I understand that
(i) I may decline to answer any question during the interview
(ii) at the end of the interview I may request that a section of the interview be erased or not used
(iii) at the end of the interview I may request that the total interview not be used in the study.

I understand that at the completion of the interviews the contents of the tapes will be transcribed.

I understand that the information may be published but my name will not appear on any part of the study, nor will any information that may identify me be used in the study.

Signature of participant .....

Signature of the researcher .....

Consent form continued.

Post interview

I.....give my consent to have the contents of the interview used in the study.

Signature of participant .....

Signature of the researcher .....

Date .....

I would like any further correspondence regarding the study to be forwarded to the following address:

In order to preserve privacy this record of consent will be stored in a locked, secure press away from the tapes and written transcripts. The record of consent will only be made available should the ethics committee have questions concerning the ethical practices of the study.

1 copy will be kept by the researcher
1 copy will be given to the participant

Appendix Thirteen: Form used to collect biographical data

Code number ☐

Grade

Clinical Nurse Manager I ☐ Clinical Nurse Manager II ☐

Clinical Nurse Manager III ☐ Staff Nurse ☐

Clinical Nurse Specialist Nurse ☐ Community Mental Health ☐

Other (Name).....

Location of current work

Community residence ☐ Day centre ☐

Day hospital ☐ Admission unit in psychiatric hospital ☐

Community health centre ☐ Admission unit in general hospital ☐

Other (Name).....

Professional Qualifications

RPN ☐ RGN ☐ RMHN ☐ RM ☐

Academic Qualifications

Diploma in Nursing ☐ Bachelor of Nursing (BNS) ☐

Bachelor of Science in Nursing (BScN) ☐ Graduate Diploma in Nursing ☐

Masters in Nursing ☐ PhD ☐

Others
(Name).....
.....
.....
.....

Biographical data sheet continued

Any educational programme currently undertaking
(Name).....
.....
.....
.....

Completed training

Within research site ☐ Outside Ireland ☐

Service other than the research site within Ireland ☐

Duration of time since qualifying as a psychiatric nurse

0-5 years ☐ 5-10 years ☐ 10-15 years ☐

15- 20 years ☐ over 20 years ☐

Years engaged in psychiatric nursing practice

0-5 years ☐ 5-10 years ☐ 10-15 years ☐

15- 20 years ☐ over 20 years ☐

Duration of time in current post

0-2 years ☐ 2-4 years ☐ 4-6 years ☐

6-8 years ☐ 8-10 years ☐ over 10 years ☐

Worked in

Research site only ☐ Service other than research site ☐

If worked in other service was it?

Within Ireland only ☐ Outside Ireland only ☐

Within and outside Ireland ☐

Gender

Male ☐ Female ☐

Appendix Fourteen: Subcategories and their properties

Core category – 'Veiling sexualities'

Sub core categories	Subcategories of sub core	Properties
Weaving the veil	Beginning the weave	*'acquiring family values', 'acquiring structured institutional values'*
	Thickening the strands	*'mechanical-ising', 'pathologising', 'minimising' '*
	Fusing the strands	*'professional comparing', 'cultural seepage', 'absorbing voices of the past'*
Hanging the veil	Limiting verbal information	*'hierarchy of disclosure', 'referring to written information'*
	Cautionary interviewing	*'routine questioning', 'avoiding taboo questions', 'vague questioning', 'passively waiting for disclosure', 'skipping over'*
	Protective surveillance	*'keeping a close eye', 'tuning in to the warning signs', 'alerting others', 'peer monitoring' 'limiting freedom of movement', 'keeping in the dark', 'paternalistic protection', 'biased protection', 'limited protection', 'professional protection'*
Lifting the Veil	Voluntary disclosing by another	*'chance happenings', 'gendered biased disclosure'*
	Sexualising the nurse-client encounter	*'sexual gesturing, 'sensitive sensing', 'calculating the risk', 'feeling vulnerable'*
	Engaging in sexual behaviour that became visible	*'sexual behaviour', 'mixed emotions' '*

Re-veiling the clients' sexuality	Re-weaving the clients' experiences	*'narrative of pathology', 'narrative of deviance'*
	Monologue-ing	'Compliance-monologue-ing'- *'speaking up the positive', 'ignoring power differentials', 'pseudo-advocating'* 'Suppressive monologue-ing' - *'communicating the label', 'laying down the law', 'speaking up the negative', 'instilling fear', 'pseud-collaborating', 'ignoring resistance'.*
	Insulating the self and others	*'erecting professional boundaries', 'deflecting the conversation', 'physically avoiding clients', 'transferring care', 'increasing personal visibility', 'putting on record', 'tipping off'*
	Darning the surveillance veil	*'increasing protective surveillance', 'separating from the person of desire'*
Maintaining the Veiling-Re-veiling Cycle	Mythical self talk	*'dividing practice', 'appealing to higher goals', 'hesitating to fuel ideas', 'minimising clients 'cognitive ability', 'arbitrarily assuming', 'comparing to self', 'fearing consequences to self', 'blaming resources', 'transferring responsibility'*

Appendix Fifteen: Educational programmes attended by participants

Nursing	Diploma in Nursing
	Primary Degree in Nursing
	Graduate/Postgraduate Diploma in Nursing
	Masters Degree in Nursing
Other	Bachelor of Arts
	MSc (Health Studies)
	Diploma in Counselling
	Diploma in Bereavement Counselling
	Diploma in Cognitive Behaviour Therapy
	Diploma in Reflexology
	Diploma in Massage
	Diploma in Management
	Diploma in Health Service Management
	Diploma in Training and Education in Supportive Employment
	Module on Psychosocial Interventions