## *Barriers to humanity: an autoethnographical exploration of nursing within Liaison Psychiatry*

### *Introduction*

The intention of this paper to explore the challenges related to the personal and professional self from the perspective of a Psychiatric Liaison Nurse working in an acute general hospital; emphasis is placed upon exploration of the ideological drivers that influence current practice and social policy.

Autoethnography is overlooked and underutilised within nursing research (Streubert & Carpenter, 2011); it enables stories to be told with depth that may otherwise remain unnoticed whilst considering ideological influences (Peterson, 2015). This paper will adopt a reflexive approach to explore a vignette from practice that was significant in terms of my development; consideration will be given to the professional decisions made in relation to power and risk. Pillow (2003) expressed critical views of reflexivity within qualitative research that conveys the researcher's perspective as the whole truth, acknowledgement is given that the story told is from the perspective of the researcher; others may have interpreted events differently and therefore a triangulation method is used.

Sections of the narrative have been adapted in order to protect confidentiality (Tolich, 2010); the identity of the patient, family and NHS trust have been anonymised in line with the Nursing and Midwifery [NMC] (2015) code.

### *Appendix 1 – Vignette:*

*It's Friday afternoon – it's always a Friday afternoon isn't it – I answer a call from a midwife in the hospital to say that Jane's baby will be removed by Social Care at 16:15, and could Psychiatric Liaison attend to assess her mental state and risks immediately following this?*

*I have always felt an undercurrent that we must provide assessment for any and every person that the hospital staff ask us to, no matter what the rationale and regardless of whether this would even have an impact on the outcome for the patient or their family. The undercurrent I feel is confirmed, my suspicion is confirmed, our team and manager enforce that we, as a Psychiatric Liaison Service, must attend to*

*assess Jane's mental state and devise an appropriate risk management plan following the removal of her baby daughter.*

*Jane had given birth to her baby 3 days ago, some of my colleagues had previously attended various professionals meetings and child protection meetings; as a team, we knew there was a very real possibility that her baby would be removed shortly after birth, but it's her first baby – surely they will give her a chance to be a mother to her baby, surely?*

*I'm working with Tim - a colleague I hold a lot of respect for, we have worked together fairly regularly having both joined the team at the same time. We discuss what we are being asked to do, we are concerned that by assessing and risk assessing her we would be facilitating the medicalisation of human emotion, human reaction, grief – how do we assess the mental state of a woman going through the loss of her baby? How exactly do we consider the risks? How do we distinguish between symptoms of mental illness and grief so rapidly after a major life event – should we have to?*

*Jane has extensive previous engagement with mental health services and a diagnosis of Emotionally Unstable Personality Disorder (World Health Organization, 2018). Our professional anxiety heightens, our sense of accountability heightens, our feeling that we must be certain and confident about her levels of risk, that we must address these risks and manage them appropriately intensifies – difficult thoughts cross both our minds and we say them: 'she's bound to up the ante', 'she might say she wants to kill herself', 'she might be seeking admission to hospital'. We discuss options, and consider, for a while, whether she may seek admission to a psychiatric hospital; we don't want to admit her to hospital as we know it probably will not help and may well serve to medicalise normal human experiences of loss, but it could "contain" her. Let's keep it in mind as an option.*

*We review her previous mental health records; the baby is subject to a child protection plan. We read that the father of the baby has been violent towards Jane and others – more thoughts cross our minds: 'are they still together?', 'What if he is present today?', 'Could he be aggressive or violent to staff?'.*

*At 16:55, two social workers arrive to remove the baby; one is particularly upbeat and I worry she is desensitised to the significance of what is about to happen.*

*We have a discussion with the social workers and midwife. The midwife says Jane has interacted lovingly with the baby, she has been breastfeeding the baby, and now she won't be seeing her baby for four more days; the social workers have said she can express breastmilk if she wants. I raise concerns, the Health Visitor in me thinks that they must not understand their words, the significance of what they are saying, just how difficult expressing breastmilk without her baby daughter with her will be – I wonder if they have any understanding about the physiological processes that are involved in breastfeeding; the difficulty mothers have in producing the hormones required without direct contact with their baby, do they know? Do they care?*

*At 17:30, the baby is removed from Jane and her partner, Jane's mother is there too. Security staff are present – just in case. Jane's partner, the father of the baby is quiet, he is not aggressive, threatening nor violent.*

*We see the baby, and she is tiny, and tinged with jaundice; the social workers carry her off the ward in a car seat.*

*Tim and I enter the room where Jane is laying on the floor crying, her mother and partner are there too; Jane is broken – fluctuating between sobbing and full blown wailing. I introduce us, we sit on the floor with her. What do you say to someone who has had her baby removed? We sit silently with her, she does not know us, she has not met us before, but we sit and we are there.*

*There is an expectation that we assess Jane's mental state and associated risks, in particular, given her extensive history, risk of harm to self. That's our job after all, receive referrals from the hospital, triage and assess within 4 hours, move on to the next patient. We are trained to use the 'I CARED & SHARED' framework for assessing someone with risk of harm to self; are we expected to use this tool now? Can we not be human?*

*A thought crosses my mind - she is likely to express thoughts to harm herself, like other patients we have assessed with this diagnosis.*

*Jane speaks with us, she is staring at the floor, her voice is quiet, her words slow, her eyes red raw, and she tightly holds a muslin close to her. She asks when she will see her baby again, we tell her in four days – she says nothing for a while, then she says that she wants her baby. We try our best to gently reassure her that by engaging with the plan, and with social care, this will give her the best chance of having her baby returned to her. She cries.*

*I want to cry, I shouldn't cry, I'm a professional, I should be strong, I cry; I cry with Jane, and with her mother, I cannot hold it back. My colleague, he doesn't cry.*

*Jane hasn't once asked for hospital admission as we had been so concerned with. She does not threaten to harm or kill herself. She asks to be with her baby. She is bereft. We tell her that a mental health team will call her tomorrow for on-going support. In this moment, I wonder is this for her, or does this serve to alleviate our professional anxiety?*

*After walking with Jane and her mother to their car, I feel silly for crying; I have been too emotional."*

***Method***

Storytelling enables the researcher to make sense of their experiences, there may be an associated emotional toll as a result of undertaking this interpretive research (Koch, 2008; Poulos, 2008). The process of narrative inquiry expands upon storytelling, it involves scrutinising information whilst taking into account the connection between the experience of the individual and the cultural context (Clandinin and Connelly, 2000); this is underpinned by a social constructivist ideological approach and challenges simplistic, Modernist views of 'truth' (Moen, 2006).

The significance of ensuring that the researcher does not simply report 'truths' but is able to recognise interpretations of subjective experience and consider where these interpretations stem from is recognised by Hertz (1997); the researcher is compelled to remain cognisant of the "politics of interpretation" (Denzin, 2014, pp. 82) when using a reflexive approach to research. Researchers using a narrative inquiry approach must acknowledge their own identity, culture, values, biases and assumptions (Attia & Edge, 2017; Chan, 2017; Jackson & Mazzei, 2012).

I utilised a triangulation method by interviewing my colleague in order to gain his perspective of events; Ellis, Adams and Bochner (2010) highlight that interviewing others can aid recall of events. Triangulation is used in research to gain additional perspectives, thus increasing validity (Heale & Forbes, 2013).

I unintentionally used the process of “emotional recall” (Ellis, 1999), whereby I visualised the experience described in the vignette and thought about being there both emotionally and physically; Ellis (1999) posits that this improves recollection of details. My ability to use emotional recall was aided by the significance of the circumstances that have proven difficult to emotionally disconnect from; Ellis (1999) warns against being too emotionally involved as it can be difficult to review events. My use of emotional recall triggered some unexpected emotions that I had either not yet connected with, or that were new; researchers should exercise caution when using emotional recall for this reason (Gariglio, 2018).

### *Analysis and Discussion*

A Neoliberalist ideologically informed perspective suggests that the process of reflective practice may ‘hollow out’ learning, can be viewed as highly restrictive and may serve as a ‘confessional’ for professionals (Cotton, 2001); consistent with this, Usher & Edwards offer that reflection can act as a practice of confession that is related to the notion of Christian confession and the idea of disclosure of the self (Usher & Edwards, 2005). Foucault describes that confession can be used to reinvent the notion of ‘truth’ and ‘truth of the self’ and is a form of power/knowledge (Foucault, 1978; Mills, 1995); Foucault expands on this and posits that universal ‘truths’ do not exist, though truths that are relative to society can be produced (Foucault, 1978). Ixer (1999) considered that reflection should move beyond individual experiences and should consider influences of a social, historical and political nature; consistent with Ixer’s view, this paper seeks to shift towards the concept of reflexivity within practice; to move away from things to simply be learnt by the researcher and towards introspection and the “process of on-going mutual shaping between the researcher and the research” (Attia & Edge, 2017, pp.1). I will utilise italicised excerpts, not necessarily in chronological order, from the vignette to provide a reflexive exploration of practice and analyse underlying ideological influences.

*"Jane has extensive previous engagement with mental health services and a diagnosis of Emotionally Unstable Personality Disorder.*

*…*

*'she might be seeking admission to hospital'.*

*…*

*A thought crosses my mind - she is likely to express thoughts to harm herself, like other patients we have assessed with this diagnosis."*

The National Institute for Health and Care Excellence [NICE] (2014) state "Personality disorders are associated with poor engagement with maternity services and perinatal mental health services and this leads to poor mental and physical health outcomes for the woman, fetus and baby" (NICE, 2014, pp.45). Fiske (1994) suggests that all words have political foundations and cannot be unbiased; in order to identify underlying assumptions within language, ideological influences must be considered (Van Dijk, 2006).

Use of the language "personality disorders" in this context serves to identify the person as their "disorder" or mental illness; it could be argued that this is consistent with a Capitalist perspective that individuals are expendable as it promotes stigmatisation and dehumanisation (Overton & Medina, 2008), increases likelihood of misuse of heuristics (O'Sullivan & Schofield, 2018) and in turn it may lead to the person internalising this identity thus becoming the 'problem identity' within social policy (Overton & Medina, 2008).

Quinney (2011) studied *the Social Location of Personality Disorder* and posits that there is an underlying neoliberal theme within social policy that focuses on self-responsibility and offers a simplified suggestion that purely by considering issues differently, social problems will reduce. Quinney (2011) identifies that a diagnosis of personality disorder may be a "tool of state control", marginalise people to a "new personality underclass with little power or privilege", and further enforce use of this 'problem identity' within social policy (Quinney, 2011, pp.55).

The concept that personality disorder is a 'problem identity' is further substantiated by the NHS England [NHSE] (2016) and NHSE (2016a) that outline the following:

“Women will not be admitted to an In-Patient Mother and Baby Unit under the following circumstances:

…

Women with severe personality disorder, learning disability or substance misuse unless they are also suffering from, or there is suspected, serious mental illness.” (NHSE, 2016a, pp.12).

Assumptive language is used to indicate that personality disorder is not a “serious mental illness”, this serves to further marginalise people with this diagnosis and reinforces the ‘problem identity’ within social policy; it is in direct contradiction with the National Institute for Mental Health in England best practice guidance (2003) which focuses on personality disorder no longer being a diagnosis of exclusion, thus the professional must again balance organisational differences alongside their own values which may potentially lead to issues related to decision-making (Torpman, 2004). In my experience, people who have diagnoses of personality disorder have often experienced multiple adversities in life, are vulnerable to experiencing further, and often complex, mental health difficulties and are arguably more susceptible to requiring support in the perinatal period thus the notion of excluding a person from a service based on this label is absurd and potentially harmful.

I held an underlying assumption associated to this diagnosis, instigated or reinforced by language used in social policy, that Jane may express thoughts to harm herself; this is consistent with the process of representativeness heuristics (British Psychological Society, 2016), in that I assumed the likelihood of an incident happening by comparison to a stereotype (Kahneman & Tversky, 1972). Payne and Crowley (2008) identified that, whilst there is a place for rapid decision-making, misuse of heuristics can lead to mistakes within practice. There is an opportunity for confirmation bias to occur as professionals tend to look for something consistent with their understanding of diagnosis and may ignore information to the contrary thus potentially having a significant impact on clinical decision-making (O’Sullivan & Schofield, 2018). *‘She might be seeking admission to hospital’* is an assumption that enables confirmation bias; consideration of hospital admission prior to seeing the patient could be viewed as prescriptive and an “expert knows best”, restrictive way of working associated with Modernist views (Szostak, 2007).

Consideration must be given to the complexities associated between language used, identity and power; Foucault theorises that the individual, and their identity, “is the product of a relation of power exercised…” (Foucault, 1980, p. 74). Recognition of the difference in socioeconomic class between myself and the patient is imperative; as someone from a less privileged background, socially and financially, the patient will likely have different life experiences thus different values (McDermott & Samson, 2005). Crenshaw’s (1991) view on intersectionality theory acknowledges the complexity within power dynamics and understanding that “social privilege” is impacted on by a number of issues; Johnson (2008) explores that those who have lesser privilege become the minority in society which holds implications within power dynamics.

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*…That’s our job after all, receive referrals from the hospital, triage and assess within 4 hours, move on to the next patient”*

Arguably, the pressure to provide standardised nursing assessment regardless of the needs of the individual is rooted in the demands of bureaucracy rather than the needs of the patient, this serves as a reductionist nursing process in line with a standardised service and fits into a Modernist perspective where by “one size fits all” (Nairn, 2014). Standardisation of processes are “presumed to be commonsensical and intuitively obvious” (Wears, 2015, pp. 89); however, Wears (2015) highlights that the underlying theoretical and ideological perspectives remain overlooked.

Alcock, Daly & Griggs (2014) research the link between ideology and social policy; consideration must be given to who decides the standards, the knowledge utilised within social policy and the purpose that the standards serve within society. NHS England (2016) published *Implementing the Five Year Forward View for Mental Health* document which sets out a “CORE 24” service requirement for Liaison

Psychiatry services in the UK; meaning patients referred to Liaison Psychiatry will be assessed within 4 hours of referral (NHSE, 2016). Consistent with a Neoliberalist perspective, this blanket policy does not consider individual patients' lives and can be regarded as an example of market principles within nursing as it is driven by organisational pressures and reduces individualisation within nursing (Bill, 2017). In my experience, people respond positively to having time to ease distress and this promotes longer term problem-solving skills. In terms of a Modernist perspective, it could be argued that this policy seeks to standardise and dehumanise interactions which could lead to a loss of individualised care.

Use of standardised processes within nursing practice is consistent with a techno-rational approach (Schon, 1987); in uncomplicated interactions with patients, there may be circumstances in which a simplified, techno-rational approach may be useful (Stewart, 2017); however, the majority of nursing assessments prove to be complex in nature and will likely require individualisation of care (Stewart, 2017). Application of neoliberal ideology suggests that the use of standardisation, underpinned by market driven principles, within policy enables the government to exercise control over autonomy and choices of the individual (Stewart, 2017); Rose and Miller (2010) expand on this, identifying that when a market-driven approach is applied to nursing practice, the power within decision-making is transferred to management structures as opposed to the practitioner. This standardised approach of providing nursing assessment regardless of individual need reduced my ability to make an autonomous decision as to whether assessment and risk assessment in this instance was appropriate; at which point did the expectant mother who was admitted to deliver her baby crossover into being a 'mental health' patient that necessitated psychiatric assessment by the nature of having mental health issues and having her baby removed?

Given that I am a younger female, consideration from a Modernist/Capitalist perspective, and application of identity theory from Polat & Sönmez (2018) suggests that my manager, as a white, middle-aged male is closer to the notion of the 'referent' within social policy; thus, in addition to legitimate positional power as my manager, personal power forms of referent power and connection power may have been exercised (Polat & Sönmez, 2018). Foucault (1980) discussed the fluidity of

power, positing it is relational rather than dynamic, this opposes the simplistic Modernist perspective that would dictate that the manager simply holds power over the employee.

*"We are trained to use the 'I CARED & SHARED' framework for assessing someone with risk of harm to self; are we expected to use this tool now? Can we not be human?*

*…*

*"We tell her that a mental health team will call her tomorrow for on-going support. In this moment, I wonder is this for her, or does it alleviate our anxiety?"*

Local policy would dictate the use of the '*I CARED & SHARED'* framework (Appendix 2) to assess Jane's risk of harm to self (NHS Foundation Trust, 2014). A Postmodernist practice landscape considers that use of a Modernist standardised assessment tool would result in reduced meaning within social interaction, potential for dehumanisation and hollowed moral meaning within assessment (Wears, 2015). In contrast to this dehumanising approach, the Joanna Briggs Institute (2006) suggest that a humanistic approach of enabling others to express their emotions following a loss may promote positive outcomes; furthermore, the National Suicide Prevention Alliance (2016) suggests that use of standardised tools when working with people who are experiencing grief may be viewed as insensitive and lacking empathy. Postmodern perspectives challenge the use of a Modernist assessment tool that serve to simplify complex human emotions and reduce individualisation; Wears (2015) argues that use of standardisation may lead to loss of adaptive, individualised and humanistic services.

According to Carson and Bain (2008), risk is uncertainty that occurs where there is one or more consequences to actions or events. I have always had a sense that I, as a practitioner, should make clinical decisions that are certain, in areas that are inherently uncertain (Vasvári, 2015). *'She is likely to express thoughts to harm herself, like other patients we have assessed with this diagnosis'* is an example of availability heuristics in that I made judgements about the likelihood of an event occurring based on the ease of bringing an example to mind (British Psychological Society, 2016).

In order to make effective clinical decisions, I am required to have an understanding of the interaction between risk and professional judgement (Taylor & Whittaker, 2018). A clinical decision was made not to use the '*I CARED & SHARED'* tool whilst assessing the patient; according to local standard processes, I should have used the tool with the patient (NHS Foundation Trust, 2014). The decision not to use the tool was non-deliberated, based on experience, and arguably an intuitive approach consistent with a Postmodernist perspective (Kosowski & Roberts, 2003).

It could be argued that the clinical decision for mental health follow up was a deliberated decision based on rational choice theory in that I had a notion, based within my assumptions and previous experience of situations of working with people with this diagnosis of what my preferred outcome would be (Levin & Milgrom, 2004). This leads me to believe that the patient was given the 'illusion of choice' but as professionals 'knowing best' we had a preconceived idea of the outcome which is consistent with a Neoliberalist approach (Evans, 2014).

Application of heuristic reasoning processes to the outcome of referring the patient for mental health follow-up the next day is arguably related to an anchoring heuristic process. Lilienfeld and Lynn (2014) suggest that anchoring occurs when the researcher neglects to adjust her assessment of the individual on the basis of new information. It could be argued that the patient did not require urgent mental health follow up, but that due to our initial thoughts of hospital admission, anchoring occurred to result in a higher level of support than may have been indicated. Misuse of heuristics has been compared to an experience of 'cognitive illusions', Lilienfeld and Lynn conclude that by acknowledging our tendency to experience these 'cognitive illusions', we can attempt to overrule them with a purpose of enabling improved clinical decision-making (Lilienfeld & Lynn, 2014).

*"We sit silently with her, she does not know us, she has not met us before, but we sit and we are there*

*…*

*I want to cry, I shouldn't cry, I'm a professional, I should be strong, I cry; I cry with Jane, and with her mother, I cannot hold it back. My colleague, he doesn't cry.*

*…*

*After walking with Jane and her mother to their car, I feel silly for crying; I have been too emotional."*

The nature of Liaison Psychiatry and working shifts to cover the 24 hour service results in a workforce which is interchangeable; my colleague and I were not chosen to undertake the assessment based on our individual characteristics; it could be argued that we were viewed at interchangeable 'cogs' within a Neoliberal machine (Oksala, 2011). A Modernist perspective would agree that a professional is an interchangeable unit and therefore asserts that issues regarding identity are irrelevant; however, a Postmodernist view would support the many 'truths' of identity, thus acknowledging the individual identities of the professional, and challenging the concept that professionals are interchangeable (Held, 1998); a Postmodernist perspective supports the significance of individual characteristics and experience that do make a difference to a given situation (Taylor, 1998).

In addition to feeling silly for crying, I recall a sense of guilt – this is not my baby, nor is it my life, do I have the right to have this reaction when something so significant has happened to someone else? In that moment, I had the urge to hold back my tears, to hide my compassion and in essence bury my humanity; I think it is ingrained in me – the need to keep calm, keep cool, and remain 'professional'. I am conflicted, what happens if a glimmer of humanity comes out? I certainly want to cry. I wonder if this internal conflict is related to conflicting messages I have experienced throughout my nursing study and career: 'compassion' – one of the '6 Cs' within the nursing values base (NHS Commissioning Board, 2012), and what is compassion but empathy, the ability to feel, the ability to put yourself in someone else's position; yet I felt this urge to 'regulate' my emotions, to promote 'professionalism' in line with NMC code (2015, p.18). These fundamentally different messages demonstrate conflicting values within health care services and, consciously or unconsciously, provoke the practitioner to question where their values sit within this conflict.

Even now, when I reflect back, I feel silly for crying, and it confirms to me that it has been ingrained in me to remain professional. It could be argued that my conflict and desire to supress my emotional response is consistent with Hochschild's emotional labour theory which suggests that professionals are required to regulate and manage their emotions whilst interacting with patients, colleagues and managers in order to

fulfil the requirements of the job at hand (Hochschild 1983). This gives way to the question, whose purpose does it serve if my emotions are quelled, if my humanity is buried, and if I become more ‘standard’ within my practice; a neoliberalist market driven approach suggests that standardisation of the workforce is sought within organisations in order to enable outcomes to be measured and quantitative data to be collected; a techno-rational discourse proposes that the ‘hysterical’ individual is the issue rather than the organisation in which they work (Bill, 2017).

Peter, Vingerhoets & van Heck’s study corroborates previous theory that women report a higher proneness to crying than men; additionally, the study confirms that there is a correlation between neuroticism and crying propensity (Peter, Vingerhoets & van Heck, 2001). Is this something that I hold in the back of my mind, if I cry does that mean I am neurotic, do I become that ‘hysterical’ individual? I am a younger female, I wonder if others expect me to cry as a result of my identity, or perhaps it is not expected, but when it happens it can be attributed to being female ‘there’s a baby involved, that’s why she is crying’.

Murray discusses the concept of the ‘boys don’t cry’ discourse and suggests that expression of emotions such as sadness is associated with a sexist concept of female inferiority (Murray, 2015); Craib places emphasis on males having emotional control to perform successfully within the scope of manliness required (Craib, 1994).

In the work environment, the most effective and successful individuals often have characteristics that are perceived as masculine such as strength; females who cry at work and in front of colleagues may be perceived negatively (Lane, 2006). Although I did not consciously think of this at the time, on reflection, I wonder if the ‘boys don’t cry’ discourse impacted on my desire to supress my emotions; I notice that my male colleague didn’t cry after all.

Perhaps the display of emotion that I had may have somehow allowed Jane to connect with another human; could it have somehow altered her perception of this heinous life event? Perhaps it didn’t matter at all.

### *Ways forward – for myself and for the workplace*

As predicted by Koch, and Poulos, this reflexive analysis of the most poignant day yet in my career has taken an emotional toll, and many tears have been shed in the

process (Koch, 2008; Poulos, 2008). I have been asked by readers whether I have experienced motherhood and I will leave that to the reader to consider should they choose to.

I sought to provide a narrative inquiry that moved beyond the simplicity of storytelling into the world of reflexivity. Navigating my way through this reflexive analysis has enabled interrogation of the underlying assumptions disguised as professional expertise and experience held by myself and within the service. An analytical consideration of the way in which my own attitudes, values, assumptions and biases, and those of the organisation in which I work, may have influenced the interaction within, and outcome of, this complex situation has been essential in terms of the epistemological rigor of this qualitative research paper. Consideration of ‘problem identities’ as a social construct has enabled contemplation of the use of power dynamics within social policy, and in turn how this can impact on nursing practice and decision-making. The process of developing awareness of my own knowledge limitations, and how my actions have interacted with, and been influenced by, organisational practice and social policy have enabled deliberation of how these practices served as a barrier to humanity when working with Jane; a person who suffered a most traumatic life event.

I hope to continue to develop my critical reflection skills in order to appropriately challenge standardised processes that serve as a reductionist approach to nursing. In terms of the workplace, I hope that by developing my own knowledge, I can help lead others into the world of critical reflection; it is for this reason that I actively encourage other professionals to consider an approach that moves beyond just “reflective” practice and invite them into the world of reflexivity.

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