

Abstract

This paper uses social constructionism to critically explore the social world of intensive care units, and to consider how the presence of mental health consumers impacts on nursing practice. Following a series of interviews with intensive care nurses, our analysis suggested consumers are disenfranchised through stigma, policing, and inattention to psychosocial needs. We argue that the maintenance of knowledge and power networks are fundamental aspects of reality maintenance in intensive care. The social reproduction of typifications among nurses about consumers positioned these patients as disrupting the proper business of intensive care units; a process that we argue is bound up with the imbalanced power relationships. Further, intensive care staff maintain power structures serving intensive care interests, such as physiological rescue and the preservation of biomedical authority. We conclude that the production and reproduction of intensive care nursing knowledge maintains a social-power structure at odds with the needs of consumers.

Key words intensive care, mental disorders, stigma, nursing, power

The social reproduction of difference: Mental illness and the intensive care environment

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Introduction

The increasing prevalence and associated disease burden of mental distress is well documented globally.[1,2] The World Health Organisation (WHO) estimates that one in four people will experience mental distress in their lifetime,[3] and notes that mental distress represents 13% of the total global disease burden.[4] The promotion and preservation of mental health has been identified as one of Australia's National Health Priority Areas as an acknowledgement of the impact of mental distress-related disability.[5]

People living with mental health issues experience structural

disenfranchisement across a number of social contexts, including health.[6] Consumer/survivors experiencing mental distress commonly face a range of physiological comorbidities resulting from the intersection of social marginalisation, self-medication through substance use, and the side-effects of psychotherapeutic interventions.[7-12] The need for physical care is at least equal to and often greater than that of the general population. Yet, as consumer/survivors access healthcare, including intensive care, they may encounter established power structures that reinforce socially-mediated stigma and deter, rather than facilitate, effective and appropriate healthcare.

A number of influences are involved when consumer/survivors are admitted into the Australian healthcare system. First, the biomedical model of health and illness forms the dominant discourse around health and is well supported in the current neoliberal/individualist political landscape. The rhetoric of neoliberalism and individualism promotes the role of managing and optimising health as a responsibility of the individual.[13,14] Second, intensive care practice is

positioned as an elite specialty within nursing, where advanced physiological knowledge and procedural skills are constructed as the pinnacle of nursing practice, and a biomedical approach to care is firmly embedded as the status quo.[15-21] This social context encompasses a number of political and social concerns related to knowledge-power and the positioning of medical and nursing staff in such power structures.

It is in this social and political landscape that the Australian health care system, including intensive care units, cares for and treats people experiencing mental distress in acute physical care settings. The research reported upon here used such a setting to explore a number of social processes associated with the positioning of consumer/survivors in Australian society.

Purpose of the research

The purpose of this research was to explore the ways in which power relationships and the persistent structural disenfranchisement of consumer/survivors contributed to the reproduction of difference. While the setting for the research was a number of Australian intensive care units, the knowledge-power structures inherent to those contexts are a replication of broader social issues related to the positioning of consumer/survivors in contemporary Australian society. We based our research on the epistemological assumption that knowledge is socially constructed, and that knowledge and power are inherent aspects of taken-for-granted social processes. This research was also informed by a conceptual review of extant literature around the construction of difference associated with mental distress.[22-25] In particular, the scholarship of stigma and othering as it related to people living with mental distress underpinned our research on how difference was constructed and reproduced through the social and political processes of knowledge and power maintenance.

Theoretical framework

Drawing primarily on the works of Berger and Luckmann,²⁶ Weber[27] and Foucault,[28] this research sought to explore the social processes around knowledge, power and understanding in intensive care lifeworlds. We explored the reproduction of difference associated with caring for consumer/survivors experiencing severe mental distress as it manifested in the lifeworld of ICU.[29-38]

Berger and Luckmann's[26] theory of secondary socialisation posits that the internalisation of common-sense knowledge is a key social process for newcomers entering an institution. The incorporation of new knowledge into the group's everyday reality is part of the work of reality maintenance

and institutional fortification, and such knowledge becomes so taken-for granted that it is regarded as 'common-sense'. Such common-sense knowledge includes the formation of typifications, much like stereotypes: accessible social 'recipes' 26 that allow group members to position and handle unknown people, without adjusting their everyday reality. Typifications function to minimise ruptures of paramount reality, preserve common-sense knowledge, and avoid the inherent chaos of social life.

From the experiences of a few nurses caring for consumer/survivors experiencing severe mental distress, the group may intersubjectively construct an explanation of what it is to care for all patients with diagnoses of mental distress. The possibility of such a social process is reflected in the literature associated with intensive care and consumer/survivors, where commentators have variously typified people living with severe mental distress as collectively dangerous, users of illicit substances, and behaviourally difficult.[39-44] Secondary socialisation into what it is to 'do' intensive care nursing related to a number of typifications of people with a psychiatric diagnosis that are also reproduced more broadly in the general community. Such typifications included the construction of consumer/survivors as responsible (and blameworthy) for their mental distress, and as inherently dangerous and unpredictable.

Social constructionism supports the notion that there is an accepted or assumed existence of power structures in everyday life. The work of both Max Weber and Michel Foucault informed the theorising of structural power and knowledge maintenance in this context. Weber's work on legitimated or rational-legal power positions a person or persons within an organisation and is structural, therefore generally unrelated to the attributes of the person exercising that power. Nurses' legal-rational power is defined and sanctioned by regulatory bodies, professional status and healthcare institutional affiliation. Foucault's work on surveillance and the relationship between knowledge and power provides a broader contextual landscape of power relationships between 'the institution', those who occupy intensive care, and the consumer/survivors who access this space.

Methods

The 17 research participants came from both metropolitan and regional cities along the Australian eastern seaboard and were practicing in a mix of level two and three intensive care units. Australian intensive care units are categorised against a number of criteria based on location, clinical capacity and acuity. Level three represents major metropolitan

tertiary referral units, and level two smaller metropolitan or large regional centres. Both tiers of acuity include units that are equipped to care for critically ill patients receiving standard intensive care interventions including ventilation, haemofiltration, and invasive haemodynamic monitoring.

All participants identified as female. The participants came from a range of career points, from graduates in their first year as a registered nurse, to senior nurses who reported practicing for over 25 years. All participants practiced in an intensive care setting that was co-located in a hospital with acute inpatient mental health services. Nurses were invited to participate in a voluntary semi-structured interview of up to one hour. Interviews centered on the participant's reflections on their perspectives and experiences of caring for consumer/survivors with mental distress in intensive care contexts. A number of prompts were employed such as 'can you share any perspectives on your role as a nurse caring for patients with mental illness?' and 'How did your experience of caring for someone with a serious mental illness turn out? Can you tell me the story of that experience?'

The research was approved by the university's Human Research Ethics Committee (HREC). Following ethics approval, participants were recruited through nursing professional organisations, who placed an advertisement on their websites or in their digital newsletters explaining the study and inviting nurses to participate. The participants responded to the researchers by answering these advertisements in professional publications and hence, hospital ethics committees were not required in the recruitment or data generation process. Following the provision of a participant information sheet, written and informed consent was obtained from each participant, and all participants were assured they were able to withdraw at any time without prejudice. Given the geographical diversity of the nurses, all of the interviews were offered as in-person, or by video-call or telephone. All of the interviews were ultimately conducted by telephone, ran for 45-60 minutes, and were recorded and then transcribed.

The analytical framework used for this research drew on a number of theoretical sources to analyse, synthesise and build theory from multiple sources of data, including participant transcripts, existing literature, and theoretical frameworks. This form of iterative process is also known as constant comparative analysis.[45] Constant comparative analysis is a useful method in an interpretivist and critical framework because it assists in developing an understanding of individual experiences firmly situated in contextual social processes as the researcher moves between interview data, theory and literature. 45, 46 Participant interviews

are acknowledged to have limitations, and this research study was strongly influenced by the scholarship of David Silverman⁴⁶ in this space, who urges qualitative researchers to consider the placement, timing and inconsistencies of participant comments, avoiding a reliance on their responses as an absolute truth. By situating participant responses as one among other sources of data, we were able to avoid interpreting and presenting their responses as 'facts'.

Discussion

Power, disruption and the control of space

An air of danger and rescue are described in a number of studies concerned with space and work in intensive care.^{47, 48} The need to maintain safety through control of the environment is a recognised interest in the business of intensive care where patients are routinely described as critical, and hovering between life and death.^{48, 49} A large body of research theorises the typification of dangerousness attributed to people with a psychiatric diagnosis,⁵⁰⁻⁵⁴ and we established this analytical outcome in our research concerned with the anticipation of danger and the control of space. A participant reflected on the routines enacted prior to the arrival of a mental health consumer in her unit:

I think safety is standard for all the patients.... but of course, mental health patients need double safety compared to other patients. So, we always agree that when the patient comes in we should be ready and more safe. There are restrainers in the trolley and we try to keep the trolley away from the room. We try to see if there is anything that will hurt the patient from inside the room and take it off. And we try to see if there are enough medications in the cupboard for this patient.

The construct of 'double safety' for consumer/survivors suggests a typification of inherent dangerousness, usually arising socially, and preceding an actual encounter with the person and, according to the study participants, devoid of any sort of formal assessment process. Control of space is enacted by removing standard patient care equipment, providing restraints, and checking sedation supplies. The presumption of dangerousness prompts policing of the space occupied by the consumer. Such policing is often extended to the consumer themselves as they attempt to enact activities of self-care such as hygiene, toileting and mobility. A participant reflected on her patient who was experiencing anxiety and wanted to walk around as a self-soothing measure:

I can understand sometimes you just want to walk around. Sometimes you know, you are well enough to make some decisions for yourself but in that ICU

setting we don't give a capacity for these people to do that.... if I wanted to walk around at night in my own home I would, but as they're in ICU and there lots of other sick people, that makes it dangerous at night time for them to walk around. We don't like that, so then we give them medication to force them to stay in their bed space.... I do think that's on the mean side but unfortunately due to safety we have to do it. They might self-harm.... or like the medication cupboard for the [scheduled drugs] - technically, you can just walk in there and take it.

Such language reinforces the notion that consumers are, by default, under suspicion. They are also held to a higher standard of behaviour and emotional control than the general population which means that the threshold for reacting to any emotional distress or irritability is much lower. Resistance to such surveillance and custodial acts are very likely a response to significant space restriction, feelings of shame and rejection associated with self-stigma, and the feedback loop of negativity and arbitrary suspicion during their encounters with some staff.

It is of course acknowledged that any person can be unpredictable or violent and quite frequently nurses deal with violence and agitation in their patient population.^{55, 56} The significance of the data above is the unquestioned assumption of dangerousness. Link and

Phelan^[57] suggest there is a trajectory from attributing a label, such as mentally ill or 'schizophrenic' or 'PD' (personality disorder), through to typification formation, such as propensity to violence and inherent dangerousness. As described, typifications generally precede discriminatory behaviour at both a micro and a macro level. These acts reflect broader social processes including the involvement of police and the use of incarceration in instances of acute assessment and initial care of people experiencing acute mental distress in the community.

The nature of power relationships in the context of this research was complex and multidimensional. Turnbull, Flabouris and Iedema^[58 p72] suggest [ICU] '....is a closed, intersubjective world...embodying a history and a set of roles and relationships, tensions, alliances, all contained within the semi-sealed physical space of the unit'. The relationship between policing the space occupied by the consumer/survivor and the consumer/survivor themselves is grounded in unequal power relationships. This research interrogated the processes that supported such normalised policing of consumer/survivors in this context. Drawing on the work of Weber,^[27] and the social processes described by Berger and Luckmann,^[26] authoritative power in intensive care settings

is legitimated, objectified and normalised. The participant accounts suggest that these acts are accepted by most as beyond question. Considered through a Foucauldian lens, these social processes point to knowledge as power²⁸ and the ongoing maintenance of the intensive care paramount reality. Social processes of knowledge reproduction are inseparable from the reproduction and maintenance of established power structures.

Preferencing one particular body of knowledge and practice diminishes alternative bodies of knowledge. The absence of alternatives may manifest as inattention to core nursing practices such as therapeutic intervention, creating a therapeutic milieu and psychosocial care. Instead, there is an unmindful reach for chemical or mechanical restraint as a physiological solution for 'managing' consumers who are perceived as resisting (or likely to resist) the rules and rituals of the institution. Indeed, such processes reflect far broader social acts, evidenced by the descriptions of encounters between the police force and consumers,^[59] and emergency services and consumers.^[60] Rather than a consideration of therapeutic or treatment alternatives, such actions are a product of knowledge - power reproduction and serve to fortify and sustain established power relationships.

Concerns about anticipatory surveillance and custody are represented in the far broader context of human and civil rights, and remain contentious in both the policing and justice systems. Exercising physical power over patients for the benefit of institutional safety and the welfare of other patients, based on a number of assumptions about the person, is a form of legitimated power, sanctioned by the institution and the available legal-rational power of the nursing and medical role.^[61]

The maintenance and legitimation of power structures

Individualism and neoliberalism rely on a negation of the influence of social health determinants and the briefest acknowledgement of structural disenfranchisement.^[62] Situated among these social norms, as the dominant authority on what health and wellbeing looks like - or how it should be experienced - is the biomedical model.

Typification concerning those with a psychiatric diagnosis includes blameworthiness for any perceived failings around managing their own health.^[63,64] Such views are reproduced in a broader social world where individualism dominates. Good health is underpinned by a series of positive and punitive government and health policies designed to remind

all citizens of our responsibility to eat well, exercise regularly, not smoke, not be overweight, and not be poor.[13,65] Such interventions are not in fact celebrating autonomy and as Foucault argued, they are a central tenet of governmentality and are 'technologies of self'. [28,65] Consumers facing multiple intersections of disenfranchisement are seen as forever failing to self-manage and rise to the obligation of good health citizenship.

We conceptualised the known authoritative dominance of biomedicine as a symbolic universe following on from the work of Dreher 67 who argued that Berger and Luckmann's symbolic universes functioned to maintain not only knowledge, but power relationships. Berger and Luckmann 26 described symbolic universes as a transcendent legitimation of knowledge and power, so objectivated and reified that it does not require scrutiny, nor alignment with the everyday lifeworld. Symbolic universes are not simply an institution, or the people in it, but a totality of theoretical tradition, philosophy, and mythology. 67 The symbolic universe of biomedicine and one of its most prominent manifestations, the hospital, transcend our everyday reality. It existed before we came along and will exist long after we are gone. Such is the social, political, and intellectual power of this symbolic universe that it preferences certain types of knowledge and the freedom to determine what is important and what can be ignored or discredited. Knowledge reproduction is not only a social, but a political act, conserving and maintaining established power structures. More simply stated, by Berger and Luckmann [26 p127] 'He with the bigger stick has better chance of imposing his definitions of reality'

The negation of social determinants of health in resource allocation is one of the practical outcomes of institutional reality-maintenance in this context. [67] Habitualisation rituals such as socialisation and the reproduction of knowledge-power relationships serve the interests of the biomedical symbolic universe but may well be at odds with the experiences of nurses and consumer/survivors as they encounter each other in the ICU lifeworld. Encountering the 'institution', consumer/survivors are regarded as ineffectual stewards of their own health concerns and are frequently rejected by a system unable, or unwilling, to accommodate them beyond brief assessment and intervention. Interview participants remarked on being in 'the business of body fluids' and saving lives, continuously re-orientating themselves and our conversations to knowledge and skills associated with the business of ICU: for example, resuscitation, ventilation, haemodialysis and 'running off numbers'. Such comments suggested a complex power relationship between the socialised understanding

of ICU nursing work, and stigma towards mental health consumers. Goffman 68 argued that discrediting attributes are an integral aspect of the stigma experienced by people, but stigma is also a social process, infused with power inequality. In this context it is inextricably woven into concerns of maintaining and reinforcing the existing lifeworld of ICU and the established power structures contained within. The tension of a discredited person disturbing a space that has not been envisaged as accommodating them is reflected in both labelling and dehumanisation of consumer/survivors and the claims about the nature of the 'real' work of intensive care. It must be acknowledged that while the biomedical approach is prioritised in this context, there is a clear and ongoing commitment to person-centred care throughout intensive care nursing and practice. Grappling with the inability or incapacity to consistently perform successful physiological rescue is demonstrated in some of the work around end-of-life care and palliative care in this environment.

There is a sound body of research on the nexus between end of life care and intensive care [69-73] but the existence of such work juxtaposed with the absence of work on consumer/survivors and intensive care is itself interesting data. The reflection from intensive care personnel on the success/failure binary is limited to death. The literature on palliative care and end of life care in this context suggests that success and failure are well established as a cultural norm and the literature merely encourages nurses to reconceptualise death as a lesser failure, or a good death through palliation as a success. [74-75] This in itself is reasonable: the critical importance of informed, sensitive end of life care is not in question. However, this binary continues to reinforce acute discomfort about patients including mental health consumer/survivors who are not perceived as success stories. Rather these cases are condemned to the status of failures instead of allowing for mental distress and chronicity to be explored as a complex experience, part of which may involve the care of intensive care nurses from time to time.

The experiences of palliative care advocates [76-77] demonstrate an existing tension between the taken-for-granted business of intensive care and patients who disrupt this context. However, the literature on the palliative care - intensive care nexus highlights just one aspect of the displacement experienced by consumer/survivors, because palliative care patients are not known to be subject to stigma and disenfranchisement. This consideration of palliative care in an intensive care setting has been offered as a point of reference in an attempt to explore people with an alternative illness-label (palliative care patient) who are also conceptualised as types

of interlopers, in an environment ostensibly set up to accept any patient. The key point of difference here is the presence of stigma in the encounters between intensive care staff and patients, and we propose that stigma is an integral contributor to the sense of disruption that consumer/survivors bring to the social context of intensive care.

The disenfranchisement to consistent, equitably-realised and appropriate healthcare afforded to people with repeated admissions in particular is reflected in broader literature around people who repeatedly present to acute inpatient facilities, and draws on historical constructs of moral decrepitude and unworthiness.[78] A notable comment came from an experienced intensive care nurse, reflecting on a consumer/survivor who had a number of admissions to the intensive care unit:

“...this is like double digit figures for this patient and they’d done a pretty good job, they weren’t successful, but they’d done a pretty good job. And....the senior nurse is saying ‘You know, this is the *whatever* attempt for this person. I don’t even know why we keep trying to bring her back. People should just let her go. She should just do a good job; it’s really not that hard to kill yourself. She’s taking up bed space. We’ve got six people who need this bed’

The dehumanisation of people who enact self-harm to such an extent that their death is perceived as preferable to timely and appropriate health care, is a profound reproduction of the disenfranchisement experienced by people with psychiatric diagnoses. The concepts of unworthiness, resource-wasting and the notion that consumers are responsible for their own mental distress underpinned fundamental concerns of reality maintenance around intensive care business.

Conclusion

This paper sought to explore a number of social processes associated with the positioning of consumer/survivors in the everyday lifeworld of intensive care and in broader Australian society. Using Berger and Luckmann’s 26 social constructionist theory, we argued that through social processes of typification formation and knowledge reproduction, a series of socially sanctioned assumptions are legitimated and reified among intensive care nurses as they encounter consumer/survivors in the course of intensive care work.

These social processes are underpinned by the everyday business of intensive care, which includes the preservation of the symbolic universe of biomedicine. The encounters between intensive care staff and consumer/survivors do little to ameliorate the social stigma experienced by this group, as

they are positioned as unworthy, blameworthy, and disrupting the proper business of intensive care.

Further, given the focus of biomedical-model nursing in intensive care settings, such disruptions to the everyday lifeworld appear to consolidate and reinforce established power disparity through acts of policing and restriction of movement. The structural inattention to therapeutic nursing work, both at macro (social) and micro level displaced by the gaze of biomedicine, and a reflexive suspicion of consumers, leaves intensive care staff with limited options beyond the physiological ‘solutions’ of chemical and mechanical restraint.

Many questions have been asked in this research about the ways in which encounters with consumer/survivors in this context are reproduced through typifications of unworthiness, blame-worthiness, and dangerousness. It is unlikely that alternative constructions of health and illness will displace the symbolic universe of biomedicine. Further, dismantling structural disenfranchisement for consumer/survivors is unlikely to occupy Australian social and political discourse any time soon, given the dominant social and political ideology of individualism and neo-liberalism – however, there is scope to reflect on opportunities for emancipatory change.

Harnessing the high value placed on education in the lifeworld of intensive care is a possible mechanism for reflecting upon and appreciating the prevalence of mental distress and the inevitability of mental health consumer/survivor presence in intensive care. Although shifting the nursing gaze away from biomedicine to a bio-psycho-social model of care is far beyond the scope and influence of this study, our hope is to start a conversation about making space, both intellectually and physically, for the effective and appropriate care of consumers who are admitted to an intensive care unit.

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