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Delirium in the older adult: A critical gerontological approach

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Abstract

The purpose of this thesis has been to explore the discursive production of delirium in people over the age of 65 years. The philosophical approaches underpinning the study were derived from the field of critical gerontology, postmodernism and the utilisation of a Foucauldian understanding of discourse and power/knowledge. Data sources included published documents on delirium, interviews with people over the age of 65 years who had been delirious (as well as their clinical notes), family members, registered nurses and a doctor.

Textual analysis revealed the presence of two contesting and contradictory discourses that impacted on being an older person who had delirium. These were identified as the discourse of delirium as a syndrome and a personal discourse of delirium. The discourse of delirium as a syndrome is underpinned by the biomedicalisation of the ageing process. This process utilises scientific methods as the foundation from which to understand, research and provide a health service to older people with delirium. Any personal perspectives on delirium are rendered unimportant and relegated to marginalised positions. Nursing through its vicarious relationship to medicine is interpellated into deploying the discourse of delirium as a syndrome and has largely ignored the personal dimensions associated with this phenomenon. Consequently, the older delirious ‘body’ is known and inscribed as unruly, problematic, physically unwell, cognitively impaired and at risk.

Conversely, a personal discourse of delirium privileges the individual narratives of people who have been delirious and provides a different perspective of delirium. The deployment of a personal discourse of delirium offers another position that views this group of older people as bringing to the health care setting a rich tapestry of life experiences that are more than a cluster of signs and symptoms. It is these varied life experiences that need to be included as a legitimate source of knowledge about delirium. This thesis demonstrates how nursing needs to espouse a critical gerontological position when working with older people who have delirium. Critical gerontology provides nurses with the theoretical tools to challenge the status quo and uncover the multiple, varied, contradictory and complex representations of delirium in older people.

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This thesis is the culmination of several years work and signifies the closing of one door, while simultaneously celebrating the opening of many more. During my time as a doctoral student I have learnt a tremendous amount not only about the research process but also about myself. The route to completion has been a creative, absorbing and challenging journey.

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Table of Contents

Abstract	i
Acknowledgements	ii
Table of Contents	iv
Chapter One Introduction – framing the study	1
1.1 Overview of the chapter	1
1.2 Background to the study	1
1.3 Outlining the field of inquiry	6
1.4 The key focus of the arguments presented in this thesis	9
1.5 Study aims	11
1.6 Structure of the thesis	11
1.7 Summary	14
Chapter Two: The philosophical location of the study	15
2.1 Introduction	15
2.2 Critical gerontology	15
2.3 Modernism	17
2.3.1 The modern subject	19
2.3.2 Modernism, nursing and health	20
2.4 Postmodernism	22
2.5 Poststructuralism	25
2.6 Foucault, discourse, power and knowledge	27
2.6.1 Foucault	27
2.6.2 Discourse	28
2.6.3 Power	30
2.6.3.1 The genealogy of knowledge as a tool of investigation	32
2.6.3.2 Power, resistance and the body	34
2.7 The postmodern subject	38
2.8 The utilisation of Foucault within nursing	40

2.9 The critical gerontological approach used in this study	41
2.9.1 Critical gerontology and nursing	43
2.10 Summary	44
Chapter Three: Research methods	46
3.1 Introduction	46
3.2 Reflexivity	46
3.3 Participant selection	47
3.4 Ethical and legal considerations	50
3.4.1 Confidentiality	51
3.4.2 Potential harm to participants	52
3.4.3 Use of information	52
3.4.4 Conflicts of interest	52
3.5 Interviewing as a means of gathering data	53
3.6 The process of transcription	54
3.7 Data analysis	55
3.7.1 First level analysis	56
3.7.2 Second level analysis	56
3.8 To validate or not validate	59
3.9 Reflections on the method	61
3.10 Summary	63
Chapter four: The emergence of delirium as a stable medical entity	64
4.1 Introduction	64
4.2 Biomedicalisation	64
4.3 Creating the discursive object delirium	67
4.4 The emergence of delirium as a stable medical entity	70
4.5 The classification of delirium as a medical entity	73
4.6 Problems with the DSM classification system	75
4.7 The positioning of delirium in the DSM-IV-TR	77
4.7.1 Diagnostic criteria	77

4.8 The creation of research agendas through the DSM	81
4.9 Summary	83
Chapter Five: The discursive field of delirium	85
5.1 Introduction	85
5.2 Biomedical discourses and the discourse of delirium as a syndrome	85
5.2.1 The positioning of delirium as an economic and clinical problem	86
5.2.2 The discursive practices associated with the discourse of delirium as a syndrome	91
5.3 Management of the problems associated with being delirious	93
5.3.1 Pharmacological management	94
5.3.2 Non-pharmacological management	97
5.3.3 Summary of management strategies	100
5.4 Nursing and resistance to the biomedical discourse on delirium:	
The emergence of a personal discourse of delirium	101
5.4.1 Overview of the publications supporting a personal discourse of delirium	102
5.4.2 Analysis of the nursing response	104
5.5 Summary	107
Chapter Six: Promoting a personal discourse of delirium	108
6.1 Introduction	108
6.2 I was different once	109
6.2.1 The contextualization of the older adult through clinical notes	114
6.3 How I came to be where I am now	116
6.4 Why contextualize a person anyway?	121
6.5 Visual representations of people with delirium	122
6.6 Summary	128
Chapter Seven: The ageist terrain of delirium	129
7.1 Introduction	129

7.2 Overview of the ageist sub-discourse	129
7.3 The subject position of a second childhood	131
7.4 The subject position of dependency	136
7.5 The subject position of older people have diminished value	139
7.6 Problematising resistance to the ageist sub-discourse	142
7.7 Summary	148
 Chapter Eight: In from the margins, unmasking delirium	 149
8.1 Introduction	149
8.2 Silencing the madness discourse	149
8.3 A reliable mind	155
8.4 Unmasking delirium	162
8.5 Mad but not mad	163
8.6 Re-masking delirium	165
8.7 Summary	169
 Chapter Nine: Repositioning nursing care	 170
9.1 Introduction	170
9.2 The contested terrain of who is the expert	170
9.3 The specialist nature of working with older people	176
9.4 Appropriate and suitable staff	180
9.5 The (mis)communication of communication	184
9.6 The discursive practice of being labeled 'at risk'	190
9.7 Summary	194
 Chapter Ten: Final reflections and concluding comments	 195
10.1 Introduction	195
10.2 Revisiting the research aims	195
10.3 The predominant discourse influencing the discursive construction of delirium	196
10.3.1 The discourse of delirium as a syndrome	197
10.3.2 A personal discourse of delirium	199
10.4 Possibilities for improving nursing practice	200

10.4.1 The current situation	201
10.4.2 Introducing the critical gerontological nurse	202
10.5 Limitations of the study	205
10.6 Suggestions for future research	208
10.7 Concluding statement	209
 Tables	
Table 1: Diagnostic Criteria of DSM-IV-TR for Delirium	78
Table 2: The Confusion Assessment Method (CAM) Diagnostic Algorithm	80
 Illustrations	
Illustration 1: Poster advertising a delirium service	125
Illustration 2: Cover illustration for the April 2001 edition of the Journal of Gerontological Nursing	126
Illustration 3: Illustration accompanying feature article in the April 2003 edition of Critical Care Nurse	127
 Appendices	
Appendix One: Information sheet A	211
Appendix Two: Information sheet B	214
Appendix Three: Information sheet C	217
Appendix Four: Participant consent form	219
 References	 220

Chapter One: Introduction - framing the study

1.1 Overview of the chapter

This chapter provides the background information which positions this thesis. It begins with an overview of my engagement with, and commitment to, the topic under investigation through the description of a critical incident. Following this I introduce the reader to the influences that result in the production of a largely objectified delirious older body while silencing the personal perspectives on this phenomenon. This includes a discussion on the influences of critical gerontology, postmodernism and Foucauldian theory on my thinking. Finally this chapter sets out the focus of the argument to be developed, determines the aims of the present study and concludes with an overview of the chapters that will follow.

1.2 Background to the study

At the outset of this chapter I need to declare my position as the researcher and writer of this thesis on delirium¹ in people over the age of 65 years. I have undertaken this research project as a 44 year old pakeha male currently employed by a university, and someone who holds a privileged position as co-chair of a New Zealand professional nursing organisation. Positioning myself in this way gives me a particular view on life. I am therefore open to being challenged on the legitimacy of my assertions. Because of my current age I accept that I may not be the best person to comment on delirium and its impact on people over the age of 65 years. However, through my long involvement with nursing, in particular working with older people, hearing their stories and worries I know enough to be concerned about the realities faced by older adults, who have been delirious, as they interface with the health care system in New Zealand.

¹ Delirium in this context is generally understood as a sudden disturbance of consciousness. Delirium manifests as a change in cognition, memory impairment, disorientation and an alteration in psychomotor activity (Truman & Ely, 2003). Note, chapter 4 traces the emergence of delirium as a stable biomedical entity and provides a critique of the concept.

I was acutely aware of the vulnerable position in which such older people who had been delirious found themselves and the potential for them to feel compelled to participate in this research project. I therefore attended to ensuring that all participants were fully informed about the research and what would be required of them. I also had contact with each person at least three times before undertaking the interview to check that they were still interested and happy to speak with me. This process is covered in greater depth in chapter three of this thesis.

The story that follows was instrumental in crystallising and shaping this doctoral study. At the time of this clinical incident I was working as a registered nurse in an assessment, treatment and rehabilitation setting in a major hospital. I had been working on the ward for approximately two months when the incident occurred.

I arrived on afternoon duty to find the ward in a state of frantic busyness. There were many quite sick people who needed intensive nursing input. I obtained a verbal report from the morning staff about the clients I would be working with that afternoon, five in total. None of the people were identified as having delirium. Before I had the opportunity to introduce myself to any of the clients with whom I would be working that afternoon, the unit nurse manager asked if I would urgently escort a client over to another major hospital to have a PICC line inserted (a peripherally inserted central venous catheter). This type of catheter is inserted into one of the major vessels that ultimately ends up in the superior vena cava. PICC lines are used for the administration of blood products or for continuous drug infusion (Bender, Yasko & Strohl, 2000). As I had never seen one of these procedures carried out I agreed.

I returned when dinner was being served. Half of the staff had themselves gone off to have their break and the ward remained busy. I went around and introduced myself to the people I had been assigned to work with for the rest of the shift. The other nurses had told each of them that I had been called away urgently and that they were covering for me until my return. Everyone seemed settled, including Ms Z. Ms Z was an 80 year old woman who had multiple health problems, had recently

undergone a surgical procedure, she was on oxygen via nasal prongs and was anxious and frail.

After dinner I began to take vital signs, administer medications and reinforce the individual rehabilitation plan associated with each client. I approached Ms Z requesting to take her vital signs. She was reluctant to have her recordings taken but agreed. While taking her blood pressure she made odd comments like “that looks like a snake, are you sure it is dead?” and “don’t tell my mother that a young man has been sitting on my bed”. I thought to myself that checking her oxygen saturations would be a good idea.

On the way to get the O2 sats machine (this is a non-invasive technique that measures the amount of oxygen in the blood) Mrs Y from the opposite bed asked if I would carry her night clothes and toilet bag to the wash room. On the way Mrs Y said that Ms Z had been citing philosophy rather loudly all afternoon and stated that in her opinion she thought Ms Z was “as mad as a hatter”.

I returned to Ms Z intending to measure her oxygen levels, speaking as I approached her. Ms Z started shouting, “Help! Help! Mum there’s a man in the house”, and screamed. My immediate response was to move towards her saying as I went “It’s alright Ms Z, my name is Stephen, I am a registered nurse and you are in ward five of the hospital”. Ms Z still screamed for her mother. My desire to comfort a person in obvious distress overrode common sense as before I knew what had happened this frail older woman had doused me with a litre of concentrated, very sticky orange juice.

One of the other women in the room rang the bell repeatedly, which brought absolutely everyone to see what was going on. I moved away and continued to attempt to reorientate Ms Z. Another nurse went over to Ms Z asking for the empty orange juice container. Ms Z screamed “I know what you are up to, all of you. You want my money don’t you? Well over my dead body” and bit and scratched the other nurse.

We all retreated to a safe distance. By this time the nasal prongs had come out of her nose and she was looking obviously distressed. I phoned the duty registrar and house surgeon while the others attempted to get close enough to put her oxygen on.

No one was successful and the other people in the room were beginning to fear for their safety so we moved them into the lounge.

The house surgeon and registrar arrived, heard what had happened, agreed that it looked as though the incident was related to lack of oxygen and was probably a delirious episode. When they went into the room Ms Z shouted, “I know what’s going on. You’re with them aren’t you? Well it won’t work. Mum! Mum! They’re back. Help mum”.

I changed into another uniform and tried to phone Ms Z’s relatives to get them to come in and sit with her. Her husband was not home and her only daughter had a hearing impairment and was not answering her phone. It took another hour before we could get close enough to Ms Z to put her oxygen back on. We then moved her into a single room and took her oxygen sats, which were 84% on air. Ideally normal oxygen saturations should be >95% on room air and if these drop below 90% further immediate interventions are required (Hoffman & Manzetti, 2000). After an hour of receiving oxygen her condition began to improve although it did not resolve entirely. That was to take a few more days.

I filled out a special incident report, notified the duty coordinator and wrote the incident up in Ms Z’s progress notes. Meanwhile the registrar also wrote his account of the incident. By the time the shift was over Ms Z allowed me to go in and attend to her, making her comfortable for the night, but she refused to take her nocte medication, as she was still suspicious that I was going to poison her. The shift ended and I went home.

I then had my days off as well as a few days annual leave so it was a further seven days before my return. During that time I had thought much about the incident. I looked forward to returning to work in the hope that I might speak with Ms Z to see what she remembered as the literature I had been reading indicated that many people do not retrospectively remember their experience of delirium.

Ms Z had indeed progressed during my absence and had been feeling really awful about “the trouble I caused the other night”. She had remembered and had been asking to speak to both myself and the other nurse she “attacked”. It had transpired she wanted to speak personally with us to apologise. I was told by the nursing shift

co-ordinator that it was not necessary to see her as it might upset her further and that they had told her “it doesn’t matter we are used to things like that happening”. Interestingly enough she was also not my allocated client and was not going to be in the future. I felt muzzled and silenced. I imagined Ms Z felt the same.

After report I walked past Ms Z’s room on my way to get something, stopped said hello and asked how she was. She asked me to come in as she wanted to discuss “the other night”. She apologised for her behaviour and said that it was nothing personal but she was convinced we were all out to get her. She had been hoping that she would catch me, as the others were not that keen to talk about what happened and she felt she needed to.

I asked her what she remembered. She said she had felt like an outsider, somewhat detached and very frightened. The whole episode felt like an awful, awful nightmare. She felt we were definitely agents working for the government who were setting out to take her possessions and papers. “I have tried to tell the other staff about this but they keep saying don’t worry about it, it’s over now”.

I wondered what was written in her notes and even then suspected that what was documented would be largely objective and clinically focussed. There were absolutely no surprises. Everything that had been written since the episode related to the pathology of her delirium. At least the nurse’s and doctor’s documentation used the words delirium and did not claim she had dementia. The notes were full of valuable objective data: oxygen saturations, vital signs, confusion absent or present, medications given and how she was progressing with her physical rehabilitation after surgery. Nothing was written about how she felt about the incident, what she experienced, that she felt remorseful or that she wanted to tell her story. In effect her objective, physical condition had been profiled, but her voice had been silenced, rendered not important. Ms Z had been reduced to a set of problems that needed to be rectified and managed.

Around the time of the above incident I had been reading ‘Sophie’s world: A novel about the history of philosophy’ and came across the following quote “Two people can be in the same room and yet experience it quite differently. This is because we contribute our own

meaning – or our own interests – when we perceive our surroundings” (Gaarder, 1995, p.380). I identified with this statement and when placing it in the context of Ms Z realised that only one half of the story had been told. Meanwhile the established nursing and medical doctrine surrounding the treatment and care of older people who have delirium has us think otherwise. It is this powerful doctrine, enshrined in Ms Z’s clinical notes, that is documented as being the true depiction of the event while the legitimacy of the happenings remains unquestioned. My reaction to this was a resolve to unsettle the status quo but as yet I was unsure how to undertake that process.

1.3 Outlining the field of inquiry

During the initial stages of planning this study literature searches were conducted using electronic databases. The databases searched were CINAHL, Cochrane Database of Systematic Reviews, EBSCOhost, Medline, Health Source/Academic Edition and Web of Science. The major key words used when searching the databases included *acute confusion*, *acute confusional state*, *confusion*, *delirium*, *elderly*, *old age*, *older people*.

The review of the literature surrounding delirium in the older adult identified a dearth of qualitative perspectives, while conversely highlighting the vast number of studies undertaken and published from a quantitative position (Foreman, 1993). Each of the quantitative and qualitative studies accessed and reviewed concluded that delirium was a serious problem not only for the older person but also for the health professionals involved in their care (Lundstrom et al., 2005; McCurren & Cronin, 2003). In addition, the literature identified that more research was needed within this field of inquiry (Francis, 1995). I found this comment interesting as studies related to delirium in this population have been published over a 30 year period at least, yet research gaps, and limited perspectives continue. These studies had attempted to predict and control delirium utilising mathematical formulae to produce a grand theory on this phenomenon with limited success (Inouye & Charpentier, 1996; Lundstrom et al., 2005). I felt another view was necessary, not to solve the ‘problem’ but to understand the human complexities associated with delirium.

My epistemological position for this research attends to addressing my concern that one perspective associated with being older and having delirium is documented and heard whilst the other is silenced, and therefore rendered unimportant. It is also imperative to me that the outcomes associated with publishing this research create future possibilities for an improvement in the care offered by nurses to older people who experience delirium. My overall goal is to offer an alternative to the plethora of research currently published on this area of concern through the utilisation of research methods that will not only question but problematise the status quo.

Both Gilmour (2001) and Payne (2002) claim that analytical inquiry is shaped through the meeting of epistemological concerns which in turn direct the questions asked, the methods used for data collection, the research approach, as well as the relationship between the researched and the researcher. I wanted to use an approach that recognised my social, critical and political gerontological leanings, as well as my desire to combat the negative views of old age frequently experienced by older people as they negotiate the health care system within which nurses play an integral role.

At the time this study was being developed, the small amount of literature published on older people's experiences of delirium was framed within a phenomenological or grounded theory framework (Laitinen, 1996; Schofield, 1997). My introduction to and readings on critical gerontology and postmodernism convinced me that more than a phenomenological or grounded theory study was needed. In my view the older person's experience of delirium required foregrounding because the literature on this topic largely highlighted the progress made by medical and nursing research, with the consequent marginalisation of the older person's own view. I wanted to avoid subscribing to the position of progressing nursing research through failing to recognise the contradictory and silent subject positions occupied by older people. My desire was to end this silence and to reveal the diversities and complexities surrounding delirium in older people.

In addition, the critical incident presented earlier in this chapter highlights the disciplinary and institutional influences that constrain the voicing of experience. Gubrium (1993, p.61) supports this by claiming that “the world of everyday life has tradition, formal organization, and political surroundings that, in practice, concretely enter into and shape the voicing of experience”. The application of Gubrium’s (1993) critical gerontological claim made me realise that more than the subjective voice of the older person who has experienced a delirious event was needed. In order for the study to be meaningful I needed to move beyond the humanist position on subjectivity to examine how older people who experience delirium take up and are taken up by subject positions within the biomedical, nursing and public discourses.

I therefore needed to include a philosophical position that recognised the continual tension that exists between, and within groups such as nursing and medicine, and older people who are delirious. This philosophical perspective needed to interrogate how the deployment of knowledge and power can be utilised as a means to create and sustain certain subject positions. My readings on critical gerontology lead me to the work of Michel Foucault and a critical discourse analytic approach. The utilisation of such an approach places the social, cultural and historical contexts as being central to the inquiry process (Crowe, 2005). In addition, Crowe (1998, p.340) goes on to assert that the assumptions underpinning qualitative methodologies, such as phenomenology or grounded theory, reveal “... an ideological position which proposes that reality can be apprehended by capturing the individual’s point of view (subjectivity) and that qualitative researchers can directly represent this lived experience in language”.

I have taken up Foucault’s suggestion regarding the use of his work as follows:

All my books ... are little tool boxes ... if people want to open them, to use this sentence or that idea as a screwdriver or spanner to short-circuit, discredit or smash systems of power, including eventually those from which my books have emerged ... so much the better (cited in Patton, 1979, p.115).

The idea of a toolbox approach enabled me to utilise certain analytic tools associated with critical gerontology, postmodernism and Foucault. Manias and Street (2000) support the use of a toolbox approach by claiming that each perspective poses different questions, and

as such focuses on particular aspects of the analytical phase of the research that the other is not concerned with. The analytic tools derived from the three philosophical perspectives outlined above formed the foundations for the interrogation of the multiple discourses available on delirium in older people. This eclectic approach fostered the surfacing of subjugated knowledges (Foucault, 1980a); the kind that have been disqualified because they are claimed to lack a scientific basis. Also this thesis exposes to critique, a health care service within which nursing plays an integral role. This critique may result in a rethink of nurses' attitudes and practices toward older people with delirium. Finally, in this thesis I explore the potential spaces where resistance can occur through the deconstruction of the complex networks of power and knowledge which support the promulgation of dominant discourses (Carrier, 1997).

1.4 The key focus of the arguments presented in this thesis

As outlined previously on page 6, the available published knowledge on delirium has occurred largely through the utilisation of quantitative methodologies. The knowledge generated by quantitative means supports a scientific and medical understanding of delirium in people over the age of 65 years. This understanding forms the foundations of the biomedical discourse. Constructing delirium in this way has major implications for the subject positions offered to this population, which in turn influences how they are treated and viewed by their families, society and health professionals.

There is no denying the importance of medical knowledge in the field of delirium; however it is a view I consider provides only a partial 'knowing' of older people with delirium. While the value and strengths associated with the biomedical discourse need to be acknowledged, for example the areas of assessment, diagnosis and cure, this discourse should also be challenged as to the primacy it has been given and its limitations exposed. Some of these limitations include offering people with delirium a particular set of subject positions, for example those associated with being dependent, vulnerable, infirm, cognitively impaired and incapable. As a result older people may be inscribed as such, and

stigmatised through a multiplicity of circulating and contradictory discourses. It is these limitations that will be explored throughout this thesis.

In addition, biomedical research has focussed on constructing a relatively stable and objective delirious body. Biomedical knowledge is but one truth among many. The dominance of the biomedical discourse has meant other discourses on delirium have not been afforded the same status in our social world. Instead they have been relegated to the position of 'other', their knowledges subjugated.

The intention of this research is to critically examine the major discourses circulating on delirium, and how these discourses influence the subject positions offered to people who have been delirious. In addition it illuminates the tensions, plays of power and contradictions that exist within the discursive field of delirium as well as foregrounding the subjugated discourses that have until now been silenced and positioned as 'other'.

The discursive field of delirium is explored through the generation of texts from a variety of sources. Foucault developed the concept of a discursive field as a means of explaining the relationship between language, power, social institutions and subjectivity (Foucault, 2002a). Weedon (1987) identifies a discursive field as sets of social processes organised through particular institutions and their respective practices. Discursive fields contain multiple discourses all competing with one another for the dominance of giving meaning to the world, and in the instance of the present research to delirium.

The texts generated for analysis in this thesis originate from interviews with six people aged 65 years and over, their clinical records, five family members, three health professionals who comprise a delirium service and the published literature available on delirium and ageing. The analysis of this textual material provides the basis for this research. Finally, throughout this thesis I refer to 'family' and 'family members' as they relate to older people who have been delirious. I use both of these terms within the broadest sense to include significant others who may not be related via kinship ties but who are as important, or more important than blood relatives. My interpretation and use of family is

supported by Friedman (1998) who defines family as people who are emotionally involved and live in close proximity to each other.

1.5 Study aims

The utilisation of a critical gerontological and postmodern frame of reference and aspects of Foucault's work has driven the development of the following research aims:

1. Interpret the meanings embedded in the discourses surrounding delirium via the collection/analysis of relevant published documents.
2. Explore the discursive production of the person with delirium.
3. Develop a position from which to explore a range of possibilities nurses could utilise to provide appropriate care to people and their families experiencing delirium.

1.6 Structure of the thesis

The presentation of a traditional thesis follows a conventional style of including, in order, chapters dedicated to introducing the topic, critically reviewing the literature, presenting the results, discussing the key findings in relation to the literature and the provision of a set of concluding comments (American Psychological Association, 2001). In this thesis I have purposely chosen to position my methodology and methods chapters before critically engaging with, and reviewing the literature on delirium. By first introducing the philosophies associated with critical gerontology, postmodernism and the work of Foucault, the language and key concepts that underpin these philosophies can then be drawn on as a means to interrogate the literature available on delirium.

Chapter one: This chapter has provided a background to the area of research interest, presented an overview of the key arguments and outlined the main aims associated with this project. Writing this chapter has further clarified my goal, which is to challenge the current focus on objectification of the older delirious body through the opening up of discursive spaces that privilege the subjective experience of these people.

Chapter two: Here the philosophical terrain within which the research is located is described. The chapter begins with an overview and examination of the philosophies associated with critical gerontology, postmodernism and Foucauldian theory. My interpretation of a Foucauldian approach will be presented along with the various techniques drawn from his work, for example the concept of discourse that has shaped both the collection and analysis of data generated.

Chapter three: A methodological account of the steps utilised to gather the data that informed this research is presented. This includes the techniques used to access participants, conduct the interviews, transcribe the data produced and analyse the texts. The ethical issues that needed to be addressed as part of undertaking the research are also discussed.

Chapter four: An archaeological and genealogical analysis (Foucault, 2002b) of the literature in relation to tracing the development of the clinical concept of delirium is provided. Delirium emerged as a stable medical entity in 1980 with its inclusion in the third edition of the Diagnostic and Statistical Manual [DSM III] (American Psychiatric Association, 1980). This section of the thesis incorporates the historical, social and political context within which medical discourse constructs older people with delirium as being problematic. The construction of older adults with delirium as problematic is one of the key features of what I have termed the discourse of delirium as a syndrome.

Chapter five: A critical examination of the discursive field of delirium is presented, utilising a review of the literature within nursing and medicine. This chapter demonstrates how both nursing and medical literature is constructed and influenced by the reductionist discourse. From within the nursing discourse I have identified the emergence of a competing discourse which has the potential to disrupt and resist the reductionist discourse. I have coined this discourse a personal discourse of delirium. Inherent in this discourse are the social, cultural and historical aspects of older people's lives that influence their interpretation of being delirious.

Chapter six: This chapter focuses on the privileging of the personal discourse. Privileging a personal discourse frames the voices of older people who have been delirious, and their families, and offers a potential site for resisting the discourse of delirium as a syndrome. This position is juxtaposed with attempts in nursing and medicine at contextualising the experience of delirium.

Chapter seven: Here the analytic process surfaces the sub-discourse of ageism and the covert and overt influences this discourse has on offering a range of negative subject positions to older people who have delirium. The discursive spaces where people resist the subject positions offered to them, as they negotiate a delirious episode, are highlighted.

Chapter eight: In line with the central tenets of the thesis this chapter once again gives primacy to the subjugated knowledges and promotes the counter discourses of people who have been delirious. The chapter begins with an analysis of how the discourse of delirium as a syndrome attempts to override and silence a personal discourse of delirium. Particular emphasis is placed on the critical examination of the metaphorical use of language in relation to madness.

Chapter nine: Here I concentrate on the texts generated by people who have been delirious and their families as they come into contact with nurses and other health professionals as part of receiving a health service. The variability of the accounts highlight that a flexible nursing service is needed to meet the needs of older people who have been delirious and the needs of their families. In addition, the nursing service offered to this population group is at odds with what is suggested in the published literature available on working with a person experiencing delirium. This is not in the best interests of older people and only serves to reinforce the negative stereotypes and myths circulating on old age.

Chapter ten: In this, the final chapter of this thesis, I review the findings of the study and their implications for gerontological nursing practice. I pursue the main theme of my thesis; that older people with delirium are constructed as objects through the deployment of a reductionist discourse. Concomitantly, this population has the potential to be marginalised

and medicalised. However, the inclusion of the discursive voices of people who have been delirious has provided opportunities for resistance and spaces where a personal discourse can become visible and serve to problematise the status quo. Also presented are the limitations of the study and suggestions for future research. Future possibilities for nursing practice do not provide another metanarrative about delirium, but do outline some suggestions for nursing to consider that I believe have the potential to positively influence the health and well-being of older people and to position nursing as a socio-political activity.

1.7 Summary

This chapter has presented the key tenets inherent in this thesis. It has traced the development of my engagement with the topic under investigation, my desire to explore how older people who experience delirium are constructed and how this construction manifests itself in day to day life. In addition the chapter has introduced the reader to some of the socio-political issues associated with ageing. This section of the thesis has also presented the key aims and an outline of the contents of the research. In the following chapter the focus shifts to locating Foucault within postmodernism and critical gerontology, outlining the major concepts associated with his work that are inherent in these two theoretical positions. However, before progressing to chapter two, I wish to reiterate that this thesis in no way attempts to generate a set of findings that can be generalised to all older people who experience delirium. Instead it offers a partial and highly contextual account of delirium, an account that offers a multitude of diverse, complex and contradictory subject positions.

Chapter Two: The philosophical location of the study

2.1 Introduction

The previous chapter has introduced the reader to the main focus of the study which is to interrogate how older people who are labelled as being delirious are constructed and how this manifests in day to day life. Accordingly, what follows is a critical overview of the philosophical lens used to view all data generated as part of undertaking this research.

In this chapter I begin with a philosophical account of my understandings of critical gerontology, postmodernism, discourse and Foucauldian theory. I do this as someone who is deeply interested in these philosophical and theoretical perspectives. Staying within the custom of these philosophical positions, the suitability of critical gerontology to nursing is argued. A major and overriding focus for undertaking this research was to generate knowledge that had direct relevance to nursing practice, and ultimately influenced the nursing service provided to older people with delirium and to their families.

2.2 Critical gerontology

Critical gerontology has been defined in a variety of ways and began to gain prominence in the literature during the 1980s and 1990s. For example, Katz (2003, p.16) depicts critical gerontology as “a thought space, a magnetic field where thought collects, converges, and transverses disciplines and traditions ...”. On the other hand, Jamieson and Victor (1997, p.177) identify that critical gerontology can best be described as “an awareness of and a commitment to the emancipatory interest inherent in the social sciences ...”.

Several writers credit the foundations of critical gerontology to the Frankfurt School set up in 1930 and associated with the 20th Century thinkers Horkheimer, Adorno and Marcuse (Jamieson & Victor, 1997; Katz, 2003; Moody, 1993). The critical perspective originating out of the Frankfurt school problematised the role of the social sciences within society,

particularly those related to politics, science and social justice, and the impact these had on everyday life. Critical theory utilised in this way is essentially a negative critique, a critique focussing on limitations as opposed to a positive critique with an emphasis on the provision of an alternative theory (Jamieson & Victor, 1997). Ray (2003) agrees but asserts that both negative and positive critiques are key features of critical gerontological work.

Critical gerontology, and its associated influences, clearly propose it incorrect to present this position as a specific theory. An extensive array of academic and practice focussed perspectives come under the umbrella of critical gerontology (see Cole, Achenbaum, Jakobi & Kastenbaum, 1993). However, it is possible to detect a number of distinctive commonalities from the plethora of writings available on the topic. Baars (1991) provides a succinct commonality when identifying critical gerontology as a conglomerate of questions, problems and analytical techniques that have been marginalised by the scientific method. Broadly, and unanimously, the term identifies perspectives on ageing that challenge and contrast with positivism, a modernist ideal (Cruikshank, 2003; Oldman, 2003).

By problematising positivism, critical gerontology questions the basis for knowing about ageing being measured solely through objective means. Critical gerontology asserts that other viewpoints are also needed and these include the hermeneutic, social, cultural and political approaches to ageing (Jamieson & Victor, 1997; Kontos, 2005). The theoretical perspectives used to critique the positivist position on ageing range from critical theory (Moody, 1992), theories of political economy (Minkler & Estes, 1991) through to postmodern theories that analyse the discursive formations of age and the life course (Featherstone & Hepworth, 1996; Katz, 1997).

The multiple theoretical perspectives presented above suggest that critical gerontology incorporates and encourages an interdisciplinary approach to the critique of the biomedical enterprise. While taking an interdisciplinary approach is useful, Moody (1993) cautions researchers to remain committed to the critique of the epistemological status and approaches associated with gerontological studies. A reflexive approach is an integral component of any critical gerontological stance, as well as focussing on the contradictions,

inconsistencies and gaps inherent in the truth and knowledge available on ageing. In order to clarify the complexities associated with the theoretical position of critical gerontology it is first useful to briefly outline the key tenets associated with modernism.

2.3 Modernism

The birth of modernism can be traced to the Enlightenment Period. The Enlightenment Period was an intellectual movement that swept through 16th and 17th century Europe and ushered in the era of modernity (Traynor, 1997). Prior to the dawning of modern times knowledge and understanding of the world was dominated by the social power of the church, the monarchy and aristocracy (Reed, 1995). Leading up to the Enlightenment Period, the church's authority was sacrosanct and understood as the only source of knowledge, thereby influencing social norms and public values. The doctrine of the church and god was upheld often through fear of punishment in this life or the next.

The Enlightenment Period saw the rise of science and the use of reason over the dogma of religion. The philosophers of this time viewed the Church and the previously dominant powers of superstition as obstacles to the development of reason and science (Rolfe, 2000). A critique of the Enlightenment Period reveals that the intellectual project was directed largely by a privileged, educated few. Hampson (1968, p.146) saw this time as an "attitude of mind rather than a course in science and philosophy" and suggests that the radical ideas were followed by very few and fully accepted by even less. However, thinking was changing, albeit slowly, as new ideas and values spread largely through educated European men.

One of the key promises associated with the Enlightenment Period was the concern of ensuring human emancipation through the development of rationality and scientific method (Giddens, 1991; Gray & Pratt, 1991; Traynor, 1997). Philosophers such as Descartes, Locke, Hume and Kant contributed significantly to the development of knowledge, truth and science through the processes of deduction, observation and rational thought. These notions form the basis of foundationalism. The principles associated with foundationalism

are inherent within modernism and therefore by association, scientific inquiry. Crotty (1998) identifies foundationalism as the epistemological belief that knowledge has secure and certain foundations.

The modern world is entrenched in the Enlightenment principles and refers to the social order emerging from that period, with one of the key aspirations being the search for the truth that can describe the world we live in (Lyotard, 1984). An inherent component of the foundations of modernism is the development of knowledge, and therefore truth, through the use of empirical methodologies. The term empirical pertains to the utilisation of observable evidence as data (Lowenberg, 1993). The ultimate aim of empirical, scientific ways of knowing is the quest for a grand narrative that can be refined and generalised to influence whole populations. This quest involves revealing the objective nature of whatever is under investigation without contamination. Therefore, within a modernist frame of reference a grand narrative is sought through the elimination of biases, contradictions and values (Neville, 1997).

Modern societies are distinguished by the economic, political, social and cultural grounds that have influenced industrial, capitalist economies, democratic political organisations and social structures. This view is typified by the following identification with modernism as

... a paradigm that framed American intellectual, social, and educational thought during the first seven or eight decades of the 20th century. It has made America a leader among the world's industrial nations; socially it has framed for us the dream of a more leisurely life ..., intellectually its methods have dominated areas well beyond its own domain - areas of philosophy, psychology, and educational theory (Doll 1993, p.1).

Capitalism, a major driving force behind modernism, is associated with a never ending quest for new materials, new sources of human labour, and an increasing focus on the development of inanimate technologies to promote consumerism. Industrialisation, a product of capitalism, has produced a division of labour, where the tasks associated with work have become increasingly more specialised whereby people have become units of

consumption (Lyon, 1999). As a result consumerism has become a major component of western life. So much so that tasks once performed by extended families, for example looking after older sick family members, are now undertaken by state run and private organisations. In this instance the older person has become a commodity and the extended family downsized into a primary nuclear unit of consumption (Lyon, 1999).

2.3.1 The modern subject

Prior to the Enlightenment period humankind was defined in relation to the cosmic order, however since this time the modern subject is identified as being self defining (Rundell, 1989). Resulting from the foundational principles inherent in modernism the modern subject has developed as a sovereign, rational, coherent and unified being (Rosenau, 1992). These concepts allow humankind to "... claim the 'right of insight', the right that nothing can be imposed on an individual that the individual has not freely chosen or seen the necessity for seeing" (Kolb, 1990, p.267). This quote also implies that the human subject is an autonomous individual, who is self-conscious, rational and capable of self-actualisation (Johnson, 1994).

The modernist ideals described in the previous paragraph are central components of contemporary western philosophical thought. The notions of unification, coherence and rationality, in relation to the human subject, are fundamentally essentialist. "Humanism is essentialist; it assumes that there is an essence at the core of an individual which is unique, coherent and unchanging ... the individual's experience and the meaning it holds originates within the person, in her or his essential nature" (Burr, 1995, p.40). Humanism allows the person to be either fully engaged, or have the potential to be engaged with their surroundings. The qualities and attributes inherent in humanism place the modern subject in a centred position in relation to the world. The human subject becomes the source of all knowledge, not only in the world, but additionally about the world. This is supported by Magee (1987) and Sarup (1993) who both attribute the centring of the human subject to Descarte's infamous dictum 'cogito, ergo sum', 'I think, therefore I am'.

2.3.2 Modernism, nursing and health

It appears that modernist ideologies have infiltrated the world of nursing and subsequently impacted on the development of nursing knowledge. This premise is supported by Meleis (1985) who suggests that nurses have always tended to be influenced by the philosophical underpinnings of the time. Nursing is heavily imbued with the progressive modernist quest for human improvement through science and rationality. This has clearly been illustrated in a review of published nursing research on delirium in older people (eg. Fick & Foreman, 2000; Foreman, Mion, Trygstad, Fletcher & NICHE Faculty, 1999; Milisen, 1999). Each of these studies have attempted, without success, to predict and control delirium utilising quantitative formula to produce a metanarrative.

The influence of modernism on nursing has been criticised as hindering nursing knowledge development (see Allen, 1985; Emden, 1988; Francis, 2000; Watson, 1995). Even Florence Nightingale could be deemed modernist because her theorising was restricted to things observable. Nursing knowledge was generated by the comparison of tangible and observable situations, therefore encouraging nurses to focus on the physical and environmental issues that impacted on the health of patients receiving care (Wicks, 1999).

On the one hand, modernism has contributed hugely and successfully to improving living conditions, and the health and well-being of many populations throughout the western world. Many of the technologies we take for granted in nursing practice, such as pulse oximetry and automatic blood pressure measuring devices were unthinkable in the early 20th century. Modernist approaches to research questions have supplemented the knowledge on delirium in areas such as incidence, risk factors, causes and practice protocols (Inouye & Charpentier, 1996; Milisen, 1999; Foreman et al., 1999). The findings of these studies have helped to decrease, but have not eradicated, as hoped, the incidence of secondary morbidity in people who have been delirious, for example pneumonia, decubitus ulcers and falls, as well as the potential for inappropriate placement into residential care settings.

Yet, on the other hand, modernism has also been accompanied by limitations and counter productivities; for example the failure of communicative practices based on the search for a single truth or metanarrative. Scientific innovations have profoundly impacted on social activities. In many instances there is no longer the need to rely on face-to-face relationships in order to communicate. As a result our social relationships are extended over both time and space, connected by digital signals and fibre-optic cables (Lyon, 1999).

Modernism has impacted on the type of health service offered to older adults by health professionals, whether these people are managers, doctors or nurses. Populations and consumers of health services are treated as knowable 'things', reduced to the roles and categories that are reserved for them in the stories told by health professionals. As health professionals, we assume to know who these people are, and how they think, because we have assigned them into a unified and stable category that has been proved through scientific research. For example, delirium, cognitive impairment and physical decline have been proved by scientific communities, through modernist techniques, as 'truths' about growing old (Foreman, 1993; Schofield & Heath, 1999). Consequently, these scientific and objective representations of older adults have seen this group of people assigned to diagnostic related groups and sets of dependency scores, determined by health professionals, as a way of knowing about old age.

In summary, the essence of a modernist view of the world can be characterised in three ways. Firstly, modernism appears to be preoccupied with the development of an objective science as the only source of 'truth' and therefore knowledge. Secondly, the history of human existence is portrayed as a linear, progressive and evolutionary process. Finally, that reason is the universal foundation for knowledge, and the capacity for reason is a key ingredient of being human and is the basis of people's rights as citizens. The focus of this discussion now shifts to an examination of other ways of viewing the production of knowledge and truth, particularly postmodernism.

2.4 Postmodernism

The previous discussion on the meanings and utilisation of modernism has laid the foundations for understanding postmodernism. There have been a multitude of articles and books published on postmodernism since the late 1950s, however it was not until the 1980s that it began to gain significant prominence in philosophical texts (Rolfe, 2000). Postmodernism is a philosophical current critical of the promise of enlightenment inherent in modernist philosophies and their assumptions, as discussed in the previous sections 2.3, 2.3.1 and 2.3.2.

Postmodernism has been described as an exasperating term due to its application to a multitude of phenomena and objects that sit within the realm of reality (Bertens, 1995). It is possible that there are as many constructions of postmodernism as there are postmodernists, if in fact there is such a thing as a postmodernist. However one thing is certain, there is no single unified position related to postmodernism, except that all variants participate in the critique and challenge of foundationalism, the view that science is built on a firm base of observable facts. Rue (1994) agrees and describes postmodernism as the rejection of the dominant foundational programme associated with western tradition when he claims:

There are no absolute truths and no objective values. There may be local truths and values around, but none of them has the endorsement of things as they really are ... As for reality itself, it does not speak to us, does not tell us what is true or good or beautiful. The universe is not itself any of these things, it does not interpret. Only we do, variously (p.272-273).

Postmodernism is an intellectual movement that is frequently aligned to architecture, literature and the arts (Burr, 1995). In the literal sense the 'post' in postmodernism may be seen by some as meaning coming after the period of modernism. This interpretation is problematic in the sense that it "defines a period in time rather than an intellectual or artistic movement" (Rolfe, 2000, p.29). The era of postmodernism should not be misunderstood as being anti modernist either. The term 'post', as in postmodernism, should be taken as signifying continuity as well as critique. Both eras can and do co-exist with

modernism merely being displaced (Lupton, 1998). Several commentators regard modernism as being very much alive and well (Giddens, 1991; Rolfe, 2000). Regardless of the multitude of definitions surrounding postmodernism its major function is to critique the assumptions inherent in the Enlightenment and modernist projects, and challenge the links between science and truth. Lyotard (1992) identifies that the utilisation of postmodernism in this way enables the rewriting of some of the features modernity had tried or pretended to gain, particularly in founding its legitimisation upon the purpose of the general emancipation of humankind.

As previously suggested, a key aspect associated with a postmodernist perspective is the rejection of the notion that the world can be understood through explanations provided by grand theories or narratives. Some examples of grand theories are capitalism, existentialism and marxism (Natoli, 1997). Postmodernists instead argue for an emphasis on multiple ways of being and knowing, with a key focus on the favouring of situated accounts. Situated accounts take the form of mini narratives (Rolfe, 2000), multiple perspectives and/or truths that occur on a micro level. Postmodernism has been described as a form of cultural representation that:

... leaves us free to acknowledge an irreducible heterogeneity. The monologue of a totalising theory, is replaced by a continual dialogue across the “hard surfaces” and “local knowledges” of these differences, where analysis does not represent the closure of the truth, but an attempted exchange conducted in good faith and with a certain scepticism towards its own language and position (Chambers, 1990, p.10).

As discussed so far, the grand narratives to which postmodernism reacts are largely representative of scientific knowledge, which postmodernism rejects as the only form of knowledge or truth available on a given subject. Lyotard (1984) identifies the metanarrative of scientific knowledge as being in continual conflict with narrative, or personal knowledge. Jameson (1982) believes narrative, also referred to as story, to be a theoretical category which presents and represents the world. For example, the narrative of medicine applies the rules of science (the maintenance of objectivity and ensuring scientific progress is made) to ensure that only one truth, or knowledge about a certain condition (such as

delirium) can be retained, at the exclusion of all others. While scientific knowledge requires scientific proof regarding its validity, personal narratives do not (Lyotard, 1984). Personal narratives are localised, contextual and imbued with social and historical meaning. It is this conceptual understanding of narrative that underpins the use of the word in this thesis.

When placed in the context of health care, and in particular delirium, postmodern thought challenges the pervasive health sector environment where all health professionals work together to ensure the best health outcome for the older person who is, or has been delirious, as well as their families. Postmodernism critiques the modernist view of scientific progress within the discourse of delirium, and indeed would challenge whether the advances identified in the delirium literature are progressive. By assuming a postmodern position for this research I am not intent on uncovering the truth. If that were the case then doing so "...implies that there is something there waiting to be uncovered. Instead, they would see truth as something that is constructed, and there can be as many constructions of the truth as there are people in the world to construct it" (Rolfe, 2000, p.3).

Davis and Glass (1999) advocate for nursing to embrace postmodernism as a philosophical lens to advance nursing practice to encompass those who are marginalised. This claim is aligned to the key assumptions associated with this research, as outlined in the previous chapter. A postmodern perspective encourages nurses to foster a respect for older people who have been delirious through opposing the search for coherence and the ultimate truth, to the promotion and celebration of difference, partiality and multiplicity of knowledge (Davis & Glass, 1999; Strickland, 1994).

Several authors view the term postmodernism as a theory of society and culture that is often used interchangeably with poststructuralism, a theory of knowledge and language (Cheek, Shoebridge, Willis & Zadoroznyij, 1998; Rafael, 1997). The separation of the two positions is difficult, as culture and language are so intricately linked (Gribich, 1999). Even though the terms used to describe the two positions are referred to interchangeably in the literature, they are not identical concepts. For example Agger (1991) proposes that postmodernism focuses on the broader theorisation about culture, history and society, while

poststructuralism is concerned with theories regarding language and knowledge. Lupton (1998) suggests the difference between postmodernism and poststructuralism needs to be highlighted, as people who embrace a poststructuralist theory may not consider themselves to be postmodern and vice versa. The following section of this chapter overviews the central tenets of poststructuralism.

2.5 Poststructuralism

There appear to be competing claims as to the origins of poststructuralism. Some lay claim to it being European, particularly French (Fahy, 2000), while others (for example Poster, 1989) claim poststructuralism is American in origin. However both agree that poststructuralism is grounded in Saussure's (1974) structuralist ideas. Structuralist writers developed Saussure's conception of language as being central to meaning with these meanings being expressed as signs. Relationships occur between the signified, or idea, and the signifier, the spoken or written form of the sign (McHoul & Grace, 1998).

Poststructuralism, on the one hand, embodies Saussure's structuralist views, but on the other philosophically reacts to the modernist pretensions associated with structuralism, therefore critiquing some of the same Enlightenment principles as postmodernism. Inherent within poststructural thought is the focus on undermining and making problematic all previous assumptions and knowledge, including those associated with structuralism. Structuralism remains situated within the modernist paradigm because in its attempt to describe language and its relationship to life it has attempted to create a metalanguage (Gadet, 1989).

The influence of the first generation poststructuralists, for example Barthes, Foucault, Lacan and Derrida, has been immense (Gadet, 1989). While Foucault remains distant from this label the others do not (Foucault's resistance to being labelled is presented in section 2.6.1). Arising out of the work of these scholars poststructuralism has led to exciting developments at the forefront of feminist research, psychoanalysis, literary theory, anthropology and sociology (Crotty, 1998). It has also led to intellectual advances in newly

configured academic fields such as film theory, media studies, queer theory and postcolonial studies.

As with postmodernism, poststructuralism cannot simply be reduced to a set of shared assumptions, a method, a theory, or even a school. It is best referred to as a complex movement that embodies different forms of critical practice and can be applied to a range of theoretical positions. It provides a way to focus attention on how theories are generated, to expose the hidden assumptions inherent within those theories, and critically question the issues that emerge from such analysis. Sarup (1993) proposes that poststructuralism is critical of the concepts associated with the Enlightenment understanding of causality, identity, philosophy, the subject and truth. Similarly postmodernism challenges the concepts associated with Enlightenment principles by emphasising and valuing plurality, fragmentation and the notion that multiple speaking positions are always present.

Derrida, a leading poststructuralist writer, believes that the text and language is central to poststructuralism and anything else is of no consequence (Derrida, 1976). Text is referred to in a semiological sense and includes stories told, client clinical notes, posters, and popular media. Texts represent “conventionalized practices ... which are available to text producers and interpreters in particular social circumstances” (Fairclough, 1992, p.194). Poststructuralism exposes the way in which meanings are constructed and maintained by texts, including the practices and assumptions that underpin the shaping of the text itself.

In summation of sections 2.4 and 2.5 the promise of postmodernism and/or poststructuralism lies in the potential to cause trouble, seeking out fluctuations as opposed to stable trends, looking for paradoxes as opposed to accepting neat and tidy answers, and finally to recognise the subtle that is often hidden behind the obvious. Crotty (1998) suggests that both perspectives inform and promote the ongoing development of the other, while at the same time not necessarily forming any attachment or relationship. Having outlined the key tenets associated with postmodernism, including its relationship to poststructuralism, the focus of this chapter now turns to elaborating on Foucault’s theories used as a means to interpret and analyse the data produced in the present research.

2.6 Foucault, discourse, power and knowledge

This section of the thesis overviews Foucault's work, particularly the theoretical concepts associated with discourse, power and knowledge. The utilisation of Foucault's work has enabled me to 'trouble' the accepted ways of thinking about delirium. His theoretical concepts have allowed me to use aspects of his work as 'tools' (see chapter one), particularly those related to power and knowledge, to expose, critique and challenge prevalent scientific understandings of what it is like to be an older adult with delirium within contemporary health care environments.

2.6.1 Foucault

Michel Foucault (1926-1984), a French philosopher and historian has been credited by Habermas, another philosopher, as both a postmodern and poststructuralist thinker (Peters, 1994). Peters then goes on to cite an interview with Foucault where the latter "professes he does not understand what either the term modernity or postmodernity means or what kind of problem is common to postmodern or poststructuralist thinkers" (p.5). However, some writers position and use Foucault's work from a postmodern philosophical position (see Huntington & Gilmour, 2001; Payne, 2002; Traynor, 1997), while others take a poststructuralist stance (see Crowe, 1998; Gilmour, 2001; Wilson, 2001). While Foucault had difficulty being associated with either philosophical position (Foucault, 1983; Hekman, 1992; Macey, 1995), this disclaimer hints at the complexity, precariousness and challenge inherent in both postmodern or poststructuralist perspectives. His assertion of not being positioned within either paradigm is itself central to postmodernism's resistance to being situated into neat and clearly delineated categories.

Regardless of whether Foucault's work is represented through a postmodern or poststructural lens a central commonality is evident in all of his work. This commonality is to challenge the fundamental liberal assumptions, originating from the Enlightenment period, that history represents, and traces, a progressive and objective representation of society (Foucault, 2002a). For Foucault, the Enlightenment Period meant a critical attitude

rather than an historical period in time so consequently he was suspicious of the many arguments surrounding the notions of modernism and postmodernism (Macey, 1995). Nevertheless, Foucault's work appears to have a certain postmodern 'flavour' in that it challenges modernism's exclusion and marginalisation of particular groups of people, and provides a critique of the application of empirical methods to the human sciences.

The scholarly work undertaken by Foucault focused on the history of the human sciences. He argued that all social relations are produced by power. Mansfield (2000, p.55) explains that the gestures, the use of language and the expression of desires inherent within social relationships are effects of Foucault's notion of power, and that power is "designed for us rather than by us". These claims were substantiated through Foucault's discursive analyses of medicine, psychiatry, prisons and sexuality.

2.6.2 Discourse

The word discourse signifies different things depending on how and in what context it is used and so like postmodernism remains a slippery term. For example, Mills (1997) claims discourse has become

... common currency in a variety of disciplines ... so much so that it is frequently left undefined, as if its usage were simply common knowledge ... It has perhaps the widest range of possible significations of any term in literary and cultural theory, and yet is often the term within theoretical texts that is least defined (p.1).

Lupton (1993) believes the term discourse is used to refer to statements that produce a shared understanding, a particular version of events that influence the way we construct our world, our conversations and ways of thinking about ourselves. These statements may be made in written texts, expressed visually or communicated via word of mouth. Parker (1992, p.5) defines a discourse as "a system of statements which constructs an object". There may be any number of discourses that surround a particular event or object. These may be complementary or contradictory but all serve to construct or represent the phenomena.

Foucault's work on discourse first emerged within his archaeological work (Foucault, 2002a). Kendall and Wickham (1999) claim that Foucault's theory of discourse was underpinned by the notion that language constituted reality rather than reflected it, which has its origination in Saussure's understanding of structural linguistics. Foucault (2002a, p.121) identifies discourse as "a group of statements (whether spoken or written) that belong to a single system of formation". Discourse is constantly mediated by texts and between speakers and listeners. In addition discourses should be regarded as practices which systematically form the objects of which they speak (Foucault, 2002a). The objects of discourses are social actors undertaking performances, which are made apparent through their daily activities.

The fundamental component of discourse is the statement or *enonces* (Foucault, 2002a). *Enonces* do not relate to just any act of speech but are confirmed as knowledge through a process of validation. Validation occurs through the statement being repeated via the enunciative function. The enunciative function ...

... reveals the statement as a specific and paradoxical object, but also as one of those objects that men produce, manipulate, use, transform, exchange, combine, decompose, and possibly destroy ... - the statement, as it emerges in its materiality, appears with a status, enters various networks and various fields of use, is subjected to transferences or modifications, is integrated into operations and strategies in which its identity is maintained or effaced. Thus the statement circulates, is used, disappears, allows or prevents the realization of a desire, serves or resists various interests, participates in challenge and struggle, and becomes a theme of appropriation or rivalry (Foucault, 2002a, p.118).

Discourses, or sets of generalised understandings, are developed in certain social contexts and according to Foucault are central to understanding the relationship between power and knowledge. For Foucault discourses are more than linguistic systems and texts, they are bodies of disciplinary knowledge that infiltrate all aspects of everyday life (Ceci, 2003). These disciplinary knowledges are historically embedded but not in the traditional sense of

looking for cause and effect as evident in narrative history. Foucault's understanding of history differs from conventional historical research. According to Foucault the development of knowledge is not always continuous and progressive, rather "[I]t signifies a different level of analysis, one which focuses not only on the history of ideas, but on the conditions in which the subject ... is constituted as a possible object of knowledge" (Smart, 1986, p.27).

Discourses create discursive frameworks, which in turn organise and influence the production of knowledge, as well as enable the ordering of reality in a certain way. Consequently discourses determine who can speak, when, and with what authority, and conversely who can not (Ball, 1990; Kendall & Wickham, 1999; Mills, 2003). Within discursive frameworks there can be a number of competing discourses that may overlap. While some discourses assert dominance over others, discursive frameworks are sites of struggle because not all discourses are afforded equal authority. Therefore multiple discourses are available and in use at any one time. Many of these discourses compete with and contradict each other. Through the influence of social, political and historical factors certain discourses gain prominence and are heard, while others are not (Cheek, 1999a; Cheek & Rudge, 1994a). Discourses that give prominence to those who are heard, influence what is socially acceptable, and occur due to the effects of power.

In summary, this section reveals that Foucault's focus is on the various kinds of statements that make up discourse, the relationships between statements and the rules that govern what can be said, and by whom, as well as conversely what cannot be said. The next section provides an overview of the effects of power and knowledge, through the deployment of discourse.

2.6.3 Power

Discourses serve to perpetuate power inequalities by defining what is going on in the world in ways that serve the interests of those with power. Weedon (1987, p.41) aptly states "[D]iscourses represent political interests and in consequence are constantly vying for

status or power”. Dominant and powerful discourses, for example medicine and psychiatry, appear ‘natural’, are coherent due to their specialisation and technical focus, and have strong institutional bases and support (Carrier, 1997; Purvis & Hunt, 1993). It can be presumed that the unlimited authority accorded to the discourse of medicine has occurred due to its coherence, status and visibility.

When writing on the knowledge/power nexus in discourse Foucault rejects the modernist notion of ideology. This rejection of ideology forms the basis for Foucault’s (1978) concept of the episteme. An episteme stands in opposition to a grand narrative. By taking this oppositional stance, Foucault rejects any notion that there is an objective and discernible truth. In his view the episteme is ...

...the total set of relations that unite, at a given period, the discursive practices ...

The episteme is not a form of knowledge ... or type of rationality which, crossing the boundaries of the most varied sciences, manifests the sovereign unity of a subject, a spirit, or a period, between the sciences when one analyses them at the level of discursive regularities (Foucault, 2002a, p.211).

It is important to acknowledge that the notion of power does not always have negative connotations. For example, Reed (1995) and Watson (1995) both identify ways of using power positively for the development of nursing knowledge. Foucault rejects the image of power as only related to repression, it is not something one group holds to oppress others and is not possessed by individuals or classes (Sawicki, 1991). An example is the social action associated with speaking about the personal context within which delirium is experienced. By making explicit these mini-narratives the use of power at a micro level has the potential to subvert attempts by the dominant competing discourses (for example medicine) to construct a definitive single truth about delirium. In effect a personal narrative of delirium is produced as opposed to a grand narrative.

Foucauldian conceptualisation of power identifies power as diffuse, anonymous and subtle. In addition, power has the capacity to be both positive and negative.

Power is everywhere; not because it embraces everything but because it comes from everywhere ... Power comes from below; that is there is no binary and all-encompassing opposition between ruler and ruled at the root of power relations, and serving as a general matrix – no such duality extending from the top down and reacting on more and more limited groups to the very depths of the social body. One must suppose rather that the manifold relations of force that take shape and come into play in the machinery of production, in families, limited groups and institutions, are the basis for wide-ranging effects of cleavage that run through the social body as a whole (Foucault, 1991, p.93-94).

Here Foucault is saying that power is not possessed but is exercised, it is not repressive but is productive and furthermore is multi-dimensional. Moreover the focus is not on the person wielding power but on why certain people seek dominance in the first instance and how power autonomously creates subjects and vice versa. In a Foucauldian sense power is best understood in terms of the techniques through which it is exercised (Ceci, 2003). The body is the site where the techniques of power are most influential. The power/knowledge nexus, or disciplinary power as it is sometimes called, is concerned with the production of willing and able bodies that support the status quo of ongoing power relations. This modern conceptualisation of power began as a mode of inquiry to answer specific questions about how to control people in specific situations and resonates well with Foucault's shift in emphasis from his earlier work on the archaeology of knowledge to the genealogy of knowledge (see Foucault, 1994).

2.6.3.1 The genealogy of knowledge as a tool of investigation

Genealogy, or history of the present, is an attempt by Foucault to illuminate a historical point in time when a discourse first appears as a way of confining populations. The term genealogy arises from the work of Nietzsche (1844-1900). From Nietzsche, Foucault derived that subjects only came into existence through the complex interplay between power and knowledge, also referred to as disciplinary power or bio-power. Foucault wrote an essay titled 'Nietzsche, genealogy, history', out of which arose the genealogical

categorisation of events that are pivotal to Foucault's focus on power (McNay, 1996). This genealogical approach goes against traditional modernist types of history, rejecting the search for the origins of some essential site of truth. Rather the genealogist searches for the "accidents, the minute deviations ... reversals ... errors, the false appraisals, and the faulty calculations that give birth to these things that continue to exist and have value for us" (Foucault, 1991, p.81).

A genealogical approach recognises and supports incidental happenings, i.e. the role of chance, the multifaceted nature of existence and the traditionally neglected forms of existence and knowledge. Foucault, in explaining this aspect of genealogy claims:

What it really does is to entertain the claims to attention of local, discontinuous, disqualified, illegitimate knowledges against the claims of a unitary body of theory which would filter hierarchies and order them in the name of some true knowledge and some arbitrary idea of what constitutes a science and its objects (Foucault, 1980b, p.83).

A genealogical study is a method of inquiry whose key theoretical ingredient is to show how different 'things' could be through disrupting what is presently self-evident with the past. Utilising this method of inquiry, Foucault investigated the contemporary functioning of the prison system, the mental health system and sexuality, focussing in each instance on power relations.

Foucault suggests that the genealogy of power relations is made clear through the reliance on certain techniques, which have their origins in the modernist paradigm, for example disciplinary power (Foucault, 1977). Disciplinary power is directed at the human body as a means to produce willing and able bodies that support the status quo. Genealogies challenge the status quo and illuminate other knowledges; knowledges that have been marginalised, silenced, rendered unimportant and insignificant by so called official histories. Foucault refers to these as subjugated knowledges and states:

By subjugated knowledges I mean two things: on the one hand, I am referring to the historical contents that have been buried and disguised in a functionalist coherence or formal systematisation ... subjugated knowledges are thus those blocs of

historical knowledge which were present but disguised ... and which criticism – which obviously draws on scholarship – has been able to reveal. On the other hand, I believe that by subjugated knowledges one should understand something else ... a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity ... It is through the reappearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work (1980b, p.81-82).

In the instance of the present study, older people who have been delirious and their families speak from a position that lacks ‘scientificity’ and as a result their knowledge of delirium is frequently not recognised as valid by health professionals. It is important at this point to acknowledge that it was not Foucault’s intention to place subjugated knowledges in a privileged position. Rather, the point is to ensure the subjugated discourses of delirium are available as potential sites of resistance. Inextricably linked to a genealogical analysis are the concepts of power and the body.

2.6.3.2 Power, resistance and the body

Power and resistance, also termed counter-discourses, both constitute and are constituted by each other. Counter-discourses, or resistance, are prevalent at the site where power relations are exercised (McNay, 1996). Power and resistance are each defined in reference to one another; therefore they are inextricably linked in all points of the web of power relations. The effectiveness of resistance is realised when it is directed at the techniques of disciplinary power (Kendall & Wickham, 1999). Techniques of power allow for power to be exercised and concomitantly for the development of knowledge, while resistance refuses and causes trouble for these techniques. By taking this position on resistance, the older delirious body is understood as a primary target of the techniques of disciplinary power (for example surveillance), but is also the point where these techniques are resisted and opposed by other discourses.

The generation of new and different discursive opportunities means other knowledges are made available, leading to the development of newly-fashioned power relations. These counter-discourses, like power can coalesce to form large rebellions, or alternatively they can remain isolated and create new alliances. For example, the accounts from people who have been delirious have the potential to subvert attempts by medicine and nursing to construct a consistent and stable discourse around what they (medicine and nursing) term a problem, through the deployment of a heterogeneous discourse of delirium. Foucault believes it is not a matter of using power to win once and for all because there are always possibilities for resistance (Sawicki, 1991). Any discourse finds itself under constant threat from counter-discourses which act as a destabilising force, constantly questioning their position as truth.

Foucault emphasised that the human body is the physical space for the operation of social micro-practices associated with the previously discussed concepts of power, knowledge and resistance. Bodies can be considered as end points in the grid of power relations between the power/knowledge nexus and resistance. The body is an important aspect in nursing. The central tenet of nursing revolves around working with 'stranger' bodies within a socially sanctioned relationship (Gilmour, 2001). It is only recently that understanding the body has moved from the discourse of medicine, where it was viewed as an object and machine, to a more postmodern position where the body is seen as a text (Lawler, 1994; Parker, 1997). So from a genealogical perspective bodies are made up of and produced by historical and cultural influences, and are objects of power, texts that can be read by others.

Foucault's writings show a disinterest in, as well as a distinct lack of concern for the material physical body. He saw the body as an object of power, a site where power is exercised. Therefore for Foucault the body is an:

...inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated self (adapting the illusion of a substantial unity), and a volume in perpetual disintegration. Genealogy, as an analysis of descent, is thus situated within the articulation of the body and history. Its task is to expose a body totally

imprinted by history and the process of history's destruction of the body (Foucault, 1977, p.83).

Viewed in this way the body is left passively positioned or as Foucault and other writers identify as docile bodies (Foucault, 1991; Gastaldo, 1997; McNay, 1996; Rudge, 1997). In other words human subjects are socially constructed and able to be manipulated, which makes for docile bodies. This is in direct opposition to the humanist notion that people are rational, stable and unified subjects.

In "Discipline and Punish" Foucault (1991) makes explicit the relationship between discipline and docile bodies, called disciplinary power by stating:

The human body was entering a machinery of power that explores it, breaks it down and rearranges it ... It defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines (p.138).

Arising out of disciplinary power are certain techniques designed to normalise bodies, thus making for efficient control by governments over life processes. The best example of disciplinary techniques is found in Bentham's Panopticon, a prison system whereby cells are arranged around a central point so warders can keep a constant watch on inmates. The Panopticon thereby sets up a system of surveillance, which Foucault extends to the hospital system and refers to as the medical gaze (1994). The medical gaze's *raison d'être* is to seek information that will inform, create or cement a discourse related to its subject matter (Foucault, 1994; Fox, 1997). It is through this gaze that bodies of knowledge construct power positions which people take up or are taken up by. For example, medical and nursing discourses construct older people over the age of 65 years who are hospitalised as "at risk" of experiencing delirium. People who are delirious are then deemed "at risk" to mortality, secondary morbidity and placement into long term care. In the case of delirium the body is made the object of the clinical gaze of doctors, nurses and other health professionals.

The medical gaze is an example of biopower, a key ingredient in the development of capitalist societies (Foucault, 1998). The key feature of biopower is the construction of a docile, as well as a productive body. In addition it is where subjects are classified according to their bodies and the functioning of their body. It dictates how bodies are managed, organised and disciplined within particular discursive fields. Hospitals exercise biopower through their association with the medical gaze, and are sites where the disciplinary practices integral to creating a docile body are deployed. The hospital operates to produce certain types of knowledges at the expense of others. For example, it is a site where highly specialised medical and nursing language is used. This language produces knowledge that is only available to those who understand it. In addition, the hospital provides the ideal environment for the laboratory, a place where causes of symptoms can be isolated and studied and where medical and nursing interventions can be trialled and monitored. The monitoring of patients, also referred to as surveillance, is the act of seeing through the eyes of the clinical expert (Foucault, 1994). Within a hospital setting, the medical gaze not only encourages but supports self-surveillance, or technologies of self, as a practice of control (Eckermann, 1997).

There is no denying the possibilities of utilising aspects of Foucault's work as a means to challenge the status quo as it relates to delirium in older people. This is supported by McHoul and Grace (1998, p. 57) who state "Foucault's conception of discourse is indispensable for an understanding of the role of 'power' in the production of knowledge – including, importantly self-knowledge". In addition, the discussion so far has explored the concept of resistance as a means of subverting the creation of a metanarrative about, in the case of the present study, delirium in older people. Inextricably linked to the power/knowledge nexus is production of subjects; subjects who have the capacity to resist or accept dominant discourses. It is the concept of the postmodern subject to which I now attend.

2.7 The postmodern subject

The concepts of subject and subjectivity are central to postmodern, poststructural and Foucauldian ways of viewing the world, and they are antithetical to the ontological assumption proposed by modernist humanist philosophy that people have an essential nature (Weedon, 1987). As discussed earlier, the modernist paradigm positions people as stable, unified, rational, self-reflexive ‘whole’ beings. This notion is in opposition to the postmodern position on subjectivity where personhood is viewed as unstable, fragmented, inconsistent and contradictory. Postmodern subjectivity is further exemplified by Burr (1995) who suggests that each time we speak we are discursively reconstituted, because of, and depending on, the number of subject positions the human subject currently occupies.

From a Foucauldian perspective, subjectivity is constituted through the production of power and the effects of power relations. Foucault (2002b) defines the word subject to mean either “... subject to someone else by control and dependence ...” (p.331) or in relationship to the individual’s own self-knowledge. Therefore, circulating discourses offer subject positions and subjectivities for people to take up. Those who take up these available subject positions speak and practice the discourses available. The meaning Foucault attaches to the notion of the subject suggests “... a form of power which subjugates or makes subject to” (Seigel, 1990, p. 276).

Foucault (2002b) argued that power creates particular types of subjects (people) and describes three ways in which power produces subjects. First, knowledge about subjects must be given the status of a science, for example the science of human biology. Second, subjects are divided according to categories such as old or young. Third, Foucault described “the way a human being turns him –or herself into a subject” (Foucault, 2002b, p.327). An example of this process is the production of the older adult. First, medicine, in concert with social beliefs, produces the category of older adult. Second, this category marks those assigned to it as old. Third, people are encouraged to adopt the descriptions provided on old age so they can conform to the lives considered appropriate for this age group.

Foucault (1984) explored the relationships which existed between the constitution of the subject, for example the older adult, or different forms of the subject, for example the cognitively impaired older adult. He also identified the self as a cultural and historical product of discourses and associated practices. The ability of human kind to care for the self and modify it according to certain requirements involves a form of agency. Work on the self is an autonomous act requiring the use of moral and intellectual capacities to determine a course of action (Moss, 1998). Moss' view is supported by Shumway (1989, p.154) who sees subjects as being agents and therefore having "the power to make choices and set goals". These choices and goals are influenced by social and cultural contexts.

Human subjects have a sense of self-awareness and the ability to reflect; hence the extent to which they take up available discourses and are subjected to discursive practices will vary. Hacking (1999, p.104) suggests that when classifications are known by individuals, or those around them (family members, doctors, nurses), it may change "the ways in which individuals experience themselves – and may even lead people to evolve their feelings and behaviour in part because they are so classified". Individuals may therefore subvert or resist classifications and normalising forms of power through moving between discourses, which ultimately might alter or change institutional practices.

Postmodernism is a philosophical approach which affords centrality and agency to the individual, otherwise known as the subject. By taking a postmodern position I am interested in reclaiming the subject, as eloquently explained by Rosenau (1992, p.21), who states "[I]n the end, it is not the death of the subject that is of greatest interest in the social sciences so much as the birth of the post-modern individual and the 'return of the new subject'". Furthermore, postmodernism claims that each subject's experiences within the world are unique and therefore cannot be explained through the deployment of some universal 'truth'. Postmodernism also rejects the modernist concept of rationality, the conscious subject, and the process of reasoning as a source of knowledge and/or truth (Payne, 2002). A postmodern subjectivity is therefore fragmented and plural (Lister, 1997).

2.8 The utilisation of Foucault within nursing research

It is only in approximately the last ten to twenty years that the work associated with Foucault has been utilised as a tool to inform nursing research and nursing issues. Gastaldo and Holmes (1999) identify that the number of publications relating Foucault to nursing have increased significantly since 1993 with a predominance of writers emanating from the Australian nursing fraternity. There is a growing interest in utilising a Foucauldian lens to view nursing and health care within a New Zealand context (Adams, 2003; Carryer, 1997; Gilmour, 2001; Huntington & Gilmour, 2001; Papps, 1997; Payne, 2002; Wilson, 2001). Many of the just mentioned writers utilised a feminist postmodern/poststructural perspective to frame Foucault's work with a particular emphasis around power, knowledge, resistance and the micro sites where power circulates.

During the early part of the 1990s a succession of articles were published by the Australian writers Julianne Cheek and Trudy Rudge (1993, 1994a, 1994b, 1994c, 1994d, 1994e). These works not only exposed health professionals, particularly nurses, to the Foucauldian lens as a means to examine health care issues, but have also encouraged health professionals to utilise the notion of surveillance as a disciplinary technique in the health care arena. Foucault's view that surveillance strategies are powerful disciplinary practices is evident in Wilson's (2001) study into New Zealand child health nursing through the work of the Plunket Nurse. This study sought to identify whether surveillance strategies employed by the Plunket Nurse lead to power inequalities in the relationship between the nurse and the mother, in light of the fact that nursing services are delivered within a partnership framework. The findings identified that there was a continual "... ebb and flow of power..." between the nurse and mother that was unstable, complex and precarious (Wilson, 2001, p.299). Surveillance strategies were a key component of the Plunket Nurse's work as visiting families in their own home provided key information that otherwise may not be passed on by the mothers themselves.

As earlier discussed, from a Foucauldian perspective, where there is power there is also resistance. The main role of the Plunket Nurse in Wilson's (2001) study was that of

monitoring and surveillance. Mothers reacted by only selectively giving information to the nurse thereby resisting the nursing discourse. The concept of surveillance as a disciplinary practice can also be applied to the docile delirious older adult body. Nurses and medicine rigidly rely on cognitive screening tools to monitor the older person whether delirious or not. In turn older people may resist these disciplinary tactics by not always telling the truth, as in Wilson's (2001) study, instead concealing key elements associated with cognition to ensure that the nurse is satisfied that the person is progressing satisfactorily.

As earlier mentioned the construction of the subject is inextricably linked to power through the deployment of discursive technologies and practices (Foucault, 1980b). Payne's (2002) doctoral thesis outlined how the subjectivity of women over the age of 35 years who had given birth was influenced by discursive practices. On the other hand Gilmour's (2001, p. ii) doctoral research investigated "... the representations and practices of nurses in the context of intermittent care for people with dementia". Both studies clearly identified that the findings were not to be construed as a definitive account to be etched in stone and referred to forever more as a single coherent representation. These studies fit appropriately within a postmodern/poststructural frame of reference and identify the availability of a multitude of subject positions that a person can take up and use to disrupt and resist any dominant discourse/s that are in circulation.

2.9 The critical gerontological approach used in this study

So far this chapter has provided a general overview of the philosophical and methodological perspectives that inform this research. The following section outlines the specific philosophical and methodological tools that have been incorporated into the critical gerontological approach used to interrogate the representation of delirium in people over the age of 65 years.

Critical gerontologists recognise and promote the multifaceted nature of ageing (Achenbaum, 1995; Kontos, 2005). Kontos argues that biomedicine has become a pervasive and dominant influence in shaping understandings of being an older adult. The

proliferation of biomedical understandings about ageing displaces and ignores subjective experiences of being older. Over the last decade critical gerontology has promoted qualitative interpretative and critical understandings to capture the meaning and experience of ageing (Hepworth, 2000).

Katz (2003) identifies the *Journal of Aging Studies* as an avenue for the dissemination of critical gerontological work. This journal provides a critically potent set of commentaries, all of which problematise and critique the scientific method as the only way of 'knowing' about ageing. A diverse range of topics are published, many of which have been instrumental in shaping the present research project. Some of these topics include the dichotomous clash between scientific understandings of frailty and older people's personal experiences of dependency (see Grenier, 2005), the inclusion of postmodern and feminist methodologies as a means to problematise scientific understandings of ageing (see Kunneman, 1997; Twigg, 2004), the importance of utilising reminiscence work, life stories and discourses analysis as legitimate ways of generating knowledge about the ageing process (see Harrienger, 1998; Ray, 1998), the promotion of interdependence in older people (see Kontos, 1998), and a critique of the ageism, consumerism, and other ageing narratives (see Biggs, 2003; Katz & Marshall, 2003; McHugh, 2000).

Postmodern thought and its rejection of the metanarratives associated with biomedical understandings on ageing is the key ingredient in the analytical tools used to interrogate the data collected for this doctoral work. The critical gerontological stance taken for this study challenges and resists the possibility of an all inclusive social theory or a unified political stance toward delirium in people over the age of 65 years. A discourse analysis derived from aspects of Michel Foucault's work provides an effective lens for me to navigate my way through the often contradictory and tension filled terrain that constitutes delirium.

Some critical gerontologists argue that knowledge of old age should come from older people with the focus on giving voice to experience (Kontos, 1998). Positioning myself within a critical gerontological frame of reference allows me to give voice to older people who have been delirious. I intend to promote personhood and the personal experiences of

older people in this thesis. These personal experiences are not related to individualism and personally created meanings. Instead my references are to the experience of being assigned to the category delirious older person.

2.9.1 Critical gerontology and nursing

Gerontological nurses work alongside older adults in a wide range of settings as they negotiate health, illness and disability. Nursing also has an increasing need to be aware of the contextually mediated choices and socio-political constraints which influence the health status of individuals and communities (Hughes, 2001). These assertions are inherent within critical gerontological methodologies, especially those analytical tools that address the socio-political determinants that influence the health status of older people, for example the discrimination of people through ageist practices.

Furthermore, nursing is currently being urged, from some sources, to adopt randomised controlled trials (RCTs) as the gold standard from which to base clinical practice decisions (Nay, 2003). The utilisation of RCTs privileges quantitative rather than qualitative understandings of, in the instance of the present research, being over the age of 65 years and having delirium. Critical gerontology offers nursing the possibility of forging new ground as well as maturing as a discipline, through the adoption of new ways of generating knowledge about delirium that are free from the constraints associated with traditional means of undertaking research. This assertion is supported by influential nursing authors such as Sandelowski (1993, p.3) who suggests “[T]he task for scholars in a practice orientated discipline is to find ways to apprehend and re-present these different representations to achieve the ‘fuller knowing’ that advances knowledge and influences practice”.

Critical gerontology has particular congruence with issues that are of concern to gerontological nursing. These concerns include the elimination of ageism, the promotion of person centred care, the centrality of the person within the caring relationship, the recognition of the interconnectedness of relationships, older people as a heterogenous

group and critiquing the appropriateness of existing modes of generating knowledge (Miller, 2004; Nay, 2003; Nolan, Davies, Brown, Keady & Nolan, 2004). This section, in conjunction with the rest of the chapter argues that the theoretical foundations of critical gerontology based on a postmodern and Foucauldian discourse analytic approach is necessary for the examination of delirium in people over the age of 65 years.

2.10 Summary

The theoretical tools associated with critical gerontology will provide the philosophical framework from which to undertake a critical examination of the available discourses on delirium, and to examine how these discourses socially construct people over the age of 65 years who have been delirious. Through a postmodern lens, Foucault's views on power will illuminate how the discourses of health professionals, for example nurses and doctors, can pathologise, control and shape the older person's experience of delirium and ageing. The narratives of a number of older people and their families who have experienced delirium, will be deconstructed to consider the discursive construction of their subjectivities. These narratives may be different from, and also may contest the dominant health discourses while providing another understanding of the experience of delirium.

It is not my intention to generate a metanarrative on delirium as experienced by people over the age of 65 years. Rather it is my desire that this research be used as a localised narrative specific to the point in time when the research was conducted and applicable to the group of people involved in the study, including myself. I provide this thesis for nurses and others to read to raise their consciousness about the existence of subjugated discourses and alternative speaking positions available on delirium. The raising of consciousness has the potential to change current clinical practice as nurses and others realise the potential or actual oppression produced through existing ways of working with older people who are or have been delirious. Through a critical gerontological frame of reference I intend to do as Traynor (1997) suggests and "cause trouble" to those in the world who claim to be an authority on delirium.

In this chapter I have broadly outlined the main theoretical ideas associated with the critical gerontological approach that are pertinent to my analysis of delirium in people over the age of 65 years. I have shown the importance of a critical gerontological approach that encompasses postmodern thought, discourse and its interconnectedness to subjectivity, power, knowledge and truth. The following chapter describes the steps involved in the research process. These include explaining the ethical procedures that were undertaken and culminated in the production of data, as well as the application of the critical gerontological concepts associated with postmodernism, discourse, subjectivity and power to both the data collection and data analysis.

Chapter Three: Research methods

3.1 Introduction

Prior chapters have identified how I came to be involved in the study, an outline of the research problem, and the critical gerontological theoretical positions that underpin the present study. As outlined in the first chapter of this thesis the aims of this research are to:

1. Interpret the meanings embedded in the discourses surrounding delirium via the collection/analysis of relevant published documents.
2. Explore the discursive production of the person with delirium.
3. Develop a position from which to explore a range of possibilities nurses could utilise to provide appropriate care to people and their families experiencing delirium.

I have purposely begun this chapter with a section on reflexivity because all aspects associated with taking a reflexive stance impact on the research process. Following the section on reflexivity a presentation of the empirical basis for the current study, particularly the methods used to collect, interpret and analyse the data is presented. This includes an overview of the issues associated with participant selection, ethical and legal matters, data collection, data analysis, issues of rigour and finally, a reflection on the data collection process.

3.2 Reflexivity

On reading the literature it appears that reflexivity, although not without its critics, is a central component in postmodern approaches to research (Koch & Harrington, 1998; Parker, 1992; Payne, 2002). Being reflexive demands researchers continually question their approach and reasoning to the data generated in a self-critical manner. Richardson (2000) claims that reflexivity unmasks complex political and ideological agendas that are often hidden in our writing. Reflexivity, from a postmodern perspective, problematises all truth claims, consequently any desire to speak for 'others' should always be suspect and open to critique.

Gerontology in general has been criticised for failing to attend to issues of reflexivity, for example the potential or actual power relations that exist during the interview process between the older interviewee and the professional interviewer (Cruikshank, 2003). However, by taking a critical gerontological position I not only acknowledge, but make visible any background assumptions, cultural agendas and influences, as well as the power differences between the researcher and the subject of the research. By utilising a discourse analytic approach my position as a researcher is highlighted and the scientific claims of objectivity, the elimination of bias and neutrality are therefore rejected (Lupton, 1992; Parker, 1992).

The intent of eliminating bias in this study is antithetical to a critical gerontological theoretical position. However, undertaking reflexivity is essential to assist with the systematic reporting of how decisions were made at all steps of the research process, and how I influenced the collection, analysis and interpretation of data. My intentions were influenced by Grace (1998), who claimed that a careful and thorough description of the methods associated with postmodern research allows others to scrutinise what was done and to debate points of departure or disagreement. The discussion now moves from the conceptual to the operational aspects associated with the research process.

3.3 Participant selection

My commitment and desire to cover as many points of view on delirium determined that the data collected would contain multiple and diverse perspectives. Originally I thought that interviewing approximately five people over the age of 65 years who had been delirious, five family members who were associated with someone who had been delirious, five sets of client hospital notes and selected scientific, medical and nursing texts available on delirium would be sufficient data sources for this study.

However, once I had begun the interview process and had completed interviews with five people who had been delirious and five family members I realised that a further and wider data source was needed. At the time the delirium team, comprising of a medical consultant and two registered nurses made themselves available to be interviewed. The interviewing of this additional group added another dimension to the object of delirium. In addition, the opportunity to interview another person who had been delirious

presented itself and so the final sources of data comprised of six people who had been delirious, their clinical notes, five family members, two registered nurses and one medical consultant, making a total of twenty sets of texts.

It was clear that the exact number of participants interviewed would depend on the number of volunteers, the range of experiences they represented and the amount of data collected in each of the interviews. The relatively small sample of participants is indicative of the labour intensive nature of utilising discourse analysis as a means of data analysis. This is supported by Potter and Wetherell who claim:

because one is interested in language use rather than the people generating the language and because a large number of linguistic patterns are likely to emerge from a few people, small samples or a few interviews are generally quite adequate for investigating an interesting and practically important range of phenomena (1994, p.161).

The age criterion for selecting the people who had been delirious was influenced by the array of gerontological texts and New Zealand public documents available identifying that in order to be considered an older person you needed to be over the age of 65 years (Ministry of Health, 2002; O'Neill, 2002). The method of obtaining participants for this study was to approach people over the age of 65 years who had been delirious or became delirious as part of their illness experience. Family members who had been associated with an older person who had experienced a delirious event were also approached to be interviewed.

The sampling method was a combination of purposive and convenience. Purposive sampling was utilised for the group who had been delirious and family members. Older people were approached after being nominated by the clinical charge nurses or the medical consultants at a large urban acute care hospital or at a medium sized assessment, treatment and rehabilitation hospital for older people. The clinical charge nurses and medical consultants were asked to identify clients who, in their assessment, were over the age of 65 years, were no longer delirious and did not have an associated dementing illness. Family members who had a significant other who had been delirious were also approached. On the other hand convenience sampling was utilised for the two registered nurses and the medical consultant. This group of people were known to me

and were available to be interviewed so in essence this approach is what Ingleton (1998) terms opportunistic.

As mentioned above, potential participants were initially approached by either the clinical charge nurses or medical consultants. Information about the study was communicated verbally and in written form through the provision of an information sheet (see appendices 1, 2 and 3). Potential participants needed to be deemed, by the clinical charge nurse or the medical consultant, no longer in the acute phase of their delirium and had to have the cognitive capacity to consent to participating in the research. If people met these two criteria and were interested in being interviewed they made contact with the clinical charge nurse or medical consultant, providing them with their contact details. These were then passed onto me. This approach was approved as the contact plan by the relevant ethics committees.

I tried, where at all possible, to make contact with people who had expressed an interest in participating in the study within 24 hours of receiving their contact details. Once contact was made and agreement was reached we identified a mutually convenient time and place for the interview to take place. If people were still in hospital then I would go in and personally meet them before organising an interview. If they had been discharged I made telephone contact with them in order to arrange an interview. If people preferred to be interviewed within the hospital setting then I arranged for a place for this to occur, otherwise interviews occurred in people's homes. The same process was used for family members.

On the day before each scheduled interview I contacted each person again to check that they still wished to have a meeting. This gave potential participants the opportunity to decline to be part of the study without me being physically present and time to decide whether they were comfortable sharing their stories with someone they knew little about. Making contact with potential participants several times before the interview took place is consistent with viewing informed consent as a process (see Reid, Ryan & Enderby, 2001; Usher & Arthur, 1998). Process consent ensures vulnerable populations, for example older people who have been delirious, have plenty of opportunities to be reminded of and understand what they are consenting to be involved in. This was important for the older adults in the present research who may still have been

experiencing some residual cognitive difficulties, even though those difficulties were not sufficient for them to be categorised as still being delirious by nursing and medical staff. By utilising this form of consent I was attempting to ensure the participation of people with delirium was voluntary. All participants contacted wanted to continue with the interview. The fourteen people interviewed were all pakeha New Zealanders. This is not surprising given the population make up of the Canterbury area. Of the people who had been delirious three were male and three were female. All five family members were female. The two registered nurses were also female and the medical consultant male.

At each interview I confirmed that each participant had read the information sheet. I reiterated verbally what the study was about by saying “so you know that this study is about ...” Doing this provided me with the opportunity to use my professional judgement to ensure all participants understood what the study was about and that they were able to voluntarily give their consent. In addition, this was also an opportunity for people to clarify any further questions that they may have had. Several people did have questions and I answered these as they arose. All people participating in the research were informed of their right to turn the tape off at any point and/or terminate their involvement in the research at any time. A consent form was signed before the interview began. A copy of the consent form can be found in appendix 4. Consent was also obtained to access the client’s hospital records. The purpose of this exercise was to identify for analysis as many representations of delirium as possible.

3.4 Ethical and legal considerations

Before undertaking any interviews and commencing the data collection phase of the research process, formal ethical approval was sought. Ethical approval was gained from three committees: the Massey University Human Ethics Committee, the Canterbury Regional Ethics Committee and the Christchurch Polytechnic Institute of Technology Academic Research Committee. At the time of gaining ethical approval for the study I was employed as a senior lecturer at Christchurch Polytechnic Institute of Technology, hence the need to gain ethical approval from three ethics committees. After this time I took leave from my academic position to work part time as a registered nurse in an assessment, treatment and rehabilitation hospital that provided services for people over

the age of 65 years. This change in employment took place during the data collection phase of my doctoral work.

3.4.1 Confidentiality

Participant confidentiality was maintained by the allocation of code names to each interviewee. All tapes, field notes and transcripts were scrutinised for any references that had the potential to identify the individual, third parties, places or institutions. Any form of identification was masked. During interviews, if a person directly referred to another person or place by name the following steps were taken:

1. A [] was placed around the reference.
2. The direct reference was substituted with either a pseudonym, symbol or the masking of potential identifiers.

Participants were reassured that the researcher would be transcribing all tapes and that all details related to the study would be kept confidential. Therefore all tapes, field notes, photocopies of client notes and transcripts would be kept locked in a filing cabinet in my office at my place of work. Access to this information was limited to my supervisors and myself. At each interview I made explicit that the working transcripts and tapes will be kept by me for ten years or longer, until completion of the dissemination of findings. The keeping of health related information for this length of time meets the Health (Retention of Health Information) Regulations (1996, p.1764) which states “health information that relates to an identifiable individual, means a period of 10 years beginning on the day after the date shown in the health information as the most recent date on which a provider provided [services] to that individual”.

All people interviewed were offered a copy of either the transcript or the tape. No one requested a copy of the transcript but the two registered nurses interviewed asked for a copy of their taped interview. Copies of the respective taped interviews were therefore provided. Finally, any findings submitted for publication will avoid identifying participants, other people, or places from the reports.

3.4.2 Potential harm to participants

As mentioned above all efforts were made to maintain anonymity of participants, other people and institutions. This helped to ensure that participants felt safe and confident when asked to share and describe their thoughts and feelings, many of which were extremely private and personal.

No problems or issues arose as a result of the interviews. As a precautionary measure I had arranged a mechanism whereby if there was an issue or problem that arose as a result of the interview process the person could contact the delirium team who were able to provide the assistance required. If by chance they were unable to assist then they agreed to refer the person onto a more appropriate person or agency.

3.4.3 Use of information

All information obtained as part of this research is to be utilised initially for the purpose of writing and submitting a thesis for the degree of Doctor of Philosophy. Undertaking and completing a research project is a pointless exercise if it is not made available to others for use and/or critique. I therefore proposed that a series of papers will be presented at national and international seminars and conferences. The thesis will be available for loan through the Massey University Libraries, as well as a selection of hospital libraries. Because qualitative research related to delirium is unique it is intended that articles for both national and international publication will also be submitted.

3.4.4 Conflicts of interest

As earlier discussed, during the data collection phase of this study I was employed as a part time registered nurse (16 hours per week) in an assessment, treatment and rehabilitation hospital specifically for people over the age of 65 years. To overcome this possible conflict of interest between my roles as a registered nurse and researcher, I did not approach people who were consumers of the service where I was working.

3.5 Interviewing as a means of gathering data

One interview was undertaken with each participant and this took anywhere between thirty minutes and two hours, with the majority lasting around one hour ten minutes. Interviews took place either in the hospital setting or in the participant's home. Finding a space in the hospital environment that was conducive to undertaking an interview with an older person was a challenge. However, in all instances an appropriate venue was found that was private and quiet. No interruptions were experienced.

Each semi-structured interview took place using open-ended questions. This method is largely synonymous with qualitative research and emphasises the subjective narrative experiences of, in this instance, people who have been delirious, families and health professionals. This style of interviewing was chosen to ensure participant's narratives were heard in as relaxed and non-threatening atmosphere as possible. Therefore subjective understandings, perceptions and meanings of the process associated with being delirious became the central focus of both the data collection and analysis phase of this study. This style emphasises that the participant's narratives "... are social constructions which are created and sustained through social interactions, at both the personal and macro level of society" (Minichiello, Madison, Hays, Courtney & St John, 1999, p.396).

Due to the critical gerontological and postmodern underpinnings of this study I wanted to capture the multiple narratives of the participants interviewed. To this end I kept my set questions to a minimum. Fontana and Frey (2000, p.657) refer to this style as "... *polyphonic* interviewing, in which the voices of the subjects are recorded with minimal influence from the researcher ...". All older adults who had experienced a delirious episode were asked "Can you describe what you remember from your episode of delirium?" "What does being delirious mean to you?" and "What were some of the things the nurses working with you did that helped or didn't help?" Each family member was asked "Can you describe the events surrounding the delirious episode?" "What does being delirious mean to you?" and "What were some of the things the nurses working with your father/mother/partner/friend did that helped or didn't help?" For the health professionals I asked, "What does being delirious mean to you?" "What

forms the basis for the protocols and procedures that you follow when assessing people who you think are delirious?” and “How should a delirious person be cared for?”

The polyphonic style of interviewing employed in the present research stands in contrast to other critical discourse analytic methods. For example, Parker (1992, p.124) asserts that the researcher has to attend to every word “with a *suspicious* eye” and challenge participants’ (as well as their own) assumptions to ensure the surfacing of any hidden or unsaid discursive practices. This type of interviewing is strongly associated with a poststructuralist theoretical position (Parker, 1992). By taking a critical gerontological and postmodern approach to interviewing, and keeping the set questions to a minimum, I was able to ensure that “[D]ata could emerge as a process of dialogue, negotiation, understanding and analytical listening” (Minichiello et al., 1999, p.398). In addition, a polyphonic approach to data collection was less intense and more suitable for interviewing unwell and vulnerable older people who had been delirious and their families than the approach advocated by Parker (1992). No examples of unprofessional or inappropriate nursing practices were disclosed during the interviews.

3.6 The process of transcription

All tapes were transcribed in full as soon as possible after each interview to provide the textual data. I consciously chose not to employ a transcriber but to endeavour to transcribe each of the tapes myself. Not only did it significantly improve my typing skills but it also enabled me to become immersed in the texts generated. However, as part of their postgraduate studies, other postmodern researchers (Carryer, 1997; Payne, 2002; Yarwood, 1999) did successfully utilise another person to undertake this task with good effect. As part of the transcription process I purposely avoided editing the texts in any way as the incomplete phrases, interruptions and messiness of everyday speech are an integral component associated with all speech acts. This is supported by Gilmour (2001) who asserts that any attempt to reproduce a more readable text invariably involves major editorial changes, which consequently has the potential to prematurely close and/or alter the meanings associated with the speech act.

Transcripts were not returned to the participants for verification and checking as employed in some other qualitative studies, for example those utilising a

phenomenological or feminist methodology. Carryer (1995, p.184) claims the returning of transcripts to people involved in research "... ensures that participants feel at all times in control of the process and have no sense of objectification in that nothing is written about them that they don't see or have the opportunity to change". Some qualitative researchers would argue that member checking is a crucial element in the process of establishing research credibility (Lincoln & Guba, 1985). Conversely, it has been argued that the researcher, on committing themselves to this process, buys into the modernist assumption that a metanarrative exists, against which the account could be measured (Angen, 2000; Sandelowski, 1993).

The critical gerontological and postmodern perspective taken in this study views the textual data as partial, tentative and constructed. The focus is on the meanings ascribed to the discourses drawn on to describe the experiences associated with being delirious rather than the people themselves who have generated these texts. Reed (1995, p.72) supports this position by stating "In postmodern thought, then, there is no autonomous subject to study; the subject is myth. What is studied is what the culture has inscribed on the object of study; in this sense, the focus of study is text".

3.7 Data analysis

Authors writing on ways to use discourse analysis as a method of analysis provide varied accounts on the 'how to', however all agree that there are no firm rules available to guide the discourse analyst and that a method is developed to suit each specific study (Fairclough, 1995; Grace, 1998; Potter & Weatherell, 1994). This assertion in no way indicates that 'anything goes'. As Cheek (1999a, p.42) indicates, "all approaches to discourse analysis involve rigorous methods and principles of systematic and explicit analysis". My method then is primarily grounded in my reading of Foucault and influenced by an array of discourse analysts, such as Gilmour (2001), Parker (2002), Payne (2002), Powers (2001) and Willig (2001).

Discourse analysis, like other methods associated with qualitative research, requires some form of organising the quantity of textual data produced from interviews. Therefore the development of techniques for the management of textual data is imperative. Some researchers rely on qualitative research analysis programmes, such as,

NVivo (Gibbs, 2002). I preferred instead to use conventional manual analysis techniques because I felt that I would need to put significant time and effort into learning a computer programme, time better spent immersed in the interpretive aspect of analysis.

3.7.1 First level analysis

Following transcription of the tapes I read the textual data several times. Doing so enabled me to become immersed in the information generated. My initial reading of the texts was guided by the questions “what’s happening here, what is being said and by whom?” I jotted down notes and ideas on these musings whilst simultaneously accepting the elusiveness of the meaning of participant’s words. My first impressions resulted from reading the narratives associated with delirium as generated by people who had been delirious, families and members of the delirium service. This fundamental level of analysis did not take into consideration the social, political, cultural and historical structures that influence an episode of delirium. However, I was cognisant that the narratives of delirium are not only culturally and politically embedded, but are a social construction and interpretation of that event. Parsons (2000, p.176) agrees and claims, “... that such experience is already mediated through the political ideology of a particular sociocultural language game and is refracted yet again through the lens of the researcher in the final account”. I was also acutely aware that in addition to the participants’ and researcher’s interpretation is another layer, that of the reader’s interpretation.

3.7.2 Second level analysis

Following the identification of my first impressions I focussed on the ways in which the texts talked about delirium. I looked at the different ways the object delirium was constructed both within and across the texts, and began to locate these within wider discourses. These references to delirium were at times both similar and contradictory. For example some participants were afraid of “losing their minds forever” while others knew that their delirious episode would pass and that they would return to their usual level of functioning. Payne (2002) identifies this phase as looking for similarities and a

difference, which in turn, illuminates the multiple discourses circulating that take up and are taken up by participants.

There were a number of discourses present in the texts, each of which were interconnected and frequently overlapping which made the process of isolating and identifying them difficult. I applied a system of coding, using coloured marker pens that first looked for the similar ways participants, both directly and indirectly, referred to the construction of what Willig (2001) identifies as the discursive object, in this instance delirium. These references to delirium were interpreted, sorted and categorised, as described above, both electronically and in hard copy, which prepared the data and made it more manageable for analysis.

The next step in the sorting of the data was to identify the various subject positions made available by the discourses associated with the object of delirium. I looked at the different ways the people interviewed talked about a person who was delirious. This also included the ways in which people who had been delirious talked about themselves. Willig (2001, p.110) believes this to be an important aspect when undertaking a discourse analysis because "... discourses construct subjects as well as objects and, as a result, make available positions within networks of meaning that speakers can take up as well as place others into".

As part of identifying the various subject positions made available by the discourses I was confronted with the dilemma of how to refer to the participants when presenting their narratives. Originally I adopted what discourse analysts commonly do, which is not to identify participants other than by a number or letter. The adoption of this practice, Wilson (2000; 2001) explains, is to ensure the focus remains on analysis of the discourses rather than the people. However, the local discourses produced by older people are in a subjugated position in relation to the dominant medical discourses, and due to my critical gerontological focus I wanted to make visible the people who had contributed so generously to this research. I therefore decided to assign fictitious names to participants. The attachment of a name to a person also identifies that there is a person who has spoken these discourses who lives within a context that is influenced by culture, society and history.

My final step in this process was to make visible the power effects associated with discursive practices as portrayed by institutions i.e. the hospital, health professionals, families/significant others and the people who had been delirious. Willig (2001) identifies discursive practices as the method by which discourses influence what can be said and/or actioned, as well as what is and cannot be said. The completion of the sorting process highlighted the diverse and often contradictory ways the object delirium was spoken about both within and across texts.

Taking a Foucauldian perspective has allowed me the opportunity of using published literature as data. Utilising the literature in this way is different from the conventional practice of critically appraising the literature available on a given topic and then presenting it as a background to the study (Payne, 2002). Furthermore, in this study I have deliberately analysed the literature relevant to the discursive object of delirium separately from the texts generated from the interviews and clinical records. My rationale for proceeding in this manner was because I wanted to juxtapose the discourses on delirium in the literature with those produced by the texts generated from interviews and clinical notes.

Therefore drawing from the work of Foucault (2002a; 2002b), Parker (1992) and Powers (2001) I developed the following set of questions as a means to interrogate the research data and to analyse each of the identified discourses associated with the object of delirium:

1. How are the objects and subjects of delirium represented in the texts?
 - Are the representations unified or contradictory?
 - Are the representations similar or different?
 - What language and metaphors associated with delirium are used in the texts and where do they originate?
 - What discourses are drawn on as a means to talk about delirium?
2. How is power exercised and by whom?
 - How is disciplinary power represented in the texts?
 - What are the dominant discourses?
 - How do resistant discourses cause trouble for other discourses?

- How does resisting dominant discourses make available alternative ways of speaking about delirium?
3. How are institutional practices supported or modified by the discourses?
 4. How do dominant discourses come to occupy such a privileged position in relation to delirium at the expense of subjugated discourses?

3.8 To validate or not to validate

The issue of validity and rigour associated with the research process is both important and contentious. Proponents of the biomedical/scientific approach to undertaking research, largely through quantitative means, frequently imply that qualitative approaches to human inquiry are full of threats to validity (Angen, 2000). This suggests that qualitative approaches have little or no scientific value.

The quantitative researcher is bound by the positivist tradition and follows a rigid adherence to research methods in an attempt to guarantee validity, rigour and the discovery of an absolute truth. Whittemore, Chase and Mandle (2001) claim that positivists believe notions of reliability and validity originating from the scientific tradition should form the benchmark from which all research is judged. This statement typifies the power/knowledge relations that underpin the concept of validity. It also illuminates that positivist means of validating the research process are not at all suited to interpretive research utilising a postmodern and Foucauldian lens (Denzin & Lincoln, 1994; Payne, 2002).

As previously mentioned quantitative research originates from a single theoretical position. On the other hand qualitative research methodologies offer an array of data gathering and ways of interpreting data without privileging any one approach (Parsons, 2000). However, the methods for ensuring reliability and validity in qualitative research originate from the field of quantitative research (Angen, 2000; Koch & Harrington, 1998; Whittemore et al., 2001). Unsurprisingly, issues arose for qualitative researchers due to the incompatibilities associated with using terms and assumptions from the quantitative paradigm. For example, in a research methods text edited by Crooks and Davies (1998) the quantitative concepts of validity, reliability, generalisability and

objectivity are compared to the qualitative concepts of credibility, dependability, transferability and confirmability as a means to ensuring a rigorous research process.

The outcome is a plethora of different approaches and terms used to ensure rigour in the qualitative research process. Having no set standard with which to measure rigour from a qualitative perspective leaves researchers vulnerable to positivist critics who ascertain that without standards of validity, research becomes an “uncritical hodgepodge” and is vulnerable to “method slurring” (Whittemore et al., 2001, p.525).

Qualitative nurse researchers have responded to the above-mentioned criticisms by becoming increasingly preoccupied with the issue of method (Koch & Harrington, 1998). Nurse researchers have therefore replaced one set of governing rules for another. For example what appears to be a gold standard rule in qualitative research is to return the transcripts to the participants for checking (Leininger, 1994; Minichiello, Fulton & Sullivan, 1999). As discussed in section 3.6, I did not return any of the transcripts back to participants for checking due to my postmodernist/Foucauldian philosophical position. Positioning myself in this way placed the issue of validity and rigour in the traditional sense into serious question.

Postmodernism challenges the notion that it is possible to uncover universal truths and therefore attain any universal understandings (Cheek, 1999a; 1999b). From a postmodern perspective, the notion that representations produced from interviews can be viewed as ‘truth’ is problematised. Payne (2002), in her doctoral work cautions the postmodern researcher in claiming the truthfulness of research participants’ accounts of their personal experiences. She implies that participants’ accounts of their experiences are partial, unstable, contradictory and socially constructed. In analysing the discourses in relation to delirium, my intention is to offer a mini-narrative that may raise the consciousness of the readers and inform the work of people who operate within the dominant biomedical discourse of delirium in order to provide alternative speaking positions. The people interviewed in the study presented particular constructions of events occurring at a particular point in time and therefore challenge the idea that the research is definitive and authoritative.

While I have provided a discussion around the issues associated with validity across paradigms I was still left with the problem of deciding how to establish and demonstrate some form of validity or trustworthiness. An approach that I used to verify the research process in this study was that of crystallisation. This is where data is obtained from numerous sources therefore epitomising the various aspects of a crystal (Richardson, 1994). Denzin and Lincoln (1994) agree and claim issues of validity related to postmodern research can also be met through crystallisation and state:

Crystallisation, without losing structure, deconstructs the traditional idea of “validity” (we feel how there is no single truth, we see how texts validate themselves); and crystallization provides us with a deepened, complex, thoroughly partial, understanding of the topic. Paradoxically, we know more and doubt what we know (p.522).

I applied this concept through looking at the data as though it were a crystal. Turning the crystal revealed the multiple layers of meaning, helping to uncover hidden assumptions and perceived ‘truths’. In other words, in line with the critical gerontological approach used in the present research crystallisation revealed the multiple discourses and ‘truths’ available about delirium.

3.9 Reflections on the method

Heslop (1997, p.52) claims that discourse analysts are concerned with the “operation of power in constructing knowledge”. This implies that the investigator must acknowledge the privilege and power inherent in any research where the objectives, methodology and analysis are determined by the researcher. Attending to the power issues associated with the research process is particularly salient in the present study. Older people who had been delirious may find themselves in a vulnerable position due to being unwell, stressed, tired, worried and then confronted with having to share their experiences with a complete stranger. Older populations, including those who have been delirious, are identified as vulnerable because of their risk for and/or susceptibility to future adverse health outcomes (Berkman, Leipzig, Greenberg & Inouye, 2001; Flaskerud & Winslow, 1998; Hancock, Chenoweth & Chang, 2003).

I have attempted to deal with the privileged and powerful position of researcher through taking a reflexive stance in relation to this study as outlined earlier in this chapter as

well as in chapter 1, and operationalised throughout this thesis. I have outlined my concerns regarding my position as a younger man undertaking research on an older population and acknowledge myself as potentially intrusive but “indispensable to the research process” (Heslop, 1997, p.54). I also attended to several pragmatic issues to ensure that the people interviewed were informed and able to participate in the interview process as fully as possible as outlined in the following sections.

I realised that there are some expected age related changes affecting the research process and some that were specifically related to the person having been acutely unwell. Hancock et al. (2003) urge researchers to consider some of the sensory changes when communicating with older people during the course of the interview. I addressed these by ensuring that the person could understand and hear what I was saying and that if they wore a hearing aid that this was working and if glasses were worn that these were clean and on. Because the people who had been delirious had experienced a cognitive event and may also have other co-morbidities that could affect comprehension, response rate and the speed at which questions were processed, I allowed more time and repeated questions as necessary.

In the case of family members I was cognisant that they too were in a vulnerable position. Not only had their loved one been acutely unwell but they also had, in many instances, displayed behaviours that were stressful and left them with many questions. Several of these questions were asked of me during the interview. Before each of the interviews I made sure that the registered nurse responsible for the person’s care would be available afterwards to answer any questions about the care of their relative. For example Allanah (family member, p.17), whose husband had been delirious asked, “What we had thought of doing and it would be good to ask you is to buy him a motorised scooter. The ones that if you take your hands off they stop. We have sorted one out. Do you think he would be able to use one?” My response was that I did not know but I paused the interview while I wrote the question down and on completion went with Allanah to find the appropriate person to respond to the question.

3.10 Summary

This chapter has presented an overview of the processes employed to undertake this research. A critical gerontological and postmodern perspective was selected as a lens to disrupt the modernist ideals associated with the research process by highlighting that diversity, partiality, contradictory, unstable and multiple worldviews available are an integral part of being delirious. Foucault's notion of discourse and power has strongly influenced the analytical framework I utilised to interrogate the texts generated from the data gathering phase of this research project.

The ethical components associated with this project have been explained as well as a discussion on validation of findings when utilising a postmodern framework. My commitment to taking a reflexive stance and utilising multiple data sources ensures that my processes are auditable. The background information associated with this study is now complete. The following two chapters represent my engagement with the relevant published literature available on delirium and addresses the first research aim *to interpret the meanings embedded in the discourses surrounding delirium via the collection/analysis of relevant published documents*. The next chapter overviews the medicalisation of the older body and traces the emergence of delirium as a stable medical entity.

Chapter Four: The emergence of delirium as a stable medical entity

4.1 Introduction

A central component of any study employing aspects of Foucault's methods is the historical tracing of events around a specific field of inquiry that problematises the stability and certainty of knowledge development. The focus of this chapter is to disrupt any notions that the concept delirium is a static, stable and/or reliable entity, through the utilisation of Foucault's genealogical analytic tools. I also argue that the emergence of delirium as a stable medical entity within medicine has produced particular knowledges, disciplinary practices and sets of conditions that influence the social construction of the delirious body. These in turn have infiltrated nursing and nursing practice.

This chapter begins with an overview and explanation of the central components of biomedicine. This discussion lays the foundation for tracing the emergence of delirium as a stable medical entity from the 1st Century AD through to its enshrinement in the American Psychiatric Association's 1980 publication, the *Diagnostic and Statistical Manual III* (referred to as the DSM). The chapter concludes with a critical analysis of the disciplinary effects and practices of this landmark action on older people who have been delirious through the implementation of surveillance strategies, such as clinical assessment screening tools.

4.2 Biomedicalisation

Chapter two of this thesis presented the core characteristics of modernism, derived from the Enlightenment Period. The key feature associated with this view is that rational progress occurs through the establishment of metanarratives or big stories. It is this notion that provides the foundations for understanding the development of biomedicine in western societies. Biomedicine is therefore the term used to articulate medicine's approach to viewing the human body. The key elements inherent in biomedicine are founded in Enlightenment principles. The discursive emergence and dominance of contemporary biomedicine occurred between the late 17th Century and the late 18th

Century (Lupton, 2003). During this period the human body was constructed in material terms with diseases of the body having their basis grounded in biological causes.

The basis of biomedicine has its roots in Cartesian thought which was heavily imbued with Descartes' philosophy. A central tenet of Descartes' ideas was the dualistic representation of mind and body so that both aspects of the human body existed and operated independent of each other. Consequently, "[W]ith the mind operating as a metaphysical 'ghost', the body became a 'machine'" (Samson, 1999, p.5). The body as a machine became central to the medical scientists of this time who became increasingly preoccupied with how the body worked. As a result, bodies were external to the person and therefore became public spaces, physical objects, and as such were freely available to be inspected.

The methods of inquiry accepted by medicine included those of observation and experimentation. It is these methods that were viewed by Enlightenment medicine as being able to "... *control* nature and *intervene* to correct the ailments that seemed to cut life short" (Samson, 1999, p.3). Medicine has based its professional identity on these fundamental scientific assumptions which have proliferated over time to ensure its legitimisation by government and the state in all modern western societies.

The discussion presented thus far is integral to Foucault's genealogical analysis of the discourse of medical experience. The emergence of the discourse of medicine occurred at the intersection of institutional and governmental events in France that ultimately provided the groundwork for the development of the clinical gaze (Foucault, 1994). The clinical gaze includes the structures that support the practice of medicine, as well as the way of seeing and analysing the disease and the patient. "Clinical experience represents a moment of balance, for it rests on a formidable postulate: that all that is visible is expressible and that it is wholly expressible" (Foucault, 1994, p.115). The utilisation of hospitals in the late 18th to early 19th centuries provided medicine with a perfect location to deploy the discursive practice of surveillance inherent in the clinical gaze. The hospital was the place where the ongoing development of anatomical knowledge took place through such activities as the dissection of corpses (Ryan, Carryer & Patterson, 2003).

In a Foucauldian sense, the medical understandings of disease and illness were inextricably linked to body parts and their function, which occurred through their representation on an anatomical atlas (Armstrong, 1983). The representation of the body in this way renders both normal and abnormal cells, tissues and organs visible to the clinical gaze undertaken by both nursing and medicine. Doing so separates the body from the person so that, in medical encounters "... the persons of the doctor and the patient are simply 'disturbances' that must be brushed aside in order that the complexities of the disease entity can be apprehended" (Samson, 1999, p.9). Consequently, the person is rendered unimportant while the focus on the physical body and its functions are privileged.

A variety of technological advances assisted in the rise in status of medicine, for example the microscope which could detect, barely visible to the naked eye, toxic organisms such as typhoid. These scientific discoveries frequently gained much public media attention thus heralding medical doctors as scientific heroes while concomitantly releasing them from the attainment of empathetic bedside skills (Lupton, 2003; Rosenberg, 1988).

What is evident in the following definition of biomedicine is contemporary medicine's preoccupation and focus on biological reductionism:

[Biomedicine] seeks to diagnose and explain ill health in terms of a malfunction of one of the body's internal biological mechanisms. The body is looked upon as if it were a machine made up of individual parts that fit together and function like clockwork, all of them interdependent. The biomedical approach of most medical services focuses on the internal workings of the body, and generally precludes consideration of 'outside' (social, economic, and environmental) factors (Knight, 1998, p.139).

The discussion thus far has made apparent that contemporary medical practice is based on a privileged, but limited, biomedical understanding of the body, as well as providing an explanation of how the body works in states of health and illness. Nettleton (1995, p.3) summarises the following assumptions inherent in the biomedical model: biomedicine interprets the body in a dualistic manner (mind-body dualism), the metaphor "body as a machine" is utilised resulting in medicine reducing the body into a

fixable human mechanical part through technological means. Medicine utilises reductionism as the mechanism to explain health and illness, with every health deviation having an identifiable cause.

The above assumptions construct individuals as biological entities while remaining incognisant of the social meanings associated with experiencing an alteration in health. What follows demonstrates how influential, powerful and pervasive the biomedical model has been in the construction of delirium as a stable medical entity. This section of the chapter begins with an historical overview of delirium that culminated in the creation of the discursive object labelled delirium.

4.3 Creating the discursive object delirium

The recognition of delirium can be traced back to the formal writings of Celsus in the 1st Century AD, although references to the condition can be found earlier, around the time of Hippocrates (Berrios, 1981; Lindesay, 1999). At this time the word delirium was associated with fever and the resulting mental deviation caused by having a high temperature. Hippocratic writers utilised the terms phrenitis and lethargus to describe what is now recognised as delirium. Phrenitis relates to the experience of a transient mental disorder resulting from a physical illness and accompanied by the inability to sleep, an elevation in mood, perceptual disturbances and agitation. On the other hand, lethargus was characterised by lethargy, decreased response to stimuli and drowsiness (Lindesay, 1999).

Tenuous links can be made between our contemporary understanding of delirium and those described in ancient times. For example, the concept of lethargus, described in the previous paragraph can be linked to what we now refer to as a hypoactive delirium, and phrenitis to a hyperactive delirium. However, a parallel use of delirium as a general term to describe madness is also in circulation. Foucault (2002c) in *Madness and Civilisation* cautions the reader of his work not to confuse his references to delirium with the psychiatric term used to describe a confusional state. His reference to delirium is in relation to madness, using metaphors such as derangement, mania, hallucinations and dreams to describe this phenomenon.

The simplest and most general definition we can give of classical madness is indeed delirium. This word is derived from *lira*, a furrow; so that *deliro* actually means to move out of the furrow, away from the proper path of reason (Foucault, 2002c, p.94).

Galen's work in the first century A.D., which was incidentally based on animal anatomy, has also been influential in the development of the meaning of delirium, although he is criticised for using the term ambiguously (Berrios, 1981). Galen's understanding of delirium reflected the Hippocratic view and began a process of attempting to understand delirium by differentiating between primary versus secondary causes. Galen also has been credited as being one of the first people to identify dementia as a disease of old age (Gilmour, 2001). What resulted from this time was a significant lack of clarity and confusion over both delirium and dementia which is still evident in contemporary times (Lipowski, 1983). This could partly be explained by the constant comparisons made between the two health issues evident in the published literature.

Willis, a seventeenth century physician, neuroanatomist, and neurophysiologist, described both dementia and delirium as phenomena affecting the mind. He observed that delirium was not a disease in itself but rather occurred as a consequence and complication associated with a variety of physical illnesses of toxic [including the ingestion of alcohol and drugs], nutritional, infectious and visceral origin (Lipowski, 1980a). On dementia, Willis also identified alcohol consumption and the ingestion of drugs as causes (Berrios, 1987). By comparing delirium to dementia Willis reinforced the notion that these two health related conditions were linked in some way, and could be viewed as one in the same thing.

The 18th century heralded a change in medical knowledge where diseases were observed in terms of symptoms and signs (Foucault, 1994). This development in medical tradition marked a shift in the construction of delirium from being classified as a disease to displaying the features of a syndrome, a collection of symptoms. Physicians interested in delirium began to utilise the anatomo-clinical approach to gaze more intensely at the delirious body to more accurately identify the underlying causative disease. For example, "the absence of fever was used to separate conventional madness (e.g. mania) from delirious states secondary to physical illness" (Berrios, 1981, p.439). Delirium was

viewed as a diagnostic sign that was used to designate a pathological state and/or differentiate from other pathological states. The incorporation of psychopathology into the discipline of medicine led to the reinterpretation of pathology as an observable and quantifiable variation of what was considered normal (Foucault, 1976).

By the end of the 18th century and during the early 19th century the medical discourse, through psychopathological descriptions, labelled delirium as a stable and consistent category (Berrios, 1981). However, this claim is disputed by Caraceni and Grassi (2003) who asserted that at this time there was significant ambiguity present around delirium resulting from inconsistent and unclear use of terminology. In addition, the nosology of delirium as a stable entity was disrupted by the discipline of psychiatry, and the madness discourse, through the links made between delirium and insanity. At this time insanity/madness was seen as being outside the realm of medical practice, and it was not until later on in the 19th century that scientific psychiatry began the process of medicalisation (Foucault, 2002c; Mills, 2003).

In these early years psychiatry identified that delirium and other mental illnesses, for example melancholia and mania, shared similar representations (Lipowski, 1990). Common representations included hallucinations, clouding of consciousness and mental deficiency, all of which are synonymous with psychiatry and madness. It was during the 19th century that the concept of confusion, through the term 'clouding of consciousness', was introduced to the talk of delirium under the guise of advancing knowledge (Lipowski, 1980a; 1980b). However, all this advancement of knowledge surrounding delirium achieved was to further create a nosological confusion through use of terms such as senile delirium, acute confusional states, acute confusional insanity and acute delirium. Thus during this time a plethora of explanations and terms surrounding delirium abounded.

The emergence of delirium as a consequence of old age, through the use of terms such as senile delirium, was significant. Firstly, the word senile has experienced a shift in meaning over time. In the 1600s it was used simply to refer to old age, while in the 1800s it became synonymous with weakness, through to being linked with a pathological state in the 19th century (Katz, 1997). Secondly, the use of the term senile dementia, although substantially different in presentation to senile delirium is

remarkably similar and easily confused. Both utilise the words senile, and the words delirium and dementia are phonetically similar. Moreover, both delirium and dementia are reported as representing global disorders of cognition featuring difficulties with information acquisition, processing, storage and retrieval (Martin & Haynes, 2000; Parmet, Lynm & Glass, 2004). Finally, the linking of old age to delirium provided the conditions of possibility that enabled the beginning construction of delirium as a problem associated with ageing.

The quandary around whether delirium, dementia and insanity were related coincided with what Foucault (1994) identified as the privileging of the anatomico-clinical gaze, via the pathological technique of autopsy. The effects of disease upon the body were therefore exposed to sight, and as a consequence created a new language of description. The medical discourse, through the anatomico-clinical gaze, depends on the knowledge presented through death. By understanding the disease as it can be seen in death, the life of the disease in the living can be understood. However, in the instance of delirium findings on post-mortem either failed to find any pathological changes or if any were located then these were identified as unspecific findings (Berrios, 1987). Even though the term delirium has been referred to and described for a significant period of time the concept remains unstable and contradictory. The following section traces more closely medicine's attempts at creating a stable and coherent category for delirium to inhabit.

4.4 The emergence of delirium as a stable medical entity

In chapter two I argued that the emergence of a discourse is due to the existence of certain rules and structures, for example social structures, that allow the object of a discourse to be named, and therefore, talked about within society (Foucault, 2002a). Foucault's rationale for examining the emergence of a particular discourse originates from the assumption that discourses do not just spring from nowhere but require material conditions in order to come into being. These material conditions are intertwined with institutional practices that have the ability to regulate social life.

Material conditions were in existence in the mid to late 20th century that facilitated the emergence of the object delirium in people over the age of 65 years. One major condition was the upsurge of interest in older populations by health professionals (see

pages 73-74 for a more comprehensive discussion on an ageing population and its relationship to delirium). An ageing population enabled medicine to create a complex set of institutional practices aimed at producing a normalising, stable and homogenous discourse on delirium.

The foundations were laid in place for the emergence of delirium as a stable medical entity in the 1940s by the American investigators Engel and Romano. These researchers are heralded as being the catalyst for launching the modern era of research into delirium (Francis, 1995). Romano and Engel demonstrated that there was a correlation between changes in electroencephalographic (EEG) activity and delirium. They proposed that by treating the underlying cause of delirium there was an associated reversal in both the clinical and EEG manifestations (Romano & Engel, 1944). This revelation provided medicine with a way to track the progression of delirium, and assist with providing a scientific explanation, and therefore the ‘truth’ about delirium.

Being able to track or monitor an event fits with Foucault’s (1991) conceptual understanding of the panopticon, as a mechanism of power, through the use of surveillance. As discussed earlier, inherent in the power of surveillance is what Foucault refers to as the anatomo-clinical method resulting in the clinical gaze. The anatomical surface of delirium is made visible through the utilisation of EEG technology. The pivotal point here is ... “there is disease only in the element of the visible and therefore statable”, and that the “manifest truth” of a disease is through that which can be seen and spoken of (Foucault, 1994, p. 95). Early attempts at gazing deep within the body at delirium were through autopsy, and this revealed no visible signs of the condition. The findings on EEG were therefore significant because it provided the medical discourse with a position from which to speak and provide a set of ‘truths’ about delirium that was previously unknowable. This, therefore, contributed to the emergence of delirium as a stable medical entity.

However, it was not until 1980, through the work of the physician Lipowski, that delirium was finally fully subsumed into the medical discourse. In the same year Lipowski published a statement in the *American Journal of Psychiatry* attempting to control the madness discourse on delirium by stating:

The credibility of psychiatry's claim to be an integral part of medicine is likely to be judged to a considerable extent on its success in advancing the knowledge, treatment, and prevention of psychopathology associated with cerebral disease and dysfunction (Lipowski, 1980b, p.674).

On one hand Lipowski's statement could be viewed as philanthropic through its concern with providing a better scientific understanding of delirium. However, discourse analysis is not only about what is said but also what is not said (Kendall & Wickham, 1999). Another position on Lipowski's assertion is that the incorporation of psychiatry within the realms of the medical discourse further subjugates the madness discourse on delirium. Psychiatry is deeply embedded within the madness discourse as identified by Foucault (1976; 2002c). The medicalisation of madness entailed a preoccupation with its biological causes based largely on biodeterministic aetiological theory, while relegating the madness discourse to the position of other (Pilgram & Rogers, 1994; Scull, 1979). The medicalisation of madness was accompanied by the deployment of discursive strategies and techniques associated with the medical discourse that inscribed the insane (Foucault, 1977). These strategies and techniques included viewing madness as a biomedical problem comparable to a physical illness, thus legitimating the diagnostic gaze as a means of classification. Delimiting madness within the medical discourse marks madness as a disease and legitimates deploying a treatment regime focussed on physical and biochemical interventions. Welcoming delirium as an integral part of medicine opens up a set of normalising techniques that are then inscribed on the delirious body.

Lipowski's (1980a) landmark book on delirium not only provided a detailed historical review of the syndrome, through a medical lens, but asserted that the term 'delirium' should be adopted in preference to other terms, such as 'acute confusional state' and 'acute confusional insanity'. Moreover, it was clear that medicine was dedicated to distancing delirium from any association with insanity (Berrios, 1981; Lipowski, 1980b; Pilgrim & Rogers, 1994). The medicalisation of delirium and the subsequent subsuming of the concept within the medical discourse had been completed. By conquering delirium in this way, medicine, through the use of scientific techniques, took a reductionist perspective treating the body as a machine and focusing its gaze on disease and the associated symptomatology.

4.5 The classification of delirium as a medical entity

The previous section overviewed the material conditions that facilitated the emergence of delirium as a stable medical entity. I also outlined the medical discourse's determination to successfully lure psychiatry into its fold. However, attempts to ascribe one term to define the concept delirium have been largely unsuccessful. This is mainly due to the difficulties associated with the classification of delirium and the plethora of terms available to describe the syndrome. Delirium, along with other mental illness categories, is problematic to systematise (Caraceni & Grassi, 2003). This may be due to the nuances involved in neatly fitting subjective and highly individualised cognitive processes into a categorisation system as a means of not only identifying appropriate differential diagnoses through the clinical decision making process, but also for determining what is health and what is illness.

Several authors argue that the implementation of a universal psychiatric classification system is imperative to ensure accurate diagnostic criteria are available to detect delirium in the older population (see Dilling, 2000; Lindesay, 1999; Tucker, 1999). There are two main classification systems for mental disorders currently in existence. The first is the *International Classification of Diseases (ICD)* published by the World Health Organisation. The ICD is currently in its tenth edition and was published in 1992 (WHO, 1992). The other classification system is the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association. The fourth edition of the *DSM* was published in 1994, with an updated version called the *DSM-IV-TR* produced in 2000 (APA, 2000). The *DSM* has been recognised as being the most authoritative classification system for mental disorders and is frequently used in preference to the *ICD* (Crowe, 2000; Gilmour, 2001).

The World Health Organisation first included mental disorders in their sixth edition of the *ICD*, with prior editions focusing on the classification of physical disease states. The first edition of the *Diagnostic and Statistical Manual (DSM-I)* did not come into existence until after World War II (APA, 2000). The emergence of delirium as a stable medical entity occurred with the publication of the *DSM-III* in 1980. At this time delirium was formally recognised as a disorder in its own right along with the

identification of specific diagnostic criteria. Decisions around what was the ‘truth’ about delirium were published and enshrined within the doctrine of the DSM based on the consensus of experts. These experts were medical practitioners who welcomed efforts to introduce consistency and order into the prevailing nosological and terminological chaos in this area (Lipowski, 1980a; 1980b; 1983).

Prior to this period, cognitive disorders were divided into either acute or chronic brain disorders in *DSM I* and psychotic or nonpsychotic organic brain syndromes in *DSM II* (Tucker et al., 1994). The classification of delirium was not present in either of these publications. The incorporation of delirium, along with dementia, into the *DSM III* reflected a radical paradigm shift. Tucker et al. politely suggest that this change reflects the integration of psychiatry into general hospital settings. However, as earlier mentioned, this also reflects the incorporation of psychiatry into the medical discourse, thereby divorcing it from any notions of madness. The *DSM III* utilised a medicalised framework that promulgated the nature, causes and treatments about specific mental illnesses that influenced mental health policies (Horwitz, 2002). Therefore, in terms of delirium, the fundamental premise of the *DSM III* was to provide a mechanism for health professionals to use to categorise and homogenise the delirious person as a discrete diagnostic entity.

Coinciding with the inclusion of delirium as a separate entity in the *DSM III* was the growing realisation that delirium, along with other organic brain disorders, was associated with an ageing population. The raised profile of delirium among the older population appeared at a time when literature on the ageing western population began to proliferate (McFarland, 1978; Siegel, 1981). Links between an increase in age with a corresponding increase in illness and disability, and the social and economic implications began to be documented (Lipowski, 1980b). In the case of delirium the medical discourse equates old age with an increase in the incidence of physical illness and disability. This particular paradigm does not leave space for the circulation of other discourses and therefore promotes the simplistic view that upon reaching 65 years there is an increased incidence of illness which in turn equates to a potential corresponding increase in the incidence of delirium.

The same is true within a New Zealand context. It has been well documented that New Zealand's population is ageing and along with this comes a concomitant increase in illness and disability (Neville & Alpass, 2002). The Ministry of Health has identified that the economic costs to the government associated with providing health services to older people would have to increase by an average of 3.6 percent every year based on current predictions (Melding, 1997; MOH, 2002). This notion constructs the older adult as an economic burden and stresses the importance of closely monitoring and controlling this population group. The DSM is one such mechanism available to achieve this means.

4.6 Problems with the DSM classification system

The development of classification systems is a process utilised by medicine to legitimate and assert its domination over the body. The purpose of classification systems is "to see, to isolate features, to recognise those that are identical and those that are different, to regroup them, to classify them by species or families" (Foucault, 1994, p.89). The DSM is used as a classification system to detect the visible signs of delirium in older people. It is utilised as an objective tool administered by a large group of diverse health professionals, within a variety of settings, on an equally diverse older population.

Health professionals who utilise the DSM as a diagnostic tool assume that by being able to observe and categorise delirium, a material entity exists. Consequently, this process determines both the existence and legitimacy of certain human conditions and experiences. Medicine has attempted to create order in what Lipowski (1980a; 1980b) earlier referred to as nosological confusion in relation to delirium. Behaviours associated with being delirious are interpreted as signs of the older person's inability to function within social norms, as defined by medicine, and coincidentally which nursing upholds and supports under vicarious authority.

However, the publishers of the DSM, the American Psychiatric Association, claim that even though this diagnostic tool is universally applied it also attempts to consider individual differences present within the older population, for example, age, culture, ethnicity, gender and education. At the same time the authors of the DSM-IV-TR also

acknowledge the limitations of a categorical approach to mental disorders based on essential criteria. They state:

A categorical approach to classification works best when all members of a diagnostic class are homogenous, when there are clear boundaries between classes, and when the different classes are mutually exclusive. Nonetheless, the limitations of the categorical classification system must be recognised (APA, 2000, p.xxxi).

A contradiction therefore exists in the attempt to provide a homogenous classification system whilst at the same time acknowledging the heterogeneity of clinical presentations in mental disorders. It is well documented that delirium varies in its presentation, is not easily diagnosed, and is often overlooked or misdiagnosed by clinicians (Inouye, 1998a; Laurila, Pitkala, Strandberg & Tilvis, 2002; Schuurmans, Duursma, Shortridge-Baggett, 2001; Truman & Wisley Ely, 2003; van Zyl & Davidson, 2003).

On the surface, the previous discussion highlights the enlightenment project's quest for progress through taking a value neutral, objective and apolitical position on delirium via the categorisation of delirium in the DSM through a medically based nomenclature. Each published edition of the DSM has been developed through the utilisation of scientific empirical inquiry. For example, the production of the DSM-IV-TR by designated workgroups used an empirical process that included reviews of published literature, the reanalyses of existing datasets and field trials (APA, 2000).

However, on closer inspection the DSM is not a value free, apolitical scientific classification of delirium in older people. The reduction of delirium to a set of prescribed data sets does not eliminate the need for a value judgement. A value is placed on older people as to what is appropriate and normal functioning for this population group. In effect the DSM constructs a normative expectation of older people. Any deviation from the norm has disciplinary and political implications.

The criteria for defining delirium in DSM-IV-TR, as set by the working parties involved in its development, shape the disciplinary project associated with older people, the funding of health care, as well as influencing the public discourse on old age. This

assertion is supported by Widiger (2002, p.32) who states “[The DSM-IV-TR] was created and is controlled by the American Psychiatric Association, and it has been suggested that the DSM is largely a tool of this organization to maintain and increase its economic wealth, social influence, and political power”. As a result, the classification of delirium within the DSM has ensured the funding for research and health services, and is legitimised by a disease diagnosis. The latest DSM-IV-TR (APA, 2000) classification is heralded as the ‘gold standard’ for guiding the diagnosis of delirium in medical discourse. What follows is a critique and problematisation of the positioning of delirium within the DSM-IV-TR manual, as well as an in-depth investigation of the contemporary definitions available on delirium.

4.7 The positioning of delirium in the DSM-IV-TR

Delirium can be found along with dementia, amnestic disorders and other cognitive disorders in the DSM-IV-TR. These disorders share in common disturbances in cognition and/or memory. In previous editions of the DSM, for example DSM-III-R, this group could be located in a division titled “Organic Mental Syndromes and Disorders” (APA, 2000). This category no longer exists in either DSM-IV or DSM-IV-TR because it incorrectly implies that other mental health disorders (non-organic disorders) do not share a biological basis. The delirium group contains four categories each differentiated by its aetiology. The four categories are ‘delirium due to a general medical condition’, ‘substance-induced delirium’ (which includes the side effects associated with taking medication), ‘delirium due to multiple aetiologies’ and ‘delirium not otherwise specified’ (APA, 2000).

4.7.1 Diagnostic criteria

The essential diagnostic criteria for delirium in the DSM-IV-TR is

... a disturbance of consciousness that is accompanied by a change in cognition that cannot be better accounted for by a preexisting or evolving dementia. The disturbance develops over a short period of time, usually hours to days, and tends to fluctuate during the course of the day. There is evidence from the history, physical examination, or laboratory tests that the delirium is a direct physiological consequence of a general medical condition, substance

intoxication or withdrawal, use of a medication, or toxin exposure, or a combination of these factors (APA, 2000, p.136).

In this, the latest DSM, the above definition is categorised as criterion and presented in table format (see Table 1). Criterion A through to C is the same regardless of whether the delirium:

1. occurs as a consequence of a medical condition
2. is substance-induced
3. is due to multiple aetiologies
4. or not otherwise specified

Table 1:

Diagnostic Criteria of DSM-IV-TR for Delirium

A	Disturbance of consciousness (i.e. reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.
B	A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.
C	The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.
D	There is evidence from the history, physical examination, or laboratory findings <ol style="list-style-type: none"> 1. that the disturbance is caused by the direct physiological consequences of a general medical condition 2. of either (1) or (2): <ol style="list-style-type: none"> (1) the symptoms in criteria A and B developed during substance intoxication (2) medication use is aetiologically related to the disturbance 3. that the symptoms in criteria A and B developed during, or shortly after, a withdrawal syndrome 4. that the delirium has more than one aetiology (e.g. more than one aetiological medical condition, a general medical condition plus substance intoxication or medication side effect).

Note table adapted from APA (2000).

The positioning of delirium within a respected and highly influential classification system, such as the DSM, has resulted in a proliferation of delirium screening tools to

aid with diagnosis that have been specifically designed for use by doctors and nurses. These tools, as does the DSM-IV-TR, have both a diagnostic and prognostic function, and therefore can serve a disciplinary function through the use of the clinical gaze as a means of social control (Foucault, 1994). The meanings that arise out of utilising diagnostic tools specifically related to delirium say something about the older person's past, present and future. The medical discourse can therefore determine the 'truth' about delirium in older people through the use of these tools.

The process of naming the behavioural aspects associated with being delirious, through the DSM classification, requires the medical discourse to extend its authority and expertise by controlling these unusual behaviours. It constructs the older person as a medical entity so they no longer are just an older adult, but are also cognitively impaired. Such naming extends medicine's authority over the older person's life, entrapping them within the resulting behaviours exhibited when delirious. Delirious behaviours are interpreted as signs of the older adult's inability to function within normal conventions, with medicine and nursing taking responsibility for managing this deviation from the norm. The process of diagnosing delirium through the utilisation of the DSM classification system is a form of social control, which Brown (1995) identifies as authorising medicine, and its delegated authorities, to label and deal with these people on behalf of society.

The DSM-IV-TR (2000) fails to acknowledge how a diagnosis of delirium may be inextricably linked to, and influence the social, cultural and historical contexts that make up, and influence older people's experience of health and illness. The older delirious body is rendered 'docile' (Foucault, 1991; 1994; 2002b), through the DSM classification system, amenable to manipulation and control by the professions of medicine and nursing. Consequently, subject positions that offer older people opportunities to speak about their experiences of being delirious are marginalised. The social control of older people who are delirious is operationalised by the mechanisms associated with the DSM-IV-TR via the deployment of various assessment instruments.

Several instruments are available to assist with a diagnosis of delirium in the older adult. Of these the most widely used is the Confusion Assessment Method (CAM) (Inouye et al., 1990). Others include the Mini-Mental State Examination (MMSE)

(Folstein, Folstein & McHugh, 1975) which is a general cognitive screening test, and the Neeham Confusion Scale, a delirium focussed tool (Neelon, Champagne, Carlson & Funk, 1996). The CAM is a diagnostic algorithm used to detect delirium in the older adult that operationalises the DSM classification of the condition as can be seen in the table 2.

Table 2

The Confusion Assessment Method (CAM) Diagnostic Algorithm

<p>Feature 1. Acute onset and fluctuating course</p> <p>This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions:</p> <p style="padding-left: 40px;">Is there evidence of an acute change in mental status from the patient’s baseline?</p> <p style="padding-left: 40px;">Did the (abnormal) behaviour fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?</p>
<p>Feature 2. Inattention</p> <p>This feature is shown by a positive response to the following question:</p> <p style="padding-left: 40px;">Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?</p>
<p>Feature 3. Disorganized thinking</p> <p>This feature is shown by a positive response to the following question:</p> <p style="padding-left: 40px;">Was the patient’s thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?</p>
<p>Feature 4. Altered level of consciousness</p> <p>This feature is shown by any answer other than “alert” to the following question:</p> <p style="padding-left: 40px;">Overall, how would you rate this patient’s level of consciousness? (alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])</p>
<p>The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.</p>

Note table adapted from Inouye et al. (1990).

The CAM has been trialled, tested and proven to be a valid and reliable diagnostic and prognostic tool for delirium that is both expedient and effective to use in the older population across health care settings (Fick & Foreman, 2000; Inouye et al., 1990;

Inouye, 1998b; Laurila et al., 2002). The ease of use enables people without formal mental health education, for example, general nurses working in an acute medical or surgical unit, health personnel in resthomes and community hospitals and general physicians to undertake an assessment of delirium in approximately 5 minutes (APA, 1999; Inouye et al., 1990; Milisen, De Geest, Abraham & Delooz, 2001).

Both the DSM and the CAM are examples of what Foucault (2002a) refers to as a grid of specification. A grid of specification is a systematic and constructive discursive ordering of concepts occurring within a discourse (Powers, 1996). Within the DSM the object of the medical discourse, delirium, is outlined by its physical and behavioural states and presented as a diagnosis. The object delirium is then formally utilised in clinical practice by both medicine and nursing, emerging on the surface of the older docile body. Both the DSM and the older delirious body are jointly manipulated and coordinated by medicine and nursing. Powers (1996) identifies that this manipulation occurs through the deployment of the medical discourse and asserts that this discourse is prevalent and integral to shaping nursing practice and the type of professional care offered to people.

4.8 The creation of research agendas through the DSM

By supporting delirium screening tools like the CAM in respected refereed journals, the American Psychiatric Association, who publish the DSM, cement their authority on what constitutes the 'truth' about delirium in older people. The 'truth' about older people who are delirious is constructed through the setting of research agendas, establishing research priorities, the political lobbying for research, the production of lay knowledge, the structure and function of health professions and hospitals (Estes & Binney, 1991). Foucault (2002b) adds to Estes and Binney's ideas by identifying the medical professionals' concern with making money but also with the power the medical discourse exercises over, in this instance, older people with delirium and their health. For example, Inouye (1994) proposes a research agenda to address some of the problems associated with being an older hospitalised person with delirium.

... [R]esearch will lay the ground work for randomized intervention trials to prevent and treat delirium. [It] is estimated that if the length of stay of each delirious hospitalized elderly patient could be reduced by just one day, the

savings to Medicare would amount to \$1 to \$2 billion annually. This extrapolation highlights the vast economic and health policy implications of delirium, and invokes a compelling imperative for timely research addressing this problem (Inouye, 1994, p.286).

Inouye, as do other expert clinicians and researchers, has eloquently linked the incidence of delirium in older people with increased hospital stay and therefore cost. The reduction of the costs associated with health care is a major focus of health care institutions. Consequently, health professionals working in hospitals become preoccupied with treating the physical problem, for example delirium, at the expense of addressing the social and cultural needs associated with being a consumer of a health service. Hospitals, which are sites associated with medical and nursing practice, allow the emergence and maintenance of specific clinical practices associated with older people who are delirious. These clinical practices frequently focus on the disease while largely ignoring the person.

The development of assessment tools that can assist the clinician with the diagnosis of delirium enables further demarcation of delirium. For example, research has identified and described the existence of three sub-types of delirium. These are classified as hyperactive, hypoactive and mixed delirium types (Lipowski, 1990; Schuurmans et al., 2001). In the instance of a hyperactive delirium the older person presents not only with increased psychomotor activity but is also irritable and overly responsive to stimuli. On the other hand, a hypoactive delirium is characterised by reduced psychomotor activity and drowsiness. Meanwhile mixed presentations include, as the name suggests, aspects of both the hyperactive and hypoactive types.

Other research has focussed on separating delirium from other cognitive disorders that present with similar clinical pictures. In more recent times the relationships and complexities between depression, dementia and delirium have been highlighted (Martin & Haynes, 2000; Meredith, 1998; O'Keeffe, 1999). Insel and Badger (2002) add another feature to the mix; cognitive decline. They assert that cognitive decline (for example, not remembering names or phone numbers) can be an expected component of the normal ageing process and needs to be differentiated from others. It is possible that

an older person can present with only one of the previously mentioned conditions or a combination of one, two or all.

In the case of dementia and delirium, an older person who has been hospitalised is more likely to experience an episode of delirium if they already have dementia (Pompei et al., 1994). Similarly links have been made suggesting an increased occurrence of dementia following an episode of delirium (Fick & Foreman, 2000).

Although dementia and delirium have been recognised as two separate entities there are points where the two conditions overlap. The DSM identifies that delirium is acute in onset, however people labelled with Lewy body dementia also present with sudden onset (O’Keeffe, 1999). In addition, it has been well noted that delirium resolves over a period of time but these times vary from hours, weeks, days through to months. For example, in one study it was reported that approximately 80% of participants still had a resolving delirium up to six months post discharge from hospital (Inouye, 1994). What becomes apparent is that the medical discourse, in its attempt to provide a stable and reliable ‘truth’ about delirium, has instead created a semantic and unstable ‘hodge podge’ of terms and ideas about what constitutes this confusional state. These findings have lead to an increased incidence of misdiagnosis as well as an under detection of delirium (Milisen et al., 2001).

Both under detection and misdiagnosis contribute not only to poor medical outcomes but also cause major disruptions to the lives of the older people concerned as well as their family member/significant other. The impact on people’s lives has largely been ignored in the medical literature which continues to focus its attention on objectifying delirium as a means of treating the physical problem associated with the delirium.

4.9 Summary

In summary, this chapter has focussed on surfacing the biomedical construction and account of the disease entity, known as delirium. The argument began by concentrating on the way in which medicine objectifies the body in relation to health and illness. This biomedical representation of health and illness laid the foundations for undertaking a Foucauldian genealogical analysis of the material conditions that enabled the emergence

of delirium as a medical entity, via the DSM III to occur. I have argued that the DSM represents a powerful and political disciplinary project that privileges the discourse of medicine.

Although nursing has not been analytically interrogated in any great detail at this point, it is substantially implicated through the vicarious authority bestowed by medicine. Later chapters of this thesis will critically analyse how contemporary nursing accounts of delirium actively suppress the limitations inherent in the medical discourse, whilst simultaneously deploying the same knowledge as medicine. The next chapter builds on the analytic work presented so far by interrogating the literature gathered from the medical and nursing journals and textbooks in relation to delirium.

Chapter Five: The discursive field of delirium

5.1 Introduction

The fixing of a set of ‘truths’ about delirium, as focussed on the older body, is reflected in the published medical and nursing literature. It is clear that positioning delirium within a pathological and medical paradigm has enabled the formation of a research and publication infrastructure to pursue treatment modalities, prevention and cure. Nursing knowledge available on delirium in the older adult, consistently provides detailed descriptions of the pathological changes and current medical research findings. As a result nursing literature is grounded in, and heavily influenced by the biomedical discourse on delirium. Such is the authority of the biomedical discourse that there remains little room for the emergence of the personal dimensions associated with experiencing delirium. Personal perspectives are largely relegated to marginalised positions. This is antithetical to nursing’s rhetorical focus of working with individuals in acknowledgement of their unique social context, all of which nursing claims occurs within a holistic frame of reference.

As such, the focus of this chapter is to interrogate the discourses of medicine and nursing as they appear in the published literature since 1980 when delirium emerged in the DSM. As the majority of the nursing literature complies with the discourse of medicine, these will be discussed together rather than separately. It is important to recognise the powerful influence the discourses of medicine and nursing have in shaping the representation of delirium to the general public. Finally, this chapter culminates in the identification of two discourses that influence the discursive field of delirium as it relates to the present research.

5.2 Biomedical discourses and the discourse of delirium as a syndrome

The previous chapter has mapped out the surface of emergence, described the authorities of delimitation and analysed the grids of specification (Foucault, 2002a) contributing to the formation of a biomedical discourse on delirium. Medical concern around getting older has shifted emphasis from infectious to degenerative disorders. “[O]ld age has been understood primarily in relation to its corporeality – its bodily

manifestations – in a framework that has given primacy to the biomedical dimension of corporeality and, in the process, excluded the social dimension of being old” (Tulle-Winton, 2000, p.65).

It is unsurprising that all articles reviewed on delirium refer to the DSM classification. Reference to the DSM is significant because it asserts clinical medicine’s quest to describe the old body through pathological occurrences, and the inherent process of decay and deterioration (Canguilhem, 1998). The inclusion of delirium in the DSM is a consequence of biomedicine’s rich and prolific description of the pathological occurrences ascribed to being an older adult with delirium. As mentioned in the previous chapter, the hospital is the site where research into delirium takes place and as such the hospital promulgates the production of certain knowledges about being older and having delirium.

Utilisation of the DSM and other instruments, such as the CAM, assists nursing and medicine with determining a diagnosis of delirium. Kempler suggests that a diagnosis can also be referred to as a syndrome, “a label for a group of signs and symptoms (2005, p.9), for example delirium (see chapter four for signs and symptoms of delirium). Indeed authors writing on the topic (see Levkoff, Safran, Cleary, Gallop & Phillips, 1988) have utilised the term syndrome in reference to delirium as far back as 1988, as well as in contemporary times (see Harding, 2004). Consequently I have interpreted and applied Harding’s (2004), Kempler’s (2005) and Levkoff et al.’s (1988) reference to delirium as a syndrome to the present study culminating in what I will now refer to as the discourse of delirium as a syndrome. The naming of delirium has also politicised research agendas. This has been alluded to in the previous chapter but will be expanded further below.

5.2.1 The positioning of delirium as an economic and clinical problem

Research findings related to delirium are published in a variety of academic journals including those published by the American Psychiatric Association, the same organisation that publishes, manages and continues to develop the classification system associated with the DSM. The major thrust of the research literature from both the nursing and medical paradigms focuses on the construction of delirium as a problem

associated with ageing. This is eloquently and convincingly played out through the deployment of an economic sub-discourse, also introduced in chapter four. For example, Inouye (1998b) claims that health system costs, associated with having delirium in the USA, run into billions of dollars annually.

Based on extrapolations from the US vital health statistics, each year delirium complicates hospital stays for more than 2.3 million older persons, involving more than 17.5 million inpatient days and accounting for more than \$4 billion (1994 dollars) of Medicare expenditures. Moreover, substantial additional costs associated with delirium accrue after hospital discharge because of the increased need for nursing home placement, rehabilitation services, and home health care. These figures highlight the importance of delirium as a clinical and health policy problem (p.745).

This assertion has ably been replicated by others, for example Jacobson (1997), Marcantonio, Goldman, Oray, Cook and Lee (1998) and Rowe, (1999). There is no similar published research in New Zealand. However, in this country general information about health costs associated with the ageing population is now in the public arena. The Ministry of Health (1999; 2002) links ageing to poorer health status, increased number of days in hospital, as well as an escalating prevalence of disability and living with a chronic illness.

In this country, health costs associated with an ageing population have also been linked to productivity by calculating the annual effect of ageing on the gross domestic product and health spending. Hence in New Zealand the message is clear that due to an increase in the numbers of older people there will be a decrease in the amount of money made along with a corresponding increase in the cost of providing health care to older people. Within this country there is also a strong fiscal concern about an increasingly ageing population that will be dependent on the state for support via the pension scheme.

A key feature in modern societies is the association of social status with contributing economically to society (Bytheway, 1995). Contributing economically to society also ensures independence. This view therefore constructs the older person who has delirium as being dependent, vulnerable and powerless. This ageist view of delirium in old age is normalised through the deployment of the biomedical discourses, in the instance of the

present research the discourse of delirium as a syndrome, and the provision of ‘hard’ facts on ageing that are seemingly quantifiable, valid and reliable. For example, the Ministry of Health (1999) provides a complicated mathematical formula to predict the cost of ‘keeping’ older people and the impact this will have on the country’s economy. The discourses associated with ageism will be discussed in greater depth in chapter seven.

The utilisation of scientific methods by biomedical discourses, as described so far, has constructed delirium in the older person as an economic and clinical problem. Many refereed research articles begin by reinforcing that delirium is a problem. For example, Flaherty (1998, p.101) asserts “[D]elirium is a common and serious problem [in the older person]”, Insel & Badger (2002, p.361) “Delirium, or the development of acute confusion, is a common problem for patients over aged 65 years”, and Inouye and Charpentier (1996, p.852) “Delirium, an acute disorder of attention and cognition, has become increasingly recognized as a common and serious problem for hospitalized elderly patients”.

There is no denying that delirium is a problem but the question needs to be asked “for whom”? Without a doubt the literature so far reviewed has not addressed the problem that delirium might have for the older person in terms of the effects this health event may have on their life, their family and any future dreams and aspirations. Rather the problems associated with delirium both in the nursing and medical literature are presented as physical and institutional issues. The older person is presented in terms of length of stay, hospital outcomes, and a statistic, as well as an alteration in a physiological process. Consequently, nursing and medical research has predominantly focussed its attention on identifying the problems associated with delirium and the ways in which these problems can be minimised or avoided.

The literature based debate on delirium, and its relationship to increasing hospital stays, is interesting. I became intrigued by the title of an article by McCusker, Cole, Dendukuri and Belzile (2003) called *Does delirium increase hospital stay?* because I naively thought it might be an attempt to destabilise other literature linking delirium to increased hospital stays. The article began by claiming that previous research on this topic was contradictory and as a result inconclusive. However, the authors concluded by

differentiating between incident (acquiring of delirium during hospitalisation) and prevalent delirium (delirium present on admission), claiming that “[I]n older medical inpatients, incident but not prevalent delirium is an important predictor of longer hospital stay” (McCusker et al., 2003, p.1539). The focus and methodological approach evident in the study presented above continued to deploy the discourse of delirium as a syndrome to promote the further development of assessment and treatment regimes aimed at addressing the economic and clinical problems that accompany being older and having delirium.

The development of ‘good’ assessment and treatment regimes requires some understanding of the extent to which delirium is a problem, through determining the incidence, as well as the identification of potential causes and risk factors that may precipitate a delirious event. From the time of the emergence of delirium as a stable biomedical entity in 1980, medicine has deployed the discourse of delirium as a syndrome to undertake epidemiological studies in this area (Lipowski, 1980a; 1990).

Epidemiological studies identify that the incidence of delirium in hospitalised older adults varies enormously from 5 through to approximately 51% (Schoormans et al., 2001). The discrepancies in the incidence reported has been attributed to the numerous words used to describe delirium, variations in study samples and the diagnostic criteria used to determine delirium. Despite these variations reported certain ‘truths’ are constructed around delirium, which include longer and costlier hospitalisations (Milisen, 1999; Naughton et al., 2005). This notion constructs the older person with delirium negatively. The biomedical response to dealing with the issues associated with being older and having delirium is to take a reductionist, mechanistic and deterministic stance, all of which are integral to the successful deployment of the discourse of delirium as a syndrome and its focus on fixing the causes of problems.

As discussed in the previous chapter, the DSM-IV-TR describes four aetiological categories of delirium. The discourse of delirium as a syndrome claims the causes of delirium in older people are complex and multifactorial (Inouye, 1994). Medicine, and to some extent nursing, has directed its attention on determining the physiological causes of delirium at the expense of other potential possibilities. For example, in a study of 94 older people who were delirious, infection was found to be the main cause (35%),

closely followed by hypoxia-ischaemia (32%) and toxicity through medication use (15%) (O’Keeffe & Levan, 1997). On review of the available literature (for example, Freter et al., 2005; Pitkala, Laurila, Strandberg & Tilvis, 2005) it is apparent that having a pre-existing cognitive impairment, being over the age of 65 years, experiencing a medical illness, as well as the consequences of being ill, for example having an indwelling catheter in situ, were all consistent risk factors for delirium. These findings are also evident and reported in nursing texts (see Milisen, Lemiengre, Braes & Foreman, 2005).

There are an increasing number of publications appearing in contemporary nursing and medical literature identifying the causes and risk factors that contribute to an episode of delirium in older adults (Freter et al., 2005; Truman & Wesley Ely, 2003). However, little is known about how to decrease the impact delirium has on length of hospital stay, cost, ending the confusion around how delirium is defined, as well as the potential for misdiagnosis. In addition, the impact delirium has on individuals or their families has to date received scant attention.

The discursive field of delirium has given rise to a powerful, pervasive and controlling enterprise around delirium based on the assumption that this group of people’s problems are merely a transitory set of technical difficulties that can be overcome by physical or biomedical intervention. For instance, Lipowski (1980a, p.531) positions the older person’s body as a technical project by asserting:

The high incidence of delirium in the elderly seems to reflect changes in the susceptibility of the aging organism to disease on the one hand, and the increased vulnerability of the aging brain to ischemia, anoxia, electrolyte imbalance, drugs, and other pathogenic factors on the other.

Lipowski’s assertion refers to the older person as an ageing inanimate object with an ageing brain, and links this to a physiological cause. The positioning of delirium in this way transforms sociological issues associated with ageing into physiological problems. Thus, positioning the older adult within the health care environment in this manner, disguises, and marginalises what it is like to be over the age of 65 years with delirium.

In addition, Lipowski's above 'truth' claims, firmly position the older delirious body within the discourse of delirium as a syndrome which is imbued with facets of the biomedical construction of old age. Biomedicine has actively participated in the regulation and governmentality of not only old age but also the older body (Tulle-Winton, 2000). Delirium, as an established biomedical entity occurs in a malfunctioning older body in need of both nursing and medical attention. Consequently, nursing and medicine deploy certain discursive practices as a means of managing the older delirious body.

5.2.2 The discursive practices associated with the discourse of delirium as a syndrome

A primary discursive practice associated with being delirious is surveillance; the careful watching, assessing and examination of the older adult for signs of delirium. On admission to hospital or during a hospital stay the older adult is continually assessed and examined by nurses and doctors for any signs that might indicate they have delirium.

The examination combines the techniques of an observing hierarchy and those of a normalizing judgement. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish. It establishes over individuals a visibility through which one differentiates them and judges them (Foucault, 1977, p.184).

When examining an older person for signs of delirium, the nursing and medical eye draws on norms that are largely based on the attributes and cognitive abilities of younger and non-delirious people. For example, research identifies that when compared to non-delirious people, people with delirium experience a decrease in function while in hospital, present with more postoperative complications, and are at an increased risk of being placed in residential care settings (Inouye, Rusing, Foreman, Palmer & Pompei, 1998; Milisen et al., 2001; Naughton, Moran, Kadah, Heman-Ackah & Longano, 1995; Naughton et al., 2005). However, this statement is an anomaly, as evidenced by Inouye (1998a; 1998b) who outlines the existence of difficulties associated with accurately diagnosing, and frequently misdiagnosing and under diagnosing delirium. The legitimacy of making comparisons between delirious and non-delirious populations, and

the assertions related to health outcomes as presented above, should therefore be questioned.

In addition, the occurrence of delirium in older people is constantly referred to as a serious problem with serious consequences, such as those presented above. As such, the discourse of delirium as a syndrome positions any person over the age of 65 years at risk, especially as published works have identified that delirium is one of the most frequent presenting symptoms of disease (Bucht, Gustafson & Sandberg, 1999). Also, delirium has been identified as a potential risk factor associated with developing dementia and with dying, even in older people without prior cognitive or functional impairment (Rockwood et al., 1999).

Through the discursive act of surveillance the older person who poses a risk for developing delirium requires “special attention by nurses and physicians so that known precipitators of impaired cognition can be avoided and early symptoms and signs of confusion can be addressed quickly” (Pompei et al., 1994, p.809). As a result, the future for older people always holds the potential for being labelled delirious, but only if the examiner is especially diligent and knows what signs and symptoms to look out for. The older adult therefore submits to the practice of surveillance, and is assessed knowingly or unknowingly. The patient is assessed through the deployment of the DSM classification system and the utilisation of delirium sensitive clinical assessment tools, for example the CAM (refer to previous chapter for an overview of the CAM). The practitioner becomes the holder of knowledge and as a result has the power to determine and classify the presence or absence of delirium. It is through the process of being assessed that the practitioner comes to know the ‘truth’ about the older person who may or may not have delirium.

For Foucault (1977), the act of assessment is a mechanism of discipline: “the specific technique of power that regards individuals both as objects and instruments of its exercise. This power is not triumphant, excessive, omnipotent, but modest, suspicious and calculating” (Sheridan, 1980, p.152). It is a system where the older person who has delirium is disciplined to conform to the normal. The cognitive impairment, confusion and behavioural changes, all of which are inherent components of a delirious episode, need to be addressed, fixed so that desired norms can be attained and maintained. It is

nurses and doctors who can prescribe pharmacological and non-pharmacological interventions. These interventions perform corrective functions and the hospital is the only place where the management of delirium can occur. In essence, this is a form of disciplinary punishment that attempts to lessen the space between normal and abnormal (Foucault, 1977).

5.3 Management of the problems associated with being delirious

The previous section has explicated the prevalence of biomedical discourses, more specifically the discourse of delirium as a syndrome, in determining knowledge about being delirious as an older person. Biomedical discourses construct delirium through the medical and nursing gaze. As such, delirium is gazed at through a complicated and multifactorial system of pathological disease processes, for example electrolyte imbalances and urinary tract infections. Surveillance techniques inherent in the clinical gaze, whether they are medical or nursing, allow the delirious body to be manipulated, so “... the emphasis of the health professions is on the management and maximization of life itself” (Kaufman, Shim & Russ, 2004, p.732).

Placing delirium within the medical and nursing gaze has resulted in, as earlier mentioned, an enthusiastic response from practitioners of nursing and medicine with a multitude of published research and best practice guidelines now available. For example, best practice guidelines have been published by the American Psychiatric Association (1999), the same organisation who produces the DSM manuals. An overview of the literature reveals that the cornerstone of managing delirium in the older adult involves pharmacological, aetiological, environmental and nursing interventions (Caraceni & Grassi, 2003; Lipowski, 1990). General principles associated with the management of delirium, as explained above, focus on early detection of causes and prompt intervention. As such, the management of delirium is divided into pharmacologic and non-pharmacologic clinical practices and these are presented below in the following two sections.

5.3.1 Pharmacological management

The utilisation of pharmacologic agents as legitimate means of treating delirium in the older adult is recommended, and features in both nursing and medical literature. Medical writers identify that “[P]alliative treatment for delirium often involves medication to restore an adequate sleep-wake cycle and reduce agitation and hallucinations (Kempler, 2005, p.209). While nursing writers still advocate the use of medicines in the management they also caution the indiscriminate use of pharmacologic agents as evidenced by the following excerpt; “... medication for behavioural management may be needed, but should always be used with caution, because delirious patients are exquisitely sensitive to side effects, especially of anticholinergic, psychotropic medications, e.g. *chlorpromazine* and *thioridazine*” (Milisen, 1999, p.37).

However, both nursing and medicine recommend the use of medicines to control the symptomatology that puts the older adult at risk of either harming themselves or others. Caraceni and Grassi (2003) identify the aim of pharmacologic management is to keep the person calm and so avoid dangerous behaviours, and to control unpleasant hallucinations and delusions. These same authors also claim that “[A]t times this aim can be obtained by relatively simple drug regimens, but more intensive approaches such as sedation or physical restraint in cases unresponsive to therapy may be needed” (p.133).

Analysis of this position immediately identifies the absence of any concern for the older person at whom these chemical assaults are aimed. The deployment of the term ‘simple’ implies something that is straight forward and uncomplicated. The utilisation of any pharmacotherapeutic preparation, even though it is a frequently used medical treatment modality, is complicated and anything other than simple. This becomes all the more salient when applied to the older adult, particularly those who are already experiencing compromised health as in delirium. The pharmacokinetic effects (what the body does with the drug) influence drug absorption, distribution, metabolism and excretion of drugs. Normal physiologic changes associated with ageing, and added to this compromised health, have the potential to cause adverse drug effects including death (Aschenbrenner, 2002). In light of this analysis, it is Caraceni and Grassi’s (2003)

assertion about medication that is simplistic, and as a result could encourage the indiscriminate utilisation of medicines as a means to treat delirium in older people.

Literature recommends the use of the drugs thioridazine, haloperidol and respiradone as a means to manage any agitated, anxious and disruptive behaviours evident during the course of a delirious episode (APA, 1999; Insel & Badger, 2002; Macdonald, 1997). The above listed medications are recommended because they are less likely to cause sedation, have limited anticholinergic effects and are less likely to cause orthostatic hypertension (O’Keeffe, 1999). However, if delirium is a result of withdrawal from chemical substances benzodiazepines appear to be the drug of choice (Jacobson, 1997; Lipowski, 1989).

Contradictions are evident in relation to the utilisation of pharmacologic agents as a means to manage delirium in the older adult. The drugs purported to successfully assist in placing the person in the best possible position to recover from a delirious episode, as in those outlined in the previous paragraph, are also identified in the literature as precipitating a confusional state. Hanley (2004) provides a comprehensive list of medications that may contribute to delirium, including thioridazine, haloperidol, benzodiazepines and respiradone, and claims that many confusional states are caused through the effects of polypharmacy. In other words prescribers are the causative agents.

Interestingly, when the pharmacological management of delirium is juxtaposed with that of dementia the mode of treatment is remarkably similar. The utilisation of thioridazine, haloperidol and respiradone, as drugs of choice for the management of undesirable behaviours in people who have delirium, also appears in the dementia literature (Brown & Hillam, 2004). In addition, Caraceni and Grassi (2003), along with others, have begun to publish statements encouraging the introduction of the same cholinesterase inhibitor drugs used for the treatment of dementia, as a means of alleviating the symptoms associated with delirium. Cholinesterase inhibitors are used in dementia management as a potential means of slowing the rate of cognitive decline. This may mean that older people assessed as at risk for delirium will be given cholinesterase inhibitors prophylactically to stop the development of delirium.

The previous discussion reaffirms biomedicine's desire to know the body. Both the nursing and medical gaze is positioned to apprehend the processes that cause any deviation from the normal physiology of the body (Davis, 2004). As seen in the case of delirium, empirical knowledge grounded in the identification of pathology derived from analysis of tissue dysfunction gives rise to the power to manage delirium as a syndrome through the dubious and contradictory utilisation of pharmacological preparations. In addition, the deployment of the discourse of delirium as a syndrome is no longer confined to body techniques and the knowledge needed to cure delirium. Rather, it will also:

... embrace the knowledge of *healthy man*, that is, a study of *non-sick man* and a definition of the model man. In the ordering of human existence it assumes a normative posture, which authorizes it not simply to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives (Foucault, 1994, p.34).

The potential for the prophylactic utilisation of Cholinesterase inhibitors in people who are deemed at risk of becoming delirious is synonymous with Foucault's (1994) assertion that the medical gaze is also focussed on healthy people. In the context of delirium there is potentially a large group of older people who may never actually be delirious, but because of their age and biomedical history could be viewed as never healthy but as having the potential to be diseased, that is delirious. This is what Osborne (1994, p.43) refers to as "social melioration" and a form of social and political control. Moreover, the introduction of another pharmacological agent (for example, a cholinesterase inhibitor) may in fact increase the risk of a delirious episode. The introduction of more chemical 'cocktails' stands in contradiction to APA guidelines (1999) that advocate the judicious use of medications and encourage the removal of all non essential medications to prevent polypharmacological delirious effects.

As mentioned in the introduction to this chapter nursing has a vicarious relationship to medicine through its allegiance to, and deployment of the discourse of delirium as a syndrome. Nurses are involved in the prescription and/or administration of medications, the monitoring of the effects of medications including adverse effects, the evaluation of medication regimes and the accurate documentation of nursing and patient responses in clinical records. Considering these functions of nursing in relation to medications, it is

somewhat surprising that published nursing literature is largely void of any critique, or response, to medicine's continual reliance on chemical agents to manage a person who has delirium, other than encouraging the use of non-pharmacologic interventions.

Several authors see chemical interventions working alongside and being complimentary to the non-chemical management of delirium. Insel and Badger (2002), writing from a nursing perspective, caution practitioners in the indiscriminate use of medicines and encourage not only the treatment of underlying causes but also the utilisation of non-pharmacologic methods as a means to manage behavioural symptoms.

5.3.2 Non-pharmacological management

As discussed in the previous section, risk reduction, early intervention and prevention management form the basis of both the pharmacological and non-pharmacological management of delirium in older adults. The majority of the literature published on the non-pharmacological management of delirium identifies the interventions that sit within the realm of nursing practice. These interventions largely focus on the utilisation of environmental and supportive strategies (APA, 1999). Non-pharmacological strategies are always presented in the literature after the promotion of medicines as a means of management even though, as earlier mentioned, the side effects of pharmacological preparations frequently are the causative agent in the presentation of delirium in this population. This indicates the focus and priority of a treatment regime.

The general goals of environmental and supportive interventions are to reduce the factors present within the hospital environment that may contribute to an episode of delirium. However, the APA almost dismisses the utilisation of environmental and supportive measures by stating "...there is no empirical evidence that the environment by itself causes delirium, certain environmental conditions may exacerbate delirium" (1999, p.9). This statement positions the environment, and by vicarious association nursing to a subordinate position. This positioning of not only nursing but the contribution that nursing makes to older populations, who are delirious, is played out in the traditional doctor/nurse relationship of dominance and subservience.

Consequently, nursing and its contribution to attending to the environment is subjugated, positioned as other. Moreover, the use of the term 'supportive' could be deemed to mean a subordinate role. When applied to film, the stage or television the word supportive means to accompany and, not the main feature, in other words is subordinate. The discourse of delirium as a syndrome asserts its dominance through the promotion of its scientific technological prowess via the political act of placing cure, through the utilisation of chemical agents, over caring practices. This position is supported by Williams and Calnan (1996) who identify that the use of pharmacotherapeutics is integral to the practice of modern medicine.

However, nursing has not been silent on the usefulness of non-pharmacological means of providing care to older people with delirium, with several authors publishing on this topic. Meagher, O'Hanlon, O'Mahony and Casey (1996) identified eight environmental strategies that are fundamental to nursing practice. These include frequent observation of vital signs, the frequent reorientation of the older person to their surroundings, maintaining staff consistency so that a small group of the same nurses provided nursing care to the person with delirium, the allocation of a single room while delirious, the provision of a night light, keeping ward noise level to a minimum, the utilisation of family/significant others to assist with reorientation to time, place and person, and an uncluttered environment. These findings are mirrored in other literature (see Caraceni & Grassi, 2003; Foreman, Mion, Trygstad & Fletcher, 2003).

Meagher et al. (1996) suggest that the non-pharmacological strategies identified in the previous paragraph, were more likely to be employed if the older adult presented with a hyperactive delirium that had the potential to upset the smooth running of the ward routine. Consequently, the focus on the nursing service offered, promotes the interests of the institution rather than the interests of the older person who has delirium. The smooth running of the hospital is imperative for the continuing production of hegemonic knowledge about the delirious body that is grounded in medical practice. This is supported by Wicks (1999) who identifies that medicine is able to maintain its hegemonic status through supporting and promoting the structures of the hospital. Doctors are therefore able to promote their biomedical understandings of delirium as "... imperatives for medicine and nursing (and for the patient)" (Wicks, 1999, p.71).

Attempts to disrupt the discourse of delirium as a syndrome by introducing psychosocial implications for the older person who has delirium are evident. For example, Nagley and Dever (1988) quite correctly identify that hospitalisation impacts negatively on an older person's ability to maintain independence and continue to undertake normal life patterns, and as a consequence may contribute to the development of delirium. As a result, non-pharmacological management techniques not already mentioned include ensuring the promotion of normal sleep patterns. Milisen (1999) identifies the importance of providing an environment with diurnal variations in lighting, the minimisation of disruptions during sleep periods and the reduction of napping during the day. The promotion of independence through encouraging active participation in self care, and decision-making in regard to various aspects of daily living (such as when to shower/bath) are recognised as strategies that have been shown to decrease confusion (Miller, 1996).

Encouraging the maintenance of usual mobility patterns as much as possible has also been recognised as a simple strategy that may decrease the risk of delirium. A decrease in functional capacity either immediately before being hospitalised and/or during hospitalisation has been directly linked to the development of delirium in older adults (Milisen, 1999; Nagley & Dever, 1988). In their study, Simon, Jewel and Brokel (1997), identify that early mobilisation following joint replacement surgery in older adults results in a decreased incidence of delirium leading to a decrease in hospital stay and an increase in health savings.

Another risk reduction strategy in both the prevention and non-pharmacological management of delirium, relates to the utilisation of physical restraints. The restraining of an older adult is associated with iatrogenic complications resulting from being hospitalised, for example dehydration, bowel/bladder incontinence, pressure ulcers and, frightened as well as disorganised behaviour. All of these factors are positively identified as contributing to a delirious event (Sullivan-Marx, 1994; 2001). Research strongly advises a standard practice of non-restraint and instead locating a person with delirium closer to the nursing station where more frequent interactions can occur, and/or the utilisation of family members as 'sitters' (Francis, 1992; Hanley, 2004). Hanley (2004) also suggests the use of 'sitters' when family members are not available. These

people remain with the older person at all times. A more in depth discussion on the use of sitters will occur later in this thesis.

Finally, a small number of articles have begun to recognise the impact delirium has on families/significant others. Borreani, Caraceni and Tamburini (1997) suggest education and counselling should be offered to families whose relative has delirium. Education should focus on the symptomatology, progression, management and expected outcomes of the delirious event, as this can ease the distress family members experience when, for example their older relative does not recognise them. Caraceni and Grassi (2003), in their work on delirium in older people receiving palliative care suggest families should be offered counselling to help them come to terms with their relative's situation and to allow the expression of their feelings.

5.3.3 Summary of management strategies

The pharmacological and non-pharmacological management of delirium is heavily influenced by the discourse of delirium as a syndrome. This discourse is largely focused on the physiological processes that create the signs and symptoms, which in turn inform and influence the development of medical and nursing care protocols. Both the medical and nursing literature reviewed construct the behaviours associated with being delirious as problematic and unpredictable. As a result, all older people are viewed as being at risk for experiencing delirium and those that are delirious, are a safety risk not only to themselves but potentially to others (Foreman et al., 2003).

The presentation of delirium as a problem portrays an unruly body that needs to be disciplined through some of the management strategies presented previously in this section. The constant assessment, reassessment and monitoring of not only levels of confusion, but also the effectiveness of treatment regimes constructs the older person with delirium as an object that is subject to techniques of disciplinary control. It appears that pharmacological management of delirium, although extremely problematic and contradictory, is foregrounded as a fundamental component of most treatment regimes. Poignantly, the use of physical restraints is deemed inappropriate in the management of the behaviours associated with being delirious, however this appears to have been

replaced with an increasing reliance on chemical restraints in the form of major tranquillisers and antipsychotic agents.

The discourse of delirium as a syndrome exists in a state of inherent tension with other discourses. As already discussed nursing and medicine deploy the discourse of delirium as a syndrome, however there exists a duality of focus not only within nursing but between nursing and medicine. Psychosocial discourses such as those identified above by Milisen (1999), attempt to disrupt the biomedical discourses espoused by nursing and medicine that focus solely on the physical management of delirium. While Milisen's (1999) work is a form of resistance by identifying that delirium is more than a multifactorial system of disease processes, it still does not attempt to address the personal experiences of older people who are delirious. Personal experiences of delirium form a discourse that exists at the margins of other discourses. These discourses have largely been unexplored within nursing and medicine. The next section critically examines the emergence of a personal discourse of delirium.

5.4 Nursing and resistance to the biomedical discourse on delirium: The emergence of a personal discourse of delirium

Earlier in this chapter I have asserted and demonstrated that there is considerable congruence between the nursing discourse and medical discourse on delirium. However, there is evidence within the nursing literature of a small but growing body of work, situated within the interpretive paradigm, which explores the experience of delirium from the perspective of the older person.

This section considers the writings of several nurses who have published work on delirium in the older adult, from an interpretive paradigm. Four of the seven articles have authors in common, indicating the existence of a professional interest and concern in the area. Although these may not epitomise all the published material available written by nurses in this area, it does represent an extensive search of the *Health Source: Nursing/Academic Edition* electronic database using the search strategy and key word *delirium*. Each of these articles is aligned with the profession of nursing's espoused allegiance to holism.

These small but select publications are strongly linked to what I would refer to as a personal discourse. Each of the seven articles attempt to pay attention to the personal experiences of having been delirious and how that experience may have impacted on the health and well-being of the older adult. In each of these reported qualitative studies the discourse of delirium as a syndrome is not given primacy but rather contributes to providing a personal understanding of being delirious.

5.4.1 Overview of the publications supporting a personal discourse of delirium.

The earliest work, published by Andersson, Knutsson, Hallberg and Norberg (1993), sought to explore the behaviours of older people who were delirious, the nursing response to those behaviours, as well as both the person's and the nurses' interpretation of the experience. The main finding associated with this study was that there existed a breakdown in communication between both the older adult and the nurse. The person who experienced delirium reported being restricted, isolated, not respected and had a strong need to be comforted. The nursing response was to approach the situation from a biomedical perspective, with interactions focussed on meeting physical care needs divorced from the emotional support the patient was seeking.

The purpose of Laitinen's (1996) study was to describe the experience of being delirious following cardiac surgery in an intensive care unit. As with Andersson et al.'s (1993) above study the need to be comforted emerged as a major theme. All people interviewed recognised how important it was for nurses to develop relationships that were therapeutic to the patients, recognised people as individuals and to give reassurance that throughout their delirium they were safe, understood and accepted. The author recommends that nurses need to distance themselves from task orientated hospital routines and attend to the holistic needs of people who are delirious.

The aim of Schofield's (1997) research was to retrospectively explore the older adults' experience of delirium to see if it left them with any unresolved feelings of anxiety. A broad spectrum of representations were reported, identifying that individuals experience delirium in distinctly different and heterogenous ways. Respondents reported feeling anxious about some of the unpleasant hallucinations they experienced, as well as fearing what would happen to them in the future. There also appeared to be little evidence of

therapeutic communication with nursing staff, particularly once the episode of delirium had resolved. Consequently, participants in this study identified the importance of nurses providing them with appropriate support and information so they could maintain some personal control of their future destinies.

The next article sought to illuminate the emergence of patterns in speech and behaviours in older adults who were delirious (Andersson, Norberg & Hallberg, 2002). Delirium was manifested in disturbances of actions, speech and mood, with the symptoms fluctuating not only during the day but also from one day to the next. Participants had difficulty in understanding the situation they found themselves in and demonstrated a desire to regain control over their lives. Fluctuations inherent in the delirious episode meant that there were times of being “in confusion” and times of “viewing oneself as being confused” (p.313). Andersson et al. (2002) identified that older adults who are delirious will draw on previous life experiences as a means to make meaning of the present. They stress the importance of nurses knowing about, and utilising aspects of the person’s social, cultural and historical backgrounds in order to connect and support people who are delirious. This assertion resonates with the intentions of critical gerontology, a major influence underpinning the present research.

In a subsequent paper, the same authors use a phenomenological lens of inquiry, and imply that understanding the lived experience of delirium enables the development of effective methods of providing nursing care to this population (Andersson, Hallberg, Norberg & Edberg, 2002). Once again the findings identified the heterogeneity of experiences that were linked to the patient’s life history. The ‘take home message’ for nurses working with this group of older people was to sensitively provide meaningful support and opportunities to verbalise their experiences both during and after an episode of delirium.

McCurren and Cronin’s (2003) research report begins with an exemplar describing an 80 year old woman’s experience of being delirious. The placing of the exemplar at the beginning of the article attempts to give primacy to the personal experience of delirium. Once again a phenomenological approach was used to increase the awareness of health practitioners to the individual needs of older people who are delirious. As with some of the other studies previously reported, a variety of responses were recorded resulting in

the presentation of a variety of behaviours. As already outlined above, the importance of developing a therapeutic relationship through opportunities to engage in meaningful dialogue is beneficial to the recovery of people who are delirious.

The final article by Andersson, Hallberg and Edberg (2003), although titled *Nurses' experience of the encounter with elderly patients in acute confusional state in orthopaedic care*, attempts to privilege a personal discourse on delirium. Interpretation of the findings showed that nurses experienced difficulty in understanding the patients' reality which ultimately and negatively impacted on the quality of nursing care provided. The authors stress the importance of being able to interpret and understand older adult's experience of delirium on an individual basis. This can be achieved through "... listening to the confused patients, evaluating verbal and non-verbal responses to assess for anxiety or physiological discomfort, seems useful" (Andersson et al., 2003, p.446).

5.4.2 Analysis of the nursing response

Commonalities exist within each of the seven articles supporting the deployment of a personal discourse of delirium. Evident in each of the papers is the desire to derive some understanding of the experience of delirium from the perspective of an older adult. Surfacing these otherwise marginalised discourses acknowledges that a set of 'truths' exist outside the realm of the dominant biomedical accounts of delirium. As a result, these published works act to decentre biomedical knowledges of delirium. The publication of the personal narratives inherent within this discourse is not only a major imperative of this thesis, but also constitutes a central position intrinsic to a critical gerontological epistemology (see Gubrium, 1993; 2001).

The papers presented above clearly identify the heterogeneity associated with older people's experiences. The authors attribute the diverse representations associated with having delirium as being shaped by the older adult's social, cultural and historical backgrounds, and experiences. Also apparent in these articles is the importance of incorporating into the nursing care provided to this group of people, communicative and other relational activities, such as forming and maintaining a therapeutic partnership. Each of these findings draws on and relates to the core activities associated with

working as a gerontological nurse, for example the utilisation of the principles associated with holism as a basis for guiding nursing practice (Eliopoulos, 2005; Tagliareni, Waters & Anderson, 2003).

A variety of research methodologies have been used across each of the papers considered, including a case study approach, grounded theory, phenomenology through to the beginning use of narrative inquiry. Clearly Andersson et al. (1992; 2003), Andersson, Norberg et al. (2002), Laitinen (1996), McCurren and Cronin (2003) and Schofield (1997) sought to elicit the individual experiences of being delirious, as mentioned earlier. While these published accounts provide an important shift in what is known as the 'truth' about delirium, they also signify a cursory and romantic concern with the subjective experience of being delirious as an older adult.

Silverman and Bloor (1990) note that many writers in the field of gerontology have become preoccupied with the romantic notions of illuminating personal meanings and lived experiences. Analysis of the seven articles outlined above suggests just that and I question whether their research has merely displaced the medical gaze from a biological understanding of delirium to include a humanist understanding of person's illness. This is supported by Gubrium (1993) who identifies these developments in the field of ageing as viewing "... patient-centered medicine as a kind of romantic reaction to body-centered medicine".

The above discussion highlights the risk of biomedicalising the subjective experience of being delirious. Research methodologies, such as phenomenology, perpetuate the myth that the modern subject is capable of being an autonomous and self-conscious rational being, all of which share the same modernist ideals associated with biomedicine. Consequently "[S]cientism [biomedicine] would have us drown voice in objective context, transforming context into conditions without voice or, as is scientific habit, into standardized and measurable units" (Gubrium, 1993, p.61).

The article by Andersson, Hallberg et al. (2002) attempts to disrupt, decentre and resist the discourse of delirium as a syndrome through the use of narrative inquiry, a methodological lens aligned with critical gerontology (Cohler, 1993; Gubrium, 2001). The use of an unstructured interviewing style, as opposed to semi-structured, and the

understanding that the resulting narrative presented one possible experience, rather than an exact record of the delirious event is a significant theoretical shift in the area under investigation. Conducting research and publishing these findings alerts readers to other possible understandings of delirium; understandings that are fragmented and contradictory.

The emerging personal discourse of delirium, as depicted in the above reviewed publications, shares a similar focus to Kitwood's (1997) work on personhood in the area of Alzheimer's disease. Personhood highlights the psychological factors that may contribute to the manifestations of Alzheimer's disease through the promotion of an "interpersonal psychology" (Kitwood, 1993, p.155). Parallel meanings shared between Kitwood's (1997) work on personhood and a personal discourse of delirium, as described above, include the importance of communicative and therapeutic relationships, recognising differences in life and social contexts, and that each person's experience is unique and should be valued as knowledge.

Four out of the seven articles identified as potentially representing a personal discourse of delirium, share the same authors (Andersson et al., 1993; Andersson, Hallberg et al., 2002; Andersson, Norberg et al., 2002; Andersson et al., 2003) and have been published over a 10 year period. The significance of this observation lies in the development of authors' methodological thinking over time. The initial publication utilised a single case study approach, progressing to a phenomenological approach and culminating in the incorporation of narrative gerontological techniques inherent within, as already mentioned, a critical gerontological epistemology. This results in promoting local spheres of meaning around being older and experiencing delirium, thus opening up potential spaces for resisting biomedical constructions which focus on the unification of delirium as a stable medical entity.

However, the question remains; is this small collection of published research on the individual experience of being delirious as an older person indicative of what I have coined an emerging personal discourse of delirium? The analysis has revealed that indeed the literature reviewed is contestable, unstable and as a result problematic. While the findings of these studies could easily be dismissed by scientific communities as biased and invalid I think the commitment and tenacity required to publish qualitative

material in refereed journals, such as the *International Journal of Geriatric Psychiatry*, constitutes the beginnings of a personal discourse of delirium. The political act of printing personal accounts of being delirious by publishing institutions, such as the *International Journal of Geriatric Psychiatry* "... have facilitated the emergence of future discourses ..." (Foucault, 2002a p.158). The emergence of future discourses is represented in the current study as a personal discourse of delirium.

5.5 Summary

In this chapter, the discourses evident in the nursing and medical literature have been explicated. Major representations of delirium in older adults, are vigorously present in the discourse of delirium as a syndrome. The authority of this discourse is particularly powerful, and I have demonstrated how the hegemonic structures of medicine have infiltrated nursing discourses through providing minimal opportunity to understand delirium, other than as an object of pathology.

The objectification of delirium largely overrides the nursing concerns for caring as it relates to the older adult. Reviewing the literature raised many questions for me about the silence of the personal experience of being delirious. However, the problematisation of the discourse of delirium as a syndrome has highlighted those discourses that exist at the margins of the biomedical discourses. One of these discourses I have identified as a personal discourse of delirium. While none of this literature critically analysed the dominant biomedical views currently circulating, their presence and availability does destabilise the discourse of delirium as a syndrome. In addition, this body of literature provides a platform for further development of a personal discourse of delirium.

This chapter marks the end of my engagement with the nursing and medical literature. The next chapter of this thesis shifts to the representations of people who have been delirious. Attending to the texts of older people who have been delirious deploys a personal discourse of delirium and further problematises the disciplinary practices inherent in the discourse of delirium as a syndrome. The importance of foregrounding personal discourses will be highlighted and juxtaposed with published documents that are influenced by the discourse of delirium as a syndrome.

Chapter Six: Promoting a personal discourse of delirium

6.1 Introduction

The focus of the next three chapters addresses the second research aim *to explore the discursive production of the person with delirium*. My understanding of, and reading on critical gerontology (Cole et al., 1993; Katz, 2003; Minkler & Estes, 1991), as well as the work of Frank (1991; 1995), Good (1994), Gubrium (2001) and others has confirmed the need to present the personal narratives generated by older people and their families as a means to resist and disrupt the dominant, powerful and pervasive discourses on ageing. In this chapter, resistance and disruption occurs through the assertion that each individual's road to, and experiences of delirium are unique and contradictory, therefore no universal claims to truth can be made.

The privileging of the personal narratives that frame the experiences of people who have been delirious and their families has the potential to expose marginalised and repressed discourses, such as the personal discourse of delirium, making available alternative subject positions other than those constructed by the discourse of delirium as a syndrome. Burr (1995) terms this warranting voice. According to Burr, we are constantly competing for the right to be heard and therefore draw on discursive constructions that offer valid and legitimate representations of ourselves. In the instance of this research, older people and their families warrant voice by speaking through the discourses, for example, of needing to contextualise themselves within their social world.

I have identified two subcategories, **I was different once** and **how I came to be where I am now**. Each of these subcategories will be discussed in turn and place the person within a social, historical and cultural context. Doing so asserts that older adults who have been delirious are a heterogeneous group of people, who have a life outside of delirium and the disciplinary environment of the hospital. These subcategories will be juxtaposed with the powerful discourse of delirium as a syndrome and the subject positions offered by health professionals to people who have been delirious. The dominance of grand narratives on delirium, as well as the limited and negative subject

positions made available to this group of people, will be demonstrated through the portrayal of delirium to the public via a poster advertising a delirium service, and photos that depict the content of a journal article, as well as a whole edition of a journal dedicated to nursing publications relating to delirium.

6.2 I was different once

The people interviewed in this research drew on multiple discourses and took up a variety of different subject positions, as determined by their individual and/or collective life experiences. Each of these life experiences culminate in the delimitation of a personal discourse of delirium. This discourse was supported by the variety of cultural backgrounds people who had been delirious brought to this research project. People's backgrounds and life experiences were influenced by factors such as age, gender, living situation, marital status, health status prior to their delirious episode and level of social support.

All participants who had experienced delirium were over the age of 65 years and there was an equal distribution of men to women. However, people's life experiences, level and type of social support, marital status, as well as prior and current health status were very different. It is these social and cultural factors that make up the rich and colourful tapestry of a heterogenous older population.

For example, George was 85 years old when the interview took place. He was admitted to hospital from a rest-home where he had been living for several years. He had gone to live in a supported living environment because of his increasing frailty and inability to live independently. At the time of the interview George had been a widower of several years. He had a sister, son and daughter in law who lived in the same city and provided him with most of his social support. He had served in World War II and since that time had kept in close contact with his 'mates' as he called them. However, in recent times the majority of his friends had died and it was evident throughout the interview that he missed his friends terribly.

Lilly is a 76 year old woman who was interviewed in her own home after having recently been discharged from hospital. When interviewed she was married and lived

with her husband in the family home. Her husband had a stroke several years prior to her delirious episode and required some assistance from Lilly to undertake and participate in daily activities. They had five children and several grandchildren. Two of her children lived close by with the others either living overseas or in other parts of New Zealand. However, all of her children took time out of their busy lives to be with their parents during her illness. Both Lilly and her husband had a vast social network and an extremely supportive family.

On the other hand, Mary located herself as the main source of contact for her Uncle John who was 76 years old when he experienced a delirious event. Mary narrated her personal understanding of her uncle's life experiences, and the social and cultural context within which he lived. She identified that when Uncle John returned from serving in the navy during World War II, at the age of 23 years, he experienced a psychotic event. He was subsequently labelled as living with schizophrenia and remained institutionalised in a psychiatric hospital until 10 years ago when he was deinstitutionalised and went to live in a rest-home. John had therefore been hospitalised for 50 years in total and had never married. He had, and still has, a very close relationship with his family. His main support person is his niece Mary, who is a community psychiatric nurse, and her family. However, all members of his family have kept in close contact with him. He had little or no social networks outside of his immediate family.

All of the people who had been delirious felt a strong desire to contextualise themselves within the world as a means to assert their identity. This was also evident in the texts generated by families who spoke about their family member in the same way. No specific question was asked during the interview about the historical context from which they came. However, each person interviewed ensured that the historical, social and cultural aspects of their life were recorded in the texts produced. The deployment of a personal discourse of delirium implies a desire to assert that the body has not always been old and delirious.

When I got married we moved to [H] and I lived there for forty years. We retired back here. At one time we owned a grocers shop and I worked in that. I worked at [LWR], they had a branch over there. I have always worked (Betty, p.14).

I was a logging contractor and owned my own business. As I got older my son joined the business. So I have always worked hard ... I was as strong as an ox. I have always been interested in racing greyhounds and so since my retirement I have been training and racing greyhounds. I've trained a few winners in my time too [laughs] (Harry, p.3).

Both Betty and Harry pride themselves on having always worked. Working for these two older people was central to their values and beliefs about how they lived their lives. In addition, Harry proudly asserts that he was once “*as strong as an ox*”, thus demonstrating his masculinity and prowess.

I have spent most of my life in the North Island. My father owned a timber yard and I used to help him cart the timber around, so I was very active. We moved around quite a lot when I was young ... I was married once but that was a long time ago. My husband died many years ago (Connie, person).

So you have any children? [Stephen, interviewer]

No, no children. When my husband died I lived on my own for a long time until I moved down here to live with my brother (p.3).

Connie identifies that she was once married, widowed for a long time, and in more recent times, had moved cities to live with her brother. These symbolic events give us an idea of how important family ties are to Connie. For example, over time Connie has fostered the type of relationship with her brother that has enabled her to move in with him when she could no longer manage to live independently.

Each of the narratives presented above, although brief, provide a glimpse into the lives of these three older adults. Each narrative paints a picture of these people once being young, married, employees, interested and engaged in their respective futures and social activities. Gubrium (2001) claims personal narratives as essential sources of information because they communicate to the listener the narrator's values, beliefs, self concept, as well as aspects that relate to their identity. Not only was it important for older people who had been delirious to contextualise their lives but their families also needed to contextualise their significant other as evidenced in the following excerpts.

She is nineteen years older than me so she has always sort of bossed me about. I think she always saw me as a daughter rather than as a sister. She bosses me about and still does! There is six of us, well there was. Betty is the oldest, and then we had a brother who died of cancer a few years ago. Then there is Shirley, she lives up in the North Island, then there is Noelene; that is the other sister who lives out this way. She goes and sees her quite a lot too. Then we had another sister Bev, she died of cancer 9 years ago. Of course Betty quite often gets her and I mixed up (Brenda, family, p.15).

He had been a very successful businessman, very keen, very with it. This is a guy who has run his own businesses throughout New Zealand (Martha, family, p. 5).

My mother used to always go to see my uncle in hospital but as we got older he would come often for Sunday tea and as my brothers and sisters learned to drive they would drop him back. I then trained as a Psychiatric Nurse so became aware that he had a significant ... a major psychiatric illness. I have just tried to carry on since my mother died in 1992 particularly, but even before that, just carry on that involvement with him as a support person really in life (Mary, family, p.1).

We have been married fifty-five years in March. We got married two months after he came back from overseas, after the war. We have known each other since I was sixteen and he was eighteen. He was away in the war for three and a half years.

What are you hoping will happen once he goes home? [Stephen, interviewer]

He still hasn't lost his interest in the garden. Through all this he has not lost any interest in home and the garden. Even if he can just sit out on the terrace and look at it, you know. But he does what he can. He is very particular about the edges. I mow the lawns and he is very particular about how the edges look. He has a particular way of doing it and they look beautiful (Allanah, family, p.11).

... The fact is that every day he walked his dogs to keep mobile and he would shuffle along like he does now with these damn dogs and walk them a kilometre

or so and get back into his van and that just kept him alive, kept him going. He knew that if he wasn't mobile he would seize up. He has been through a hell of a lot. He has worked in the bush and had a tree fall on him. He has had a hard life. He has worked from sun up to sun down (Henrietta, family, p.29).

As with the narratives produced by older people who had been delirious, the above excerpts produced by families surfaced similar things. For example, being married, being economically productive, and belonging to a wider family with sisters and brothers. While some of this information can be obtained through social history taking, for example the information gathered by nurses about a client on admission, the documentation of this data only reflects the facts, for example “married, wife alive and supportive”. However, documenting information in this way misses the often subtle nuances associated with attending to a person who is sharing their personal history and experiences. It is these insights that are privileged through the deployment of a personal discourse of delirium. An analysis of how nursing and medicine documents the social, cultural and historical aspects of an older person's life will be presented later in this chapter.

While a sense of identity and integrity has been promoted through the deployment of a personal discourse of delirium another reading of the above textual excerpts reveals a socio-cultural construction of delirium and ageing that is shaped by a socio-economic discourse. The need to contextualise the older person who has been delirious within a cultural and historical context becomes a site of tension and resistance that is played out in the body because the above excerpts also serve to highlight the dominance of the economic and political discourse in this group's social construction. For example, Betty identifies that she has worked all her life, Harry owned and operated a logging business, and Martha asserts that her father was a successful businessman.

Each of these assertions could be read as a reiteration of the dominant discourses associated with living in a contemporary western society. Writing from a critical gerontological perspective, de Medeiros (2005) notes that culturally dominant themes and values, for example those associated with “... achievement, success, productivity, work, progress, social usefulness, independence, self reliance, and individual initiative” (p.7) are often expressed in older adult's narratives of their lives. Each of these points is

expressed in the textual data presented above and highlights the pervasiveness and influence more dominant discourses, such as economic discourses have on shaping the personal narratives of older adults who have been delirious.

One reading of the texts demonstrates how participants have been interpellated as subjects of an economic discourse. The concept of interpellation was originally developed by Althusser (1971) whose central thesis is that a person is hailed or interpellated as a subject and therefore is positioned within a discourse. Interpellation has been adopted by writers such as Burr (1995), Parker (1992) and Payne (2002) who identify that the result of being hailed by a specific discourse leaves the individual with two options, to either accept or resist the subject position.

Accepting and utilising aspects of the economic discourse allows the speakers of the above texts to deploy a personal discourse of delirium that interpellates readers of this thesis into seeing older people with delirium as being more than a complicated and multifactorial system of pathological disease processes. However, doing so leaves this group of people vulnerable to other disciplinary forces and highlights the pervasive political nature inherent in biomedical discourses of ageing.

6.2.1 The contextualisation of the older adult through clinical notes

Appropriate documentation of nursing and medical care is both a professional and legal requirement and includes pieces of information such as special incident reports, fluid balance charts, nursing and medical admission and discharge information and clinical progress notes (Jamieson, 1999). In this section I have drawn on the clinical records of three people whose social, cultural and historical contexts were explicated in section 6.2; Lilly, Harry and Allan. Allan's personal narrative was captured through an interview with his wife. When juxtaposed with the personal narratives presented earlier, the clinical notes that accompanied the people through their hospital experience deployed the discourse of delirium as a syndrome to construct and contextualise the older person within a social, cultural and historical frame of reference.

Analysis of Lilly's clinical notes provided only a superficial and cursory reference to her cultural and historical context; that she was a woman and 76 years of age. This occurred at the beginning of her admission to the intensive care unit:

... 76 year old woman transferred from [SG's] hospital for high dependency care post op laparotomy for division of adhesions today. Two day history of small bowel obstruction, previous history of chronic subacute small bowel obstruction – ileostomy (10 years) in place, ? cause (medical entry, Lilly's clinical notes, p.1).

The next entry occurred the following day and was written by a registered nurse assigned to her care. Again a cursory mention of Lilly's cultural context was provided and was documented as follows:

Social: Lilly's husband phoned shortly after her admission and spoke to her briefly (nursing entry, Lilly's clinical notes, p.3).

These above information is also mirrored in the following two extracts:

Social history: Lives in [A] with his wife, 5 children, retired sawmill/motel owner, non-smoker, ETOH [use of alcohol] occasionally (medical entry, Allan's clinical notes, p.2).

Social history: Non smoker, no significant ETOH, lives alone, MOW [meals on wheels], Nurse Maude [district nursing service] daily, three children – two daughters and one son in [C] – supportive, mobilizes with crutch independently secondary to OA [osteoarthritis] hips (medical entry, Harry's clinical notes, p.3).

Both of these entries were written by admitting doctors who attempted to contextualise and give Lilly, Allan and Harry some identity as part of their admission process.

The information presented in the above excerpts supports the findings of Heartfield (1996), whose discourse analysis of nursing documentation concluded that clinical records were heavily influenced by the dominant discourses of medicine and science. Both nursing and medicine have deployed the discourse of delirium as a syndrome in order to assign a diagnostic label, which has ignored Lilly, Allen and Harry's social and historical contexts. As a result, these people have been subjected to the rituals of assessment, examination and treatment, and consequently were stripped of their

personal identity. None of these older people were referred to by name but were given descriptive labels such as '76 year old woman'. Heartfield (1996) identifies that patients therefore become recipients of the hospital regime, docile and passive.

The discourse of delirium as a syndrome is dominant in the clinical records outlined above, while each of the older adult's personal discourses associated with being delirious is silenced. However, not only is delirium a biomedical issue, it also impacts personally on the lives of, in the present research, Lilly, Allen, Harry, Connie, George and Betty. Beard (2004) claims it is beyond the jurisdiction of medicine to attend to the personal contexts of older people. On the other hand, Hallberg (2001) asserts that attending to personal meanings associated with a health event is integral to providing a quality nursing service. Therefore nursing has the potential to bridge the gap between biomedical and personal representations of delirium. Ensuring that both personal and biomedical representations are adequately documented in clinical notes provides a more holistic view of the older adult with delirium, and promotes care that is patient-centred. Holism and patient-centred care are integral to gerontological nursing (Anderson, 2003; Eliopoulos, 2005; Kelly, Tolson, Schofield & Booth, 2005)

6.3 How I came to be where I am now

In section 6.2 each of the narratives deployed a personal discourse of delirium that attended to the historical context of their lives. Inherent in each of the texts were references to, and descriptions that related to when they were young. Drawing on personal past experiences is a process older adults utilise as a means of explaining and/or understanding the present and the changes that occur as a part of ageing (Westerhof, Dittmann-Kohli & Bode, 2003). For this group of older people they are in their later years, faced with a finite lifespan, and at a time in their lives when the state of their physical body experiences some degree of deterioration leaving it susceptible to disease and illness.

I asked all participants if they could describe the events leading up to them being delirious. The responses to this question were lengthy with most people ensuring that their story was told in full. All deployed the discourse of delirium as syndrome, as one means to talk about how they came to be delirious. However, each version of events

leading up to the delirious episode provides a very different depiction of the older person and deploys a personal discourse of delirium. The various narratives assert and contextualise the person within a social context of health, variations on health and the ageing process. Once again these personal narratives are juxtaposed with what is formally documented in the clinical records about each person.

Well um 24 years ago I had a colectomy, which is the bowel ... taking out, as you well know. Immediately after I had that surgery I kept getting this very bad pain, very debilitating pain across here. Nothing would come out of the appliance, no faeces, no gas, no nothing. It was just like a flat balloon. This went on for 23 years or so and I was in and out of hospital. Of course it got so bad they would take me in to re-hydrate me. I was back and forward to Doctor [R], who was very kind and very nice but he said he honestly didn't know what to do and he couldn't open me up until they found out exactly where it was. He said they could be travelling all over the place trying to find out what it was. So I said "really I have had this for 23 years and I am really sick of it because I am getting older and it is knocking me around so much". You know getting this very bad pain until I vomited. I never sort of got any relief. So he said to get hold of him if I got the pain again, which I did. I got hold of him so he rushed me straight into [hospital] and they x-rayed me while I was in the throes of pain you see so they knew what to do then. So the next night, the next afternoon he operated and that is when I sort of passed out and everything went wrong and what have you (Lilly, p. 2).

Lilly's clinical notes say very little about the events leading up to her hospitalisation other than providing a cursory and simplistic overview that deploys the discourse of delirium as a syndrome:

2/7 day Hx [history] of small bowel obstruction. Previous Hx of chronic subacute small bowel obstruction – ileostomy (10 yrs) in place ? cause (medical entry, Lilly's clinical notes, p.1).

Harry's narrative of events leading up to him coming into hospital spanned several decades and a series of health events. The following is a synopsis of the most recent events that lead up to his hospitalisation:

It was a build up of pain, slightly getting worse and worse all the time. The stage where I couldn't take much more and arh. I didn't want to become a zombie but [D], my medical practitioner all the way through knew all about it. I was in a hell of a lot of pain. I'd have to go and ask [D] to help me. If I couldn't get help from [D] I'd go and get some... Um panadol or something like that from the what's his name [the pharmacist]. The pain was intolerable. I couldn't sit on my chair. It got to the stage [D] had me on 7.6 grams of morphia. He wouldn't give me any more. But arh I used to make up the difference by having um arh panadol and he'd give me 90 to 100 pills a month of paradex. So that was my total influx of pills. But you know arh they used to give me turns and I would have all sorts of pains. It went on and on like that ... I go to church. I'm a very very strong church goer. If it weren't for my belief in god I wouldn't be here. But to cut a long story short umm, the night of what put me in here I had a friend coming over. I was busy doing things; jumping up and down and I was having a bad time with my urine and that sort of thing. I couldn't hold it. I had been doing the plates [dishes] when my cobber from the church came in. I forgot all about it [the water running] because I was talking to him. I next minute I went out there and oh my god there is a flood. Well I went to try and get it and the next thing I went head over kite and that's all I remember (Harry, p.4-6).

Harry's daughter also recounts the events leading up to her father going into hospital. Her narrative is more immediate and recounts a version of events that is similar but different to her father's. This highlights the difficulties associated with homogenising the experience of delirium.

We knew he was going down hill ... he was getting slower and more forgetful about 3 weeks before this actually happened. We just kept an eye on him because he is very independent person, he doesn't like you to know his private things in life. So he doesn't often let you in the door of how he is feeling but every now and then he goes on a sympathy trip so he will let you know that he had a 'bit of a stroke a wee while ago' or 'my this and that is not feeling too good'. We got a phone call from my sister in law to say that someone from dad's church had found him and he was really ill and perhaps a family member should go round and check him out. When we got round there he was sitting on his chair and not really aware of what was happening or where he was. He was

covered in vomit and he was just in his underclothes and um ... he recognised me but you would talk to him and try and get something out of him and he would just be away with the fairies ... sort of drift off into space, go quieter every now and then. Then he would come back and know that you were there. One of his church people had rung to say his bathroom was flooding and they had come round to help and at some stage he must have had a bit of a turn and they'd stripped him down as much as they could and cleaned up the bathroom and then put him on the chair. But they left him ... left him in that state. We were a wee bit concerned because he hates hospitals and he always said he would die if he ever goes into the hospital and that there is no way anyone would get him into that hospital. He said "I'll die in my bed" and so I had to sort of gently talk to him and say "Dad I'm going to get someone to come and see you and check you out and see how you are, is that all right?" He was just nodding his head but I don't think he really understood what I was saying. I rang St Johns and got the ambulance out and they said they would assess him at home first. They came around and brought out the bed and everything. They checked him. His respiratory was very, very low so that concerned them in a big way. So they wanted to take him into hospital but he didn't know he was going into hospital. He thought he was going into After Hours. So we didn't say anything about that (Henrietta, family member, p.2-3).

H's clinical notes document the events leading up to his hospitalisation as follows:

72 year old male. Presented with collapse today. Vomiting yellow fluid - ? frequency. Yesterday suprapubic pain and haematuria. Long standing difficulty voiding and previous haematuria secondary to suspected prostate Ca. Also 2/7 cough with yellow sputum, SOBOE [shortness of breath on exertion], feels hot and sweaty, decrease appetite (medical entry, Harry's clinical notes, p.1).

While the above narratives focus on the presenting health concern, it is still presented within a rich and diverse socio-cultural context. However, what appears in the clinical notes is a sanitised and abridged version of events leading up to the person being admitted to hospital in a delirious state. Gass (2001, p.219) identifies that this is not uncommon, health professionals frequently get the full story but "... medicine has

generally taken the story from the patient, removed it from the individual concern, and discussed it to develop a medical understanding of what is occurring”.

Attendance in nursing and medical documentation to the biomedical understanding of delirium is referred to by Witney and Crofton (1999) as charting by exception. The idea behind this form of documentation is grounded in streamlining and standardising clinical records, ensuring the process is time efficient yet effective. The resulting subject positions offered to the people participating in the present study are therefore limited and vulnerable to the disciplinary practices associated with the nursing and medical gaze. The delirious body becomes “... anonymous, de-personalised, passive, and, inevitably, reduced to the sum of its malfunctioning parts and related remedies” (Lawler, 1997, p.35).

Consequently, health professionals, through the deployment of a discourse of delirium as a syndrome, silence the older person and/or their family in their attempts to contribute to any discourse on delirium. However, attempts at totally silencing these marginalised knowledges have not been entirely successful as glimpses of a subjugated personal discourse of delirium surface in some of the clinical notes. For example:

Patient doesn't remember ringing anyone at 2am but can't remember what she was doing at 2am. Doesn't know why she's back here – feels her sister bullied her in to returning. Admits she may have been confused (medical entry, Betty's clinical notes, p.2).

Feels he's 'on the mend' (medical entry, George's clinical notes, p.10).

The above entries were documented by the registrars of the wards in which the two participants were accommodated. Notice the use of quotation marks in the last entry to signify that what is written was spoken by George. This is a superficial and weak attempt at allowing George's narrative to surface. Betty's narrative is portrayed in greater depth and gives the reader of her clinical notes some insight into her interpretation and understanding of the events leading up to her being hospitalised with delirium. For example, not fully understanding why she has returned to hospital and that she suspects her sister was influential in her being readmitted. This is important information for the nurses working with Betty as they develop a plan of care that is

patient-centred and individualised. Suhonen, Valimaki and Leino-Kilpi (2005) note that patient-centred nursing care facilitates improved health outcomes, including patient satisfaction and feelings of well-being.

6.4 Why contextualise a person anyway?

As earlier mentioned, privileging the social, cultural and historical context of people who have been delirious promotes a sense of identity and integrity. Knowing the social, cultural and historical context within which a person is situated is one of the key assumptions inherent in holistic nursing practice. Eliopoulos (2005) promotes the concept of holistic gerontological practice as a major concern for the discipline of nursing. Holistic gerontological nursing practice implies that the whole person is considered within their family, socio-political and cultural context in terms of planning and providing appropriate care. This concept recognises that older people are unique individuals who experience health and illness differently, the goal for nursing is “... not to treat the disease but to help the total person” (Eliopoulos, 2005, p.11).

Carrier (1997) asserts that a major philosophical premise supporting nursing practice and research is nursing’s allegiance to holistic practice, as a means to distinguish itself from the reductionist approach inherent in the medical model. The rhetoric of holism as the cornerstone of gerontological nursing practice is obviously not a concern of nurses represented in the texts examined here. Attempts by nursing to address the social, historical and cultural contexts of people who are delirious remain as scant as that of medicine. Both disciplines draw on the discourse of delirium as a syndrome, with their respective foci being on addressing the physiological needs through a systems approach to the older adult. Morse and Johnson agree when they state that the “[M]edical model necessitates that the practitioner focus solely on the disease rather than on the person” (1991, p.2). This is demonstrated in the following entry in Connie’s clinical notes. In addition this is the first nursing entry documented and follows on from the set of admission notes produced by the admitting doctor.

Nursing pm:

Tired slept most of shift. One to two nurse transfer. Has trouble pivoting when transferring. No c/o [complaints of] pain. Quite vague and slow to respond to

conversation. Ate .5 of tea and will drink when reminded. Continent, up to commode x2. States family are sick of her and that is why she is here. IV fluids commenced 1915hrs, due through 0715hrs. Recordings normal. FBC [fluid balance continues]. Urine spec sent to lab. BNO [bowels not open]. Eye sight poor (nursing entry, Connie's clinical notes, p.7).

This nursing entry records only Connie's physical state. The documentation is clear, concise and useful, but tells us little else about the 'other' equally important aspects associated with this person's delirious episode. This is supported by Frank (1995) who asserts that postmodernism provides the medium for reclaiming and surfacing individual stories about the experience of illness. Therefore, a delirious episode cannot be detached from the older adult who is experiencing this health deviation; rather it becomes part of the individual's life narrative. Mordacci & Sobel (2004) identify that health and illness are dynamic and both have a past, a present and a future. For participants in this study their life narratives have focussed for a period of time on being delirious. Hence, a critical gerontological framework is a vehicle for ensuring the cultural legitimacy of the deployment of a personal discourse of delirium.

Through the disciplinary practices associated with the deployment of the discourse of delirium as a syndrome the older adults in the present study have become isolated from their everyday lives, can no longer act autonomously, their future may now be in doubt, and all attention is focussed on their illness. The deployment of a personal discourse of delirium overcomes the limitations inherent in the discourse of delirium as a syndrome, and ensures that older adults are treated as people first and not as objects. Morse and Johnson (1991) agree and support this position by identifying that this perspective integrates the illness within a social context, acknowledging that people are more than physiological entities. The contextualisation of older people who have been delirious reconnects these people with their lives outside of the institution and provides a mechanism for nurses involved in their care to be interpellated into a holistic discourse.

6.5 Visual representations of people with delirium

Images of older people with delirium are represented through oral and written language, as well as other media, for example photographs. Photography is omnipresent in

contemporary life and frames advertising messages, captures personal moments, as well as adorning book covers, magazines and newspapers. The use of photography is viewed by Short (1997) as a cultural practice that provides us with meaning about something. Short (1997) goes on to suggest that photography is inherently truthful and has the ability to create and/or portray bodies in a certain way to a particular audience. This statement emphasises the powerful influence that photographic images have on the social construction of delirium.

For analysis I have chosen three different images depicting delirium in the older population. Each has been published and is available in the public arena. As such, all three can be accessed by health professionals, in particular nursing, as well as the general public. The first image (Illustration 1 – see page 124) was published as a poster that was to be used to raise the profile of delirium within a hospital setting. In addition, it served to promote and encourage the utilisation of a delirium service. The caption reads that delirium will affect three out of 10 hospitalised older people. It is blatantly obvious who these people are. They appear as ghostly figures, a pale turquoise colour, almost invisible to the eye. Each person is sitting, and all are seated in the semi-shade with bright light behind and small shafts of light to the front. While all three look as though they are interacting in some way, smiling, laughing, looking, they are not. Closer analysis reveals they are looking in different directions.

To me the image represented in the poster appeals to Descarte's notion of the mind/body split discussed earlier in this thesis. Beard (2004, p. 416) identifies that we live in a "hypercognitive society" where older people are defined by their mind. The three older people portrayed in illustration 1 are depicted as having delirium. In biomedical terms they are defined as cognitively impaired, and are therefore reduced to a ghostly physical shell. However, another representation could be the difficulty in detecting delirium in older populations. This is evidenced in the literature identifying the nosological confusion and difficulty in distinguishing delirium from dementia and depression (see earlier chapters for an in-depth discussion on this issue) (Arnold, 2004).

The second image (Illustration 2 – see page 125) was used to illustrate the cover of a special issue of the *Journal of Gerontological Nursing* (April, 2001). This illustration conveyed to me impressions of disturbances associated with a satellite map of a

meteorological service. The face and subsequent person is once again almost indiscernible. The lines below the eyes that radiate out from the nose could be isobars. Isobars that appear on a meteorological map that are close together, as in the imagery shown on the cover of the journal, indicate stormy conditions and rough weather. The florid red and yellow/orange tones indicate extreme disturbances.

The third and final image (Illustration 3 – see page 126) was used to illustrate a feature article on delirium in *Critical Care Nurse*. The picture portrays an aspect of the neurological system, probably a neuron. The representation of delirium in this way does not include an older person who is part of a cultural and social context but rather promotes delirium as a cellular process. Representing delirium as neuronal activity implies that the implementation of scientific measures is the only mechanism that could be used to overcome this health issue.

The illustrations presented suggest support for a discourse of delirium as a syndrome while continuing to marginalise and subjugate a personal discourse of delirium. Any representation of the older person with delirium as a human being with emotional and social needs is absent. The older delirious body, its signs and its images, as portrayed in the media, has the potential to influence nurses as they determine and operationalise nursing care. The above representations are firmly embedded in dominant western discourses of ageing which depict old age as a time of deterioration, a set of physiological problems that need to be managed (Reed & Clarke, 1999).

Gilmour's (2001) thesis on dementia found similar representations to those presented above. However, this researcher was able to juxtapose the biomedical construction of dementia with the utilisations from Kitwood's (1997) text, and focus on the promotion of personhood in people living with dementia, to draw attention to the power of different discursive images as a means to disrupt the status quo. In the present study, no imagery has currently been published with the capacity to cause trouble for the discourse of delirium as a syndrome. What Gilmour's (2001) findings highlight is the possibility for resistance and the importance of foregrounding the social, cultural and historical contexts of older people through the deployment of a personal discourse of delirium, as presented earlier in this chapter.



Illustration 1: Poster advertising a delirium service. Used with permission from the Medical Consultant responsible for the delirium service.

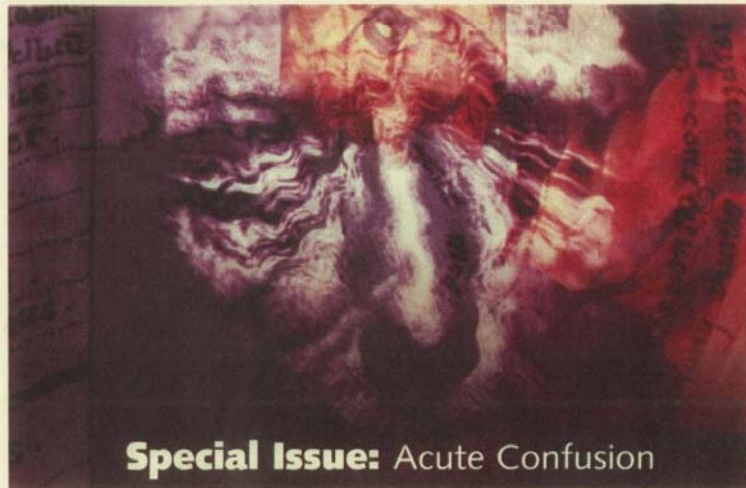
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Special Issue: Acute Confusion

Delirium in Elderly Patients: An Overview of the State of the Science

Marquis D. Foreman, PhD, RN, FAAN, Bonnie Wakefield, PhD, RN, Kenneth Culp, PhD, RN, Koen Millisen, PhD, RN

Acute Confusion/Delirium Protocol

Written by Carla Gene Rapp, PhD, RN, CRRN, and Iowa Veterans Affairs Nursing Research Consortium

Edited by Janet C. Mentes, PhD, RNCS, GNP, and Marita G. Titler, PhD, RN, FAAN

Training of Acute Confusion Resource Nurses: Knowledge, Perceived Confidence, and Role

Carla Gene Rapp, PhD, RN, CRRN, Lisa L. Onega, PhD, RN, Toni Tripp-Reimer, PhD, RN, FAAN, Paula Mobily, PhD, RN, Bonnie Wakefield, PhD, RN, Mary Kundrat, MS, RN, Jackie Akins, MA, RN, Karen Wadley, MA, RN, Janet C. Mentes, PhD, RNCS, GNP, Kenneth Culp, PhD, RN, Jean Meyer, MA, RN, and James Waterman, MSN, RN

Studying Acute Confusion in Long-Term Care: Clinical Investigation or Secondary Data Analysis Using the Minimum Data Set?

Kenneth Culp, PhD, RN, Janet C. Mentes, PhD, RNCS, GNP, and Eleanor S. McConnell, PhD, RN

Acute Confusion in Terminally Ill Hospitalized Patients

Bonnie Wakefield, RN, PhD, and Julie A. Johnson, RN, BSN, OCN

Achieving Restraint-Free Care of Acutely Confused Older Adults

Eileen M. Sullivan-Marx, PhD, RN, FAAN

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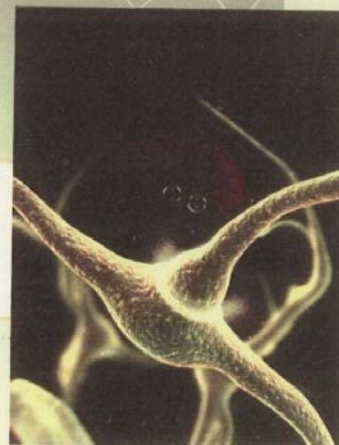


Illustration 2: Cover illustration for the April 2001 edition of the Journal of Gerontological Nursing. Used with permission from the publisher.

Monitoring Delirium in Critically Ill Patients

Using the Confusion Assessment Method for the Intensive Care Unit

Brenda Truman, RN, MSN, ACNP
E. Wesley Ely, MD, MPH



CE This article has been designated for CE credit. A closed-book, multiple-choice examination follows this article, which tests your knowledge of the following objectives:

1. Identify risk factors associated with the development of delirium during critical illness
2. Distinguish between delirium and dementia
3. Discuss the clinical subtypes of delirium
4. Describe the use of the Confusion Assessment Method for the Intensive Care Unit

Authors

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Critical care nurses are well aware that many patients in medical and surgical intensive care units (ICUs) experience some degree of cognitive impairment, which may range from coma to delirium. In order to perform invasive procedures and provide lifesaving, supportive care, patients are given potent psychoactive drugs such as benzodiazepines and opiates, which often lead to increases in cognitive abnormalities. For many healthcare

Illustration 3: Illustration accompanying feature article in the April 2003 edition of Critical Care Nurse. Used with permission from the publisher.

6.6 Summary

This chapter set out to foreground the personal discourses of delirium through the texts generated by people who had been delirious and their families/significant others. Two subcategories were apparent from the textual analysis. These were **I was different once** and **how I came to be where I am now**. The juxtaposition of these categories with clinical notes and literature demonstrated the powerful and pervasive influence the discourse of delirium as a syndrome has on the older delirious body.

The speech acts of older people and family members captured in the texts revealed how important it was that they could socially, culturally and historically contextualise themselves and their family member as part of their illness experience. Doing so deployed a personal discourse of delirium and provided opportunities for resisting the discourse of delirium as a syndrome. In addition, these people were also interpellated by the ever present discourse of delirium as a syndrome, which was always there, always competing and jostling to banish any personal discourses of delirium to the margins, silenced and subjugated.

Attention has also been drawn to the visual images of delirium as they appear in the public arena through poster presentation and journal articles. These images constitute powerful discursive representations of delirium that are partial and contestable. Currently they offer limited and negative subject positions of delirium. However, their contestability offers possibilities for resistance through the interpellation of nursing by the personal discourses of older people who have been delirious. The next chapter deals with ageism and the associated ageist practices that older people who have been delirious experience.

Chapter Seven: The ageist terrain of delirium

7.1 Introduction

In this chapter I focus on the covert and overt influence the ageist sub-discourse has on the subject positions offered to older people with delirium. The chapter begins with a brief and general overview of ageism, followed by how each of the texts generated by the research process in this study, drew on this discourse as a means to construct delirium in people over the age of 65 years. It is beyond the scope of this thesis to provide a comprehensive overview of ageism as whole books are written on the topic (see for example Bytheway, 1995; Nelson, 2002; Palmore, 1999). However, what is offered is a summary of the major aspects associated with the development and deployment of the ageist sub-discourse. Finally, the complex and contested terrain of possible sites of resisting ageist practices, through the promotion of a personal discourse of delirium, is presented.

7.2 Overview of the ageist sub-discourse

Ageism can and does occur across the lifespan along with a range of other ‘isms’, for example racism and sexism (Bytheway, 1995; Nelson, 2005). Butler (1969) first utilised the term ageism to describe the negative and stereotypic bias resulting in older people experiencing first hand, society’s bigoted views about old age. It is these biased attitudes that reinforce discriminatory practices, for example infantilisation of the older person. Butler (1980) extended his definition of ageism to include how institutional practices, guidelines and policies promulgate negative stereotypes about older people. Butler claims that ageism moves the focus of ageing away from it being a natural process into it being a social problem. The problem of ageing often results in older people experiencing detrimental consequences, including social death as a result of paternalistic and infantilising practices. These practices will be discussed in greater depth later in this chapter.

Western society’s dis-ease with ageing materialises within the biomedical context of body maintenance and/or transformation. The emphasis on youthfulness has reached epidemic proportions and further serves to deploy an ageist sub-discourse to manage the

problem of older age. Through the utilisation of biotechnological means old age can be transformed or masked through techno scientific techniques (Clarke, Shim, Mamo, Fosket & Fisherman, 2003). For example, the reconstruction of stigmatised and undesirable older bodies through surgical interventions brings them in line with the prevailing cultural mandate that privileges youthfulness. The sanctioning of youthfulness promotes a representation of a body with energy that contributes productively, and by association a body that has control over infantile impulses. Conversely, the marginalisation of older people promotes the irrational fear society has with getting older.

When placed within the context of the older person the ageist sub-discourse positions ageing in binary opposition to youth (Chater, 1999; Hockey & James, 1993). The conceptualisation of binary oppositions underpins the work of Derrida (1976) where each of the oppositional pairings are hierarchically organised, with the former always distinguished as superior when compared to the latter. Instead of youth there is old age; strength associated with being young is contrasted with frailty; instead of growth there is decline; independence versus dependence; productivity versus being unproductive and mental capacity versus mental incapacity. In addition, older people find themselves the subject of negative, stereotypical and pervasive attitudes that represent their worlds as unable to learn, selfish, economically disadvantaged, as well as a threat to the future economic viability of the world, isolated, lonely, disabled, unwell and alien to the life in the 21st century (Cruikshank, 2003).

Central to the industrialisation of western culture inherent in modernist ideologies is the preoccupation with productivity and amassing wealth. This represents another factor contributing to the deployment of an ageist sub-discourse toward older people. Within this context productivity is narrowly defined in terms of economic potential, resulting in both end points of the life cycle spectrum becoming prime targets for disciplinary practices. Both the young and old are labelled unproductive. Therefore adults are perceived as carrying the burdens imposed by both groups (Butler, 1969). Children, however, are viewed as having future economic potential, an economic investment, something to be nurtured and encouraged. On the other hand, it is unsurprising that older adults are perceived as a financial liability and consequently face the prospect of filling their unproductive time with activities that mimic productive work, for example,

embroidery and gardening (Hockey & James, 2003). Positioning old age in binary opposition to being a child ensures that the hegemony of adulthood remains intact. The stigmatisation and betrayal of the older body operates through the prominent images of dependency which take away adult status and subsequently threaten personhood in the older person (Featherstone & Wernick, 1995).

Each of the points discussed above locate and position older people negatively. The stereotypical view of older people inherent in western society constructs an image associated with getting older. It is these constructions that create what Chater (1999, p.132) refers to as the “reality of ageing”. Indeed these constructions are forced onto the older population as values and norms which materialise into truth through the adoption and generation of taken for granted assumptions. As discussed earlier in this thesis the ‘truth’ about ageing attempts to interpellate (Althusser, 1971), or hail older adults into being social subjects of the ageist sub-discourse which in turn offers limited and negative subject positions to this group of people. The interpellation of older adults, who have been delirious into the subject positions, of **a second childhood, dependency and older people have diminished value** will now be presented.

7.3 The subject position of a second childhood

As a result of the ageing process the ageist sub-discourse constructs for older people who have been delirious, the subject position of behaving like a child and therefore experiencing a second childhood through the deployment of the discursive practice of infantilisation. Baby talk and terms usually reserved for children are applied to older people, particularly those labelled with having a cognitive impairment, limited functional status and/or other disabilities (Albert, 2004; Nelson, 2005).

Speaking to older adults with language usually reserved for children offers a subject position of helplessness and innocence, and elicits the same protective urges seen in parenting young children, such as the desire to hug or comfort. It could be argued that terms used to talk to children, like ‘darling’, ‘honey’ and ‘sweetie’, are purely a form of affection that are utilised within intimate relationships associated with all ages and subsequently are harmless. To this end, these figurative expressions of affection, as

Hockey and James (1993, p.11) aptly point out “... are symptomatic of more damaging and embedded practices of infantilisation”.

A review of the clinical notes generated as a consequence of an older person experiencing delirium created the following texts for interrogation. The following excerpts were produced by both nurses and doctors and clearly demonstrate the potential for infantilisation of the older person who has delirium.

Washed and settled on his side [Harry, clinical notes, p.14].

Molinap [an incontinent pad resembling a nappy] in situ ... sat out in lazy boy for dinner [George, clinical notes, p.9].

Given full cares and needs assistance with feeds [George, clinical notes, p.20].

Toileted and changed into nightie – settled into bed [Betty, clinical notes, p.24].

Off colour today “grizzly” [Allan, clinical notes, p.21].

Analysis of the above excerpts reveals several possible readings. My claim is that these documented accounts of care are deeply offensive and resonate with the powerful discursive practice of infantilisation which will be interrogated in greater depth throughout this chapter. Other readings could provide a counter critique claiming that my analysis was trivial, that I had read more into the accounts than needed and the documentation merely offered an overview of the care provided to older adults who were delirious. However, Hockey and James (1993) assert that what often seems trivial (as in the above texts) has a cumulative effect that over time becomes entrenched in the everyday talk, attitudes and practices of society, including the political and legislative arena. Legislation requires that any clinical documentation of care cannot be altered nor destroyed. Therefore, the infantilised accounts presented above will forever be available as ‘truth’ about the type of care provided to these older people who have been delirious.

The infantilisation of older people with delirium is associated with the caring role as demonstrated in the above texts produced by nurses and doctors. The health professionals who produced these statements in the clinical notes position themselves as adults who have become metaphoric parents to these older delirious ‘babies’. This figurative shift from older adult to childhood status by health professionals is operationalised through the caring acts previously outlined.

The act of attending to and ensuring the older delirious person's nutritional, hygiene, elimination and mobility needs are met is undeniably well meaning and associated with providing a quality and professional service. On the other hand, the texts above produce a particular type of knowledge about older people who have been delirious. As outlined in previous chapters Foucault (1980a) describes knowledge as being a union of power relations and information identified as power/knowledge. Therefore it is impossible for power to be exercised without knowledge and vice versa. Mills (2003) argues that where there are imbalances or power relations between groups of people, knowledge will be produced with those marginalised most frequently being the object of such knowledge development.

Nurses and doctors deploy the discourse of delirium as a syndrome through the discursive practice of infantilisation, and as such give older people with delirium little choice but to take up the subject position of experiencing a second childhood. This subject position is further cemented as knowledge through the permanency of documenting infantilising practices in the clinical records. It should be noted that clinical records are legal documents and therefore enshrined with 'truth' about those who are being written about.

Thus the words produced in the above texts can be compared to parenting where, in particular, the mother attends to the baby's every need, feeding, expelling excess wind, and changing nappies before being put to bed. This is evidenced in the Plunket Societies' handbook on modern mothercraft (Deem & Fitzgibbon, 1945). This hugely influential text on parenting states that baby should be put down on their side in a cot large enough "to permit baby to be turned easily from side to side ... " (p.37); 'needs assistance with feeds' equates with "From twelve months of age onwards a child should be encouraged, gradually to feed himself. He will, or course, require help at first ..." (p.92); having a 'molinap in situ' and being 'sat out in a chair' can be likened to wearing nappies and "[I]f baby is held out regularly after a feed, say, at 10 a.m., he will gradually learn what is expected of him and his mother will be saved a good deal of work and time in washing soiled nappies" (p.45).

The deployment of the word 'grizzly' refers to teething or having 'colic' in parenting texts, identifying that all is not right with the baby (Begg, 1970). So in the case of Allan,

who is documented as being ‘*Off colour today “grizzly”*’ [Allan, clinical notes, p.21] by the ward registrar, all is not well. Allan has an alteration in his health status as the registrar goes onto describe:

Sore L) ear + discharge

Sore L) submental area and sore tooth

O/E [on examination] mildly unwell ... [Allan, clinical notes, p.21].

The texts portrayed in the clinical notes have produced a subject position of second childhood for older adults who are delirious. Each of the texts are about people who are extremely unwell, frail and dependent on health professionals to assist them in meeting those activities of daily living they cannot undertake for themselves. However, being dependent as an older adult is both a signifying and stigmatising marker placed on the ageing body (Hockey & James, 1995). Thus the older person who is delirious is seen as being impaired both cognitively and physically. This loss of cognitive and physical abilities provides the literal foundation for social identity, in this instance the loss of adult status. Similarly, childhood is not accorded adult status either. Tucker (1977) positions childhood as not being an adult and similar to the older adult the child is inscribed as experiencing cognitive limitations and physical immaturity. Therefore the representations of children, and in the instance of the present research, older people who are delirious, are both compared and marked with truth in comparison to adults. While children are valued because of their potential as adults, older adults are not.

The discursive practice of infantilisation of the older delirious person sanctions not only the physical practice of treating older adults like young children but also the speaking practice of conversing through the powerful use of metaphors. Both Betty [person, p. 1] and Martha [family, p. 7] utilised the metaphors “*away with the fairies*” as a means to describe delirium. Fairies are fictional beings depicted in human form, who have magical powers and are significant in children’s lives, for example the tooth fairy. Referring to fairies is encouraged in children, discouraged in adults but yet resurfaces in older adults who have been delirious. In addition the notion of being “*away with the fairies*” denotes madness. Foucault (2002c) also links madness to childhood and as a consequence identifies that the mad are afforded minority status and therefore denied the right to operate as an autonomous and self determining individual. Autonomy, self

determination and independence are the hallmarks of adulthood but should an older adult become delirious these are no longer offered as subject positions.

Sandra, a registered nurse working in the delirium team, refers to delirium as one of the “*Geriatric giants*” [Sandra, nurse, p.9]. This metaphorical term is used to describe delirium due to its high prevalence and being a major contributor to poor health outcomes for older people. Reference to delirium as a ‘geriatric giant’ results from it being difficult to detect and therefore often going undetected with dire prognostic consequences (Edwards, 2003). None the less giants, like fairies, are fictional beings that live in the minds of children and have no place in the arena of older person’s health. The use of the word geriatric also draws on the ageist sub-discourse. Geriatrics is a medical speciality, as evidenced by the use of the word geriatrician to denote a doctor specialising in medical care of older people. It deals with the physiology associated with ageing, and the diagnosis and treatment of diseases that affect this population (Wold, 2004). When health professionals refer to delirium in the older population as a ‘geriatric giant’ they offer a subject position of frailty, dependence and biological disturbance that requires medical, and by vicarious association, nursing control, intervention and management. Thus a range of negative meanings can be read off the older delirious body, which further serve to alienate and problematise old age (Twigg, 2004).

There is no doubt the professional excerpts presented above were not designed to humiliate, demoralise, denigrate or even willingly deploy the ageist sub-discourse as a means to position older people as children. However this is the effect. The infantilisation of older people who are delirious reduces them to biological and cognitive disabilities while concomitantly denying a sense of personhood through “...obliterating their life history and social identity ...” (Hazan, 1980, p.30).

I have argued that the powerful inscription of the delirious body as a child occurs through infantilising practices. However, the following excerpt demonstrates how, through references to being delirious as a child, Lilly attempts to make sense of being delirious as an older person.

I remember having measles once when I was a little child and I got very delirious. There was a floral wallpaper. It is a similar thing really you see. And all the flowers started to move around the wall and I was quite young. I must

have been about eight or ten I guess. Mum had to move me into another room because the wallpaper was upsetting me so much. I suppose that is a similar thing [Lilly, p.16].

Lilly has deployed a personal discourse of delirium through what gerontological writers term reminiscence work (for example Kitwood, 1997; Webster, 1999; 2001). Lilly has drawn on her childhood experience of being delirious, the way the flowers in the wallpaper came alive and moved around the wall, to relate to the hallucinations she experienced when in the same situation as an older adult as evidenced below:

I was in a room and there was a Vietnamese funeral going on in the bed next to me and I said to the nurse “what’s that in there?” She said “oh it’s a Vietnamese funeral, we have decorated things all up for them”. It was full of all of these red lights and lanterns and streamers and it was beautiful. There were children running around the floor with all of their wooden toys” [Lilly, p.6].

Kitwood (1997) identifies that reminiscence is more than just a matter of revisiting the past, but provides metaphorical resources for people to talk about what is happening to them now. Linking her childhood experiences of delirium with those as an older adult has enabled Lilly to rationalise what she identified as “...*the fact that everything is wrong and you are getting so frightened*” [Lilly, p.16]. Lilly has reasserted her identity through cognitively searching through her life in order to explain her current predicament. This is what Webster refers to as reconstructing “... a past that serves some current goal” (2001, p.160).

7.4 The subject position of dependency

The previous section addressed the discursive practice of infantilisation of the older person who experiences delirium. The deployment of infantilising practices, positions older people as children and continues to reinforce and problematise the process of ageing. The positioning of ageing as a time of decline, deterioration and the loss of all aspects of functioning creates, offers and reinforces the subject position of dependency. It is the concept of dependency in older people who have been delirious to which this thesis now attends.

Independence and self-reliance are commonly acknowledged as the cultural imperative of western societies (Baltes, 1996; Sampson, 1985). Therefore the notions of autonomy and individualism are socially, politically and culturally sanctioned. Unfortunately dependency in old age is widely considered an inevitable consequence of the ageing process, as is dependency in children. Both older adults and children are positioned as other, marginalised both materially and ideologically from the subject position of productive and independent adult. This is captured in the following excerpt:

I think he is a lovely old guy and sometimes it is the nice old guys you become more aware of. Because he is very visible tottering down with his little stick you are aware of his presence [Rachel, nurse, p.6].

The frailty of the man described in the above text is imbued with notions of dependency, for example “lovely old guy”, “tottering down with his little stick”. This can be juxtaposed with the innocence that inscribes ‘little’ children and provides a good example of structured dependency. The theoretical foundations of structured dependency are rooted in social control theories and are based on the premise that human worth is determined by productive capacity (Baltes, 1996; Hockey & James, 2003; Townsend, 1981).

Both children and older adults are socially segregated from adulthood through socio-political acts, for example the implementation of compulsory schooling for children and the provision of an old age pension for older people. Unlike older adults, children are viewed more positively by the hegemony of adulthood and are provided with nurturing and support due to their productive potential. In addition they grow to be independent. However, older adults are not afforded the same respect. Instead they are marginalised, stigmatised, disempowered, infantilised and objectified (Heal & Husband, 1998). Moreover, increasing age is marked by increasing dependence.

The older man described above who has delirium is assaulted through a complex web of marginalisation and stigmatisation. He is portrayed in terms of his functional status. He requires the assistance of a mobility aid and through the deployment of the metaphor “tottering” conjures up visions of being unsteady on his feet and frail. This reinforces the all powerful adult world view of old age as a time of physical decrepitude and dependency (Hockey & James, 2003).

If nursing upheld the holistic rhetoric, so prevalent in the discourse of nursing, then the problems associated with being older and having delirium would also include, and consider the subject of that body. Avoiding the subject of delirium normalises frailty and dependence as a negative, inevitable, as well as an integral and expected component of the ageing process. These negative meanings are available to be read off the older body, "... which is then itself in turn taken to be a source of the problems of old age" (Twigg, 2004, p.61).

The avoidance of the subject by the disciplines of nursing and medicine is evidenced in the following text. Here a nurse narrates the story of an 86 year old woman who was delirious and as part of that experience exhibited what was deemed inappropriate sexual behaviours toward a male member of staff. The details of this were not documented in her clinical notes.

... I said it wasn't documented in the transfer note and she said "oh no we wouldn't write things like that down. It wouldn't be fair on the lady". They thought it wouldn't be fair on her to write those sorts of things about her ... They were protecting her by not documenting [Sandra, nurse, p.9].

This view is further reinforced later in the same interview when the nurse claims:

I try to protect older people and try not to ruffle them too much I suppose [Sandra, nurse, p.11].

On one level the above excerpt could identify the nurse as being respectful through the act of not formally documenting the person's sexual advances. On the other hand, another reading of the text identifies that the expression of sexuality for this older woman has been denied by nurses and doctors, resulting in the older delirious body being marked with the ageist and stereotypical subject position of asexual elderly. This is further reinforced in the Positive Ageing Strategy (Minister for Senior Citizens, 2001) and the Health of Older People in New Zealand Strategy (Ministry of Health, 2002). Both initiatives develop and implement frameworks to encourage the promotion of health and well-being in later life, through, for example, improving nutrition, reducing social isolation and depression and increasing physical activity. However, sexual well-being is not overtly addressed. While the importance of positive and healthy sexuality is acknowledged as government priorities scant mention is made of the relationship

between sexual health and ageing (Ministry of Health, 2001). The failure to acknowledge and include later life sexuality in both policy and the ‘truths’ documented in clinical notes about older people by health professionals reinforces the idea that sexuality is not an integral part of being an older person (Calasanti & Slevin, 2001).

In addition, the older woman presented in the above text has been positioned by the nurse and other health professionals as needing protection due to experiencing delirium. The role the nurse and others play in this scenario is parental and fits with anecdotal evidence collected when talking with a group of resthome workers who identified that “... to work with the elderly all you need to be is a parent ...” (personal communication, April 15th, 2004). A key role of parents in relation to their children is one of providing a protective environment. The above excerpt is an example of the reframing of a parent – child relationship into that of a nurse/health professional – older person relationship whereby due to the older woman’s delirium and consequent decrease in cognitive functioning she is deemed in need of protection. The delirious and sexually inappropriate body is reframed as needing protection and therefore inscribed with being dependent. A subject position is offered to the older person who is delirious through treating dependency as if it were akin to that exhibited by children (Baltes, 1996; Hockey & James, 2003).

7.5 The subject position of older people have diminished value

I have already suggested that the American Psychiatric Association Diagnostic and Statistical Manual (DSM) has reified the truth about delirium in older people through normalising, disciplinary and regulating practices. Foucault (1991) describes the regulatory procedures of the DSM as producing ‘docile bodies’ that are able to be subjected, used, transformed and improved. While the following texts do not show how the older delirious body is improved they do illustrate how these bodies are subjected, used and transformed into bodies that do not matter, as demonstrated in the following excerpt:

If you are young, really unwell, critically unwell on any ward you will probably get a pretty good deal. You will get the ward nurse [meaning the permanent experienced nurse on the ward] but if you are older and maybe you are not

going to receive active treatment then you are likely to get whoever [Rachel, nurse, p.13].

An initial read of the above text could rationalise the deployment of the experienced and permanent registered nurse to the younger and acutely unwell patient as a result of the current international shortage of nurses, which is also reflected in New Zealand figures (Holloway, 2000). It is clear from the text that having enough staff to provide safe and appropriate care to patients on the ward is an issue and where there are not enough permanent experienced nurses available these gaps are filled with either casual staff or new graduates. However, what becomes problematic is the perceived rationale behind the allocation of staff. In the above situation, decisions on staff allocation are made through the deployment of the ageist sub-discourse, i.e. if you are young and unwell you receive the attention of the nurse with the most experience and by association ability. This situation exists despite literature identifying the complex nature of working with older people in general, as well as those who have delirium, and the assertion that highly skilled and knowledgeable nurses are needed to respond swiftly to a change in this person's health status (Lueckenotte, 1998).

There was this lady in a resthome who had delirium and she was dehydrated and needed some fluid. The GP said "oh she is just an old lady, she is not delirious, she is just dying, let her die". So the poor lady died. She had an awful death [Rachel, nurse, p.19].

Through the deployment of the ageist sub-discourse professional decisions were made to not treat the older woman depicted in the above text, resulting in her death. The doctor dismissed assessment data identifying the presence of delirium and dehydration in this person, taking up the subject position of "older people have diminished value". This subject position is heavily infiltrated with prejudice and negative stereotyping of the older adult leading to withholding treatment based on age alone, especially those experiencing some form of cognitive impairment (Fick, 2000). In this instance, the silence of the nursing voice is also evident and highlights how nursing has colluded with medicine by not challenging the doctor's decision not to treat. There is no evidence to suggest that the older person was included in the decision not to treat. Instead she was interpellated into the subject position "older people have diminished value", marked with the negative ageist view that being dependent on others for her care needs negates

any right to actively participate in the decision making process to pursue active treatment.

The above text suggests that the attitudes, beliefs and values health professionals hold about delirium and old age have significant consequences for the quality of care provided. Several authors have demonstrated that nurses and doctors are not immune to the negative attitudes and stereotypes that surround the older adult even though both professional groups receive educational instruction in the effects of ageism on this population (Butler, 1975; Nelson, 2005; Treharne, 1990; Williamson, Munley & Evans, 1980).

... there is not due regard for the older frail person. I heard of one patient that had eight changes of bed in their hospital stay which is getting a bit ridiculous. I think it is acknowledged now that basically hospitals are bad places for people with delirium to be [John, doctor, p.10].

This comment overtly draws on the ageist sub-discourse and at an institutional level acknowledges that “older people have diminished value”. A paradoxical situation is therefore evident. Through the deployment of the ageist sub-discourse the older person with delirium experiences eight bed changes. This institutional action occurs despite evidence suggesting that a frequent change to the person’s environment is not only a risk factor contributing to delirium but in addition inhibits recovery from delirium (Cole, 2004; Foreman & Zane, 1996). John is undeniably accurate when stating that hospitals are bad places for people with delirium to be. In this instance, it is the health professionals who are interpellated into the subject position of “older people have diminished value”. The resulting clinical practices are played out on the older delirious body resulting in these people being indiscriminately moved around the hospital to suit the needs of the institution rather than ensuring the maintenance of a stable and therapeutic environment conducive to promoting recovery from a delirious event.

The previous three excerpts clearly reinforce the subject position that being older and having delirium doesn’t matter. Politically it can be argued that being older does matter. After all the Minister for Senior Citizens (2001, p.30) in *The positive ageing strategy in New Zealand* document states that the health goal is to provide “Equitable, timely, affordable and accessible health services for older people”. In addition the strategy

focuses on the promotion of independence and well-being. Both of these concepts form the cornerstones of positive ageing and successful ageing (Albert, 2004). The key messages inherent in the Positive Ageing Strategy are to be commended in their attempt to view the ageing process as an expected process in the life cycle. Even so, by not adequately addressing dependency in the strategy, the document marginalises those older people, who experience delirium and positions them negatively.

7.6 Problematising resistance to the ageist sub-discourse

The conceptual notions of positive ageing and successful ageing will now be interrogated. Here my goal is to revisit and problematise positive ageing and/or successful ageing, both of which are portrayed as a means to address ageism. I then proceed to argue that problematising ageing creates a space for the emergence of a personal discourse of delirium.

As earlier mentioned, to age positively and/or successfully denotes viewing older people positively and implies combating and contesting existing notions of ageism. Successful and positive ageing has been hailed as the new gerontology (Holstein & Minkler, 2003). Both these constructs are comprised of a larger movement in the field of gerontology which has an emphasis on remaining healthy and engaged. This new field attempts to counteract, replace and provide potential sites for resisting the negative and stereotypical notions of old age that are equated with frailty, cognitive impairment and dependency (Unger & Seeman, 1999).

Rowe and Kahn (1987) found in their research that the core elements of successful ageing are the absence of disease, the absence of risk factors for disease, the maintenance of physical and cognitive abilities, and engagement in productive activities. The operationalisation of Rowe and Kahn's (1987) assertions reveal that minimal numbers of older people are able to meet these criteria, even though many of the participants self-rated themselves as ageing successfully (Albert, 2004). This narrow view, labelled successful ageing, is merely the deployment of the ageist sub-discourse in disguise. It sets successful ageing up in binary opposition (as discussed earlier) to unsuccessful ageing; independence, activity, health versus frailty, cognitive impairment and disease, with the majority of older adults being positioned negatively.

When placed in the context of delirium the concept of successful ageing remains problematic. The DSM-IV-TR identifies a delirious event as episodic and therefore resolvable (APA, 2000), which implies that successful ageing is achievable. Equally, there is literature asserting that delirium takes longer to resolve. For example, a study by Dolan et al. (2000) found that older adults with delirium were approximately twice as likely to have a residual cognitive impairment two years after an initial diagnosis. Evidence also asserts that significant adverse events accompany delirium, for example increased mortality and morbidity and inappropriate placement into long term care institutions (see Jackson, Gordon, Hart, Hopkins & Ely, 2004, as well as chapter five for further information). Consequently, when placed in the context of Rowe and Kahn's (1987) view of successfully ageing, incorporating the maintenance of cognitive abilities (as an example), a lingering delirium relegates and constructs some older people as ageing unsuccessfully.

Similarly positive ageing attempts to produce and represent images of the older adult positively (Vincent, 1995). On the other hand, the images presented and offered as subject positions have evolved out of the achievements of a small group of outstanding and successful older people, for example an eighty year old person who still participates in marathon races. These achievements should indeed be applauded for their attempts at resisting aspects of the ageist sub-discourse through portraying positive images of being an older person. However, the above attempts are still problematic because it equates successful and positive ageing with the youthful qualities associated with health, fitness and vitality. Consequently, the positive representation of being older is misplaced by a focus on retaining and promoting youthful attributes (Friedan, 1993; Holstein & Minkler, 2003). Therefore positive ageing, like successful ageing presents two images of being older: one is frailty, dependence and cognitive impairment while the other is being youthful, remaining active and healthy. Positive ageing, successful ageing and anti-ageing concepts are therefore normative terms that are not value neutral. Instead these concepts are laden with comparative, either-or and hierarchically ordered dimensions.

Through the deployment of the concepts, positive and successful ageing, the latter part of the 20th Century has seen the emergence of what has been labelled the new old age.

This view attempts to take a positive and successful ageing stance by promoting youthfulness and halting the ageing process. Halting the ageing process is largely achieved through biotechnological and biomedical means, such as cosmetic surgery, hair transplants, Botox and Viagra (Clarke et al., 2003). The utilisation of these technologies results in people looking and acting as young people. For example cosmetic surgery and Botox, are heralded as removing the visible effects of ageing, smoothing out wrinkles through snipping, tucking and injecting small doses of botulinum toxic type A. The result is people who are 65 and older now looking 10 years younger.

The use of biotechnological and biomedical means to mask chronological ageing offers particular subject positions and identities for older people. Firstly it challenges, resists and unsettles the negative and stereotypical assumptions inherent in the ageist sub-discourse. This is achieved through what Featherstone and Hepworth (1996) identify as masking the ageing process. The remodelling of the physical body is advantageous because it masks the person's true age and resists the negative and homogenous connotations associated with being older. By looking more like an adult, as opposed to an older adult, older people are seen politically, economically and socially as contributing meaningfully to society. This capitalist notion carries with it a certain social status bolstered by our western preoccupation with subscribing to the youth culture (Featherstone & Wernick, 1995).

Biotechnological and biomedical means of altering an older person's appearance to look younger not only draws on the economic discourse, largely benefiting entrepreneurial doctors and health care institutions, but are also technologies of the self, forms of self governance that people apply to themselves (Clarke et al., 2003; Foucault, 1988; Rose, 1996). The result is the deployment of a 'not if but when' subject position that insidiously pervades older social groups. Individuals constantly monitor themselves for signs of ageing; for example grey hair, sagging stomachs and bottoms, wrinkles on the face and neck, and stained teeth. The transformation from looking old to looking younger is socially reinforced through the media, for example the television programme 'extreme makeover' where an older person received a face lift, hair transplants and teeth whitening. When this person was re-presented to his family and friends all were unanimous in voicing their approval of the new and younger identity.

It could be argued that there is nothing wrong with looking and acting younger than an individual's chronological age, and enjoying the social acceptance associated with this. This form of resistance offers many benefits integral to the concept of positive ageing, for example avoiding disease and disability, staying active through maintaining a fitness regime, the maintenance of cognitive abilities and engaging actively in life. These benefits also subscribe to the notion of successful and healthy ageing (Holstein & Minkler, 2003; Rowe & Kahn, 1987). However, the antithesis of this position promotes an ageist message, to visibly age is to be unhealthy or to have somehow failed in the ageing process. It is this aspect of successful and positive ageing that is contested.

Defying the effects of ageing can only be sustained for so long. As the population of the world ages so do the number of people who are now living into their 80s and 90s. Ageism has merely shifted 20 years along the ageing continuum. In addition, it has been clearly demonstrated earlier in this thesis that people biologically age at different rates resulting in some people at 65 experiencing health deficits usually only seen in people in their 70s and 80s. The promotion of a personal discourse of delirium is a way older people who have been delirious can resist the ageist sub-discourse.

Gordon (2002) presents a Foucauldian understanding of resistance as "... there is always something in the social body, and in each person, which evades or wrestles with others' attempt to act on our own ways of acting" (p. xx). Therefore, resistance is everywhere and can occur at both micro and macro levels. While none of the participants in this study resisted the ageist sub-discourse on a macro level there are instances where resistance is evident within individual narratives as identified below.

George resists any notion that he had was cognitively impaired by vehemently denying throughout the text that he was delirious. The same text can be reread as a form of resisting the ageist sub-discourse.

And then they said you became delirious?(Stephen, interviewer)

Eye wash. Utter eye wash. Who ever told you that? (George)

I talked to you about it the other day and you said that they thought that you were delirious, but you didn't think you were? (Stephen, interviewer)

No and I would debate that with anybody (George, p.3).

The conviction with which George resists any label of delirium is clearly evident. He goes on to say:

... We have got interests because ... which I want to pursue personally. My nephew and I have got a considerable sum of money that I have got to ... after all it is only sensible and proper that I do something about it at my time of life. I sit and think and think this out and then I make my arrangements. A man who was delirious couldn't do what I am doing. Delirious, utter eye wash (George, p.5).

There is no doubt that George is in a vulnerable position through his illness experience, hospitalisation and consequent dependence on others to assist him with his health needs. In the face of adversity he is able to resist the ageist sub-discourse that constructs him as frail, cognitively impaired, dependent and as a financial burden. Through asserting he has financial interests that he takes seriously George promotes a positive sense of who he is and concomitantly resists the negative images of ageing inherent in the ageist sub-discourse. The promotion of a positive sense of self is identified by Krauss Whitbourne and Sneed (2002) as the identity assimilation effect.

However, George's assertions are more than claiming that he still has interests to pursue and is actively engaged in life. George has reinscribed himself as an adult, not in the physical sense, but in terms of his actions. Aligning himself with the adult activities of independently managing and investing large sums of money, distances George from the ageist construction identifying old age as a time of physical and cognitive decline. This strategy of resistance affords George with "... a fragile and transitory membership of the more powerful social category 'able-bodied adult'" (Hockey & James, 1993).

Similarly, but in a less overt manner, Lilly also resists the ageist sub-discourse by accepting and acknowledging her illness as a transitory event.

So even when you came home you were discharged with support? [Stephen, interviewer, p.10]

Yes, a district nurse came the whole time. They were very good, they were excellent. But I just couldn't do anything, I was just so weak. I had all sorts of things. This septicaemia or something, god knows what so the poor old body was full of drugs. It took me a wee while to come right. But I bounced back quite

quickly. I am very lucky I've got Scottish genes in me and my daughter says "it's those Scottish genes you have got in you mum that pulls you through the whole time" [Lilly, p.10].

Rather than resisting the ageist sub-discourse from a successful ageing position, which earlier in this section was identified as being imbued with ageist ideals, Lilly acknowledges her interdependence on others due to having been delirious as a result of a surgical intervention. Both Higgs (1999) and Nolan (2001) contend that the way successful ageing is promoted and understood needs to be transformed to include those older people who are not capable of "super-ageing" (Nolan, 2001, p.451). These authors suggest the focus should shift to acknowledge the importance of interdependence and the promotion of personal narratives.

Lilly freely identifies how necessary the help she received was in getting her back to functioning the way she would like to. She articulates a sound rationale for her delirium, which was caused through septicaemia, and due to all of the drugs she was taking her body took some time to recover. Consequently, Lilly is interdependent on others to do things for her that she was unable to do for herself. Besides having been delirious Lilly also lives with a chronic illness:

I've got a heart condition and my energy levels aren't very high and I have got to reserve it and use it in moderation. I am not that terribly active. I do the garden and the house work but I just do it gently, quietly and I might have the next day off. So I have got to be careful [Lilly, p.20].

While the above excerpt does not fit the ideals of successful ageing, as identified earlier by Rowe and Kahn (1987), Lilly continues to resist the ageist sub-discourse by deploying a personal discourse of delirium. While the previous chapter promoted this discourse through the contextualisation of the older adult with delirium leading up to a delirious event, Lilly undertakes the same process post-delirium. She identifies that her existing and permanent heart condition, in combination with her recovery from delirium, means that she has to not only accept assistance from others but also space out her daily activities and allow plenty of time to recover before attempting another task. Through the use of humour she attributes her return to health, as defined in her terms, to her Scottish heritage.

In addition, Lilly expresses a certain confidence, as demonstrated in the excerpt below, identifying that her body may be physically unwell but that she still has a life and future outside of delirium. This resists the often negative and ageist trajectory the discourse of delirium as a syndrome portrays of older people.

Were you worried at any point that you may not have come home or did you just know within yourself? [Stephen, interviewer]

No I never thought that at all. Not for a moment. I know I would come home. I knew that it would take me a while to come right again [Lilly, p.21].

Lilly resists any notion of an inevitable decline in terms of her physical and cognitive abilities. Although the events around her delirious episode caused significant health related problems Lilly considers that it is her right to return to her former life even if that requires certain modifications.

7.7 Summary

In this chapter I have focussed on explicating the pervasiveness of what I have termed the ageist sub-discourse. It is also apparent that this discourse has infiltrated all aspects of contemporary society including the discourse of delirium as a syndrome. I have also demonstrated how some anti ageist initiatives, such as successful ageing and certain government policies (for example, *The Positive Ageing Strategy*), actually perpetuate and deploy an ageist sub-discourse. This offers limited subject positions for people who have delirium to resist the disciplinary power inherent in these discourses.

Opportunities for resistance do exist and frequently occur on a micro level. The excerpts presented demonstrated the presence of resistance by participants that were often subtle, and were deployed through a personal discourse of delirium. The importance of attending to the historical, social and cultural aspects, also identified in the previous chapter, is central as a strategy of resistance to prevent older people who are delirious from being type-cast as an unruly, unreliable and problematic body.

Chapter Eight: In from the margins, unmasking delirium

8.1 Introduction

My intention in this chapter is to continue one of the foci evident in the previous two chapters, which is to give primacy to the subjugated knowledges and to highlight the personal discourses associated with delirium. The personal narratives of people's understanding, and what they remembered about their delirious episode, will be presented. Once again I will reveal attempts by nursing and medicine to silence the personal experience of delirium.

The metaphorical use of language related to delirium will also be examined. The diverse range of metaphors used to describe the embodied experiences of delirium serve as a way to discursively illustrate how doctors, nurses, families and older people communicate their understandings of delirium. In addition, the differences evident in the experiences of a delirious event identify the various discourses circulating and vying with each other for our attention.

8.2 Silencing the madness discourse

Previous chapters have already identified how the discourse of delirium as a syndrome delimits delirium as a discrete biomedical entity and disregards the older person's social, cultural and historical context. The discourse of delirium as a syndrome marks the body as a biomedical entity emphasising the physical and psychological problems considered to be part of being an older person, as well as diagnosing and treating the physical body as a machine. As a consequence, the discourse of delirium as a syndrome offers limited subject positions to older people who are delirious.

The medical and nursing description of delirium embraces the following points that have already been explicated in earlier chapters. These are firstly, a faulty body that is physiologically not functioning, secondly a body that is a potential burden on society due to its inability to be economically productive as expected within a capitalist society, and finally, a disruptive body that upsets the institutional peace and smooth running of

the hospital ward. In addition, alterations to the older body's physiological processes that result in delirium mean the mind is also faulty. The mind is not concentrating; it commands the body to respond or not respond, to behave inappropriately or not at all, to shout, fight or take its clothes off. In other words, the discourse of delirium as a syndrome is reduced to a set of symptoms many of which are exhibited as bodily manifestations. These bodily manifestations are referred to as problems, and it is these sets of behaviours that the disciplines of nursing and medicine react to and attempt to understand through deploying the discourse of delirium as a syndrome.

The institutions where data were collected for this study attempted to understand delirium in the older adult through the development of a delirium service. This institutional initiative was operationalised through the employment of two registered nurses and an experienced psychogeriatrician. These three people agreed to participate in the study and all described how the delirium service came into being, including the consumer consultation process that occurred during the development phase. What the following excerpts identify is that nursing and medical representations of delirium and madness in older people marginalises a personal discourse of delirium (and/or madness).

So what was the consumer input into that project (Stephen, interviewer)?

Initially, in the very early days there were people from the community, from rest homes and things in the group.

Are you talking about health professionals or potential consumers (Stephen, interviewer)?

Health professionals. It was once things were written that they got sent out to consumer groups and they sort of critiqued it and said "what is this language that we don't understand"? They questioned the medical jargon used. The consumer group was a group of ... I can't remember the number to be quite honest.

But there were no patients or potential patients who had been delirious ... (Stephen, interviewer)?

No, no. Everyone had a medical background of some sort. So there was community and hospital but no one who had been delirious (Rachel, nurse, p.2).

This view is also evident in the texts generated from interviewing the psychogeriatrician.

Did they ... they would have got consumer input (Stephen, interviewer)?

Yeah there was. When you say consumer input talking about people having been through delirium or their carers; that was pretty minimal to be honest. In the early stages we didn't have anyone like that who was part of the planning group. We probably should have but it didn't happen that way. The consumer input was done at a slightly later stage when there was a draft report sent out to the [xxx] consumer group for them to pick over and there were a number of comments that came back that were taken heed of. In particular in relation to the information leaflet that we designed for families (John, doctor, p.4).

The preceding textual excerpts demonstrate that scant attention, if any, has been given to a consumer consultation process associated with the development of a service designed to meet the needs of older people who are delirious. The involvement of consumers, or potential consumers, should be evident at all stages of the consultation process. Clendon (2003) refers to the collaboration and participation of communities at all levels and stages of the planning process as community development. Utilising a community development model has been shown to positively influence health and well-being in populations (McMurray, 1999), and it is these that are the key tenets of both *The Positive Ageing Strategy* (Minister for Senior Citizens, 2001) and *The Health of Older People Strategy* (Ministry of Health, 2002). Leaving potential consumers of a delirium service out of the consultation process deploys an ageist discourse that reinforces the stereotypical view of increasing age equating to cognitive impairment, and therefore by vicarious association, an unreliable mind (Hazan, 1994). This construction of old age denies older people opportunities to make decisions that may influence their future health care should they experience a delirious episode.

The biomedical discourse frequently assumes that biological determinants take on a greater significance in accounting for the problems associated with ageing. These determinants are normalised and enshrined in what is the 'truth' about older bodies. The discourse of delirium as a syndrome is entirely focussed on the iatrogenic causes and searches for explanations that may have contributed to the delirious event (Simon et al.,

1997). Sandra, a registered nurse working as part of the delirium team, reinforces the nursing and medical focus on explaining delirium as resulting from a biological cause.

I have always been given the sort of psych patients ... the people with medical illnesses that cause psych symptoms [Sandra, nurse, p.2].

They [older people] tend to react in different ways [when delirious] because their bodies react in different ways because all their systems are old and they have all been subject to lifestyle influences that have ended up in multiple medical illness, lots of drugs or cerebral deterioration ... If a person is off their legs it is enough to tell you that something is not right. Delirium is an indicator of some other underlying pathology [Sandra, nurse, p.10].

In the next excerpt John, the psychogeriatrician, also reinforces the biomedical stance on delirium.

... [T]here is good evidence that delirium can be the triggering event of a dementia and many elderly people with frail brains don't fully recover from the delirium and take a drop in their cognitive functioning after they have recovered. I think there is going to be heaps more of it [delirium] simply because there are going to be many more elderly people with frail brains in the next generation [John, doctor, p.6].

Both Sandra and John utilise a biomedical perspective to make sense of their understanding of delirium in older people. This understanding reaffirms the previously described subject position of the faulty older body. John signposts the fact that increasing chronological age equates to changes in biological processes that predisposes people over the age of 65 years to becoming delirious. The notion of linking chronological age as a marker of biological processes is limited as it fails to consider the heterogeneity of older people. Bookstein and Achenbaum (1993) identify that relying on chronological age alone is a poor predictor of ageing and that health professionals should broaden their repertoire to include other measures, for example functional abilities, as a means to comprehensively explain the ageing process.

Both Sandra and John refer to incorporating functional abilities as an integral component of determining delirium in the older person through the use of metaphors, such as, 'off their legs' and 'frail brains'. However, it is Rachel who provides a

compelling example of utilising a person's functional ability as a marker to identify delirium in an older person.

I looked after a man yesterday morning and previously I would get to work and he would be up and dressed. He wouldn't have showered because he doesn't usually shower in the morning. But he would be up and dressed and looking nice. When I got there yesterday morning he was lying in bed, he was muddled and just really sleepy. I knew that something was wrong. The doctors came to see him and yes he has a delirium due to a chest infection. The only outward sign that he presented with was he wasn't up like he normally is and a wee bit muddled [Rachel, nurse, p.5].

The above speakers position themselves in an authoritative position by deploying an ageist and normalising discourse linking being older and delirious as a physiological response involving being “off their legs”, having a “frail brain” and a decrease in functional ability. Delimiting delirium through an ageist discourse inscribes the older person with the belief that cognitive decline is associated with getting older. Even though this has clearly been proven to be false, an alteration in thought processes remains an expectation of ageing (Foreman, 1993).

In chapter four of this thesis, I demonstrated how the delirious body emerged as a stable biomedical entity in 1980 through the introduction of the DSM III. Several power techniques, including treating the older person who has delirium as an object have resulted in the perception of a docile body that is kept under constant surveillance and can be inscribed with truth (Foucault, 1991). Not only does John believe older people have frail brains but also ...

[I think that] every elderly person coming into hospital deserves to have one done [a cognitive screening tool] to make sure they are obviously intact [John, doctor, p.14].

John's desire to screen every older person on admission to hospital is reflected in the medical literature (see Larkin, 1999). If an older person was assessed as at risk of becoming delirious then they could be further exposed to inspection and surveillance over which they may have little, if any, knowledge regarding its occurrence. Clarke et al. (2003) refer to John's desire to cognitively assess all older people admitted to

hospital as “problematizing the normal” (p.172) and the rise of “surveillance medicine” (Armstrong, 1995, p.393).

An example of problematising the normal can be found in The New Zealand Guidelines Group (NZGG), a national non-profit organisation, which has recently published a best practice evidence-based guideline outlining assessment processes for older people with varying abilities and disabilities (NZGG, 2003). This guideline, in conjunction with the plethora of cognitive screening tools, creates what Foucault (1978, p.138) refers to as “regulatory controls: a biopolitics of the population”. Biopolitics is an aspect of biopower that has, in this instance, created an intricate, subtle but yet constant and powerful set of assessment processes designed to manage older people who are delirious, as well as those at risk of becoming delirious.

Best practice guidelines specifically targeting older people, for example those produced by NZGG, as well as those with a focus on delirium (see APA, 1999), is what Clarke et al. (2003, p.172) refers to as “... the elaboration of standardized risk-assessment tools”. In the case of the present study, the risk factors of being older and experiencing delirium as an iatrogenic consequence associated with an episode of ill health, has been transformed from a generalised population statistic to one deemed meaningful at the level of the individual. The assumption that everyone over the age of 65 years has the potential to develop delirium is one of the major contributors to the ongoing development of surveillance mechanisms inherent in the discourse of delirium as a syndrome.

The exclusion of previously delirious people from influencing the development of a service that ultimately will impact on older people and their families is a technique of power. Foucault identifies a technique of power as one which:

Categorises the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him. It is a form of power that makes individuals subjects (2002b, p.331).

Through the deployment of biomedical principles to develop best practice guidelines on the assessment, treatment and management of delirium, the discourse of delirium as a syndrome is accorded the status of knowing the ‘truth’. The consequences of this are

that other knowledges/truths, for example personal discourses of delirium, are largely silenced by both the disciplines of nursing and of medicine.

The next section brings to the surface the personal discourses of delirium. These discourses resist the discourse of delirium as a syndrome through the privileging of the subject positions of the people who have been delirious.

8.3 A reliable mind

The transcripts of the interviews with people who experienced delirium and their families provide a variety of insights about delirium, each one localised and contextualised within their view of the world. Many of their hallucinatory experiences appear to have been constructed by this group through the lens of their past life experiences.

My intention in surfacing the personal discourses of delirium is mirrored by the feminist writer Bloom (1998, p.64) who claims:

One of the purposes of examining subjectivity in women's personal narratives is to redefine what it means for women to write, tell, discuss and analyse their life experiences against the backdrop of the prevailing discourses that seek to silence them. To change the master script is to change reality; to change reality is to participate in making a history different from the one the status quo would produce.

Consequently, the primary focus of this section is to present the personal narratives associated with the delirium experience of older people. Doing so highlights the various contradictory and fragmented positions people who have been delirious take up when describing their experiences of a delirious episode, and as such provides opportunities to disrupt the dominant representations of delirium deployed through the discourse of delirium as a syndrome.

The following excerpts show that some people do not remember a thing about being delirious, whilst others can vividly recall most aspects of the event. Betty begins by not knowing at all what happened to her. She remembers going to hospital, being discharged and then readmitted but has no idea why.

I honestly don't remember a thing. My son said I was outside. I don't remember being outside.

Do you remember being at home? [Stephen, interviewer]

No I can't. I know my son said that him and my sister were trying to get me, I don't know where, into the ambulance or something. They couldn't do anything with me. But I honestly didn't know what he was talking about.

So had you ... have you been quite well? [Stephen, interviewer]

As far as I know nothing wrong with me. My son said I was away with the fairies.

I knew I was there [in hospital]. The reason I was there I don't know but ... then I come back ... what did I do ... I come back ... I came out of this one didn't I? Went home for a couple of days and came back again.

So people have been telling you that you have been delirious haven't they? [Stephen, interviewer]

Yes, yes. Have I been very delirious? (Betty, page 5)

On the other hand, Lilly clearly describes her experience of delirium in great detail.

Well um I remember lying in a bed and there was a ... all this carry on. There was a dog running around barking and I said to the nurse "you shouldn't have a dog in here". She said "I'll chase it away for you". She was just appeasing me you see. And that seemed to go on for such a long time. All these sort of characters against the wall, frightening. And then they moved me. I sort of vaguely remember moving and I was in what I thought was a ... in a room with all these kilns that fired pottery, because I have done pottery over the years. Everything was white and there were people coming and going. Then it turned into a cave. It was a, a prison and I thought I needed to get out of there. I tried to get someone to give me a phone (Lilly, page 5).

Lilly attempts to make some sense of being delirious. She explains the event by linking her hallucinations around kilns to the fact that in the past she had undertaken pottery as a hobby.

Harry, like Lilly was able to remember his delirious episode and again described his experience in detail as outlined below:

To my mind I was being attacked by the prince of, the prince of darkness, the prince of the earth. It's a force, his force is ... All I know is this thing was sucking at me as if I was ... everything was distorted. Just as though there was a barrier which I couldn't get through. It was a force of everything that seemed to be stuck together like that [respondent clasped hands together at this point] and I was trying to run back through those things. And the nurse, the dark nurse gave me the presence that she was demonic. It drove me nuts (Harry, page 8).

Harry drew on a madness discourse to explain his delirious episode. He made sense of what had happened to him through linking his experience to his Christian beliefs. Harry described himself as believing in god and for him delirium represented the prince of darkness which he described as a dark force. The nurse represented a devil, someone who was not on his side, someone who stood as the antithesis to the god he worshiped. He uses the metaphor 'drove me nuts' which is synonymous with the madness discourse as a means to explain how he felt.

Lipowski (1990) identifies that in some older people who have been delirious "confabulation" occurs. When referring to the subjective experience of delirium, the discipline of medicine has relied on anecdotal reports produced by other physicians who have been delirious (Caraceni & Grassi, 2003). This position reinforces the biomedical view that increasing age equates to a decrease in cognitive functioning, which in turn offers a subject position of unreliable mind to the older person who has been delirious. While there is evidence suggesting that the speed and amount of information that can be processed declines with age (Lui & Park, 2003) this does not mean that all older people will be cognitively impaired. The current construction of the older person who has been delirious as having an unreliable mind, reinforces the singularity of medicine's epistemological focus on identifying and fixing the problems that caused the delirium.

The above excerpts provide insights into the embodied experience of delirium thus privileging a personal discourse of delirium. The variations in the texts generated around the delirious event are clearly evident as demonstrated above. What is not so evident is how worried, concerned or fearful older people who have been delirious may be. The deployment of the discourse of delirium as a syndrome, through its focus on managing the faulty older body, fails to address and in effect silences any concerns or

feelings older people may have as part of being unwell and away from their usual living environment. This is evident in the following text:

Nursing pm:- Requiring assistance and direction due to confusion and poor eyesight. Fell this evening. Pt stood up from a sitting position on bed, lost her balance, slipped and landed on her bottom. Duty H/S [House Surgeon] notified see above. Incident form completed. Falls assessment forms completed and bracelet applied. Frequently using toilet and commode. Pad damp x1 (Connie, clinical notes, p.14).

This comment, while acknowledging that Connie was confused, remains focused on functional ability, use of the toilet and that this person was experiencing some urinary incontinence. At the same time it fails to attend to the psychosocial elements that may have been present, for example the distress at being incontinent and/or confused. The manner of the reporting Connie's condition and progress is taken predominantly from the physical body. As readers of this text we know little, if anything, about what meanings Connie makes of being delirious. This nursing entry only allows the reader to know the physical body.

Connie's docile body is further inscribed with what Foucault (1977) believes are disciplinary techniques applied to the body through surveillance. These disciplinary techniques are identified in the checking of Connie's pad and the application of a falls bracelet, reinforcing Connie's frailty and vulnerability. The excerpt also demonstrates how the nurse colluded with the institutional practices of the hospital to control and discipline Connie through the deployment of the discourse of delirium as a syndrome. Connie's admission to hospital has resulted in her being stripped of her clothing, her body marked with an 'at risk' bracelet. Her identity is reframed in reference to a decrease in function, urinary incontinence, a diagnosis of confusion and needing to be kept an eye on. In effect her identity has been inscribed with medicalised meanings, offering her an associated subject position involving increasing age, being physically unwell, a decrease in cognition, infirmity and dependence. In other words a faulty body.

The deployment of a personal discourse of delirium privileges and allows the subjective, for example worries, fears or concerns to surface in the texts generated by

older people who have been delirious. Frank (1995, p.xii) captures the telling of illness experiences eloquently by stating:

... telling does not come easy, and neither does listening. Seriously ill people are wounded not just in body but in voice. They need to become storytellers in order to recover the voices that illness and its treatment often take away. The voice speaks the mind and expresses the spirit, but it is also a physical organ of the body; in the silences between words, the tissues speak.

Texts generated by people who have been delirious express their fear in a number of ways. This can occur non-verbally, manifesting in physical behaviours, and through being given the opportunity to voice their experiences to others.

... I remember roaring and carrying on ... they were always at me [the nurses and doctors]. I remember saying "go away, go away", and I was trying to push out of this area. I ripped the things I had in my arms out. And arh, yeah it was frightening to me [Harry, p.9].

I knocked the doctor's glasses off. I can remember that. Then I thought well ... there was something wrong with my brain. The whole thing was the most frightening thing I had been through, it really was. I don't want to go through it again [Lilly, p.7].

When juxtaposed with these people's clinical notes it is apparent that the discourses of delirium as a syndrome and the personal discourses of delirium are polarised and oppositional. The clinical notes associated with the texts produced by both Harry and Lilly do not mention Harry removing things from his arms, Lilly knocking the doctor's glasses off nor that either person felt or may have felt frightened. Instead what is documented in Lilly's notes by the registered nurse is:

Transfer from [intensive care] @ 1900hrs. IVF [intravenous fluids] 100ml/hr via cvc [central venous catheter]. IDC [indwelling catheter] hrly, output satis. Oxygen sats [saturation] 91-93%. Ileostomy output 160 ml. NG [nasogastric] not aspirated. Orally = sips. Becoming increasingly agitated as shift progressed ... Seeing spiders and asking inappropriate questions. Trying to get out of bed. S/B H/S [seen by House Surgeon] – given regular nitrazepam. Haloperidol

*charted. PRN [as required] – nil given @ time of report. Mobilised in chair x1.
Wound satis. Temp 37.7 [Lilly, clinical notes – nursing entry, p.10-11].*

This brief extract highlights several major points requiring analytical attention. Firstly, it appears the registered nurse working with Lilly has abandoned one of the key concepts associated with nursing, that of caring. The literature abounds with the concept of caring as being central and pivotal to nursing practice (see Benner, 1984; Benner & Wrubel, 1989; Roach, 1992). Since the 1980s Benner's work on caring has both infiltrated and influenced the development of nursing knowledge in New Zealand, where this study took place, as well as internationally. For example, in her book on caring for the older adult O'Neill (2002) advises nurses working with older people in a hospital setting to be attentive to older adults experiencing feelings of fear. O'Neill encourages gerontological nurses to utilise Benner's work on caring to imagine what it would be like if it were them in the bed, and using this imagery to form the basis for working with a hospitalised older person.

Secondly, a number of authors have documented the existence of the routinisation of care related to older persons whilst in hospital (Armstrong-Esther, Browne & McAfee, 1994; Koch, Webb & Williams, 1995; Nolan, Grant & Nolan, 1995). The routine style of caring for hospitalised older people is evident in the text above with its emphasis on attending to Lilly's physical requirements. For example, the monitoring of urine output, the condition of the wound and temperature. When considering the importance of holistic care as being fundamental to nursing practice, the documentation of the attention given to Lilly's physical needs implies that the provision of nursing care in this instance is inappropriate. This is because the physical care provided objectifies the body and denies it the qualities that construct embodiment (van der Riet, 1997). It is not the embodied person being cared for in this scenario; it is the symptoms that manifest due to delirium. The manifestation of symptoms results from some physical malfunction that the registered nurse treats, reports on and manages. Failure to attend to the older person who is experiencing delirium in a holistic way is antithetical to the rhetoric underpinning nursing practice.

Nolan et al.'s (1995) work also highlights how the routinisation of care with a focus on task orientation, leads to a lack of communication between nurses and older people,

resulting in a disregard for the social and emotional aspects of patient care. These authors also found that despite nurses' belief in the importance of talking to older hospitalised people, the actual amount of time spent in social interactions of any kind was extremely limited. By deploying the discourse of delirium as a syndrome there is potential for communication between nurses and older people who are delirious, to take the form of instructions during the performance of specific tasks. Instructions do not form the basis of social interaction which is fundamental to acknowledging and understanding the varied and contradictory experiences of people who are delirious. Privileging the embodied experience of delirium allows for the surfacing and deployment of a personal discourse of delirium.

The registered nurse working with Lilly has carried out the doctor's orders faithfully as evidenced by the documentation presented above which mirrors medicine's treatment plan prescribed for Lilly earlier in the day. The importance of following a treatment regime is undisputed as being vital to the recovery of an older person with delirium. However, it is the absence of any reference to the holistic caring discourse so integral to the rhetoric of nursing that is problematic. The privileging of the discourse of delirium as a syndrome is reflective of the hierarchical status of the social and professional relationship that exists between medicine and nursing, the origins of which can be found in, and reinforced by Nightingale in 1865 (as cited in Wicks, 1999, p.40) who asserts:

It is the duty of the Medical Officer to give what orders, in regard to the sick, he thinks fit to the Nurses. And it is unquestionably the duty of the Nurses to obey or to see his orders are carried out.

The advent of advancing nursing practice through the utilisation of critical thinking as a basis for making clinical judgements is firmly embedded in contemporary nursing literature (Cody, 2002; Parker & Claire, 2000). It is anticipated that the nurse working with Lilly utilised critical thinking skills, as part of the clinical decision making process, to ensure appropriate and safe care was delivered based on the outcome of assessments undertaken. Hedberg and Larsson (2003) assert that nursing decisions are influenced by established guidelines for care set down by doctors. This is evident in the above excerpt. However, the utilisation of critical thinking as the foundation for making clinical decisions in providing safe and appropriate care to Lilly is questionable.

The registered nurse appeared to adhere to the directives of the house surgeon unquestionably, therefore upholding the Nightingale ethos of obeying the doctors orders. In addition, Lilly recently had an anaesthetic and was hypoxic, as evidenced by low oxygen saturations. Therefore a registered nurse utilising nursing knowledge based on the abundant evidence available on delirium, in combination with critical thinking skills, would have questioned the medical directive of giving nitrazepam to help Lilly sleep and withholding the Haloperidol. The use of hypnotics, such as nitrazepam (a benzodiazepine), can induce a delirious episode in the older person (Caraceni & Grassi, 2003; Flaherty, 1998). Best practice guidelines in this case would include the regular administration of a low dose antipsychotic, such as haloperidol or respiradone, and replacing nitrazepam with non-pharmacologic approaches to sleep, or if a hypnotic was really necessary then utilising temazepam (Canterbury District Health Board, 2000; Foreman et al., 2003).

8.4 Unmasking delirium

The disciplines of nursing and medicine inscribe, and by association mask, delirium through the discourse of delirium as a syndrome. This discourse locates and therefore speaks of delirium through physical causes. The unmasking of delirium privileges personal discourses of delirium through surfacing the texts of people who have been delirious and their family's notions, or beliefs of what delirium is.

I specifically asked George what he thought delirium meant:

Well when you get delirious, to my way of thinking, you run a high temperature I think. And arh you um ... your conversation is arh silly. You can't ... you can't get a logical conversation. That doesn't come into a person that is delirious. Your conversation is a little bit stupid (George, p.5).

However Martha volunteered the following definition of delirium:

Dolally and knocked off. If a man like dad couldn't fold a piece of paper in four as he had been asked to and somebody who had kept up with politics like he had couldn't think who the prime minister was and stuff like that ... yeah that's what it means to me. It is a type of madness really for a short period of time. That's how I look at it, a type of psychoticness ... [Martha, family, p.14].

Both George and Martha draw on previous personal life experiences, as well as from social representations of delirium to rationally explain their understanding of what delirium means to them. Metaphors such as ‘silly’, ‘a little bit stupid’, ‘dolally’ and ‘knocked off’ are utilised to give meaning to being delirious. Each of these metaphors does not represent anything dangerous or sinister but rather represents “... a life more disturbed than disturbing, an absurd agitation in society ...” (Foucault, 2002c, p.33).

8.5 Mad but not mad

The utilisation of other metaphors associated with madness is also used by older participants, as well as their families, who also attempt to distance themselves from being labelled cognitively impaired.

They put me out at a small hospital, all the half wits were there, and arh 90's, you know old deranged men. Breakfast time would come and they'd bang the plates and the ... and the knives and things (Harry, p.5).

Here Harry candidly uses metaphors such as ‘half wits’ and ‘deranged’ to communicate his experience of convalescing in a small rural hospital. However, he later distances himself from the situation by demonstrating he was cognitively intact by claiming that he discharged himself home before he finished convalescing and managed independently. In addition, by drawing on metaphors associated with madness to describe behaviours of other older people he further reinforces hegemonic beliefs that to be old and unwell is to have an unreliable mind. Rudge (1997) identifies that the reinforcement of hegemonic beliefs, as described above, acts to suppress certain forms of thinking and behaving. In this instance, Harry deploys and reinforces an ageist discourse to contextualise and assert his social situation as an older person who has been delirious as a result of being physically unwell, while concurrently suppressing the potential to construct delirium as a temporary and resolvable state of mind.

When I asked Allan what he thought having delirium was he replied:

Oh, well, dizzy spells or periods of delirium or dizziness which I don't think I have. I just get off balance. Balance is my biggest problem and sometimes it is worse than others.

So you don't think delirium is related to things like hallucinations? [Stephen, interviewer]

No I felt quite sane. I was just trying to protect myself and my home. I really felt that. I think I had it in the back of my mind and that is what triggered it off. It could have been something I had read in the paper. That is what probably triggered it off. It didn't last long [Allan, p.11].

Allan utilises metaphors such as 'dizzy spells' and 'off balance' to describe his experience of delirium while vehemently distancing himself from delirium as madness. He makes a point of saying that he was not mad and eloquently provides conceptual evidence as to why he behaved in the way that he did, clearly demonstrating that he is of sound mind. Allan in effect is not seduced by the subject position equating chronological age with an unreliable mind. Instead, Allan positions himself as a man who has trouble with his balance but is still capable of reading the paper, looking after himself and his home. Allan is promoting a positive image of ageing. Davey and Gee (2002) identify positive ageing as incorporating remaining involved, active and interested in life to counter the ageist perceptions associated with old age.

Like Allan, George resists the discourse of delirium as madness in the following piece of text ...

You can't get an intelligent conversation with them [talking about the nurses and doctors involved in his care]. Gracious me I might be stupid but I still have got a bit of common sense left. They think "leave that silly old fool, he doesn't know what he is talking about anyway".

Is that what you think they think? (Stephen, interviewer)

Yes that I'm not with it enough to enter into a sane conversation.

Do you think some of that relates to them thinking that you had been delirious? (Stephen, interviewer)

That gets back to the fact that I will dispute that I ever was delirious. How that came about I don't know, whether it is official or whether it is just um ... they say "oh there he is he is just delirious". All I was trying to do was to get into a decent conversation, a discussion. They say "oh he is delirious" (George, p.13).

This text utilises the metaphors associated with the madness discourse: ‘stupid’, ‘silly old fool’ and ‘not with it’. The text also demonstrates George’s tactical response to being labelled as having been delirious. Here he resists the madness discourse by asserting that he still has got a bit of common sense left and contests the biomedical labelling as being delirious by vehemently denying that he was.

Ageist infantilising discourses are also in play. Foucault in *Madness and Civilisation* asserts that “Madness is childhood. Everything at the Retreat is organized so that the insane are transformed into minors” (p.239). George is relegated to the position of minor through being denied the opportunity to speak, and being inscribed with the label of delirium. George’s assertions of being able to engage in a decent conversation and resisting the label of delirium resonates with the positive ageing discourse. *The New Zealand Positive Ageing Strategy* (Minister for Senior Citizens, 2001) identify as one of its foci, that positive attitudes to ageing and expectations of continuing productivity challenge the notion of old age as a time for withdrawal from society.

8.6 Re-masking of delirium

The silencing of the personal discourses of delirium, by nursing and medicine, through the deployment of the discourse of delirium as a syndrome has been addressed earlier in this chapter. Also this thesis has earlier determined that delirium is a nebulous and ambiguous condition that is difficult to diagnose and therefore treat, with often dire consequences for the older person. Both the popular and academic literature identifies that both nurses and doctors should be familiar and confident with utilising one of the many valid and reliable delirium screening tools. In the case of this study, contradictions occur between the rhetoric and practice of what John, a psychogeriatrician, identifies as “good delirium cares” [John, doctor, p.9].

An analysis of the clinical notes of older people who have been delirious has revealed minimal, if any, use of a delirium screening tool. This is further supported through the examination of the texts generated by people who have been delirious and their families who identify that the word delirium was rarely used, if at all, in their interactions with health professionals.

When asked whether the nurses and doctors utilised the word delirium in their interactions with them, the following responses were recorded:

No, no one said that I was delirious. They said nothing. The only thing they said was that my bowel infection was passing (George, page 5).

Nobody mentioned it no. But my daughter probably picked up on it because she is a nurse (Lilly, page 18).

No I don't think so (Mary, family, page 7).

No. I haven't had any [information] except I did ... one of my sisters picked up a booklet they had downstairs last week [delirium information booklet] (Brenda, family, page 13).

An audit of the clinical notes of people who had been delirious revealed that only occasional references to delirium were made. However, these references were not supported by evidence of how the decision was reached. No nursing entries utilised the term delirium except on one occasion when the documentation from a multidisciplinary meeting, where nurses contribute, identified that Betty was experiencing delirium due to having a urinary tract infection. The other instance occurred when the nurse from the specialist delirium service reviewed Lilly at the request of the doctor to undertake a specific delirium assessment. The documentation from this assessment was comprehensive and provided a detailed set of suggestions for caring for Lilly.

The metaphor 'confusion' was frequently used in all texts to describe the cognitive status of each of the participants. For example:

Confused and drowsy (doctor, [Lilly's clinical notes], page 15).

Currently settled and pleasantly confused (nurse, [George's clinical notes], page 7).

Some confusion evident – cats, cars in room (nurse, [Connie's clinical notes], page 8).

Lipowski (1980a; 1980b; 1990), a key medical writer in the area of delirium, is critical of the use of the term confusion, claiming it is ambiguous, used too loosely and should not be applied to the older adult as if it were a diagnosis. It is certainly apparent, particularly within the nursing documentation that the term confusion is largely used in

preference to delirium. The closest documentation relating to using some form of delirium assessment framework is found in the following excerpt:

Altered levels of consciousness, disorganised thinking, speech illogical, unclear and rambling. Not orientated to time, place or person (nurse, [Betty's clinical notes], page 12).

An analysis of the nursing discourse on delirium has identified that many nursing writers use the terms acute confusion, confusion and confusional state interchangeably with delirium (see Culp, Menten & Wakefield, 2003; Insel & Badger, 2002; McCarthy, 2003). The medical discourse is more consistent in its use of term delirium as opposed to confusion. The deployment of the term confusion in the nursing discourse, as opposed to delirium, may explain its dominance in nursing documentation in the clinical notes.

On one hand, the deployment of the term confusion (and its variations) within the nursing discourse could be viewed as a strategy of power, a means of resisting the medical discourses attempt to delimit delirium as a biomedical entity through the DSM. However, on the other hand it further adds to the ambiguity surrounding delirium, what it is and how to appropriately provide care for older people who are delirious. The term confusion is also used in reference to older people who live with dementia. As earlier identified, there is a marked difference between the syndromes, delirium and dementia.

The synonymous use of the term confusion to mean both delirium and dementia by the nursing discourse offers a subject position to older people that delimits, and is imbued with, negative connotations that have already been discussed. A misdiagnosis and undertreatment of delirium may result in the instigation of inappropriate treatment regimes, for example placement into a long term dementia care unit (Foreman, Wakefield, Culp & Milisen, 2001).

Both the nursing and medical discourse identify that nurses, as opposed to doctors, are best placed to identify and document delirious episodes because they have contact with an older person over the duration of a shift (Cole, 2004; Gustafson, Brannstrom & Norberg, 1991). Even though nurses appear to be positioned best to detect subtle changes in an older person's cognition, some research suggests that nursing assessment

still fails to detect delirium in a significant number of cases (Foreman et al., 2001). This assertion is certainly confirmed by the current study and is bewildering because of the vast quantities of published accessible research based evidence on assessment protocols for detecting delirium.

As already mentioned, nurses document behaviours associated with confusion which are vague and at times patronising, for example “pleasantly confused”, yet are either unable, or unwilling to utilise one of the valid and reliable diagnostic tools available to detect delirium in the older population, for example the Confusion Assessment Method. This instrument has been heralded as being both quick and easy to use (Cole, 2004; Inouye et al., 1990). The absence of any use of a delirium screening tool by nurses is an enigma, considering the rhetoric of nursing seeks recognition as a profession which bases clinical decisions on evidence (Carryer, 2002). The evidence on delirium clearly suggests that early detection through the use of a delirium screening tool significantly improves patient outcomes in older people (Cole, 2004).

An examination of the medical documentation reveals no use of a delirium sensitive assessment tool, however occasional use of general cognitive screening instruments are evident.

Became odd last weekend, MSQ [mental status score] 10/10 (doctor, [Allan’s clinical notes], page 28).

Delirious secondary to UTI [urinary tract infection]. Looks unwell, pale, thinks she is at home, drowsy but opens eyes to voice, speaks, follows commands (doctor, [Betty’s clinical notes], page 8).

Not obviously confused – can complete serial 3s and give complete dates (doctor, [Betty’s clinical notes], page 23).

The lack of recognition by nurses and doctors about delirium offers limited subject positions to older people who have been delirious. This lack of recognition is evident through the minimal use of the term delirium when speaking to older people and their families, as well as in the documentation produced in the clinical notes. In addition, there is predominantly only cursory utilisation of appropriate delirium screening tools. The discourse of delirium as a syndrome colludes with the institutional practices of the hospital which is fixated on cost containment to re-mask delirium and silence personal

discourses of delirium. This re-masking only serves to create a negative subject position for hospitalised older people who are delirious.

The disciplinary and institutional practices of the hospital may contribute to creating adverse health outcomes for, as well as reinforcing ageist and stereotypical assumptions about, older people with delirium. Nursing and medicine, through their non use of a delirium sensitive assessment tool, set up the older person with delirium to experience the iatrogenic consequences of late or misdiagnosis, for example cognitive decline, falls, fractures, pressure ulcers, high mortality rate and permanent decline in functional status (Foreman et al., 2001; Inouye et al., 1998a; 1998b). The iatrogenic consequences of late or misdiagnosis presented above places the older person with delirium on a downward trajectory of events that further reinforces the negative subject position, 'being old and delirious is to have an unreliable mind and faulty body'.

8.7 Summary

The discussion presented in this chapter resonates with the findings presented in previous chapters. Nursing and medicine deploy the discourse of delirium as a syndrome as a means of understanding delirium. However, through the utilisation of critical gerontological analytical tools, that is those associated with postmodernism and Foucault's work, the discourse of delirium has been destabilised.

Bringing the personal discourses of delirium in from the margins allows the narratives of older people who have been delirious to have their experiences represented and acknowledged. However, more importantly these personal discourses provide opportunities for resistance. Personal discourses of delirium contest and resist biomedical accounts of delirium especially those that offer negative and ageist subject positions for older people. The next chapter continues with the promotion of the personal discourses of delirium through representing the health care experiences of older people who have been delirious and their families.

Chapter Nine: Repositioning nursing care

9.1 Introduction

This chapter addresses the third research aim *to develop a position from which to explore a range of possibilities nurses could utilise to provide appropriate care to people and their families experiencing delirium*. The focus in this chapter is to ensure the health care experiences and texts of those currently silenced by the dominant discourse of delirium as a syndrome are repositioned, moved in from the margins. It is intended that the tensions generated through juxtaposing the discourse of delirium as a syndrome with the personal discourse of delirium, in relation to the provision of health care, will stimulate opportunities for insightful reflection by nurses, as well as other possibilities for providing a nursing service to both older people who have been delirious and their families.

The texts presented in this chapter result from the data sources outlined in chapter three of this thesis. People who had been delirious and their families were asked, as part of the interview process, “[C]an you tell me the things the nurses did that helped and didn’t help”? Unsurprisingly, the responses generated from this question produced a series of fragmented, contradictory, frequently contested texts, as well as a set of common responses. The analogous, yet contested critique of the health care received by people who have been delirious and their families will be presented in the proceeding discussion.

9.2 The contested terrain of who is the expert

People who have been delirious assert that they know themselves better than anyone else; after all they have been acquainted with all aspects of their lives a lot longer than any health professional that generally only has a brief and fleeting encounter. This is made all the more salient by national and international evidence identifying that consumers of hospital services can expect shorter hospital stays (Finlayson & Gower, 2002; Gauld, 2001). Shorter hospital stays mean less opportunity for nurses to get to know older people who are delirious. Due to a decrease in the number of days spent in

hospital it could be expected that nurses would acknowledge the personal expertise of the individual in knowing themselves. Taking this position deploys a personal discourse of delirium with a focus on the contextualisation of the older person within a social, cultural and historical context as already outlined in chapter six.

Participants identified that they need help rather than needing to be managed and that they have managed themselves for sometime now. This assertion challenges the idea that health professionals ‘know what’s best’ and shifts the emphasis onto the older person knowing what they need. The following comment illuminates the dichotomous position that exists between the foci of health professionals to that of the person who has been delirious.

... Well I was incapacitated to some extent, I realise that ... You see I am 86 now and I can't do what I used to. There are many things I'd like to do but I can't get around as I used to. I wanted to try physiotherapy to help with my walking but they don't give much of that ... The little of physiotherapy you get is um is just a tiny bit. There was nothing at all yesterday. Arh ... I would like to give more time to it. Then perhaps I might be able to get on my feet again [George, p.11].

The above excerpt highlights George's priorities in terms of his care needs. While acknowledging his frailty and the limitations this places on his mobility he is clear about what he needs assistance with. George asserts he needs more physiotherapy so he can maintain what mobility he has. The literature on delirium clearly identifies that early mobilisation assists with orientation, a key component of providing care to a person who is experiencing delirium (Foreman et al., 2003; Inouye, 1998a). Analyses of George's clinical notes reveals there is scant mention of his mobility needs and no mention that he has a desire to improve his mobility through physiotherapy as evidenced in his problem list below.

- A.
 1. Urinary retention
 2. Decrease LOC [level of consciousness]
 3. Increase plantar on R)
 4. Constipation
 5. Hypotension [George, clinical notes, p.4].

Allan identifies that he is an expert in his own care by trying to manage the cause of his nightmares that were an integral component of his delirium. He did not directly refer to having been delirious but tended to talk about his health event as resulting from the medication he was taking for his Parkinson's disease. While at home, Allan tried to manage his health himself and part of that strategy was to not go to the doctor immediately. He attempted to work through the process himself. This act is a form of resistance. Allan resists the ageist discourse that to be old is to be cognitively impaired and argues that he still has the capacity to try to solve the problem first without input from health professionals.

I had a change in medication. That wasn't the only thing I was doing to try and ease my Parkinson's. It is hard to pinpoint what would cause the nightmares. I am always trying something different, diet wise or more sleep or something to try and get relief [Allan, p.3].

*So you think that your delirium was related to the medication you were taking?
[Stephen, interviewer]*

Yeah it was. But that is only my opinion. I am no expert. I tried to analyse everything I did to see if what I was doing would increase or decrease. I tried sleeping more, sleeping less and working harder [Allan, p.5].

Although Allan is taking responsibility for his own health and experimenting by manipulating his environment he is also deploying self surveillance strategies, that of monitoring his own health status. By undertaking a process of experimentation Allan was able to reach a conclusion that his nightmares were related to his Parkinson medication which is affirmed and documented in his clinical records. However, what is legitimated as 'truth' originates through the deployment of the discourse of delirium as a syndrome, and via the clinical notes written by the physician and nurses. Allan's text of his discovery is absent as it is not documented.

Allan also claims that some of the treatment regimes deployed were not in his best interests and did not aid in his recovery from what he termed 'the nightmares':

Well I get the impression in the old people's ward that they are trying to get the old people to do as much as they can for themselves. But I think there is a limit as to what we can do. At home I have got everything I need to hang onto, rails etc. I can get around quite fast ... When I got here they took all the rails off my

bed and the monkey bars off my head of the bed so I can't get up so well. I am supposed to get up and around on my own but I can't and that upsets me [Allan, p.9].

In addition, Allan also identifies how he mistakenly wet the bed because he didn't have a monkey bar to help him get up and therefore reach his bottle on time. As a result at night the nurses put on a urodome and attached this to a leg bag strapped to Allan's leg.

... I started to wear these bags. You know the ones you can wee in and make less work for everybody. You know. They are quite simple but I couldn't manage them because of my tremor. The pressure of the bag on my leg gets so great that it makes my leg jump so I took it off and wet the bed. The nurses were very short with me [Allan, p.10].

Examples of families being experts about delirium in relation to older people are also evident in the transcripts. Martha felt that the health professionals dealing with her father did not listen to her family, resulting in them not recognising he had delirium.

They didn't realise that dad was delirious. I kept saying "this guy has delirium". They were shouting at him as though he were deaf. They would shout "Mr [X] for god sake stop trying to pull that IV out". I said "the man is delirious". She just ignored me ... They kept shouting at him ... they were trying to ...but they weren't explaining what they were doing but they were also getting very upset which was transferring onto all of us [Martha, family, p.6].

Further on in the transcript Martha reinforces the position that health professionals are not always the experts.

The GP, who came out to him had made the assumption that this man couldn't cope and that he wasn't being looked after by his family. He didn't realise that dad had been puttering around for two days really unwell and that is why he had been incontinent. The moment I saw him I knew he was delirious. It was the look on the face and in the eyes. It is like people who sleep walk. You can actually see behind their eyes ... there was nothing there [Martha, family, p.11].

If health professionals deployed a personal discourse of delirium through privileging the social, cultural and historical aspects of the person then they would have wondered

whether Martha's father's behaviour was out of character. In addition, if they had asked his family about his recent health history they would have learnt that he had experienced three previous episodes of delirium prior to his recent hospitalisation.

However, the privileging of a personal discourse of delirium is evident in some of the texts produced by health professionals, for example, those generated by the nurses and doctor who make up the delirium team.

It is really helpful if someone from the family says "they were so different yesterday". Often that is not identified somehow. If you get someone who just comes in ... they might come in in the middle of the night and you think "oh god they are eighty-seven and are they always like this?" Then the family comes in the following day and says "oh no he is usually off to bowls and doing this and that". That is really good [Rachel, nurse, p.16].

This position is a dichotomous contradiction from the practice of nurses (those who are not members of the specialist delirium team) working with people who have been delirious and families. Rather than acknowledging the expertise of the person through incorporating their perspective on their health event they position them as non experts by formally documenting ...

Background

... Vague historian, seems rather confused. Not orientated to time/place/or person [Connie, clinical notes, p.1].

Referring to Connie, under the heading of 'Background', as a 'vague historian' denies her the opportunity of being taken seriously and offers a subject position that she has always been confused, old, cognitively impaired and therefore unreliable. Up until her admission Connie had been living with her brother and had regular contact with her niece, all of which is not evident in her initial nursing assessment data. The nurse undertaking an initial assessment of Connie could have spoken to her family, who visited regularly, to find out more about her past so others working with her could place her within a context outside of the institution. Paterniti, a critical gerontological writer, claims:

[T]his leaves residents undistinguished and their experience framed in terms of the daily practices of "bed-and-body work" – the routine cares of nursing

assistance in such facilities. It is a story bereft of personal meaning, which in the case of the nursing home, dissolves residents' individuality into institutional practices (2003, p.58).

On the other hand, the doctor who is a member of the delirium team is critical of nurses' abilities to listen to families/significant others ...

I think the nurses don't recognise just how valuable the families can potentially be as a source of information about their relative. If they spend time with the families and listen to their concerns and list them as co-carers it may make their task a lot easier [John, doctor, p.8].

Interestingly enough John goes on to admit ...

I haven't had the opportunity to spend a lot of time with families of people who have been delirious I really have to say [John, doctor, p.9].

On one hand, recognition is given to the importance of taking notice of the stories provided by families about the older person who is delirious, and there is criticism of nursing who it is claimed do not take the time to listen. However, John admits to not spending time with families either. In addition, it appears from the excerpt that the focus of listening to families is only to make the nursing tasks associated with providing health care to people with delirium easier rather than developing some understanding of the personal experiences associated with being an older person who is delirious.

Nursing prides itself on utilising the concept of holism to underpin nursing practice when working with older people (Eliopoulos, 2005; Reed, Stanley & Clarke, 2004). In the case of this research an integral component of holistic nursing practice is knowing about and attending to the social, historical and cultural aspects of older people who have been delirious and their families. However, the rise of evidence based practice, also known as evidence based nursing has been seen by many as having seduced nursing into believing the result will be best nursing practice (Nagy, Lumby, McKinley & Macfarlane, 2001; Street, 2001; Walker, 2003).

Positivism and empiricism are key features underpinning evidence based practice and these forge what Foucault (1980a) refers to as a regime of truth. In the instance of the present study, the intertwined nature of positivism and empiricism has authorised a

certain 'truth' about delirium to be circulated via the deployment of the discourse of delirium as a syndrome. This 'truth' is generated, circulated and upheld as the gold standard for delirium cares through the production of knowledge via the use of randomised controlled trials (see Cole, Fenton, Engelsmann & Mansouri, 1991; Cole et al., 1994; Cole et al., 2002; McCusker et al., 2001). Randomised controlled trials are viewed as providing the highest level of evidence (Evans, 2003; Thompson, 2003). Localised and personal knowledge in the form of participant accounts, do not conform to the essentialist notions of 'truth' about delirium as prescribed by evidence based practice and played out via the discourse of delirium as a syndrome.

Personal knowledge is specific to each person's life and provides a rich tapestry of evidence that does not conform with traditional notions of rigour associated with evidence based practice (Rycroft-Malone et al., 2004). The privileging of a personal discourse of delirium allows the notion of personal expertise to surface. The emergence of this subject position resists the professional assertion that the only way to knowing the 'truth' about delirium is through the deployment of the discourse of delirium as a syndrome.

9.3 The specialist nature of working with older people

Providing a nursing service to older adults who are delirious in any hospital setting presents a number of opportunities and challenges. Opportunities include undertaking a person centred care approach when working with older people that enables members of this population group to actively participate in their care through what Nolan (2000, p.24) terms "interpersonal mutuality". Unsurprisingly, challenges include the establishment of a therapeutic relationship that is integral to enabling older people to actively participate in their care.

Gerontological nursing is being heralded as a distinct nursing speciality with a specific set of knowledge and skills required in order to provide a nursing service that meets the needs of the older adult in a timely and age appropriate manner (Eliopoulos, 2005; Miller, 1999; Nolan, 2000). Consequently, there are as many commentators on the knowledge and skills required by gerontological nurses as there are perspectives. However, certain commonalities are evident and these can succinctly be encapsulated in

the elimination of ageist practices, the promotion of person and relationship centred care, and valuing interdependence (Nolan et al., 2004).

The texts clearly identify differences in approach in an assessment, treatment and rehabilitation setting specifically for older adults as compared with treatment/care offered in an acute general setting. A registered nurse who works as part of the delirium service articulates the difference between the acute hospital and the assessment, treatment and rehabilitation hospital in the following manner:

Comparing nursing at [ATR hospital] to public for me is so grossly different. I think from a point of view of a nurse at public to [ATR hospital] is sort of the poor relative, where it has a lower profile. It is just not highly thought of. It is where you go when you can't do real nursing. Having had the experience of both I can see where the experience and the real expertise lies [in the specialist hospital for older people]. At [ATR hospital] it is a holistic thing. It is not just a technician running around (Sandra, nurse, page 6).

This excerpt also refers to an ageist discourse that suggests that if you are old you have no worth and by association if, as a nurse, you choose to work with the older adult then you are not considered to be as credible as the nurse who works in the technological environment of an acute hospital setting. It has been well documented that choosing to work as a nurse with the older population is not an attractive career option and is sometimes referred to as the 'Cinderella' of nursing (McCormack & Ford, 1999; Nolan & Tolson, 2000; Reed & Clarke, 1999). However, in light of the demographics associated with the utilisation of hospital services, the older population are high users of acute nursing services.

Sandra resists the subject position of 'Cinderella' by identifying that nurses choosing to work with the older adult, as a clinical specialty take the clinician back to the very essence of clinical practice, that of holistic nursing practice. This view deploys a personal discourse of delirium. However, Sandra identifies this is in opposition to nurses working in an acute setting whose major concern may be on the technical aspects associated with caring for the physical body which can be aligned with the discourse of delirium as a syndrome. Sandra's assertion here espouses rhetoric surrounding the core beliefs underpinning gerontological nursing practice.

Earlier in this chapter, members of the delirium team identified the importance of recognising the family as a legitimate source of information about their family member and their needs. This is articulated here by two family members, Mary and Henrietta, who describe the difference between the care received in an acute hospital setting and that in an ATR hospital specifically focussed on the older adult.

Well that is their specialty down there isn't it? And the fact that he has his own room in a quiet environment and the rest of it. A big difference. He will feel as though it is more like a home and not a hospital so much. Staff not wearing uniforms and that sort of thing. We certainly feel a huge relief that he is there. I think we feel really confident that the best outcome that can be got. He will have the best opportunity to get the best outcome there. I feel as though we would be contacted before any decisions would be made. I feel really confident about that, and that he will get good overall care. His mental health will also be provided for as well as his physical state. At Public they clearly struggled with meeting his mental health needs because it isn't their specialty (Mary, family, p.24).

[At public] they seemed to ignore dad and us at the same time which my sister [R] was getting a bit peeved with. They would do things to dad and leave the sheets down and so he was totally exposed and walk off. So we would tuck him back in again and they would come back and do something else and leave him untucked. We would have to tuck him in again. Whereas over here the nurses I found were very good because they just interacted with us, you know and are so so human [Henrietta, family, p.17].

When asked what made the difference between the acute care hospital and the assessment, treatment and rehabilitation hospital that specifically focuses on older people the reply was ...

I found they were just too busy [at Public], they just didn't have the time to do all those things they do at [ATR hospital]. If we didn't go in at the right time and get the right nurse no one else would give you any information. You would get a lot of run around. At public I never met his primary nurse whereas over here we

have quite a lot of contact with her. It was very frustrating [Henrietta, family, p.18].

The above excerpts demonstrate that family members recognise and value a specialist gerontological nursing focus as an important component of providing care to family members who have delirium. The focus in both of the above texts resists the discourse of delirium as a syndrome and its preoccupation with addressing and meeting the physical and technological needs of the delirious body. Instead, value is placed on nursing care that is founded on the concepts of holism, a core component of gerontological nursing practice (Eliopoulos, 2005; Reed et al., 2004).

In the ATR hospital the family was included as an integral part of the delirious experience. This is a strategic move on the part of the hospital as contemporary literature suggests including the family in the caring process breaks down some of the traditional barriers existing between health professionals and lay carers (Allen, 2000). On discharge it is usually the family who supports the person who has been delirious and so it would be prudent to ensure they are well versed with all aspects of the health and care needs to ensure successful readjustment into the community.

Gerontological nurses working in the ATR area may have actively promoted the involvement of the family because the older person with delirium, or a resolving delirium, may be unwilling or unable to express themselves. Family members may be able to interpret gestures and noises that have no meaning to the nurse providing care. Therefore families act as, not only a reliable source of information, but also an advocate and in some instances an interpreter for the older person (Isola, Backman, Voutilainen & Rautsiala, 2003).

As earlier identified, nurses working in the acute care setting also have considerable experience in working with older adults but the perception of care received is markedly different. Obviously the focus in the acute setting is the stabilisation of the delirious episode and so through the deployment of the discourse of delirium as a syndrome, the physiological basis for the confusional state is given primacy.

9.4 Appropriate and suitable staff

It is clearly evident in the literature that keeping an older person safe while they are experiencing delirium is an important component and focus of any nursing action (Caraceni & Grassi, 2003; Foreman et al., 2003; Truman & Wesley, 2003). Failure to address the safety of an older person who has delirium is not only professionally remiss but also increases the occurrence of iatrogenic events, such as falls which are likely to trigger a negative trajectory of health events, such as hip fracture for the individual. The importance of monitoring safety is highlighted in the following excerpt:

Probably the biggest problem with the management of the delirious patient is recognising that they need to be kept safe ... [Sandra, nurse, p.16].

The focus on decreasing risk and maintaining safety for an older person who is delirious requires a specific skill set by the nurse. Foreman et al. (2003, p.118) identify the key principles involved in minimising risk and maintaining safety include "... administering medications judiciously, preventing infection, maintaining fluid volume, promoting electrolyte balance, encouraging mobilization, and engaging in cognitively stimulating activities. The second principle is to provide a therapeutic environment and general supportive nursing care". The above quotation identifies that older people who have delirium require specialist nursing care by a skilled and educated nursing workforce if a positive health outcome is to be achieved.

In the present research older people who had delirium, and required specialist care, were frequently provided with an unskilled and untrained person as evidenced below:

... the people who are delirious, old and/or frail having the casual nurses, pool nurses ... just anyone you can get. Often the care is not as good as can be. You know people know that you have to make sure that people have a drink. The drinks get missed, they might miss their lunch. They need their lunch ... You know no one knows when they last went to the toilet [Rachel, nurse, p.9].

The sitters are so fat and lazy they need a boot up the bum. They sit there and they will be reading their book and I will be saying "don't sit there and read your book. You could make sure that they get a drink every so often" [Rachel, nurse, p.16].

... they give them those nursing custodians. These nurse custodians ... or sitters are not in the main equipped to do the job ... They have no experience of knowledge about what is going on so often it can make it more difficult and make the patients sometimes worse [Sandra, nurse, p.17].

Alternatively if the person required a registered nurse then they were frequently provided with the casual nurse who was only on the ward for the evening, the consequences of this are described below:

... you can't expect the casual nurse just to pick up on that when she is there for only one night. I think that is the great tragedy of casualising nursing ... There was a high number of casual staff and two of the people I talked to said "I don't know anything about him but I will look up the notes to see what the doctor said today". So it wasn't as if the nurses weren't helpful when we could find them. They just didn't know. I believe that he could have been in a ward where they had consistent staff on and there would have been a completely different experience [Mary, family, p.20].

... It just reinforced to me having to know your client because unfortunately every time I went there was a different nurse I had to talk to. I seemed to always explain that he had been in hospital for fifty years. I thought that it would have been useful if they had of provided a little profile ... Like just a page, so someone gets just a little picture, some background about the things that are really relevant for them. I always seemed to have to tell them that he had been in a psychiatric hospital and go through the story again [Mary, family, p.8].

The literature available on delirium has remained unchanged in the view that one of the corner stones in non pharmacological management of the phenomenon is to ensure that a skilled and consistent group of nurses are assigned to work with an older person experiencing delirium. For example Caraceni and Grassi (2003, p.154) state ...

... staff members who care continually for the patient should be maintained in their rotation scheme, so as to avoid the patient being attended by new, unknown, and unfamiliar professionals. Creating an atmosphere of trust is easier

if the patient is familiar with at least one nurse per shift. This reduces strangeness and reinforces alliances and interpersonal relationships.

Allen (2000) and Reed et al. (2004) claim that knowing an older adult (through deploying a personal discourse of delirium) is a vital component of providing a nursing service to older people. In addition, these authors identify that the trend toward the utilisation of untrained caregivers' further challenges registered nurses' ability to get to know older adults as it is this group of non-professionally qualified personnel who work most intimately with this population group.

Creating an atmosphere of trust is not only important for the person experiencing delirium but also for the family. This is evidenced in the previous section where Mary is confident that a positive outcome will happen because her uncle has access to a gerontologically skilled group of nurses. Many gerontological texts outline the importance of considering and/or attending to the family when working with an older person (see Anderson, 2003; Eliopoulos, 2005; O'Neill, 2002). Gaining the family's trust in the nursing service being provided to the older adult who is delirious opens channels of communication and serves to allay the family's worries about the health and well-being of their loved one.

The experience of discomfort and/or stress was portrayed in each of the texts presented below about the appropriateness of assigning a person from another culture to the care of an older man. Each of the men represented below had served in World War II in the Pacific region against the Japanese. Henrietta begins by providing an example of where her father resisted being cared for by a person from another culture in the following excerpt:

When he first came into the hospital on the Saturday he would go floppy all of a sudden and then the next thing he would be making his arms go all stiff. This happened especially with the Asian one [the nurse] ... it was in his body language, his manner. He is quite racist [Henrietta, family, p.27].

Similarly Mary's uncle had served in the Second World War and one day a nurse from the Philippines had been assigned to his care.

The nurse ... there was a nurse from the Philippines, a male nurse. He seemed to be doing more than what the other nurses, the sitters, were doing. But anyway he seemed really nice ... But uncle [J] was not very PC [politically correct] and was saying really inappropriate things because he was from the Philippines and he had fought in the Second World War and served in the Pacific against the Japanese [Mary, family, p.18].

In addition Allan provides the following dialogue ...

... I'm not against coloured people but they seem to have two or three classes of nurses in learning stages working with older people. That put me down. The language in the background all the time ... I don't like the foreign voices all the time. You hear it and sometimes it gets a bit garbled. I am also getting a bit deaf which doesn't help [Allan, p.15].

A first read of the above excerpts could suggest that each of the speakers is inherently racist toward people from Asian cultures, in particular, those working with them. A plausible explanation is that each of these men has seen active service against the Japanese during the Second World War and due to their ill health are unable to discriminate between various Asian cultures. However, Allan intimates that another reason is the inability to discern what people from another culture are saying due to the effects of hearing loss.

Extraneous and unfamiliar background noise such as the garbled voices to which Allan refers, when combined with the strange and often threatening environment of the hospital ward, can lead to misperceptions and heightened anxiety contributing to delirium. Sensory overload is commonly associated with delirium (Caraceni & Grassi, 2003; Foreman & Zane, 1996; Levkoff, Besdine & Wetle, 1986). Sensory overload is compounded by the sensory deficits, which in Allan's instance pertains to hearing loss. The ubiquitous noise from the hospital environment, including what may be incomprehensible communication from nurses whose primary language is not English may increase stress and contribute to agitated, and/or aggressive/passive behaviours (Foreman et al., 2003; Francis, 1992).

9.5 The (mis)communication of communication

The previous section has demonstrated that the utilisation of health professionals for whom English is a second language, and the casualisation of the nursing workforce is problematic for the recipients of care whether they be older people themselves or their families. Problems communicating with health professionals appeared to be a commonality within the texts. These miscommunications negatively influenced the care received. A breakdown in communication was often distressing for their families who were worried about the health and well-being of their family member.

Communication is an integral component of gerontological nursing practice with Anderson (2003) asserting that it consumes approximately 85% of nurses' time every shift. The skilful use of communication techniques by nurses is essential in gaining assessment data as the basis for providing quality care to a person who is delirious and their family. Weber and Kelley (2003, p.35) caution nurses about not taking enough time to communicate effectively by stating "[T]aking time with clients shows that you are concerned about their health and helps them to open up. Finally, rushing someone through an interview process undoubtedly causes important information to be left out ..."

The following excerpts provide evidence as to the consequences of what happens when inappropriate communication occurs. Mary begins by recounting a situation whereby she, as a family member, knew that her uncle was not drinking adequately and felt that if the staff had spoken with her they would have found out a way of ensuring his hydration needs were met.

I'm not sure what the sitter's task is but I just felt things weren't done. Just because he didn't want water once it should be reoffered later because you might get a different response. I think that they could have been a bit more proactive, you know because one could see that he had an infection and should be drinking and he wasn't drinking much which was a concern. We had provided lemonade and other drinks that he liked. I thought that could have been monitored a bit more closely. There could have been a chart at the end of the bed or something. If there was we could have just written down what we had

given him. I was just told that he was not eating or drinking but I knew that if you persevered he would [Mary, family, p.21].

No one had communicated to Mary what the role of the sitter was and what they could do. Either the registered nurse assigned to her uncle should have met with the family to discuss his care needs, or the sitter should have introduced who they were and what their role was. Doing so would have improved communication and trust between the health care provider and the consumer of health services. If the ethos of the health care provider encompassed Nolan's (2000) notion of interpersonal mutuality the registered nurse, sitter and older person, in conjunction with Mary (family member) would have engaged in communicatively mutual dialogue. The outcome of this dialogue may have been that Mary's uncle would have had a chart at the end of the bed which everyone could then mark off when he had a drink. The published literature on delirium in the older adult clearly links dehydration as one of the causative factors contributing to a delirious episode (Jacobson, 1997; Menten & Buckwalter, 1997). It is therefore imperative that all people involved in working with the person with delirium monitor fluid intake until this fundamental physiological requirement is able to be met independently by the older person.

Henrietta also describes an experience which speaks of the consequences of poor communication but this time in relation to her father being restrained.

Quite often I would get a phone call from him and it was really terrifying. He had been in jail when he was much younger and he was saying things like "they are going to tie me up to the posts and they are gonna kill me, they're going to get me" ... and it was just terrifying, he made no sense at all. I thought "Oh my god what are they doing to him in there?" He said "The people in here want to kill me and the nurses are after me". Here I was with these wee kids and nobody really to ring because everybody else was working. That was really hard, you see they were taking him off the morphine and he was going into delirium and reliving his past [Henrietta, family, p.6].

This is also echoed in the following text produced by Mary ...

... of course restraint is something else. He had been secluded many times over the years because of his elevated mood. So he would have probably associated

being restrained [this time in hospital] with that. You see he is on chair restraint and he spends all his time pulling at the straps [Mary, family, p.23].

So he has been restrained? [Stephen, interviewer]

Yes a sheet tied to him and the bed rails up. I can understand that from a safety point of view because he was trying to get his leg up and over the side. I guess a lot of the time he would have thought he was in a seclusion room. The interesting thing is when I took the table away he did just sit there [Mary, Family, p.24].

The use of restraints in the non-pharmacological management of older people with delirium has been shown to be ineffective, hazardous, and an indicator of poor quality nursing care (Sullivan-Marx, 2001). Impaired cognition frequently predicates the use of physical restraints in the older population with its use being all the more salient in delirium. Physical restraints increase the risk of delirium through associated factors, such as dehydration, bladder and bowel incontinence, pressure ulcers and frightened and disorganised behaviour (Mion, Strumpf & NICHE Faculty, 1994; Sullivan-Marx, 1994; 2001).

The two men depicted in the excerpts above were restrained even though the literature published, via the discourse of delirium as a syndrome, opposes this regime of care. In addition, there was minimal concern for the consequences of this action on the older men, as well as the impact on their families. Both Henrietta and Mary intimate that if the nurse, identified as being responsible for their relative's care, had moved beyond the technical aspects of providing a delirium service to deploying a personal discourse of delirium then the outcome may not have been as traumatic. In other words, if the nurses working with Henrietta and Mary's family member attended to their context then they would have realised that any form of physical restraint was inappropriate.

Obtaining information about a person's social history is an integral component of any health history (Jarvis, 2004; Milligan & Neville, 2003; Weber & Kelley, 2003). By deploying a personal discourse of delirium and asking pertinent questions of the older person or their family, then the nurse would have realised that other non-pharmacological means would have been more appropriate as both men had experienced being restrained through imprisonment and seclusion due to mental illness.

Psychological distress manifested as anger and increased agitation are synonymous with being restrained (O'Connell & Mion, 2003). This distress is also communicated to the families of both of these men causing worry to both Henrietta and Mary.

As earlier identified, the published literature promotes a stable, consistent and routinised environment as positively promoting recovery in older people with delirium. The utilisation of orientation strategies has also shown to aid recovery from a delirious episode. Orientation strategies include techniques such as calling a person by name and stating what day and time it is. However, orientation strategies are not always deployed as evidenced in the following text.

The next day when I went in he seemed much improved and he was sitting in a chair. I was able to sit beside him and he was able to say hello. The nurse was a different one from the day before and said "Who is that John?" I said "Oh his name is [S]". She said "Oh it has got John up there". So I said what his name was and that they needed to get it changed immediately [Mary, family, p.6].

Mary describes a personal situation whereby her uncle had been called by the wrong name over a period of time, which illuminates the potentially contradictory terrain of nursing practice. Nursing practice is fundamentally therapeutic and interactional, the essence of which is based on communicative relationships. The focus of any communication between nurse and client should be of benefit to the recipient of care (Bradley & Edinberg, 1990; McMahon, 1992).

The above text challenges the communicative and therapeutic influences of the nurse as a provider of care. Nurses working in acute hospital settings frequently focus their attention on the technical aspects of care to the detriment of promoting/maintaining personhood (McMahon, 1992). Since the emergence of delirium as a stable medical entity, evidence relating to the non pharmacological management of delirium promotes the utilisation of orientation strategies. These strategies include "... frequent orientation, reassurance, and help interpreting his environment ..." (Foreman et al., 2003, p.121). This should include introducing the care staff and inquiring how the older person would like to be addressed. This did not occur in the above example.

In addition, incorrectly calling the older gentleman above 'John' is further evidence of ageist practices. The focus on fixing the technical aspects of the person is paramount with the person themselves being positioned on the margins of the delirious experience. Ageist discursive practices have been explicated in greater depth in chapter seven, and include the subject position of 'older people have diminished value'. In this instance, not only does being old not matter but being called by the correct name is also inconsequential. This view is supported by McLafferty and Morrison's research investigating nurses attitudes to hospitalised older adults which found that "[N]urses don't always bother to learn the name of an older patient" (2004, p.450).

(Mis) communication occurs at all levels of the health care system from the ward clerk to the consultant through to the nurse as evidenced below ...

I would ring the registrar and try to get something out of them but the registrar was never available. So I would talk to the ward clerk because she is the one who has all the information about the patient and tells you who he's under and who the specialists are. One day I rang the ward clerk, she said "No Mr [R] is not under Dr [M] any more and I can't tell you any more, it is confidential. You will have to talk to the surgeon. Well I tried to get hold of him but no he was not available and so it went on, round and round in circles. I gave up in the end. I just thought I can't handle this anymore. I don't know where my father is at let alone me. If I go in they say "Yes we might be able to get the specialist to come in and talk to you but they are busy". Not even dad knows what is going on. He goes "they tell me this and they tell me that but I don't what they are doing". And then yesterday he again said that he doesn't know what is happening [Henrietta, family, p.17].

The people working in the acute setting, as portrayed in the above text, are positioned authoritatively and their views of what information can be given to who are presented as being irrefutable which results in Henrietta feeling confused and unsure. In addition, my reading of the above text suggests there is little personal investment on the part of the institutional staff in developing a communicative relationship with Henrietta. Henrietta finds herself positioned on the margins of an acute medical service. Before her father's admission to hospital she was a key person in his life and therefore intimately connected with his daily concerns. This relationship has been interrupted and the institutional

practices of the hospital have excluded Henrietta from knowing her father. This is supported by both Gilmour (2001) and Schofield (1996) who found that the medical model of care and hierarchical structuring of hospitals were significant factors negatively impacting on family members being actively involved in their family members care.

The lack of communication between a family member and the people working in the acute setting, as outlined above, is imbued with power and reflects a certain power differential (Lupton, 1995). The discursive formation of the above delirious body is supported by the hospital environment and the practices of both nursing and medicine. The hospital environment acted to silence Henrietta in her quest to know and be kept informed about her father's delirium through the use of administrators, who stand as guardians to the people who know the truth about the patient concerned.

When I asked Henrietta what some of the things her family needed were, her response was:

We needed someone to sit us down and tell us really what was happening. Is he ever going to go home because if he does he is always going to have a problem with the cancers and things like that [Henrietta, family, p.19].

However, this text stands in contradiction to the one presented below. An explanation for this contradiction may be in the different care settings and highlights the divisions evident between the acute hospital and the assessment, treatment and rehabilitation hospital that specifically focuses on the care needs of older adults (outlined earlier in the chapter).

They [nurses] have looked after him wonderfully well ... They have always communicated with us as a family and we felt we were always kept in the loop. Anything I asked about they were quite willing to sort out for me [Allanah, family, p.14].

Henrietta highlights that as a family they needed to be kept informed about her father's progress. Conversely, Allanah, whose experience is in the ATR hospital, praised the nurses' ability to communicate to the family about her husband. She used the metaphor 'being kept in the loop' to describe her experience. The notion of loop can be

conceptualised as being enclosed. Allanah is part of the loop, enclosed in it, while for Henrietta the loop has been closed and she has found herself positioned on the margins of communication.

9.6 The discursive practice of being labeled ‘at risk’

Nursing options in the management of the risks associated with an older person who is delirious involve the utilisation of both pharmacologic and non-pharmacologic interventions. These interventions were outlined in greater depth in chapter five. What will be exposed in this section is how the deployment of the risk sub-discourse may not always be in the best interests of the older adult who has been delirious.

Nursing assessments are frequently concerned with the assessment of risks. For example, Farahmand (2001, p.250) identifies that it is imperative for nurses to formulate nursing diagnoses for actual and potential risks in relation to confusion by stating “*Risk for Injury* – state in which an individual is at risk as a result of environmental conditions interacting with the individual’s adaptive and defensive resources. Poor judgement, confusion, impulsivity, and wandering are of concern”. The focus on the identification and management of risks associated with older adults who are delirious subjugates a personal discourse of delirium, while concomitantly privileging the discourse of delirium as a syndrome.

While I do not doubt the appropriateness and necessity of keeping a person safe who is experiencing delirium, the discourse deployed to manage issues of risk should not be accepted uncritically. The following texts provide a commentary surrounding the deployment of the discourse of delirium as a syndrome in managing issues of maintaining safety for Betty.

The family have concerns about [person’s] safety as she leaves her doors unlocked – lives at the back of a school. Plan – to talk to [person] about care options when she is better [Betty, clinical notes, p.15].

This position is reasserted further on in the clinical notes, this time at the multidisciplinary meeting:

Wants to go home. Family ? looking at rest home ? concerns re safety and want her in care [Betty, clinical notes, p.20].

Family meetings are a core component of receiving rehabilitative care for the group of older people who participated in the present research. These meetings involve all members of the rehabilitative health team, in conjunction with the older adult and members of their family to discuss issues such as ‘where to from here’. The focus of family meetings should assist consumers of the service and their families to meet mutually agreed on goals in a supportive, inclusive and positive environment (Hargrove & Derstine, 2001).

However, Betty’s own views of family meetings are less than complementary ...

What good are they? If I had a mind to I would take my suitcase down off the wardrobe, pack it, walk out the gate and catch the bus to [suburb]. It would take me right through to home.

So you don’t think anything good or useful is going to come out of the family meeting? [Stephen, interviewer].

No. it will only be to get me family help. Well I had family help twice a week ... I think I am well enough to go home [Betty, p.12].

I just want to go home ... Yes I am well enough. If I could get home I would be alright I think (Betty).

What do the rest of your family think? (Stephen, interviewer).

“Stay in hospital”. Well I am sick of being in hospital. They say “stay there until you get better”. God I might be here forever. [No] I want to get home to my cats. One is a great big black and white one. God knows where he came from. The other is a little tortoiseshell one (Betty, p.3).

The above excerpts all relate to issues of risk and safety in relation to Betty and are provided from several viewpoints; health professionals (including nurses), members of the family and from Betty herself. It is apparent that the health professionals and the family think Betty should go into a care facility and move out of her house, whilst Betty has become preoccupied with going back to her own home.

Armstrong (1995) utilises Foucault’s (1994) conceptualisation of the clinical gaze to expose how surveillance has escaped the walls of the hospital to infiltrate the personal spaces associated with older people’s homes.

Not only is the relationship between symptom, sign and illness redrawn but the very nature of illness is reconstrued. And illness begins to leave the three dimensional confine of the volume of the human body to inhabit a novel extra-corporeal space (Armstrong, 1995, p.395).

Not only is Betty being represented as a set of problems associated with the signs and symptoms of delirium but she is now being subjected to another diagnostic tool, that of assessing for risk, which further pathologises Betty's body. Through comments made by the family about aspects of Betty's behaviour in her own home health professionals, including nurses, can legitimately, as Chater (1999) asserts, include risk as a diagnostic tool to diagnose extra-corporeal spaces.

In this instance, Betty's older delirious body has been interpreted as pathological, in a current state of illness, at risk and consequently in need of surveillance through the deployment of the discourse of delirium as a syndrome. Betty's family willingly, or unwillingly, have collaborated with health professionals to offer a subject position to Betty of being at risk. The extension of the clinical gaze beyond the confines of Betty's delirious body into her home and section has formed part of her treatment plan, that of being placed into a care facility. Therefore the identified risks to her safety through living alone, down the end of a long drive, backing onto a school has challenged her status as an older adult that can only be matched by that of infancy, thus offering the subject position of second childhood through the disciplinary practice of infantilisation.

An explanation for Betty's family collaborating with health professionals may be explained through Kolb's (2003) work which identifies how ageist discourses influence family dynamics. Kolb contends that family members tend to make paternalistic decisions if they have a negative attitude toward older people in general. This is evident in the above excerpt where Betty's family think it is in her best interests to go into a care facility even though Betty herself is adamant that is not what she wants. Betty's resistance strategies are to constantly assert her desire to go home and demonstrate that she is capable of living alone through being able to articulate how she could pack her bag and catch the correct bus, which incidentally leaves from outside the hospital gates, to get back to her home. Doing so deploys a subject position of an independent capable older woman who can look after herself.

The notions of risk and non-compliance are also closely related (Chater, 1999). Being a noncompliant at risk older adult, who is delirious, further invites the clinical gaze to leave the confines of the physical body and extend into the extra-corporeal social spaces (Peerson, 1995). Therefore being compliant, and by association, not criticising the quality of care received, may be a resisting strategy by older adults who are delirious. A commonality exists in the texts produced by people who have been delirious around a general reluctance to criticise the nursing care received.

The initial responses from three older people who had been delirious were as follows ...

I am reluctant to criticise them. They have done a hell of a good job (Allan, p.8).

I haven't been digging my toes in because it is not worth it ... it doesn't get you anywhere. I just put my head down and do as I am told [Betty, p.15].

When you start complaining you are starting to get well ... I don't complain enough I think. I didn't really [Lilly, p.15].

If I hadn't of had my daughter here they would have wanted me to go to a convalescence home for a little while ... I wouldn't have enjoyed it but if they had of wanted me to go I would not have put up any barriers [Lilly, p.21].

Each of the texts presented above assume both a passive and a subject position of doing as they are told. This reluctance to criticise the quality of the health care service received by older people who have been delirious is present in the gerontological nursing literature (see Isola et al., 2003).

The disciplinary project of older person's health has produced a docile body in need of surveillance, and therefore one that is reluctant to criticise. Foucault's (1978) articulation of normalising disciplinary practices illuminates how older people who have been delirious become the subjects of what Foucault describes as disciplinary power. Each of the above speakers demonstrated a reluctance to challenge outright the care they received. Instead these older adults provided a regulated response according to the historical, social and cultural contexts associated with their chronological ages. For example, both Gould (1992) and Isola et al. (2003) claim that older people grew up in a period of time where they were socialised into being content with little and therefore grateful for any form of assistance no matter how small.

9.7 Summary

The concluding comments do not culminate in the creation of a what Lyotard (1992) coins a grand narrative, a definitive list of tasks nurses should undertake to provide an appropriate service to people who have been delirious. Rather my intention has been to promote the heterogeneity of the older people who have been delirious.

Generally the politics of knowledge production do not allow people in this study to question the legitimacy and authority of the discourse of delirium as a syndrome as well as the nursing service provided. Walker (2004) asserts that to do so would seriously destabilise and jeopardise the very foundations of what presently passes as knowledge. This has been the focus of this chapter and suggests why those knowledges described by Foucault (1980b, p.82) as “disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity” have been foregrounded as another epistemological view.

So far in this thesis I have demonstrated how the dominant mode of knowing the ‘truth’ about delirium is through the deployment of the discourse of delirium as a syndrome. I have problematised this dominant discourse through the promotion of personal discourses of delirium and the variety of knowledges that older people who have been delirious and their families bring to the wider field of delirium. It is imperative to continue to propose new ways to (re)represent delirium so as to nurture and value human kind beyond adulthood into old age through the promotion of personhood. Doing so takes nursing back to the core of its existence, the notion of professional caring.

This chapter now completes the analysis and discussion of the research findings. The final section of this thesis deals explicitly with the relevance of this work to nursing practice, research and education, as it stands now and as it could be in the future.

Chapter Ten: Final reflections and concluding comments

10.1 Introduction

The time has now come to pull together the central tenets of this thesis so that the theoretical work of critical gerontology, postmodernism and Foucault coalesce. Recognition needs to be given to each of these theoretical positions, as they have provided me with the tools to undertake this discursive analysis connected to delirium in older adults. I chose these three frameworks for their potential to expose the diverse discourses that comprise the discursive field of delirium, and to call to question the taken for granted assumptions associated with providing a health service to this group of people. I offer in this, the final section of work, a summation of what I have learnt from addressing each of the three research aims identified in Chapter one. I also provide an expression of future possibilities and understandings about delirium in people over the age of 65 years that may help to shape or reshape nursing practice.

I begin this chapter with revisiting the research aims and providing a summary of the main findings presented in this thesis. Then I present the possibilities for improving nursing, which includes a section on the construction of a fictitious nurse called a critical gerontological nurse. This nurse has been constructed through the critique of care received by people who have been delirious and their families, and through the deployment of many discourses. This reconstructing of nursing care offers a fragmented and partial account of how to work with people who have been delirious and their families. Finally the limitations of the study are presented along with suggestions for future research.

10.2 Revisiting the aims of the research

The utilisation of a critical gerontological and postmodern perspective, along with aspects of Foucault's work, was instrumental in the development of the research aims framing the present study. The aims of this study were three-fold. Firstly, to interpret the meanings embedded in the discourses surrounding delirium via the collection/analysis of relevant published documents. Various documents, including

published research articles, posters, textbooks and clinical records were sourced, as well as texts produced from interviews with people over the age of 65 who had been delirious, their families and health professionals (two nurses and one doctor) who were involved in providing a delirium service. These data sources formed the foundations for the discourse analysis undertaken.

The second research aim focused on exploring the discursive production of older people with delirium. A variety of comparable, competing, and at the same time, contradictory discursive positions were identified as comprising the social construction of the older person with delirium. The third and final research aim related to developing a position from which nurses could explore a range of possibilities as a means to providing an appropriate and meaningful health care service to people, and their families, experiencing delirium. In accordance with the last research aim, this chapter turns its attention to addressing the implications for nursing practice that arose from undertaking this study. However, before undertaking this task the two predominant discourses that were recognised as discursively influencing the social construction of delirium will be summarised.

10.3 The predominant discourses influencing the discursive construction of delirium

In this thesis the conventional view of power being held and welded by one party over another was rejected in favour of a critical gerontological analysis utilising the analytical work of postmodernism and Foucault. In the present analysis, I have demonstrated how power operates through the discourses and practices of established social institutions by offering "... 'obvious' or 'natural' ways of being" (Weedon, 1987, p.100). There are a number of scholars writing in the area of older person's health from this perspective and their ideas have infiltrated, as well as influenced the key arguments presented in this thesis (for example Cole et al., 1993; Cruikshank, 2003; Featherstone & Hepworth, 1996; Hockey & James, 1993; 1995; 2003; Katz, 1996; Oldman, 2003).

The analytical tools utilised in this work have unearthed two predominant discourses that I have identified as significantly influencing the discursive field of delirium. These two discourses stand in stark contrast to each other. They are complex, contradictory,

unstable, and as such provide multiple opportunities for nursing to reconsider how they might provide an appropriate and inclusive nursing service to older people who are delirious. This section of the thesis now provides an overview of these two discourses.

10.3.1 The discourse of delirium as a syndrome

In chapter four of this thesis I provided a historical analysis utilising Foucault's genealogical tools to trace the changing meanings of delirium through time and showed how these meanings were constructed. In addition, I also explicated how the construction of delirium as a stable biomedical entity occurred in 1980 through its inclusion in the DSM III (APA, 1980). The DSM carries considerable weight and is positioned as a socio-political machine capable of determining the social, cultural and historical conditions within which people that have delirium live.

The truths of science and the powers of experts' acts as relays that bring the values of authorities and the gods of business into the dreams and actions of us all. These techniques for the government of the soul operate not through the crushing of the subject in the interests of control and profit, but by seeking to align political, social and institutional goals with individual pleasures and desires, and with the happiness and fulfilment of the self. Their power lies in their capacity to offer the means by which the regulation of selves – by others and by ourselves - can be made consonant with contemporary political principles, moral ideals and constitutional exigencies (Rose, 1990, p.256).

The inclusion of delirium within the DSM III allowed the delimitation of this health event to occur within a pathological paradigm. This paradigm associates ageing with an inherent process of decay and deterioration (Tulle-Winton, 2000). The DSM has enabled the deployment of a biomedical discourse. The discourse of delirium as a syndrome originates from biomedical understandings of ageing and has decontextualised the delirious bodies of older people, and reinterpreted them as homogenous biological entities with their own properties and laws. These properties and laws sustain and produce certain legitimate 'truths' about older people, who in the instance of the present research have delirium.

In chapter five the discursive field of delirium was considered. The interrogation of the discourses of medicine and nursing revealed that nursing is largely complicit with the biomedical construction of delirium and enables the dominance of the discourse of delirium as a syndrome. This discourse positions delirium in older populations as a serious economic and clinical problem. Positioning delirium in this way is a socio-political act and promotes disciplinary practices such as surveillance, self surveillance and a complex array of contestable clinical and institutional management strategies.

Hegemonic structures cement the discourse of delirium as a syndrome as an authority and the only way to know delirium. As such, older people with delirium are offered limited and negative subject positions. The positioning of delirium as a problem enables the deployment of an ageist sub-discourse and paints a picture of older people with delirium as being dependent, behaving like children and having diminished value (see chapter seven).

Sustaining the discourse of delirium as a syndrome as the only legitimate source of 'truth', about delirium produces a level of complicity by disallowing the critique of its very assumptions. Doing so might reveal its real agenda which I suggest is to conserve the politics of delirium in people over the age of 65 years as a group who are unable to contribute meaningfully (in the capitalist sense) to society, are in an inevitable state of physical and cognitive decline, as well as being constantly at risk of becoming delirious. This thesis has exposed the manner by which the discourse of delirium as a syndrome has come to secure for itself, the legitimacy and authority from which it speaks about delirium, in other words how it exercises its 'truth effects' (Foucault, 1980a).

Personal perspectives of delirium have been relegated to marginalised positions, rendered unimportant. As earlier discussed, nursing through its vicarious relationship to medicine has been interpellated into deploying the discourse of delirium as a syndrome and as a result has largely ignored the personal dimensions associated with being an older adult and having delirium. However analysis of the literature and interview data collected for this thesis has identified the emergence of an oppositional discourse, a personal discourse of delirium.

10.3.2 A personal discourse of delirium

There is evidence within the nursing literature of a small and discrete body of work that has begun to attend to the personal experiences of older people with delirium. In chapter five I called this discovery an emerging personal discourse of delirium and concomitantly a potential form of resisting and unsettling the dominance exerted by the deployment of a discourse of delirium as a syndrome.

Chapters six, seven, eight and nine were devoted to repositioning the personal discourses of delirium. The dominance of the discourse of delirium as a syndrome ensured this discourse was pushed to the margins of the discursive field of delirium. Foregrounding a personal discourse of delirium ensured the social, cultural and historical aspects of participant's life experiences were foregrounded. Doing so promoted the heterogeneity of being older and having delirium.

Furthermore, the above chapters rather than demonstrating a coherent and stable personal discourse of delirium, presented a discursive field that was filled with contradictions, uncertainties and instabilities. This became increasingly evident when the discourse of delirium as a syndrome was juxtaposed with a personal discourse of delirium. The continual positioning and re-positioning of these two discourses ensured the hegemony and dominance of the discourse of delirium as a syndrome was always in question, problematised and destabilised.

For example, in chapter eight I identified how the privileging of older adult's narratives about being delirious, through the deployment of a personal discourse of delirium, reauthorizes their respective positions as a heterogeneous group with a mind that is still cognitively intact, and who each have an existence outside of their age and presenting health event. This is in opposition to biomedical understandings that identify the ageing process as being synonymous with a decrease in cognitive functioning. Unsurprisingly, the narratives presented by this group of people around their experience are viewed by medicine in particular as mere confabulations and as such should not be considered reliable depictions of what occurred during their delirious event.

The utilisation of a critical gerontological lens has enabled me to not only critique dominant biomedical understandings of delirium, but to address the social, political, cultural and historical influences that construct the delirious older body. As a critical gerontologist I have argued that knowledge about the occurrence of delirium in old age should come from older people themselves and rather than occupying a marginalised position these should also be accepted as legitimately knowing about this phenomenon. I have achieved this through ensuring the various personal discourses of delirium are presented as valued and meaningful representations of delirium in older adults.

10.4 Possibilities for improving nursing practice

As noted throughout this thesis there is a degree of uniformity about the nursing response to older people who have delirium. Nurses have largely complied with the premise espoused by medicine that the old and delirious body is unruly, problematic, physically unwell, cognitively impaired and at risk. This finding is surprising considering nursing has over the last few years, come to pride itself on the possession of a separate body of knowledge that is ‘unique’ to the profession.

Nursing has vigorously identified this ‘unique’ knowledge as being separate to, and different from that of medicine. This separateness is articulated in the following quote from Ryan et al. (2003, p.53) who assert that “[T]he core business of nursing which sets it apart from all other professions [including medicine] is that nurses work to integrate or encompass the lived body as they care for the corporeal body”. Nursing has also prided itself on realising that older people cannot be nursed effectively without considering the socio-political context in which they negotiate their health and well-being. However, the rhetoric and practice of nursing is contradictory, or as Wicks (1995, p.134) claims there is a “... fundamental schism in nursing knowledge and nursing practice”.

The following two sections of work relate to providing opportunities to improve the nursing service offered to older people who have been delirious. Chapter nine of this thesis specifically provided a critique of the nursing care provided to this group of older adults and their families. It also addressed the third research aim of this study *to develop a position from which to explore a range of possibilities nurses could utilise to provide*

appropriate care to people and their families experiencing delirium. When interviewing participants I specifically asked them the following question, “can you tell me the things the nurses did that helped and didn’t help”. The next section will focus on providing a summary of the key issues raised from this thesis relating to the nursing care provided to the older people with delirium and their families. Section 10.4.2 will then move on to introduce some future possibilities for improving nursing practice.

10.4.1 The current situation

The promotion of a personal discourse of delirium in chapter nine of this thesis surfaced several key issues that I believe have impacted both positively and negatively on the lives of older people who have been delirious and their families. Firstly, people who had been delirious unanimously identified that although nurses knew a lot about delirium so did they. This finding produced what I termed *the contested terrain of who is the expert*. Through the deployment of a personal discourse of delirium participants were able to represent themselves as the experts and re-position health professionals at the margins of the discursive field.

The second major finding related to *the specialist nature of working with older people*. Several people interviewed identified a distinct difference between the care provided in the acute setting to that received in an assessment, treatment and rehabilitation hospital (ATR hospital) specifically focussed on working with older adults. Nursing care in the ATR hospital was more person centred and holistic in nature. A person centred and holistic approach to providing nursing care to older populations is central to gerontological nursing in New Zealand and internationally (Eliopoulos, 2005; New Zealand Nurses Organisation, 2002). Unfortunately the care received in the acute setting remained focussed on the physiological aspects of delirium with little concern for the social, cultural and historical contexts within which older people with delirium inhabited.

The third finding related to the utilisation of *appropriate and suitable staff*. The literature presented within the discursive field of delirium clearly identifies that an experienced gerontological nurse is required to ensure the safety and well-being of older people with delirium (see Caraceni & Grassi, 2003; Foreman et al., 2003; Truman &

Wesley, 2003). However, the present study has illuminated that through the deployment of an ageist sub-discourse this group of people are offered nursing care by casual nurses in conjunction with unskilled 'sitters'.

Finally, evident throughout the texts examined, were significant issues relating to communication. Miscommunication, or in some instances no communication, served to cause further psychological and physiological complications. Once again the theory and the practice of nursing stand in binary opposition to each other. The use of appropriate communication strategies by nurses has been shown to positively influence patients and their family's interactions with health professionals, and to improve understandings of their medical condition resulting in a decrease in stress and anxiety (Dillon McDonald, 2000). However in this research, problems with communication meant that the consumers of nursing services were left feeling anxious, frightened and unsure, resulting in some instances in the development of further health deviations.

The findings relating to chapter nine of this thesis provide several strategies that nurses could attend or re-attend to that would not only ensure the theory and practice of nursing was congruent, but also that the nursing care offered to older people with delirium met this population's health care needs. As nurses, we need to move beyond our current and largely uncritical stance associated with the grand narratives surrounding delirium that pervade western culture. Instead we need to acknowledge the many ways we have been conditioned by those dominant and persuasive narratives (Walker, 2004). I suggest one of the ways forward is to persistently resist their various effects of truth.

10.4.2 Introducing the critical gerontological nurse

Despite the authoritative presence of critical gerontology within other disciplines, this theoretical position is largely absent within nursing and remains limited to a very few nurse scholars. This is remarkable considering nursing has embraced critical perspectives about health care and health care practices through the utilisation of a variety of critical methodologies. In New Zealand the utilisation of critical and analytical tools by nursing saw the development and implementation of cultural safety to the point that it is now a regulated requirement for all registered nurses to

demonstrate that their practice is culturally safe (Nursing Council, 2002; Ramsden, 2002). Culturally safe practice incorporates a broad perspective of cultural groups, including older adults with delirium.

Unfortunately the intent inherent in the concepts associated with cultural safety has not been fully realised in older people in general and even less so in those with delirium. The deployment by nurses of a critical gerontological discourse is one answer to meeting the 'short falls' identified in this research. Utilisation of a critical gerontological paradigm for nurses can address both the macro and micro issues of delirium and old age.

Addressing macro and micro issues is a political activity. Hughes (2005, p.331) asserts that nurses need to understand and participate in the politics of healthcare "... because our consumers, patients and clients need us to be". Identified throughout this thesis are stigmatising practices that offer older people with delirium negative subject positions. On a macro level, the critical gerontological nurse would have the skills and knowledge to actively challenge the stigmatisation of older adults through working collectively and alongside older communities. This political act could be achieved through the formation of consumer alliances with key older person focussed and run organisations. An example of one of these organisations existing in New Zealand is Grey Power whose key aim is to politically reflect the concerns and needs of older people.

While the notion of consumer participation is not a new concept within health, gerontological nursing in New Zealand has yet to formally develop consumer alliances with gerontological groups (Neville, 2004). I do not see this as a solitary pursuit but suggest the development of a formal relationship would occur through the professional organisations that represent nursing. Professional nursing organisations have the infrastructure to support such alliances and the combination of organisations such as Grey Power with nursing would represent a powerful political force. The major focus of consumer alliances would be for gerontological nursing to truly understand, lobby for and promote the key concerns identified by older people themselves.

In preparation for any political activity, whether on a macro or micro level, the critical gerontological nurse would need to be familiar with and able to undertake a critique of

the structures of society which construct old age negatively via the perpetuation of overt and covert ageist practices. The construction of old age in this way is both powerful and oppressive thus propagating fear and distress at all levels of society. Ageing is an inevitable consequence of living and rather than being viewed as undesirable should be celebrated and valued. The same applies to the presence of delirium in people over the age of 65 years. Delirium should not be portrayed as an inevitable consequence of a deviation in health that has become synonymous with the permanent loss of cognitive abilities.

A fundamental premise underpinning critical gerontology is that knowledge about being an older person should be determined by older people themselves (Kontos, 1998). This thesis offers a vehicle for critical gerontological nurses to reclaim the delirious subject who until now has been rendered invisible. Therefore the older adult who has delirium is not seen as an object of investigation and social practices, but as a subject who is constituted through individual experiences. What the gerontological nurse sees today is a culmination of a rich tapestry of life events. Taking this theoretical stance "... emphasizes a view of the individual as ... participating actively in fashioning a life course" (Marshall, 1986, p. 13). Nursing scholars (see Falk-Rafael, 2005; Georges, 2005; Lynam, 2005) assert that the theoretical perspectives associated with critical caring should underpin and guide all nursing practice. Attending to the social, cultural and historical contexts that accompany older people who have delirium, as they negotiate the health care environment, ensures the critical gerontological nurse espouses caring as is reflected above.

In the final phases of editing this thesis I discovered a series of articles recently published in the *International Journal of Older People Nursing* relating to geographical gerontological nursing. Geographical gerontological nursing is a relatively new concept for gerontological nurses to consider, and is imbued with the philosophical underpinnings associated with critical gerontology (Andrews, McCormack & Reed, 2005). Each of the articles refer to geographical gerontology as recognising the importance of place, which includes the contextual, social and cultural aspects, as being integral to older people as they negotiate health, health services and health professionals (see Andrews et al., 2005; Cutchin, 2005; Wiles; 2005).

The importance of attending to an older person's context has been reinforced as paramount throughout this thesis, and aspects of this focus can be found in the emerging nursing literature relating to geographical gerontological nursing. As such, the critical gerontological nurse would incorporate the geographies of ageing and of nursing when providing a nursing service to older people who have delirium and their families. For example, the utilisation of what Cutchin (2005, p. 124) terms "therapeutic landscapes", ensuring the health care environment is culturally, socially, historically and contextually appropriate for the older person with delirium to support the healing process. Doing so requires a theoretical shift from attending to the physical body, to incorporating a holistic approach when supporting people with delirium and their families.

10.5 Limitations of the study

As with any research project there are limitations that can be identified. This is inherent in the very nature of research and the undertaking of any research process. I see the process of undertaking a study as important as the findings, for throughout the journey a great deal of reflection takes place every step of the way. This reflection in turn identifies issues that in hindsight the researcher would have liked to have undertaken in a slightly different manner. In addition, research and the resulting knowledge gained is constantly changing, it is a dynamic procedure. Consequently, several limitations associated with this thesis need to be highlighted.

Firstly, undertaking this research raised some epistemological concerns for me. The utilisation of Foucauldian epistemology was both useful and constraining. The use of his genealogical tools allowed the emergence of previously marginalised personal discourses of delirium to emerge, not only to provide another perspective on delirium but also to resist and cause trouble for the dominant biomedical discourses. The genealogical analysis utilised in the present study critically examined the political relevance of the past that enabled the emergence of delirium as a stable biomedical entity through the DSM. Doing so problematised the material conditions that existed such as institutions, political events and economic practices that promulgated the emergence of the discourse of delirium as a syndrome.

There are as many critics of Foucault's work as there are supporters. The epistemological concerns that arose for me while utilising his work centred on the provision of a set of tools that enabled the deconstruction of power and truth as related to delirium in people over the age of 65 years. However, once the key issues were deconstructed and problematised I was not provided with any hint of a solution. This epistemological concern is mirrored by Cheek and Porter's criticism (1997, p.113) who claim that "a Foucauldian analysis can tell us a lot about what is wrong with where we are, it can tell us very little about where we should go". However, criticism aside, the utilisation of his analytical tools, within a critical gerontological frame of reference, have enabled me to reveal the institutional and practice protocols, procedures, and hegemonic structures that consequently offer negative and limited subject positions to older people who have delirium.

A second limitation relates to the cultural viewpoints expressed by the participants interviewed for this study. All participants identified themselves as being of European descent. The participation of older Maori people and their families would have provided another perspective on delirium. A perspective that might have challenged the current delirium service provided to older adults from a different world view. Furthermore, contemporary New Zealand legislation reflects the views and aspirations of older Maori (see Ministry of Health, 2002), however the operationalisation of the legislation has not fully been realised in the practice arena. For example, the Ministry of Health (2004) identifies that specialist health services for older people (delirium classifies as a specialist service) do not meet the needs of Maori communities, as evidenced by this population either not being referred or not choosing to access these services. A major finding of this thesis is that the health service offered to older people who have delirium needs to be adaptable enough to meet individual care needs. Consequently, if the principles of the Treaty of Waitangi were fully operationalised the health and well-being needs of older Maori people who experience delirium, and their whanau, would also be better met.

Thirdly, if I were to commence this research now, knowing what I currently do, I would want to ensure the study design had more of an emancipatory focus. I would seek to actively engage older adults in the research process from the outset. The mutual sharing

of information, resources and ownership of the research process has the potential to radically alter how, and what type of nursing service is offered to this group of people.

Finally, at the outset of this thesis (see chapter one) I positioned myself as a middle aged, rather than older adult, and acknowledged that I may not be the best person to comment on delirium, and its impact on people over the age of 65 years. Also, throughout the research I have been acutely aware of the vulnerable position in which older people who had been delirious found themselves, and the potential for them to feel compelled to participate in this research project. Both of these issues could be dealt with through collaborative and active participation in the research process by consumers of delirium services. I have been cognizant of these two concerns throughout the entire doctoral journey.

I believe my uneasiness with both positions identified above helped rather than hindered the research process. At every step I constantly reflected on how I was being discursively positioned by the texts, and also how I positioned others regardless of whether the texts were the published literature or the transcripts generated by the research participants. I also acknowledged the potential power differential that might have existed between myself and older participants, as well as their families.

I addressed the above issues by firstly identifying that the people involved in this study were a vulnerable population. Vulnerable persons have been defined as those who experience any form of diminished autonomy due to physical/psychological factors, and/or whose status is diminished or unequal (Silva, 1995; Weaver Moore & Miller, 1999). The people interviewed were in a vulnerable position due to having been physically unwell, delirious, and as evidenced by the research findings and literature, were stigmatised on the basis of age.

In addition to adhering to the ethical principles already outlined in chapter three of this thesis, as part of the consent process I informed participants that they may not directly benefit from taking part in the research project but that other older adults who become delirious, and their families, might benefit from the knowledge gained from this research project. Each person accepted my explanation and agreed that participating in the research was important if it would in any way help others in the future who were in

a similar situation. Also several people at the end of the interview acknowledged that being able to tell their story, as they saw it, was important to their recovery. These insights are mirrored in the literature by Weaver Moore et al. (1999, p.1036) who assert that psychological benefits including “... gaining a sense of catharsis, self-acknowledgement, purpose, self-awareness and empowerment” are consequences of vulnerable populations participating in research projects. Without the willing contribution of this group of people gaining insight into the health care needs and desires of this population would not have occurred, and any possibilities for improving nursing practice would not be possible.

10.6 Suggestions for future research

There is unlimited scope for future nursing research in this area. The literature has already identified a significant prevalence of both nursing and medical research into delirium utilising a quantitative lens of inquiry. Through the process of undertaking this study I realised there was a small and emergent body of literature that utilised qualitative methodologies to investigate the present phenomena. A nursing commitment to investigating and publishing about delirium in older populations utilising a variety of critical gerontological methodologies is imperative.

The small number of published qualitative works written by nurses has formed the foundations for future work. Each of the data chapters presented within this thesis forms the basis for future research projects. For example, further investigations into how ageist practices threaten the psychological, economic, political, social and cultural landscape inhabited by older people, and how these practices impact on quality of life and well-being in older populations. In addition, as mentioned above in the limitations section, future research should investigate how specialist older adult health care services can best meet the needs of Maori and other minority groups. Finally, as identified earlier in this chapter, nursing should work more closely with consumer groups (those that focus on the needs and desires of older people) to form participatory and reciprocally beneficial research relationships.

In section 10.4.2 I discussed the recent emergence in nursing research of the concept of geographical gerontology and geographical nursing. Further research would incorporate

the investigation of the meanings and relationships older people with delirium have to their environment. Due to the geographies of ageing and nursing being in their infancy Andrews et al. (2005) call for researchers to test these theoretical concepts within specific specialities of nursing, for example, delirium.

10.7 Concluding statement

In seeking answers to the research aims presented in section 10.2 of this chapter I have applied a critical gerontological lens of inquiry utilising aspects of postmodernism and Foucauldian theory. Taking this philosophical position initially seemed onerous and daunting, but through the process of crafting this doctoral thesis the complexities associated with the utilisation of these methodologies became clearer and consequently more manageable and ‘user friendly’. A critical gerontological approach enabled me to examine and re-examine the key events, activities and texts that culminated in the emergence of delirium as an entity, and resulting from this emergence allowed the deployment of specific discourses that construct and disrupt understandings of this phenomena.

The present research has taken an epistemological position that has not previously been utilised to investigate delirium in older populations. The use of a discourse analytic approach has brought to light a complex array of discourses that are deployed in relation to older adults who are delirious. Out of these discourses, two major but yet opposing discourses were identified, the discourse of delirium as a syndrome and a personal discourse of delirium. Analysis of the identified discourses revealed a diversity of subject positions and subjectivities that were offered to older people who were delirious.

The dichotomous relationship explicated through juxtaposing the discourse of delirium as a syndrome and a personal discourse of delirium has problematised the status quo in relation to delirium in people over the age of 65 years. Foregrounding marginalised perspectives, through the deployment of a personal discourse of delirium, is a form of resistance that is integral to Foucault’s concept of power. Foucault sees power as always in play, always contestable and therefore strategies for resistance are always present. The concept of resistance, as utilised in the present study, has demonstrated that disciplinary techniques such as the deployment of an ageist sub-discourse that

promulgates negative perceptions on what it is to be an older adult and have delirium can be contested. Nursing with its concerns for health, wholeness, inclusiveness and caring has the potential to work with older populations in new and innovative ways to positively influence the health and well-being of older communities.

As I reach the end of my doctoral journey I have realised the value for nursing of utilising a critical gerontological perspective. Critical gerontology offers a vehicle for advancing our understandings of older people that is anchored in both individual and collective narratives, and contexts. These foci give primacy to the socio-cultural aspects associated with ageing, and compensate for the emphasis on the bio-physiological factors so prevalent in the discourses of nursing and medicine. As the population of older people increases so do the opportunities for critical gerontological nurses to make a difference. I offer a challenge to all nurses who provide a nursing service to older people, including those with delirium, to commit to making visible the social complexities, similarities, differences and ambiguities of being an older adult, not only now, but in the future.

Appendix one

Understanding delirium through the experiences of hospitalised older adults and their families

Information Sheet A for the older person who has experienced delirium

Principal Researcher:

Stephen Neville,
44 Richmond Hill Road,
Sumner,
Christchurch 8.
Phone: (03) 326 5812
Fax: (03) 326 5817
E-mail: s.neville@it.canterbury.ac.nz

You are invited to take part in a study that explores the experience of delirium for older adults and their families/significant others. This study will involve talking to two groups of people. The first group will be people like you who have experienced an episode of delirium. The second group will be family members/significant others. They will be asked to talk about the things they experienced during the period time their family member/significant other was delirious. We will also be asking what the nurses and other staff did that helped or didn't help them during this time.

Who is the researcher?

My name is Stephen Neville. I am a graduate student enrolled in a Ph.D at the School of Health Science, Massey University. I am a registered nurse and have been nursing for 22 years. I am currently working at the Princess Margaret Hospital, Older Person's Health Division. Prior to that I worked as a nursing lecturer for 13 years. My supervisors are Professor Jenny Carryer, Professor Julie Boddy and Dr Sally Keeling and their contact details appear at the bottom of this information sheet.

This study has grown out of my interest in the older person and involvement in The Elder Care Canterbury Project. I want to help ensure that the needs of people who experience delirium and their families/significant others are met. I am interested in talking to people about their experiences and this is an invitation to be part of the study.

If I decide to take part, what would I have to do?

If you agree to take part in the study I would like to:

- Talk to you about having a delirious experience; what it was like and the things the nurses and other staff did that helped or didn't help.
- Tape record the interview. I expect the interview will take approximately one hour but it may be longer if you have the time. After the interview I will make a typed transcript of our conversation and you can have a copy if you wish.
- Have access to your hospital records to see what was written about you during the time you were delirious.

What will happen to the information I provide?

- The information you provide will be kept confidential.
- Your real name will not be used anywhere. Instead you will be asked to choose a pseudonym or code name and this will be used on the tape recording, the transcripts and the final written thesis. I may want to share some of the information and

insights you give me with the other participants, but this will be done in such a way that you will not be identifiable.

- All research materials will be kept in a locked metal filing cabinet. The tape recordings will either be returned to you or wiped clean once the research has been completed.
- When the interviews have been completed and the tapes transcribed, the findings will be written up as a research report which may be used by nurses and other health professionals interested in care of people who have experienced a delirious episode and their families/significant others. I will be happy to make this report or a summary of the report available to you either to read or to discuss with me.

At any time during the study you have the right to:

- decline to participate
- refuse to answer any particular questions
- withdraw from the study at any time
- ask any questions about the study at any time during participation
- provide information on the understanding that your name will not be used unless you give permission to the researcher
- be given access to a summary of the findings of the study when it is concluded.

Are there any risks involved in my taking part?

Your participation in the study is entirely your choice. If you do agree to take part, then change your mind, you are free to withdraw from the study at any time without giving a reason and this will in no way affect your future health care.

I am aware that discussing this time may be upsetting for you or it may bring back unpleasant memories. We can stop the discussion at any time. If unresolved issues about the time arise for you, I will be happy to discuss options that you may wish to pursue for further information or support.

Are there any benefits in my taking part?

There may be no immediate or direct benefit to you from participating in this study but you will have a chance to talk about your experiences and find out about other people's experiences of delirium. In taking part you will be adding to our understanding of the experiences of people when they are delirious and the issues arising for families/significant others during this time. The information we receive will help us to improve future care and services provided for people who have been delirious and their families/significant others.

What do I do to take part?

If after reading this information sheet you decide not to participate then you are free not to proceed. Deciding not to participate in this study, or withdrawing from the study will not affect any health care services or assistance you are receiving. If you agree to participate I will provide a consent form for you to sign and will then arrange a suitable time for us to talk.

This study has received ethical approval from the Canterbury Ethics Committee, the Massey University Human Ethics Committee and the Christchurch Polytechnic Institute of Technology Academic Research Committee.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Services Consumer Advocate, telephone (03) 377 7501 or 0800 377 766 outside Christchurch.

Supervisors' Contact Names and Phone Numbers:

Professors Jenny Carryer and Julie Boddy
School of Health Sciences
Massey University
Phone: (06) 356 9099 ext 7719

Dr Sally Keeling
Department of Medicine
Christchurch School of Medicine
(03) 337 7932

If you have any questions or would like more information, please contact the researcher.

Appendix two

Understanding delirium through the experiences of hospitalised older adults and their families

Information Sheet B for the family/significant other.

Principal Researcher:

Stephen Neville,
44 Richmond Hill Road,
Sumner,
Christchurch 8.
Phone: (03) 326 5812
Fax: (03) 326 5817
E-mail: s.neville@it.canterbury.ac.nz

You are invited to take part in a study that explores the experience of delirium for older adults and their families/significant others. This study will involve talking to two groups of people. The first group will be people who have been delirious. The second group will be people like you who, as family members/significant others, have been involved with a person who has experienced an episode of delirium.

Who is the researcher?

My name is Stephen Neville. I am a graduate student enrolled in a Ph.D at the School of Health Science, Massey University. I am a registered nurse and have been nursing for 22 years. I am currently working at the Princess Margaret Hospital, Older Person's Health Division. Prior to that I worked as a nursing lecturer for 13 years. My supervisors are Professor Jenny Carryer, Professor Julie Boddy and Dr Sally Keeling and their contact details appear at the bottom of this information sheet.

This study has grown out of my interest in the older person and involvement in The Elder Care Canterbury Project. I want to help ensure that the needs of people who experience delirium and their families/significant others are met. I am interested in talking to people about their experiences and this is an invitation to be part of the study.

If I decide to take part, what would I have to do?

If you agree to take part in the study I would like to:

- Talk to you about what it was like for you having a family member/significant other who was experiencing a delirious episode and the things the nurses and other staff did that helped or didn't help you during that period.
- Tape record the interview. I expect the interview will take approximately one hour but it may be longer if you can manage the time. After the interview I will make a typed transcript of our conversation and you can have a copy if you wish.

What will happen to the information I provide?

- The information you provide will be kept confidential.
- Your real name will not be used anywhere. Instead you will be asked to choose a pseudonym or code name and this will be used on the tape recording, the transcripts and the final written thesis. I may want to share some of the information and insights you give me with the other participants, but this will be done in such a way that you will not be identifiable.

- All research materials will be kept in a locked metal filing cabinet. The tape recordings will either be returned to you or wiped clean once the research has been completed.
- When the interviews have been completed and the tapes transcribed, the findings will be written up as a research report which may be used by nurses and other health professionals interested in care of people who have experienced a delirious episode and their families/significant others. I will be happy to make this report or a summary of the report available to you either to read or to discuss with me.

At any time during the study you have the right to:

- decline to participate
- refuse to answer any particular questions
- withdraw from the study at any time
- ask any questions about the study at any time during participation
- provide information on the understanding that your name will not be used unless you give permission to the researcher
- be given access to a summary of the findings of the study when it is concluded.

Are there any risks involved in my taking part?

Your participation in the study is entirely your choice. If you do agree to take part, then change your mind, you are free to withdraw from the study at any time without giving a reason and this will in no way affect your future health care.

I am aware that discussing this time may be upsetting for you or it may bring back unpleasant memories. We can stop the discussion at any time. If unresolved issues about the time arise for you, I will be happy to discuss options that you may wish to pursue for further information or support.

Are there any benefits in my taking part?

There may be no immediate or direct benefit to you from participating in this study but you will have a chance to talk about your experiences and find out about other people's experiences of delirium. In taking part you will be adding to our understanding of the experiences of people when they are delirious and the issues arising for families/significant others during this time. The information we receive will help us to improve future care and services provided for people who have been delirious and their families/significant others.

What do I do to take part?

If after reading this information sheet you decide not to participate then you are free not to proceed. Deciding not to participate in this study, or withdrawing from the study will not affect any health care services or assistance you are receiving. If you agree to participate I will provide a consent form for you to sign and will then arrange a suitable time for us to talk.

This study has received ethical approval from the Canterbury Ethics Committee, the Massey University Human Ethics Committee and the Christchurch Polytechnic Institute of Technology Academic Research Committee.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Services Consumer Advocate, telephone (03) 377 7501 or 0800 377 766 outside Christchurch.

Supervisors' Contact Names and Phone Numbers:

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Dr Sally Keeling

Department of Medicine

Christchurch School of Medicine

(03) 337 7932

If you have any questions or would like more information, please contact the researcher.

Appendix three

Understanding delirium through the experiences of hospitalised older adults and their families

Information Sheet C for health professionals.

Principal Researcher:

Stephen Neville,
PO Box 2983,
Christchurch.
Phone: (03) 326 5812
Fax: (03) 326 5817
E-mail: s.neville@it.canterbury.ac.nz

You are invited to take part in a study that explores the experience of delirium for older adults and their families/significant others. This study will involve talking to three groups of people. The first group will be people who have been delirious. The second group will be family members/significant others who have been involved with a person who has experienced an episode of delirium. The third group will be people like you who are health professionals working within the area of delirium. No discussions about individual people will occur during interviews with health professionals.

Who is the researcher?

My name is Stephen Neville. I am a graduate student enrolled in a Ph.D at the School of Health Science, Massey University. I am a registered nurse and have been nursing for 22 years. I am currently working at the Princess Margaret Hospital, Older Person's Health Division. Prior to that I worked as a nursing lecturer for 13 years. My supervisors are Professor Jenny Carryer, Professor Julie Boddy and Dr Sally Keeling and their contact details appear at the bottom of this information sheet.

This study has grown out of my interest in the older person and involvement in The Elder Care Canterbury Project. I want to help ensure that the needs of people who experience delirium and their families/significant others are met. I am interested in talking to people about their experiences, including health professionals and this is an invitation to be part of the study.

If I decide to take part, what would I have to do?

If you agree to take part in the study I would like to:

- Talk to you about your role within the delirium service, your understanding of what delirium is and the type of service you provide and to whom.
- Tape record the interview. I expect the interview will take approximately one hour but it may be longer if you can manage the time. After the interview I will make a typed transcript of our conversation and you can have a copy if you wish.

What will happen to the information I provide?

- The information you provide will be kept confidential.
- Your real name will not be used anywhere. Instead you will be asked to choose a pseudonym or code name and this will be used on the tape recording, the transcripts and the final written thesis. I may want to share some of the information and insights you give me with the other participants, but this will be done in such a way that you will not be identifiable.

- All research materials will be kept in a locked metal filing cabinet. The tape recordings will either be returned to you or wiped clean once the research has been completed.
- When the interviews have been completed and the tapes transcribed, the findings will be written up as a research report which may be used by nurses and other health professionals interested in care of people who have experienced a delirious episode and their families/significant others. I will be happy to make this report or a summary of the report available to you either to read or to discuss with me.

At any time during the study you have the right to:

- decline to participate
- refuse to answer any particular questions
- withdraw from the study at any time
- ask any questions about the study at any time during participation
- provide information on the understanding that your name will not be used unless you give permission to the researcher
- be given access to a summary of the findings of the study when it is concluded.

Are there any risks involved in my taking part?

I anticipate that there will be no risks associated with being involved and your participation in the study is entirely your choice. If you do agree to take part, then change your mind, you are free to withdraw from the study at any time without giving a reason.

Are there any benefits in my taking part?

There may be no immediate or direct benefit to you from participating in this study but you will have a chance to talk about your experiences and find out about other people's experiences of delirium. In taking part you will be adding to our understanding of the experiences of people when they are delirious and the issues arising for families/significant others and health professionals during this time. The information we receive will help us to improve future care and services provided for people who have been delirious and their families/significant others.

What do I do to take part?

If after reading this information sheet you decide not to participate then you are free not to proceed. If you agree to participate I will provide a consent form for you to sign and will then arrange a suitable time for us to talk.

This study has received ethical approval from the Canterbury Ethics Committee, the Massey University Human Ethics Committee and the Christchurch Polytechnic Institute of Technology Academic Research Committee.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organisation.

Supervisors' Contact Names and Phone Numbers:

Professors Jenny Carryer and Julie Boddy
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Phone: (06) 356 9099 ext 7719

Dr Sally Keeling
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Christchurch School of Medicine
(03) 337 7932

If you have any questions or would like more information, please contact the researcher.

Appendix four

Participant Consent Form

Project Title: Understanding delirium through the experiences of hospitalised older adults and their families

Principal Investigator: Stephen Neville.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 00/152. It has also been approved by Canterbury Ethics Committee and Christchurch Polytechnic Institute of Technology Academic Research Committee.

- I have read and understand the information sheet titled “Understanding delirium through the experiences of hospitalised older adults and their families”. I have had the opportunity to discuss this study and I am satisfied with the answers I have been given.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future health care.
- I have a copy of the information sheet and I know whom I can contact if I want further information or I wish to make a complaint.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
- I have had time to consider whether to take part.
- I understand that I may ask further questions at any time during the project.
- I understand that I have the right to change my mind, refuse to answer particular questions or withdraw from the project at any time.
- I agree to my interview being audiotaped Yes No

I, _____ (full name), hereby consent to take part in this study.

Participant Signature:

Date:

Name of Researcher: Stephen Neville.

Contact Phone Number: (03) 326 5812

Researcher Signature:

Date: