2018

The Lived Experience of Registered Nurses Working in Mental Health Under Surveillance

Rodney Wallace

THE LIVED EXPERIENCE OF REGISTERED NURSES WORKING IN MENTAL HEALTH UNDER SURVEILLANCE

DISSERTATION

Presented in Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy in Nursing

Barry University

Rodney Wallace

2018

THE LIVED EXPERIENCE OF REGISTERED NURSES WORKING IN MENTAL HEALTH UNDER SURVEILLANCE

DISSERTATION

by

Rodney Wallace

2018

APPROVED BY:

Claudette R. Chin, PhD, ARNP
Chairperson, Dissertation Committee

Jessie M. Colin, PhD, RN, FRE, FAAN
Member and Program Director, College of Nursing and Health Sciences

Diann Carr, Ed. D, ARNP
Member, Dissertation Committee

John J. McFadden, PhD, CRNA
Dean, College of Nursing and Health Sciences

Abstract

Background: Electronic surveillance including Closed Circuit Television (CCTV) has become ubiquitous at the workplace. The inpatient mental health unit has seen an increase of CCTV surveillance. CCTV surveillance is known to increase production, deters unwanted behaviors, and increase safety. Despite its benefits, some employees that worked under CCTV surveillance have experienced stress, fear, and feelings of vulnerability.

Purpose: The purpose of this hermeneutic phenomenological study was to understand the lived experience of nurses working under constant CCTV surveillance in the mental health unit.

Methods: A qualitative hermeneutic phenomenological approach based on Heideggerian and Gamaderian philosophy was used to answer the research question: What is the lived experience of nurses working under CCTV surveillance in the mental health unit? There were 16 participants with at least 2 years working experience in the inpatient mental health unit. All participants worked in South Florida. Data analysis was guided by the hermeneutic circle of understanding.

Results: The five themes that emerged from the data are *Disappearing Status Quo Ante*, *Deterring Litigation*, *Feeling Uneasy*, *Limiting Caring*, and *Normalizing the Present*. They reflected the meanings the participants attached to the phenomenon.

Conclusions: Nurses that worked under constant CCTV surveillance in the mental health unit experienced deterrence, feeling uneasy, and limitations in the caring options.

Despites these disadvantages, the nurses have supported the use of CCTV surveillance in the inpatient mental health unit because of its benefits in risk management.

ACKNOWLEDGMENTS

Firstly, my deepest gratitude goes to my dissertation chair, Dr. Claudette Chin whose guidance and insight was immeasurable throughout this process. Dr. Chin, I truly appreciate all your help. Beside my chairperson, a special thank you to Dr. Jessie Colin, committee member, for your support along the journey and for introducing me to Martin Heidegger's *Being and Time*. To Dr. Diann Carr, committee member, many thanks for remaining committed to my cause despite your impending retirement, I appreciate all your feedback and support. Next, I would like to thank Barry University and the College of Nursing and Health Sciences for providing the opportunity for me to attain this goal. The organization is providing a great service to adults who want to continue their education. Finally, I would like to thank Mrs. Balkys Bivins for being there to share ideas and provide support.

DEDICATION

I dedicate this dissertation to my family and friends all of whom have contributed to this journey in some measure.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

PROBLEM AND DOMAIN OF THE INQUIRY

The World Health Organization (WHO) has specified that the quality of the work environment is a predictor for attracting and retaining professional medical staff members, enhancing job satisfaction, uplifting morale, and improving the quality of patient care (Wiskow, Albreht, & Pietro, 2010). Studies have linked several factors as primary contributors to burnout and dissatisfaction across the spectrum of Registered Nurses (RN) practice environments (Schaufeli & Buunk, 2003; Estryn-Mehar et al., 2007; Aiken et al., 2008). At the same time, other studies have shown that nurses who work in mental health units experience dissatisfaction and burnout, but they do so for a multiplicity of other reasons than their counterparts in other medical practice areas (Paris & Hoge, 2010; Johansson, et al., 2013). Two reasons are patients' verbal abuse, and threats of physical violence to the nurses (Merecz et al., 2006). Desai (2011) additionally has suggested that the introduction of Closed Circuit Television (CCTV) Surveillance in the nurse work environment could be an additional cause of dissatisfaction and burnout.

The inpatient mental health environment is designed to provide care for acute patients with the most severe symptoms. It is a common practice to have inpatient mental health units locked for the safety of the patients and others (Cleary, Hunt, Walter, & Robertson, 2009). Given this condition, working in this environment can be very challenging and at times volatile as altercations among patients can lead to violence. Notwithstanding, the inpatient mental health environment is a structured therapeutic milieu. The therapeutic milieu is a physical, social, as well as a cultural one. Patients benefit from the milieu by gaining adaptive coping skills from peer pressure, social

interaction, social support, reality feedback, and structuring of their experience (Townsend, 2014). It is moreover a fundamental part of the nurse's role to engage patients in the environment therapeutically to help them recover from their illness, and anything that impinges on such role should be explored (Roche, Duffield, & White, 2011). Consequently, there is a need to conduct a qualitative study to understand the nurses' lived experience working under CCTV surveillance because there is a lack of such studies.

Background of the Study

According to Lyon (2010), surveillance means to routinely "watch over" for the purposes of directing and supervising those being monitored. For example, law enforcement officers watch over the community; a mother watches over the child, and the supervisor watches over the worker. There are other means of supervision: A simple form is to have someone physically walk about checking on workers. Another form includes workers checking themselves by signing in and out on a work roster. Electronic surveillance methods such as video, telephone, and Internet have, in recent years, supplemented more traditional surveillance systems. According to Lyons (2010), all surveillance has two elements: care and control. An employer who monitors workers to prevent dishonesty cares about the survival of the business, and such monitoring is also a form of control when it limits the workers to only certain types of behaviors.

The concept underlying CCTV surveillance is called Panopticon, meaning "all seeing." The 18th century English philosopher Jeremy Bentham (1748-1832) coined the term to explain a means of surveillance he conceptualized that was more efficient than other forms at the time (Magubane, 2008). Bentham published a plan in 1791 to construct

a semi-circular surveillance mechanism in the penitentiary so guards could view the prisoners, but at no time could the prisoners see the guards (Lyon, 1993). Its purpose was to encourage the prisoners to become their own guards and comply with the rules since they would believe they were under constant surveillance. The concept and principle embodied in Panopticon continued to have far-reaching implications in society, despite the fact that this prison was never built. Even so, current electronic surveillance tools are based on Bentham's Panopticon (Ball, 2010).

CCTV was developed in the 1940s and used by the Germans to monitor a rocket launch in 1942. CCTV cameras were first used in England in the1960s for monitoring traffic and in the retail sector (Williams, 2003; Norris, McCahill, & Wood, 2004). The demand for the cameras world-wide in subsequent decades has increased due significant upgrades in technology, concern about national security, and a change from a labor-intensive economy to a technology-intensive one (Cho, 2014).

Global Surveillance

It was not clear prior to 2013 what countries engaged in global surveillance because it is mainly a clandestine operation. Global surveillance involves states that have the wherewithal to cross national borders and enter sovereign states to collect data. According to Keiber (2015) countries that engage in global surveillance have vast resources, institutional framework, and material power to legitimize their actions. Then again, reports on global surveillance have been scarce. Reports of intelligence agencies in countries such as the United States and Russian alleging spying operations occasionally surfaced (*Dallas Morning News*, 2010; Arutunyan, 2013). These countries were not the only ones implicated in spying operations: Other countries such as Israel and Britain were

also implicated in spying operations. However, it was the American Edward Snowden, a former National Security Agency (NSA) employee turned whistleblower, who divulged the extent of global surveillance in 2013.

Edward Snowden revealed that the governments of the US, United Kingdom, Australia, Canada, and New Zealand had signed an agreement in 1946 to conduct global surveillance and share the data among themselves (Nyst & Crowe, 2014; Bakir, 2015). The *Five Eyes*, as they were called, found ways to infiltrate modern telecommunication networks, coerce companies to hand over their customers' data, and tapped into fiber optic cables to intercept communication (Nyst & Crowe, 2014). Snowden further revealed that the National Security Agencies partnered with telecommunication companies Microsoft, Yahoo, Google, Facebook, Paltalk, YouTube, AOL, Skype, and Apple to collect metadata on their customers (Nyst & Crow, 2014; Bakir, 2015; Keiber, 2015). The revelation further exposed the intent of governments to engage in industrial surveillance to gain economic advantage over their competitors beyond the need of national security (Price, 2014), bringing forward suggestion that global surveillance is more about economics than it is about security.

According to Wood and Webster (2009), surveillance technology was first developed for military use during the cold-war between the U.S and the Soviet Union, but when the cold-war ended, these companies began marketing the technology to commercial and civilian interests. This shift in focus has led to what is called a *Surveillance Economy* driven by a cumulative public perception that countries and communities are at risk for terrorism or public disorder, and surveillance is necessary for safety (Lyons, 2001). Acts of terrorism around the world reinforce the notion that

governments and corporations need to invest in surveillance technology to protect their people despite evidence that electronic surveillance is limited in its effectiveness in preventing crime (Gill & Hemming, 2006).

Countries such as Canada, United States, Korea, and other parts of Asia and Europe are among largest consumers of electronic surveillance equipment (Deisman et al., 2009; Cho, 2014). It was projected in 2014 that the world-wide consumption of CCTV technology would grow to approximately $100 billion per year (Cho, 2014) and as of 2014, it has been estimated that there were 250 million CCTV cameras installed globally and 65% of them in Asia (Jenkins, 2015). However, the UK leads all countries with the most CCTV cameras per capita. The UK has 5.9 million cameras monitoring public spaces or one camera for every 11 people (Barrett, 2014). Other countries that have invested heavily in overt and covert CCTV cameras for public safety are South Africa, China, Japan, India, Pakistan, and Middle Eastern States (Norris et al., 2004).

National Surveillance

The U.S. has been engaged in clandestine surveilling of its citizens since the1940s. The first CCTV surveillance cameras may have been used in the U.S as early as the 1960s. Nonetheless, there is evidence that there were at least 13 city police departments around the country using CCTV video surveillance systems to monitor pedestrian traffic and some commercial use by the end of the 1990s (Norris et al., 2004). At the same time, there was a gradual improvement in the CCTV technology and a corresponding increase in its use by private citizens and commercial entities. Schmitz (2005) documented that surveillance technology had grown to the extent that approximately 80% of American corporations were monitoring their workers with it by

2004. The events of September 11, 2001, further intensified the use of surveillance equipment in the U.S.

The U.S. government first expanded its surveillance law, known as the Patriot Act, to give its intelligence agencies more freedom to spy on Americans (Price, 2014). The government then increased its security-spending budget to approximately $791 billion (Dietrich, 2015). Cities around the country also began increasing the numbers of CCTV cameras mounted in public and private spaces: Cities such as New York and Chicago saw an increase in CCTV cameras to 4000 and 10,000 respectively (Proctor, 2013). Even so, Americans remain divided on whether or not they should allow unlimited government monitoring of their daily lives. The Boston Marathon bombing of 2013 highlighted such divisions on the issue, as the Huffington Post poll found only 43% of American want CCTV cameras on their streets despite the significant role they played in apprehending the suspect (Swanson, 2013). This ambivalence underscores the difficulty Americans have in accepting the notion that to achieve national security they need to give up their privacy.

Nevertheless, Americans are documenting police officers' misconducts using smartphones. The death of Eric Garner in New York City, Michael Brown of Missouri, and Walter Scott of North Carolina while police officers tried to apprehend them are among such misconducts recorded on smartphones by witnesses (Sousa, Coldren, Rodriguez, & Braga, 2016). Many police departments around the country have begun experimenting with their officers wearing body cameras to gain the trust of the public. Shortly after Garner's death, the NY City Police piloted the use of body cameras with some of their officers. In one police department in the city of Rialto, California

complaints against the police dropped 88% and use of force incidents dropped 60% (Stross, 2013), but not all police department are eager to introduce body cameras because of privacy and accountability concerns.

Unlike other forms of electronic surveillance, police body-worn cameras are not just capable of documenting those that are the focus of surveillance, but it also documents those that are not the focus of concern and stores the data (Lippert & Newell, 2016) and the cameras are mobile as police officers enter public and private spaces. There is also the question of consent to record in both spheres. Should officers seek consent? When should they seek consent? A body-worn camera is so small it could be considered covert surveillance when in use since it camera may not be noticed by anyone (Lippert & Newell, 2016). Civil liberties groups have raised concerns that police body-worn cameras are another form of government surveillance that should be held in check (Joh, 2016).

Surveillance in the Workplace

Surveillance has been an essential part of workers experience for centuries (Holland, Cooper, & Hecker, 2015). Employers have always had the need to ensure that workers do not idle or abuse work time. Workplace surveillance goes back to the days of slave-holding societies of masters supervising slaves (Fuchs, 2013). During the Industrial Age of the late 1800s to early 1900s, the division of labor and the factory system brought about a more efficient system of work detail and surveillance. Fredrick Taylor (1856-1915) conceptualized the principle known as "scientific management," or Taylorism, to divide work into little specializations to maximize efficiency and profit and limit the power of the worker (Littler, 1978). By separating the knowledge of work from its manual execution brings each unit of work under direct surveillance (Bryant, 1995). This

meant that supervisors could monitor the worker more closely because he or she had only one task to perform. A form of Taylorism, known as Fordism was even more efficient at monitoring workers as its assembly line was mechanical paced to move the workers along in a predictable manner (McIntyre, 2000).

The healthcare industry has just begun to catch-up with some of the industrialized changes in the workforce that began in the mid-20th century. According to Rastegar (2004), the healthcare industry began adopting Taylorism because of its potential benefits for better quality and more efficient healthcare. Example of such restructuring is noted in the deskilling or narrow specialization of physicians and nurses, the fragmentation of work into specializations, and the standardization of care (Rastegar, 2004). These forms of control of labor and machine, which has only recently reached the healthcare industry, have been some of the driving forces behind surveillance (Wood, 1998).

Electronic Surveillance in Healthcare

Electronic surveillance in the healthcare industry is primarily a tool used to assist in meeting hospital core measures, monitor nursing home residents, prevent baby abduction in hospitals (mother-baby or labor and delivery units), and prevent suicide in correctional facilities. van Mourik et al. (2015) conducted a comprehensive systematic review of the literature and identified 57 studies involving electronic surveillance. There were 15 studies involving catheter-associated urinary tract infections, 14 studies related to ventilator-associated pneumonia, 12 studies on central line associated infections, and 16 studies were related to a combination of other infections. Video surveillance has been shown to improve hand washing among staff members when they are aware of the monitoring and provided feedback study (Armellino et al., 2013; Khan & Nausheen,

2017). The Center for Disease Control (CDC) suggests that hand washing is the single most effective measure against person-to-person transmission of diseases. Khan and Nausheen (2017) conducted a study on a surgical team's compliance with hand washing in the surgical operating room under video surveillance before and after timely feedback. The researchers found a base-line compliant rate of 28% with hand washing, but an increase to 71% compliance after video surveillance and feedback. Armellino et al. (2013) conducted a similar study in a surgical intensive care unit and found comparable results. The study found that the staff washed their hand on average 30% of the time before video surveillance and feedback, but after they were informed of the video surveillance and given feedback on their performance, their hand washing improved to 80%.

Some long-term care facilities have begun trying out video cameras (granny cam) as a tool to help curtail neglect and abuse of their residents (Meier, 2014). According to Bharucha et al. (2006), as much as 20 % of long-term care facilities in the United States are substandard leading to neglect and abuse. Some of the residents experience avoidable pressure sores, weight loss, falls leading to broken bones and serious cuts (Bharucha et al., 2006). However, such use of video cameras to record activities in the residents' room is not without resistance. Nursing homes lobbyists have succeeded in blocking legislation in states such as Alabama, Arkansas, Louisiana, Massachusetts, Michigan, New Jersey, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia on the basis of privacy rights (Meier, 2014). Notwithstanding, some states such as Illinois, Texas, Oklahoma, and New Mexico have enacted long-term care facilities laws that allow electronic surveillance of the residents with their consents. Video cameras serve as

deterrence to abuse and theft in long-term care facilities, and the captured data can be used as evidence in abuse and neglect cases.

The National Center for Missing & Exploited Children reports that between 1983 and 2014 there has been 292 child abductions in the United States, and approximately 33% of the cases happened in healthcare facilities (Rabun, 2014). Based on the number of babies delivered, it amounts to approximately 0.5%. However, the number is significant enough that the Joint Commission made child abduction from hospitals a sentinel event. One of the preventive measures healthcare facilities have adopted is to use CCTV surveillance and infrared monitoring devices to prevent child abductions (Burns, 2003; Miller, 2007; Rabun, 2014). Electronic surveillance of baby units in hospitals is believed to contribute to the low rate of abductions.

Electronic surveillance of inmates in correctional facilities is a standard procedure because prison populations are at risk for violence and attempts at escape. A segment of the prison population that has mental illness, and some of them are at risk for suicide. These individual also are vulnerable to abuse from other inmates because of diminished abilities to make rational decisions, and the correctional service has an obligation to protect these inmates. Observation of the mentally-ill is one of the standard procedures to ensure safety and correctional facilities have installed a wide range of electronic surveillance tools, including CCTV, to aid in the prevention of inmate suicide (Hayes, 2013).

Electronic Surveillance in the Workplace and Privacy

A mental health facility in Britain was one of the first healthcare facilities to experiment with CCTV cameras in the 1960s to monitor patient behavior as a routine

safety measure (Stolovy, Melamed, & Afek, 2015). Davies (1962) reported that psychologists and sociologists used the cameras to observe patients' behavior in various situations including monitoring drug trials and medication effects. Even then the nurses were apprehensive about working under the cameras' gaze and objected to them. The nurses' union consequently negotiated a compromise with the employer that the nurses would be informed when the cameras were turned on (Davies, 1962). However, employers began using a wide range of electronic monitoring devices in the workplace to monitor their employees during the 1990's to improve production, manage risks, and deter crime (Ball, 2010; Wood, 1998). Schmitz (2005) identified some of these devices in the following statements:

> Employers use video cameras, telephone tapping devices, and computer monitoring systems. Today it is possible to archive and search all e-mail and voice communication in call centers, to count keystrokes, or to track the amount of time employees spend away from their computers. In hospitals, nurses have started to wear ID badges that electronically transmit their location to a computerized map, increasing the pressure to move from bed to bed. (p. 728)

Employers subsequently have identified four main reasons why they need to conduct electronic surveillance of their employee: namely, to manage resources, maintain productivity, protect corporate interest and trade secrets, and manage risks (Ball, 2010). Employees and their advocates have raised objections to workplace surveillance on the basis of privacy rights; however, such claim to privacy has not been persuasive enough to influence the United States courts.

Employees reject electronic workplace surveillance on the basis of privacy, but privacy is viewed from different perspectives and accordingly does not have a single definition in the courts. For the purpose of this study, privacy is defined as an individual's ability to avoid being interfered with or having the power to exclude others from interfering with him or her (Miller & Weckert, 2000). Workplace privacy remains a contentious debate among privacy advocates, employers, and national security interest. The debate is centered on the degree of privacy one should expect in the public and private domain. The Fourth Amendment to the Constitution of the United States (U.S.) has guaranteed some privacy to its citizens against unreasonable searches and seizures; however, the Fourth Amendment is only limited to actions committed by the state (Smith & Burg, 2012) which indicates that private employers are not constrained by the Fourth Amendment. The curtailment of employees' privacy at the workplace is a result (Rothstein, 2000) as employers are legally empowered to electronically monitor their employees except for locker rooms and bathrooms (King, 2003).

Employers have consistently maintained that surveillance measures are required to to safeguard their businesses from rogue employees, while employees and their advocates have insisted that wholesale electronic monitoring of employees is a violation of their civil rights (Riedy & Wen, 2010). Courts in the U.S. have consistently supported the employers' argument for surveilling their employees as more compelling than the employees' need for privacy (Ghoshray, 2013). The U.S. courts have interpreted the employee's need for privacy at the workplace on the following basis: the employee has a reasonable expectation of privacy; the employer has a legitimate business purpose for the surveillance; and the employer's intrusion into the employee's privacy is highly offensive

to a reasonable person (Sprague, 2007). That is the employee who enters the employer's place of business, uses the employer's equipment, moves about the work area, and interacts with other workers should not expect privacy (Findlay & McKinlay, 2003; King, 2003). In others words, the employee is in public space. Conversely, the U.S courts rule that it is reasonable for an employee to expect privacy in a restroom or locker room at the workplace. Another exception to the privacy rule is that unionized workers holding collective bargaining contracts with the employer may stipulate the level of monitoring acceptable for its members. Continued litigations indicate that workplace electronic surveillance continues to be a source of much debate and disagreement between employers and employees (Jeske & Santuzzi, 2015).

It was noted in 2005 that CCTV cameras were increasingly used in mental health units as tools to help manage safety (Desai, 2010). CCTV is known to be pervasive and intrusive (West & Bowman, 2014; Stolovy, Melamed, & Afek, 2015) and can lead to restricting the performance of workers mainly normative ones. It is not known how nurses respond to electronic surveillance while they work. However, if electronic surveillance restrict nurses to only normative functions, it would amount to a restriction in practice because nurses' practice beyond normative functions (Oermann & Heinrich, 2005). At the same time, the Institute of Medicine (IOM) has recommended that every nurse should practice to his or her fullest extent (Fitzpatrick, 2010) which means combining scientific and artistic expertise to meet the patients' needs (Oermann & Heinrich, 2005). Robinson (2014) maintains that the practice of the art of nursing does not rely on a purely scientific systematic approach; rather, it relies on effective communication skills, experience, intuition, imagination, and attunement to the patient's

needs. This qualitative study was designed to gain a better understanding of the lived experience of the mental health nurses who practice under constant CCTV surveillance in the mental health unit.

Statement of the Problem

The ideal therapeutic milieu in the mental health unit is one that promotes patient recovery when nurses are allowed to practice without barriers. The use of Closed Circuit Television (CCTV) surveillance in the environment may pose a potential barrier for nurses. Studies of other industries have identified stress, fear, and feelings of vulnerability among workers who experience CCTV surveillance. However, this condition is in direct conflict with the employers' quest to achieve their goals for using CCTV surveillance, such that they fail to view its disadvantages as urgent (Rafnsdottir & Gudmundsdottir, 2011; Sewell & Barker**,** 2006). This results in a potential barrier to nurses practicing to their fullest extent in the therapeutic milieu of the mental health environment. Nurses need to deliver nursing care services in an environment that supports their role as a patient advocate.

Purpose of the Study

The purpose of this qualitative hermeneutic phenomenological study was to understand the lived experience of nurses working in the mental health unit under constant Closed Circuit Television (CCTV) surveillance.

Research Question

The guiding question for the study was: What is the lived experience of nurses working in the mental health unit under constant Closed Circuit Television (CCTV) surveillance?

Philosophical Underpinnings

A study must be grounded within a philosophical worldview or paradigm to generate knowledge (Creswell, 2013). *Interpretivism, constructivism, and positivism* are common philosophical worldviews researchers use to undergird studies. The worldview stipulates the boundaries and rules that govern a research. This qualitative research is grounded in the interpretivist-constructivist paradigm.

Interpretivism

Interpretivism is believed to have emerged in the late 19th and early 20th centuries as an alternative to the dominant philosophy of logical positivism that proved inadequate in addressing human's social conditions. Interpretivist thinking dates back to Greek thinkers such as Socrates (470 BCE - 399 BCE) who as relativists and assumed that everything is in flux, with no objective foundations for reasoning (McCormick & Kuchuris, 2013). Guba (1990), asserts that Interpretivism is situated in relativistic assumptions that are contextually, socially, and experientially grounded. Intrepretivists view reality as both multiple and socially-defined, but it also refers to subjective experiences and ways in which people construct their worlds (Williamson, 2002a). The Interpretivist standpoint maintains that consciousness is essential because without it, the world is meaningless (Scotland, 2012). Interpretivists assume there are many differing realities in the world; such that the researcher must take into account how human situations, behaviors, and experiences influence the construction of inherently subjective and multiple realities (Booke, 2013). A tree, for example, may be viewed by some individuals as vegetation to protect the environment, whereas others may view it as timber for fire or building construction (Crotty, 1998). It is through the senses and

language individuals actively assign meanings which conceptually emerge as individuals reflect on their experiences while stirred by interaction and dialogue (Ponterotto, 2005). A researcher adopts an interpretivist's paradigm when he or she is interested in learning more about a specific social phenomenon instead of its predictive values for generalization. According to Goldkuhl, (2012):

> The core idea of interpretivism is to work with these subjective meanings already there in the social world; that is to acknowledge their existence, to reconstruct them, to understand them, to avoid distorting them, to use them as building-blocks in theorizing. (p. 138)

Early pioneers of interprevist philosophy were Max Weber (1864 – 1920), Alfred Schulz (1899 – 1956), Han-Gadamer (1900 – 2002), Harold Garfinkel (1917 – 2011), and Wilhelm Dilthey (1833 – 1911). Constructivism and constructionism are complementary to the interpretivist paradigm so they will be discussed here.

Constructivism

According to Denzin and Lincoln (2003): "The constructivist paradigm assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and a naturalistic (in the natural world) set of methodological procedures." (p. 24). Constructivist ideas have been around for over a hundred years providing eclectic framework, but it was the work of the Chicago School and Berger and Luckmann's (1967) seminal work, *The Social Construction of Reality* that has come to be considered among the more prominent contributions to the current philosophy of constructivism. Constructivism encompasses a spectrum of meanings; however, it is generally understood to be primarily a mental process by which individuals

construct meanings about the world in which they live (Denzin & Lincoln, 2003). Constructivists assert that people filter meanings through their prior experiences. Individuals form diverse ideas and concept about their day-to-day experiences as they mature. These ideas and concepts progressively evolve as individuals gain new information and more experience about their world. Denzin and Lincoln (2003) further explained that individuals do not construct meanings about their circumstance in isolation; rather, they do so within a context of shared understanding. Constructivists do not attempt to control variables or predict outcomes; instead, they explore and give an account of how individuals make sense of a situation in a particular context (Guba & Lincoln, 1998).

Constructionism

Constructionism emerged during the intellectual movement of postmodernism to reject the idea that there is ultimate truth in favor of shared versions of knowledge based on social construction (Burr, 1995). The dominant logical empirical methodology termed positivism was also found lacking in advancing the needs of social inquiry. Constructionism is an alternate paradigm situated within the interpretivist spectrum of relativistic assumptions. Gergen (1985) defines it as an ongoing collective construction of knowledge informed by social conventions and interactions with others. Constructionists view knowledge as a constructed, rather than a discovered perspective. Unlike constructivism which directs the researcher to focus on the mental processes of constructing individual meanings of reality, constructionism presents a perspective that is consensus-driven leading the researcher to be concerned with the shared meanings of a community or group. According to Steedman (2000), most of what is known has little to

do with scientific knowledge; instead, knowing is based on how people make sense of what it means to be human.

The works of pioneers such as Vygotsky (1896-1934), Berger and Luckmann (1967) among others have shaped constructivist thinking. In their pursuit to identify the nature and construction of knowledge, they concluded that knowledge was created by interacting with individuals. Vygotsky (1975) explains in his pioneering work that a duality is always at play between the social entities that influence the mind in the construction of reality and vice versa. The process suggest cyclic process of internalization and externalization in which the mental processes of a person guide an individual in the construction of reality based on the information received from social interaction, culture, and history. In turn, such constructed reality provides the source for engaging other socio-cultural relationships that leads to more reality construction.

Berger and Luckmann (1967) share similar views except that they view, but also suggest that individuals construct both objective and subjective realities. From the objective standpoint, individuals' interactions with the social world lead to conditioning and embedding knowledge passed on later to generations as facts. Subjective reality, on the other hand, is gained from society through a process of socialization whereby individuals' meanings in one's social realms are passed on as objective reality. Such reality is mediated by language which individuals use to structures the way the world is experienced. This is accomplished by transmitting thought, concepts, and feelings (Burr, 1995). This process provides and individual with the external world as a primary source of influence on the construction of reality.

Based on these assumptions, it follows that employees that work under surveillance are likely shaping their reality about surveillance from the socially and culturally embedded narratives about the technology that already exists at the workplace. An inquirer who investigates nurses' lived experience under electronic surveillance using hermeneutic phenomenology should be attuned to the complex set of factors leading to the participants' reality because they will factor into the interpretation of the findings.

Critical Theory and Marxism

Critical theory (CT) originated in Germany at the Frankfurt School in the 1920s. The theory is grounded mainly in Hegelian, Freudian and Marxist philosophies. Critical theories posit that social arrangements any rational society has built-in structural flaws undergirded by power and control to systematically disadvantage certain groups and exclude them from accessing certain ideals (Swartz, 2014). At the base of the CT construct are two of Karl Marx's (1818-1883) ideas as expressed in this writing. The first concept is that the division of labor leads to progressive enslavement of individuals by the productive apparatus which prevents them from benefiting significantly from their efforts**.** The second idea is that individuals are transformed into instruments of productive objects or commodities for easier control. The primary goal of CT proponents is to empower and emancipate such disadvantaged individuals to ensure that they receive a fair and just treatment in their circumstances which are often related to the dynamics of management versus labor, encompassing issues of race, gender, class, disability, religion, sexuality, ageism, and nationality (Kelly, 2011).

According to Fuchs (2015), the modern state still depends on the control of workers, consumers, citizens, with the utilization of surveillance measures as an inherent

feature of the process. Marx (1867) considered surveillance as a coercive and technological method of controlling and disciplining workers (Fuchs, 2013). Moreover, the major power imbalance between employers and the employees ensures a continued systematic hegemonic advantage by the dominant group. In other words, employers have the resources to engage in limitless monitoring of the citizens to further their agenda ensuring that workers are constantly on task to achieve the employer's goal of maximizing profit. It is within this context that workers experience disempowerment and other disadvantages associated with surveillance.

Habermas (1929-2007) identified "emancipatory knowledge" which can be combined with CT to emancipate and liberate the oppressed. Emancipatory knowledge leads an individual to understand the condition of unsatisfactory circumstances and the forces and root causes of such circumstances. Stevens (1989) identified the following three assumptions as primary when incorporating CT as a paradigm:

1. All research and theory are political, in that social, political, and economic influences tend to shape the direction of scholarly investigation.
2. Oppressive structural relations pervade society—they are usually taken for granted, function automatically, and thus are rarely examined.
3. The liberation from oppressive structures is an indispensable condition of the quest for human potential, completion, and authenticity.

Workers who experience electronic surveillance should recognize that CT is a tool that can be used to shape and redress their complaints. More importantly, researchers can use CT to investigate such complaints when advocating workers' causes.

Qualitative Research

Qualitative research is an umbrella term that emerged in the 1960s to characterize a group of empirical research approaches that are exploratory, inductive, descriptive, emergent, interactive, naturalistic, and humanistic (Campbell, 2014; Alasuutari, 2010). Researchers in the fields of anthropology and sociology have used qualitative techniques since the 1890s (Jones, Powell, Watkins, & Kelly, 2015). However, it was not until 1960s that researchers Barney Glaser and Anselm Strauss used the terms "qualitative research" in their book: *The Discovery of Grounded Theory*. Shortly after that, theories underlying the methods began to emerge in Journal literature and books detailing methods and approaches to conducting qualitative research (Jones et al., 2015; Cohen & Crabtree, 2008).

Qualitative research is aimed at gaining a better understanding of a phenomenon that is not well known from the participant's perspective by using multiple approaches. Researchers employing these approaches have access to interactive, humanistic, emergent data rather than predicted data, and fundamentally interpretive materials. Qualitative researchers seek to discover, describe, and explore the "what" and the "why" of a phenomenon in its natural setting (Gelling, 2015). The process does not place restrictions on the participants through predictions and control in the way its quantitative counterpart does; rather, participants are allowed to determine and express what is important to them. The five commonly used qualitative approaches are ethnography, grounded theory, narrative study, case study, and phenomenology.

Scientific Assumptions

It is necessary for the qualitative researcher to explain the five scientific assumptions from the perspective of the interpretivist-constructivist paradigms used to guide the study. The scientific assumptions are *ontology*, *epistemology*, *axiology*, *rhetorical*, and *methodology*.

The Ontological scientific assumption is used as a guide to questions about the nature of reality (Creswell, 2013) or what can be known. A qualitative research approach is based on the assumption of multiple realities. Reality can be assumed to be single, objective, fixed, and exists despite humans' conception or involvement. However, from a qualitative standpoint and within the interpretive-constructivist paradigm, reality is multiple. Nurses who work in mental health units under CCTV surveillance view their experiences differently because they filter their meanings through varied backgrounds (Creswell, 2013). The common understanding that nurses under CCTV surveillance share is of interest in this study. The researcher, therefore, intends to identify such understandings and present them as themes to reflect these shared realities.

The Epistemology scientific assumption lends the researcher to question the nature of knowledge and how it is acquired. The researcher asks questions such as: How is it knowledge acquired? What do we know? What form does knowledge occupy? Knowledge is assumed to be subjective, transactional, value-laden, and progressively understood through experience in a qualitative stance. Furthermore, knowledge is progressively understood through experience from an interpretivist-constructivist standpoint (Ponterotto, 2005). According to Brinkmann (2012), knowing is not something that simply happens; rather, it is something that individuals do as part of their

daily lives. It follows that the nurses working under surveillance will construct knowledge based on their social and cultural backgrounds. Some nurses under CCTV surveillance may find it untenable due to prior negative experiences under that condition. Other nurses may find surveillance necessary due to past positive benefits from it. The researcher then should be keen at uncovering the basis from which participants acquire knowledge.

The Axiological scientific assumptions concern the role of a researcher's values in the scientific process. Values and lived experiences are inextricably linked to the research process and cannot be abandoned in a qualitative study. Some researchers design their studies to minimize value in its process because it is believed to be a source of bias. However, value is emphasized in the interpretivist paradigm because it is assumed that one cannot detach his or her value from the research (Ponterotto, 2005). The population with which nurses work in mental health units is considered vulnerably; therefore, nursing values such as caring, social justice, and advocacy should be evident in the participants' narratives. The researcher's role is to acknowledge this factor and not restrict a fluid exchange of ideas.

The Rhetorical scientific assumption clarifies the language, value, meanings, and voice the researcher intends to project through the work. The researcher makes explicit experience, biases, and expectations since they will inevitably be part or the research process. The question in qualitative research is: How does one convince readers that the knowledge or a "finding" is worthy? Convincing the reader entails evidence that the researcher has immersed him or herself in the study so the story has something plausible to offer (Hogg & Maclaran, 2008). A thick literary and personal description has been

used to document the findings regarding the lived experience of nurses working under constant CCTV surveillance.

The Methodological scientific assumption allows the researcher to identify and outlines the procedures that will be undertaken to conduct the study (Ma, 2015). Researchers in qualitative studies use procedures that are inductive, emergent, and shaped by the researcher's experience (Creswell, 2013). The researcher works from the ground up and makes modification to the research question, data collection, and analysis strategies as may be necessary to better understand the research problem. The procedures used to conduct the research into the lived experience of nurses working under constant CCTV surveillance in mental health units are based on a model of hermeneutic phenomenology.

Phenomenology

Phenomenology is a qualitative approach borne out of a long philosophical tradition in Germany. From as early as the 18th century scholars such as Kant (1724 – 1804), Hegel (1770 – 1830), and Fichte (1762 – 1814) were using the term phenomenology in their discussions. However, it was not until the late 19th century that Franz Brentano's (1738 – 1917) work inspired Edmund Husserl (1859-1938) to make phenomenology a major philosophical movement (Moran, 2002). The aim of a phenomenological study is to explore the hidden meanings or essence participant's lived experience of a concept or a phenomenon as it presents itself to them (Sokolowski, 2000; Creswell, 2013). Powers and Knapp (2011) explained that phenomenology is about returning to a prior experience or one that has already taken for granted to reflexively reexamine it by bringing it into awareness. The researcher's purpose in this framework is

to have participants return to their lifeworlds of experience for a description of constructed meaning.

Merleau Ponty (1908-1961) identified the key concepts of *consciousness, embodiment, perception,* and *experience* as essential to phenomenology. Consciousness is, according to Merleau-Ponty and Smith (1962), human awareness of environment. Consciousness is neither exclusively internal nor external; rather, it is a unified force of mind and body that leads to an experience of the world as both subjective and objective. Merleau-Ponty regarded consciousness as a reflection of lived experience.

Embodiment encompasses both the physical and non-physical "body" engaged in human experience as a cohesive body of awareness (Merleau-Ponty, 2016). Human thoughts, feelings, emotions, and physical body are deeply intertwined into daily experience (Munhall, 2012). Human behavior is thereby understood within a context of relationships to things and situations (Munhall, 2012).

Perception as phenomenological concept is significant because it has a role in making meaning (Munhall, 2012). For example, a participant's perception of a particular phenomenon is reality, regardless of the "truth." More than one individual will perceive the same phenomenon differently in this context. Merleau-Ponty and Smith (1962) additionally conceptualized perception as establishing a two-way dynamic and interactive process of interconnectedness.

Experience is another concept that constitutes concern with the lived world or the taken for granted as pre-reflexive. Merleau-Ponty (1945), posits that individuals are thrown into an existing world which is never fully-formed, with its intentionality and possibilities. Moreover, there is a dialectical interrelationship between the lived body and

the world (Sadala & Adorno, 2002).This relationship indicates a state of continuous eternal coming-into-being whereby an individual is constantly on the move to new possibilities and discoveries fueled by changing circumstances (Sadala & Adorno, 2002).

Phenomenology is rooted mainly in the philosophies of two Germans Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976), as well as their contemporaries Hans-Georg Gadamer (1900—2002), Maurice Merleau-Ponty (1908-1961), Jean-Paul Sartre (1905-1980), Amedeo Giorgi (1931-), and Max van Manen (1942 -) later made significant contributions (Thomas, 2005; Langdridge, 2007). The two main schools of phenomenology include *transcendental phenomenology* grounded in Husserlian philosophy and *hermeneutical phenomenology* rooted in Heideggerian and Gadamerian philosophy. An explanation of transcendental phenomenology from Husserl's perspective and hermeneutical phenomenology from Heidegger's and Gadamer's standpoints is indicated to bring the current study into focus.

Transcendental phenomenology (also known as descriptive phenomenology) was Husserl's attempt to isolate a phenomenon in human consciousness. Husserl, who was also a mathematician, attempted to escape the subjective trap by proposing an objective means to identify the content of human consciousness so it could be the focus of phenomenological scientific study (Lopez & Willis, 2004; Fleming, Gaidys, & Robb, 2003). However, Husserl's aim to construct an objective framework for phenomenology seemed to be influenced by Cartesian duality. Cartesian duality is an ancient (400 BC) concept that there are fundamentally two worlds: one of mental objects and the other of material things (Baker, Morris, & Baker, 2002). Perception of pain, desire, and beliefs are examples of mental objects, and material things are the physical things that occupy our

surroundings such as humans and animal bodies (Baker, Morris, & Baker, 2002). Furthermore, *Intentionality* is a term Husserl used to explain the state of consciousness as a person is directed to some real or imagined object (Creswell, 2013). It is within such consciousness Husserl proposes his three-part reduction to isolate the "essence" of a phenomenon namely *transcendental reduction* (*cogito*), *eidetic reduction* (*noema*), and *phenomenal reduction* (*noesis*) to prevent such tainting (Fleming et al., 2003).

Transcendental reduction (*cogito*) or bracketing involves withdrawal from the natural attitude, the everyday world, or a suspension of one's presuppositions and assumptions about the phenomenon of interest (Gill, 2014). Bracketing is, according to Husserl, a means of isolating the essence of the phenomenon without the researcher's influence. *Eidetic reduction* (*noema*) is the process of isolating a phenomenon through intuitive imagination that identifies the salient attributes that make up the phenomenon, also known as "the things themselves" (Gill, 2014). That is identifying those characteristics of the phenomenon without which it could not exist. Phenomenal reduction (*noesis*) is the process of applying meaning to an intentional object of consciousness. Thus, in Husserl's quest to provide methodological trustworthiness, transcendental phenomenology must be based on objectivity and logic (Fleming et al., 2003).

Hermeneutic phenomenology was Heidegger's response to transcendental phenomenology. Heidegger, who had been a protégé of Husserl, disagreed with his mentor's epistemological construct, which provided the incentive for Heideggerian Hermeneutic Phenomenology (Annells, 1996). In his attempt to construct a phenomenology, Heidegger managed to pivot away from the epistemological focus of

transcendental phenomenology and the traditional use of hermeneutics to an ontological orientation of human existence. Traditional hermeneutics dealt with the interpretation of ancient texts based on the author's original intent (Kennedy, 2014). Conversely, Heidegger (1962) reintroduced hermeneutic methodology with an ontological focus of human understanding and interpretation as a mode of being in the world. In other words, humans intuitively engage in understanding and interpretation in a taken-for-granted manner, instead of as a conceptual exercise. According to Heidegger (1962), humans are intrinsically interpretative beings who go about instinctively projecting understanding on the world of their existence. Heidegger's phenomenology is therefore radically different from Husserl's, because it emphasizes the individual human being as an interpretive entity and deemphasizes the reduction of consciousness as a way of knowing.

Heidegger was concerned with what it meant for humans to be existing in-the-world (Being) (Miles, Chapman, Francis, & Taylor, 2013). Heidegger believed meanings are embedded in one's everyday experience and that there is a need to move beyond the description of an experience to understanding its hidden meanings through interpretation (Munhall, 1993; Johnson, 2000). Heidegger further viewed "understanding" not as a cognitive process or a method or procedure for reflection, but more as a practical mode of being-in-the-world (Wright & Losekoot, 2010). In other words, the understanding of concern to Heidegger is the practical, taken-for-granted, ready-to-hand mode, instead of a conceptual process.

Heidegger (1962) understood that human understanding through interpretation could only be gained by an awareness of time as a horizon. Heidegger, in this instance used the term "temporality" to mean the awareness of time that grounds all

understandings. Temporality is the ordinary world-time such as yesterday, tomorrow, or holiday, and less about clock-time (Heidegger, 1962). A phenomenological experience from Heidegger's perspective is temporally-perceived in the context of the past, present, and future coming together as one. Thus, a participant who examines the lifeworld pre-reflectively asks the questions: Who have I been? Who am I? And, who will I be (Trujillo, 2014)? The researcher who conducts a hermeneutic phenomenological study must consequently be attuned to study participants' temporal horizons of understanding (Mackey, 2005).

Heidegger constructed the concept of pre-understanding to mean one's background, worldview, and the cultural experience one brings to a situation (Warnke, 2011). According to this perspective, one cannot step out of or put aside a pre-understanding due to an individual's continued presence in the world (Laverty, 2003). Researchers who use Heideggerian Hermeneutic Phenomenology need to make their pre-understanding explicit because that is the position from which they think and accesses Being. Heidegger proposed the use of the equally-important *hermeneutic circle* as a means of gaining understanding through dialogue with the participant and text (Debesay, Nåden, & Slettebø, 2008).

Gadamer, who had been a student of Heidegger, shared many of his mentor's concepts and developed his own. These concepts used in this study include the perception that humans are interpretive beings, *dasein* (being –in-the-world), prejudice, the model of the hermeneutic circle, the fusion of horizons, and understanding. Gadamer was also critical of Husserl's transcendental phenomenology from the standpoint that describing a phenomenon in one's consciousness was not that relevant (Fleming et al., 2003).

Gadamer believed humans were *interpretive beings* first, and then they engaged in cognitive problem-solving activities as a secondary task (Gadamer, 1998). Gadamer likewise, shared the concept of *dasein* as referent to a human entity thrown into-the-world of possibilities (Gjesdal, 2006). Gadamer used the term *prejudice* in the same context of Heidegger's preunderstanding to mean judgments one renders about a particular situation before he or she encounters it, and not in a normatively negative sense (Gadamer, 1998). According to Gadamer, everyone has preconceived ideas because it is the horizon from which understanding begins.

Gadamer also uses the hermeneutic circle as a means of understanding a phenomenon. The hermeneutic circle is an ancient rhetorical method of reasoning about a subject to arrive at its understanding. It begins with the anticipation of meaning by starting from the whole text, then to the parts, and back to the whole until understanding is reached**.** Another concept Gadamer posits is the *fusion of horizons* to mean the merging of one's pre-understanding with current understanding to arrive at a more specifically-focused understanding of reality (Gadamer, 1998). In other words, individuals always have some understanding about a certain subject that may or may not be correct. If one maintains openness during a dialogue with the subject, he or she may arrive at a more realistic understanding through the fusion of horizons. Next, Gadamer explains that the *understanding* with which he is concerned is specifically identified as self-understanding or the taken-for-granted "action oriented" and not the "cognitive oriented" exercise in which one engages (Holroyd, 2007).

Gadamer (1998) rejected the objective, value-free readings of a text, in his quest to identify the conditions that could lead to understanding. Gadamer believed, instead

that one could arrive at the inter-subjective meaning of a text from attention to ones pre-understanding, the language of interpretation, the hermeneutic circle, and a fusion of horizons. He asserted that language and dialogue were the essential modes of operation in being-in-the-world (Gadamer, 1998), and that dialogue required an attitude of openness, sincerity, equality, and freedom without hegemony between researcher and participants (Liu & Sui, 2014).

Husserl, Heidegger, and Gadamer did not design methods to conduct phenomenological research. Others such as Moustakas, van Manen, and Fleming et al. designed methods to conduct this mode of research. Each method is not universal in its application, but is based on a particular phenomenological philosophy. Moustakas' qualitative method in particular is based on Transcendental Phenomenology, while the Fleming et al. (2003) model is based on Gadamer's Hermeneutic Phenomenology. van Manen maintains that the method of phenomenology constitutes an attempt to transform the lived experience into a textual mode so that readers can reflectively experience its essence (van Manen, 1990). This study examined the lived experience of nurses working under constant CCTV surveillance has been guided by the Fleming, et al. (2003) five-step approach based on the Gadamerian Hermeneutic Tradition (See Figure 1).

Figure 1: Philosophical Conceptualization

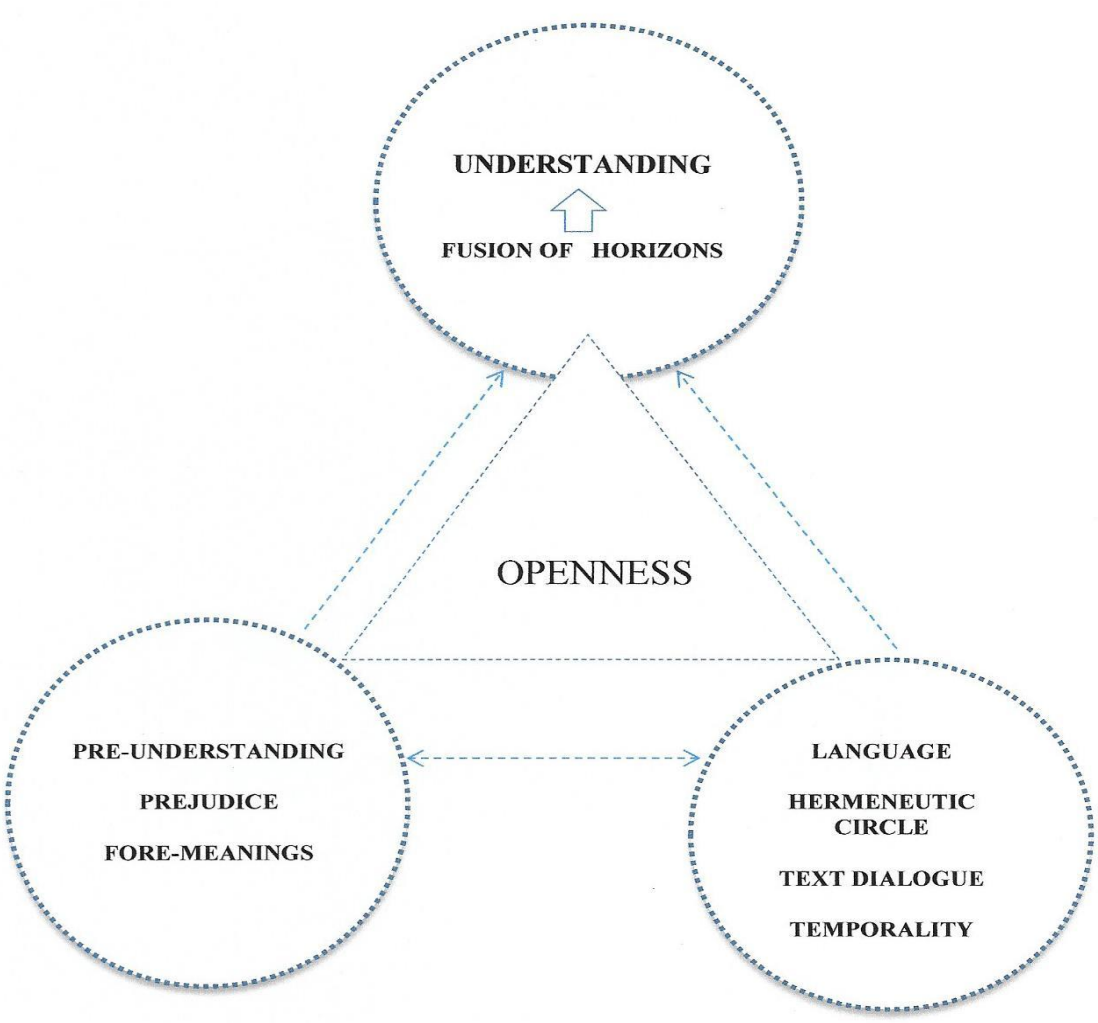


Figure1. Rodney Wallace (2018). A conceptual representation of Heideggerian and Gadamerian philosophy.

1. Preunderstanding is an individual's preformed history and understanding of the world before beginning to think about it that the researcher brings to the study. Since the researcher cannot set aside his or her pre-understanding, Gadamer recommends that the researcher makes it explicit so that the reader can understand what influences the researcher's interpretation.
2. Prejudice is a judgment or set of judgments rendered about a particular situation before it is encountered. The researcher in the current study acknowledged he has formed ideas about electronic workplace surveillance. Gadamer recommends that the researcher remains open to new revelations from the study participants that could add to those ideas.
3. Fore-meaning assumes an individual always enters an encounter with the assumption that it has complete meaning. Such assumptions can be an obstacle to true dialogue. The researcher remained open to other possibilities as they emanated from the text by way of addressing that concern.
4. Language illuminates reality by bringing it into focus. Language is a mediator from the standpoint of both researcher and participants in this study. The researcher spoke clearly for the participants, and asked clarifying questions of the participants when necessary.
5. The Hermeneutic Circle is a means of understanding by which one circles through the whole and part of a text while simultaneously, mixing in preunderstanding, prejudice, fore-meaning, language and imagination. The researcher first read the whole text of interviews taken with participants to gain an initial overall sense of the topic, followed by engagement, reflection, then read small portion of the text, and engaged

in more reflection. This exercise was repeated until understanding of the text was reached.

6. Text dialogue is the process of moving forward and backward between the interpreter and the text. The researcher engaged in repeated reading and interpretation of the text with the understanding that the exercise was always anchored in pre-understanding.
7. Openness is the act of moving away from one's familiarity and allowing for what is new and different. Such action makes one vulnerable to change. The researcher maintained an atmosphere of calm and neutrality with participants and be receptive to new information.
8. Fusion of horizons is the concept of moving from a current understanding (one horizon) to a new understanding (second horizon), thus the fusion of horizons. The researcher's pre-understanding was the current horizon, and the exercise of text dialogue within the hermeneutic circle led to the fusion when a new understanding was reached.
9. Understanding is the natural taken-for-granted mode of being. Understanding in the instance of the current study is the lived experience of nurses working under surveillance as spelled out by the study results (Fleming et al., 2003).

Relationship of Phenomenology to the Study

Healthcare and its related entities are subjective phenomena benefitting from objective measurement and analysis to maximum health as a social good. However, a phenomenological approach is necessary to understand the complex, multidimensional, subjective actions, to optimize the quality of care and health services (Bourgeault, Dingwall, & De Vries, 2010). A hermeneutic phenomenological approach has been

adopted in the current research to study the lived experience of nurses working under constant surveillance.

Phenomenology is about the "lifeworld," also known as the "natural attitude" or the-taken-for-granted world of the lived experience (Pivčević, 1970). Husserl used the term as the taken-for-granted intersubjective reality that provides the foundation for ordinary everyday function (Meisenhelder, 1979). The lifeworld is where humans live, practice, and survive. According to Alfred Shultz, the lifeworld is an individual's naive acceptance of the intersubjective reality of everyday life without doubting one's self and with the understanding that others do the same (Jung, 1974). van Manen (1990) identified the lifeworld as four categories he named existentials. He recommends that the researcher use them as a reflective guide throughout the research. They include *lived space* (spatiality), *lived body* (corporeality), *lived time* (temporality), and *lived human relation* (relationality).

1. Spatiality is the environmental milieu in which people experience their daily lives. It can be safe and comfortable, but it can also be insecure and hostile. The researcher of the current study hoped to understand how nurses working under constant CCTV surveillance view their environment, or their lived space.
2. Corporeality is the body in which one lives, but it is also the one that encounters others. The body conceals and reveals according to various situations. For example, nurses working under constant CCTV surveillance could be concealing therapeutic interventions because of the gaze of the cameras or vice versa.
3. Temporality refers to subjective time and not clock-time. Time seems to speed-up during fun activities, and time seems to slow down during boredom. Individuals take

into account the past, present and future when they deal with others. It is the horizon from which understanding is reached. Nurses who work under constant CCTV surveillance could have a negative temporal experience or positive temporal experience.

4. Relationality refers to the connections individuals maintain with others whereby they form physical impressions of them and develop conversational relationships which allow them to transcend themselves. It is not known if nurses who work under constant CCTV surveillance are able to develop and maintain such relationships.

The focus of the inquiry is directed toward the participant nurses' lifeworld as it relates to working under constant CCTV surveillance. This is understood as the embedded, taken-for-granted, socio-cultural routine of their daily work-life as they interact with each other and relate to the environment in a predictably understandable manner. It is this taken-for-granted lived experience that is the focus of a phenomenological inquiry which has the philosophical and methodological framework the researcher would need to extract subjective meaning. The nurses' role in the mental health work environment is such that the nurse must engage in a series of individual and group encounters that vary considerably daily, and one of the few constants in the work environment is the CCTV surveillance. A hermeneutic phenomenological approach is the appropriate choice for this study, because it is attuned to handling the subjective and unpredictable nature of the daily working routines of the participants. Especially since there is no intent to predict or control the meanings the participants ascribe to their experiences, but to allow them to share their experiences without restriction.

Significance of the Study

A study of the lived experience of nurses working under surveillance was significant because the aim of the researcher has been to bring in focus a potential barrier to optimum patient care and nursing practice. Feelings of stress, fear, and vulnerability have been identified as disadvantages experienced by employees working under surveillance in other industries. Surveillance has also been cited as a limitation on those monitored to only normative functions. If these disadvantages are applied to nurses' workplace, there are clear potentially negative implications for patient safety, nursing practice, health and public policy. This is especially relevant to the profession, since nursing is one of several disciplines in which collaboration is necessary to achieve the goal of optimum patient care in the mental health unit. This study has the potential to provide valuable information to mental health therapists, social workers, counselors, and physicians who share the same treatment milieu and are subjected to CCTV surveillance. A study of this caliber as it highlights the nurses' experiences working under constant CCTV surveillance in mental health unit stands to shed new light on an otherwise under-investigated phenomenon.

Significance of the Study to Nursing

Mental health nursing has witnessed the proliferation of constant CCTV surveillance in the workplace which may be a stressor adversely affecting job satisfaction, exacerbating an overall national and global nursing shortage, and negatively impacting quality nursing care (Lee & Kleiner, 2003; Al-Rjoub, Zabian, & Qawasmeh, 2008). A great number of nurses quit the profession prematurely due to factors in their work environment beyond their control perceived as making it difficult to provide safe

patient care (Hinshaw, 2008). Studies in other industries have confirmed that employees working under electronic surveillance experience low morale, stress, uncertainty, and an uncomfortable vulnerability (Vorvoreanu & Botan, 2001). Although electronic surveillance is not unique to nursing, the potential problems nurses might experience due to this condition would be uniquely theirs. This study stands to provide evidence to address potential problems in nursing such as job dissatisfaction, the nursing shortage, and negative nursing care outcomes.

Implications for Nursing Education

Nursing education is tasked with the responsibility of preparing nurses to work in various healthcare settings. It is important that nursing students are fully-aware of the environment in which they will practice, any potential barriers, and the implications for their job satisfaction inherent to those barriers. If electronic surveillance of nurses causes them to experience stress, fear, and feelings of vulnerability, nursing education should address such barriers in nursing student population so they can prepare before they enter the workforce. Such preparation could inform students' career choices and add to their job satisfaction. This study may reveal important information that nursing educators can integrate into their curricula to alert nurses regarding the implications of constant CCTV surveillance on their practice. Information gleaned from the study also may be of value to nurses already in the workforce to guide their decision-making about their work environment.

Implications for Nursing Practice

CCTV surveillance was initially conceived and developed for the prison system to deter deviant behavior with the threat of punishment. The implication of wrong-doing

inherent in surveillance measures has a different effect in the medical field because nurses are perceived as highly ethical and trustworthy among professionals according to Gallup (Riffkin, 2014). Nurses need the freedom to use all their expertise to care for the patient. Artistic nursing often requires that the nurse steps away from normative functions to be imaginative, intuitive, and creative to meet patients' needs that do not fit the norm (Robinson, 2014). One of the four messages that came out of the Institute of Medicine (IOM) initiative on the Future of Nursing is that nurses should practice to the full extent of their education and training (Fitzpatrick, 2010). The report identified regulatory issues, policy barriers, the high rates of turnover among nurses, and the aging workforce as obstacles preventing nursing professionals from fully practicing. A study of nurses working under constant CCTV surveillance could add to the literature on the potential barriers to nursing practice.

Implications for Nursing Research

Nursing is a caring profession, but it is grounded in nursing research (Carter, 2007). It is often taken for granted by the frontline nurses that the techniques, procedures and technical information they use in day-to-day practice are generated through nursing research. Nursing research is necessary to expand the body of nursing knowledge, but its findings are also an opportunity to enhance nursing care and job satisfaction (Bassett & Bassett, 2003). A study of the lived experience of nurses working under constant CCTV surveillance stands to add not just to the body of knowledge dealing with workplace surveillance, but to current literature on the nurse workplace experience. The researcher of this the study aimed to give voice and opportunity to the nurses to speak about a potential barrier to patient care and nursing practice. The findings from this study can

inspire other nursing researchers to conduct other studies about the surveillance of nurses using other methods and approaches.

Implications for Health and Public Policy

Electronic monitoring of workers has become commonplace at in mental health inpatient treatment settings in the U.S. This practice has received a great deal of statutory and public support because its proponents have advanced a more compelling argument for its use. However, if the disadvantages of CCTV surveillance apply to nurses who work in the mental health units, as they do in other industries, the negative implications for the quality of patient care and nursing practice could be greater than expected. When nurses work in an environment that is stressful, or they are limited in their practice (Fitzpatrick, 2010), it adversely affects patient care (Moustaka & Constantinidis, 2010).

This study could be informative in helping the nurse take steps to prevent negative health problems that occur in the work environment, alleviating stress, depression, and sense of vulnerability due to constant CCTV surveillance. Policy makers could use information from the study to inform their decisions on nursing shortages, working conditions, and patient care outcome. Studies have shown that factors in the work environment can become barriers to nursing practice and job satisfaction.

Scope and Limitations of the Study

The study was restricted to a small number of RNs who have worked under constant closed-circuit television (CCTV) surveillance in inpatient mental health facilities of South Florida. Each RN participating in the study has had a minimum of two years FL license, at least two years working experience in a mental health unit under constant CCTV surveillance, worked a minimum of 24 hours per week performing direct patient

care, and hold non-managerial or supervisory positions. The aim of the study has been to provide a voice to a highly-trusted group of professional RNs to share their experiences of what it has meant to work under surveillance. The adopted hermeneutic phenomenological approach provided both researcher and participant's unlimited range to explore the phenomenon. The limitations of the study include the novice researcher's level of experience with conducting research, the Hawthorn Effect, and the possibility that participants may not have been candid.

Chapter Summary

This chapter has provided an introduction to the study of the lived experience of registered nurses working under constant close circuit television (CCTV) surveillance in the inpatient mental health unit. It began with a background addressing the history of surveillance globally, nationally, and in the workplace. A discussion of the statement of the problem, the purpose of the study, and the research question guided the study have been presented. The philosophical underpinnings were discussed clarifying interpretivist –constructivist assumptions, Heideggerian and Gamaderian hermeneutic phenomenology, and the relationship of phenomenology to the study. The significance of the study to nursing, as well as implications for nursing education, practice, research, health and public policy have been addressed. The scope and limitations of the study were delineated. Chapter Two will ensue with a review of the literature and experiential context.

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this hermeneutic phenomenological study has been to understand the lived experience of nurses working in mental health units under constant Closed Circuit Television (CCTV) Surveillance. The intent of a literature search is to gather material to deepen one's understands of these other perspectives on this topic (Munhall, 2012). The researcher undertakes a literature review to identify the salient topics, analyze them, and present them to the reader who will not have to access each individual research report (Aveyard, 2014). However, there is no consensus on when to conduct a literature review in a phenomenological study. Munhall (2012) is for an early literature search for experiential reasons.

There are no universally-agreed upon inclusion and exclude criteria for a literature review. Olivier (2012) believes the selection of literature depends on how the researcher decides to present the argument to the reader. Dawidowicz (2010) recommends, as a general rule, that the inquirer should include sources from a wide variety of literature including report summaries, quantitative studies, and qualitative studies. Other recommendations include that the researcher should identify the research frameworks, study design, methodology, data gathering tools, and results. Ultimately, the aim of this literature review is to identify what has been written about the lived experience of nurses working under constant CCTV surveillance. A synthesis of the studies exposed the gap in the research literature and validated the need for this study.

An extensive literature search was conducted using the electronic databases and University Libraries: PsycINFO, ProQuest, Medline, CINAHL, Google Scholar, and

EBSCOhost for English language, peer-reviewed, scholarly literature**.** The keywords include: "workplace electronic surveillance nursing," "workplace closed circuit television surveillance nursing," "video surveillance of mental health /psychiatric nurse, "workplace electronic surveillance," workplace electronic surveillance and privacy," advantages and disadvantages of workplace electronic surveillance." The terms "video surveillance" and "closed circuit television (CCTV)" are used interchangeably, as are the words "monitoring" and "surveillance." The literature search initially was restricted to five years. However, since miniscule relevant data was found on CCTV surveillance in nursing over the time period, the search was extended to twelve years. Relevant data on workplace electronic surveillance in other industries has been included. The literature review is presented in the following categories: historical context of electronic surveillance; outcomes of workplace electronic surveillance; workplace electronic surveillance and privacy, and the paradox of workplace electronic surveillance.

Historical Context of Electronic Surveillance

According to Holland, Cooper, and Hecker (2015), workplace surveilling is not a new phenomenon. The practice of monitoring workers goes back as far as slavery when the masters monitored slaves to ensure they worked (Fuchs, 2013). Modern surveillance has its roots in the industrial age of the factory system. Fredrick Taylor (1856-1915), one of the architects of the factory system in the U.S. made surveillance more efficient when he introduced "scientific management." Late in the 20th –century a proliferation in electronic surveillance at the workplace and worldwide occurred because of an advancement in surveillance technology and a subsequent decrease in its cost. According to Schmitz (2005), it was in the 1990s that a sharp increase in the use of surveillance in

the workplaces was noted. By 1996 it was reported that 80% of all (U.S.) companies keep their employees under regular surveillance (Schmitz, 2005).

The boom in commercial use of electronic surveillance has been viewed by some as a deliberate marketing move by companies that develop electronic equipment for the military (Wood & Webster, 2009). Electronic surveillance technology initially had been developed for the military during the Cold War between the U.S. and the then Soviet Union. When the Cold War ended there is a variety of electronic surveillance tools available to the public. Software is now available for monitoring e-mail, voice communication, count keystrokes, or to track the amount of time employees spend away from their computers; ID location badges that electronically transmit employees' locations to a computerized map; global positioning systems (GPS) in smartphones and motor vehicles, and mobile and stationary CCTV cameras in many public spaces (Schmitz, 2005). The global electronic surveillance economy is estimated to be $100 billion (Cho, 2014).

Employers have presented four main reasons why they need to conduct electronically surveilling of their employees namely to manage resources, maintain productivity, protect corporate interests and trade secrets, and manage risk (Ball, 2010). It is difficult to dismiss their claims when it is reported that there is an estimated $400 billion annual loss among businesses in the U.S. from employee illegal activities such as theft, embezzlement, acts of sabotage, misuse of time, and false claims (Gomez-Mejia, Balkin, & Cardy, 2004). It is also understandable why the U.S. Courts have found the employers' needs to monitor their employees more persuasive than an employee's need for privacy at the workplace (Ghoshray, 2013). There are nevertheless numerous

unanswered questions about the potential adverse effects of electronic monitoring of the employees that warrant investigation (Rosenblat, & Kneese, 2014).

Employees have identified diminished privacy, stress, other emotional problems, and distrust between employee and employer as disadvantages of electronic surveillance. It is argued that humans need a protected private space to think new things, germinate new ideas, and meet with others without surveillance (Allen, Coopman, Hart, & Walker, 2007). Studies have shown that electronic monitoring of employees can lead to poor health problems and hostile work environments (Lee & Kleiner, 2003). Electronic monitoring the employees can put strain and tension on the employer-employee relationship leading to distrust, especially when the employees' concerns are ignored (Ball, 2010).

There have been a number of studies done on industrial surveillance, but the effects of surveillance in the mental health nurse environment are not well documented. Closed Circuit Television (CCTV) was introduced in British mental institution for the first time to observe patients' behavior in the1960s (Davies, 1962), but it was not until 2002 CCTV cameras were noted more frequently in mental health workplace in Britain (Desai, 2011). Chambers and Gillard (2005) found that nurses who worked in mental health units under constant CCTV surveillance were very concerned about being watched by managers: In the same review, some nurses reported that they changed their practice by not engaging certain therapeutic activities with patients to avoid being misunderstood by the camera viewer (Chambers & Gillard, 2005). These revelations that CCTV surveillance has negative consequences on nurses' therapeutic actions are troubling, since it places limits on the quality of care the patient receives.

The historical information on electronic surveillance has highlighted salient issues related to the topic. One constant is that electronic surveillance has become so pervasive and integrated into modern society that it is now being taken for granted. However, such change has been allowed to happen without much research to determine its individual or collective effects on individuals' lifestyles. Some studies have identified possible benefits and shortcomings of electronic surveillance; but very little has been written on its implications for nurses working under surveillance in mental health units.

Outcomes of Workplace Electronic Surveillance

Jeske and Santuzzi (2015) conducted a quantitative exploratory study of 190 students from higher education institutions located in the Midwest of the United States to examine the effects of different electronic performance monitoring (EPM) techniques on attitudes such as job satisfaction, affective commitment, organizational citizenship behaviors (OCB), and perceptions of control. The students were employed in various industries that used a variety of electronic surveillance means to monitor them. The students were invited via email to participate in an online two-part survey to learn which electronic surveillance monitoring techniques (video cameras, data entry, chat and phone recording) were associated with negative employee reactions. They were asked the following questions: What is the overall effect of different electronic performance monitoring (EPM) techniques on attitudes, organizational citizenship behaviors (OCB), perceived control and self-efficacy? To what extent are attitudes such as job satisfaction and affective commitment influenced by different forms of monitoring? To what extent is (individually achievable) OCB influenced by different forms of monitoring? To what

extent are perceived control and self-efficacy influenced by different forms of monitoring?

The participants were asked to answer two questionnaires two weeks apart. One questionnaire was about the employee (first variable), and the other was the environment (second variable). The data was analyzed using analysis of variance (ANOVA) to measure the overall effect of various monitoring techniques on each of the outcome variables: techniques on attitudes, OCB, perceived control, self-efficacy, and job satisfaction. The findings of the survey were significant for work attitudes depending on which activities of the work were monitored and the type of monitoring device in use (e.g. chat, data entry, telephone, cameras at work stations). Other significant findings were that:- electronic chat, camera, activity monitoring, and location monitoring decreased OCBs in the workplace ($F(1,163) = 6.227$, $p = <.014$, $\eta 2p = <.037$) ; while perceived control and self-efficacy were negatively affected by data entry and chat monitoring ($F(1,163) = 6.210 p <= .014$, $\eta 2p = <.037$), and self-efficacy was lower when the monitoring involved access monitoring ($F(1,188) = 7.288$, $p = <.008$) . The results were consistent among all outcome variables that monitoring employees with electronic devices has a negative impact on their morale. The authors recommended a balanced and transparent approach when introducing EPM to improve employees 'morale. However, the study was inconclusive about the negative effect of EPM on employees' perception and productivity. Additional research was recommended by the researcher of this study to explore such factors.

Rafnsdóttir and Gudmundsdottir (2011), surveyed 984 employees that worked for six high-technology companies in a mixed study (cross-sectional and qualitative semi-

structured interviews). Questions included opinions about the electronic performance monitoring (EPM) of employees, their attitudes to the monitoring, and their psychosocial work environment. Employees were selected from two different working groups—those who worked under surveilled by EPM technology and those who did not work under EMP technology. The hypothesis was that employees who worked under EPM technology would report a worse psychosocial work environment than those who did not, independent of their work tasks. Respondents were asked to complete a questionnaire containing 76 items based on *The General Nordic Questionnaire for Psychological and Social Factors at Work*. The questionnaire contained multiple-choice questions about the work experience under EMP.

The qualitative data of this survey was based on semi-structured, in-depth interviews with 12 employees. Using Chi-square analysis, women and men who did not work under EPM disagreed on whether or not it increased their security (74.4*%, $p < .05$); and those who worked EPM also disagreed that it did not increase their security (65.6*% $p < .05$). In addition, chi-square analysis of data on men and women that worked under EPM, and those who do not work under EPM, reported psychological discomfort among them (72.5** % $p <.001$; and 59**% $p< .001$ respectively). The results showed significant statistical evidence that employees working under EPM experienced a worse psychosocial work environment than their counterparts. Employees who did not work under EMP surveillance and who thought it would be bad for them psychologically had a higher statistical significance that those who did (72.5%). Despite the negative psychological outcome participants reported having experienced during the study, the authors expressed pessimism about any change in EPM because it has become a

competitive tool in the marketplace. The recommendation offered was for a study to be conducted to examine longer-term data on the effects of EPM on employees' psychological work environment since cross-sectional studies are known to be weak on generalizability (Rafnsdóttir & Gudmundsdottir, 2011).

Kassim and Marzukhi **(**2014**)** conducted a correlational study among 185 employees in three organizations in Klang Valley, Malaysia to determine the effect of EPM on employee organizational commitment. The three levels of commitment were determined as based on Allen and Myers (1990) organizational commitment models including affective commitment, continuance commitment, and normative commitment. The affective commitment is recognized as a belief in and desire to accept the organization's goals and a willingness to focus effort on helping the organization achieve them. Continuance commitment is defined as the willingness to remain in an organization because a "nontransferable" investment the employee has in the job. Normative commitment is the feeling duty, and obligation one feels to his or her workplace.

The study measured employees' commitments against three variables: intention to alter or manipulate the EPM system; accept or comply with the EMP system; or avoid or escape the EMP systems. A 35-item questionnaire was used to conduct the survey. It met Cronbach's Reliability Standard of greater than 0.5 for social science research. All items on the questionnaire were between 0.610 - 0.923. A proportionate stratified random sampling strategy was used to reduce errors. The study produced nine hypotheses.

A regression analysis was conducted to analyze the correlation between variables. The result found a negative correlation (r = -.145, $p < 0.05$) between affective commitment and intention to *alter or manipulate* EMS; a positive correlation (r = .292, p

< =0.001) between and *accept and comply* with EMS; and a positive correlation (r = .485, p = 0.001) between *avoid and escape* the EMS. In general, there was a positive correlation (r = 0.485, p = 0.001) between *intention to comply* with EMS and a negative correlation (r = -0.155, $p < 0.05$) between *accept and avoid* the EMS. Five hypotheses were supported (H1, H5, H7, H8, H9). The most significant was H9 with the highest strength (B = 0.495, p = 0.001) in two areas; continued commitment and the intention to avoid or escape. A conclusion that can be drawn from the study is that employees who share continued commitment were the most threatening to the organization because their commitment was based on rewards instead of identity. It is assumed that if a better salary and job became available, those employees would probably leave the organization. The recommendation arising from the survey included the points that employers should recognize how EMS mitigates employees' sense of commitment, what type of commitment the employees have to the organization, and make policy changes to rectify them.

Haley, Flint, and McNally (2012) conducted a two-part cross-sectional correlational study at call centers in Canada to determine the effects of employees' perceptions of organizational monitoring systems on employee turnover intentions. In-house and external agencies monitored the calls. The first part of the study dealt with employees who handled inbound calls. Seventy-eight participants were randomly selected form an employee pool of 428. The second part of the study dealt with employees who handled outbound calls. A total of 89 employees out of a pool of 312 employees were randomly selected. There were significantly more women in the study than men (t = 4.36, $p < .001$). Employee perception of the monitoring was measured on a seven-point Likert-

type scale ranging from 1 (strongly disagree) to 7 (strongly agree). The Cronbach's α scores were 0.91 and 0.93 for items measuring perceptions of in-house monitoring procedures and for items measuring perceptions of external agency monitoring procedures respectively. The hypothesis drawn from the survey was that employees' general perceptions of monitoring procedures inversely affect employee turnover intentions.

A regression analysis of data from the first group showed that employees' reactions to the monitoring of in-house conversations had a significant effect on their turnover intentions (β = -.31, p < .01). The result likewise showed a significant effect on turnover intentions related to external monitoring agencies (β = -.35, p < .01). Both results were consistent with the hypothesis. For the second group, regression analysis of data showed reaction to in-house monitoring where the agents' conversation had significant effects on turnover intentions (β = -.23, p < .05); and reaction to monitoring on time spent between calls showed a significant effect on turnover intentions (β = -.32, p < .01).

Both results supported the hypothesis. The study underscores the need for employers to balance their need to monitor the employees against the downside risk of frequent turnovers within the organization, since it could contribute to reduced production in the long run. Despite the significant information gained from the study, the authors recommended a more extensive study involving more call centers due to the cross-sectional nature of the study that has limited generalizability.

A comparative study was conducted by Suri and Rizvi (2008) in India on the stress levels of domestic versus international call center employees under intense

electronic monitoring to meet deadlines. The study also compared female and male stress scores among employees in both domains. The Life Stress Scale of 55 items (reliability score 0.88) and Mental Health Inventory (reliability score 0.75) scale of 33 items were the tools used to measure stress levels. Convenient samples of equal number of domestic (N=50) and international (N=50) call center employees were selected from domestic and international call centers. The sample had equal numbers of males and females. Stress tests were administered to the participants. Data was analyzed with the help of analysis of variance (ANOVA) and *t-test* to determine significance among the groups.

Results from ANOVA demonstrated that the effect of stress on call center employees produce significant scores, F (1) =8.55; p<.004; and the main effect of gender on stress scores was also significant F (1) =8.01; p<.005. The interaction of call center and gender also showed high significant values as F (2) =10.1; p=<.002. Male employees from domestic and international call center differed significantly with one another on stress scores (t=5.33, p=<.01) as international call centers participants have higher stress scores. Men and women from domestic call centers differed significantly (t= 5.26, p=<0.01); men had higher stress scores. The researchers believed that because men and women in the international call centers perform similar tasks, there was no significant difference in their stress scores. However, men in the domestic center performed mainly fieldwork leading to higher stress scores than women. Call center employees are under intense pressure to perform because of intense monitoring to maintain productivity. The subsequent recommendation was that employers should institute stress management programs in call centers to address mental health issues. Another recommendation was to

conduct a more extensive study of call centers on call center stress levels, because the sample size was too small for comparison of the global market with a domestic one.

A correlational study was conducted by Chang, Liu, and Lin (2015) of 81 employees whoworked in various organizations that were culturally control-oriented, flexible-oriented, and performed various types of electronic monitoring on their employees. These organizations provided financial, educational, manufacturing, technology, legal and accounting services. The aim of the study was to determine the effect of organizational cultures on employee surveillance. Control-oriented organizations contain elements of effectiveness and consistency; that is their employees work according to strict guidelines and expectations. Conversely, flexible-oriented organizations contain characteristics of innovativeness and cooperation (Chang, Liu, & Lin, 2015). Six hypotheses surfaced as a result.

Data was collected using a questionnaire found to be reliable based on the partial least squares method of structural equation modeling (PLS-SEM) and Cronbach alpha. Each questionnaire was measured on a seven-point Likert Scale, ranging from "strongly disagree" (extremely unimportant) to "strongly agree" (extremely important). A regression analysis found H1, H2, and H5 to be statistically significant (B= -0.382, p=0.0008; B=-0.267, p=0.0075; B=-0.482, p=0.0032).The perceived degree of monitoring significantly and negatively affected employees' trust in the employee monitoring policy (B= -0.0.481956, p = -0.003169). The study, furthermore found that control-oriented organizations are associated with distrust because of boundary turbulence between employee and employers generated by the coercive nature of work environments enhanced by electronic surveillance. A flexible-oriented working environment had, by

contrast, a higher degree of trust because there was less boundary turbulence among workers, including more communication, creativity, empowerment, teamwork, and dynamism among them. The recommendation for future studies was that larger sample sizes should used and an organization should be studied according to its size, which correspondingly may yield different perceptions of electronic monitoring.

These studies identified a wide range of outcomes under these conditions whereby electronic surveillance is in use at the workplace. Jeske and Santuzzi (2015) conducted an exploratory study on the outcome EPM on employees relative to negative attitudes toward work, less self-control, and less self-efficacy. Rafnsdóttir and Gudmundsdottir (2011) conducted a mixed study and uncovered outcome such as report of poor psychological work environment among employees working under EPM. Even those employees who did not work under EPM voiced negative views about it. Kassim and Marzukhi (2014) held a correlational study and found similar negative experiences among the employees. Employees working under EPM expressed little loyalty to the organization, and were prepared to leave the job at any time. The cross-sectional study conducted by Haley, et al. (2012) and Suri and Rizvi (2008) found that call center employees working under intense EPM expressed a high level of intention to leave the job stress and burnout. Chang, et al. (2015) found that when an organization employs too much surveillance over its employees, the practice leads to distrust and boundary turbulence, while the opposite leads to increase communication and creativity**.** These studies have highlighted several significant shortcomings of EPM in relation to its psychological toll on employees. However, none of the studies addressed the lived

experience of nurses working under constant CCTV surveillance in the mental health unit. Hence a study of this type warrants exploration.

Workplace Electronic Surveillance and Privacy

Ball, Daniel, and Stride (2012) conducted a mixed-method study of two call center employees who experience electronic surveillance, to highlights the importance of privacy to the employee. A sample size of 91 answered a 6-point questionnaire on a 5-point Likert Scale, and a smaller sample gave semi-structured interviews for the qualitative aspect of the study. The study questions were: What are the distinct dimensions of privacy that can be identified in the chosen organizational setting of a telephone-based call center? How do these dimensions of privacy identity relate to the demographic and employment characteristics of employees? How are employees' levels of these dimensions of privacy associated with their training in customer data protection, and the importance of such data protection in their role?

Statistical analysis was done using Spearman's *r* Correlation Coefficients to test the relationships between each of the three privacy dimensions and the survey items relating to data protection training, withholding information, and leaving employment due to privacy concerns. The study investigators identified three notions of privacy: personal information privacy, architectural privacy (workplace environment), and solitude. There were positive correlations among the variables ($0.27 < p < .30$), albeit moderate in strength. That is, employees had a negative perception of the organization when these privacy boundaries were crossed. A gender difference was identified regarding privacy, as women crave architectural privacy more than men (Ball, Daniel, & Stride, 2012). The study showed that there are wider dimensions to the notion of privacy

than the usual information privacy classification and that employers should attend to how they affect the employee and the organization. Designing the workspace to accommodate employees' privacy needs is a novel idea. Recommendations were made for future research to explore these new concepts of privacy in the context of open-plan working, email circulation, and social networking.

Coultrup and Fountain (2015) conducted a quantitative correlation study of full-time faculty and administrative staff members at a small Southern liberal arts university in the Sandhills of North Carolina. The point of the study was to verify a prior finding (Samaranayake, & Gamage, 2012) that if employers are transparent with electronic surveillance in the workplace, employees will trust the employers, be more amenable to compromise privacy and agree to constant electronic surveillance. The authors assumed that employees had established a psychological contract with their employers interpreted as an exchange of multiple-agreed upon promises based on trust, equity, and procedural fairness.

Ninety-two questionnaires were distributed to faculty members of which 63 were returned. A further eight were disqualified due to open-ended write-in responses, and 55 questionnaires were usable. Each question had a five-point Likert-type scale ranging from "agree" to "disagree." The average age of the respondents was 46 years old, with nine years working experience at the current institution. Men represented approximately 51% of the sample, and women 49%. The following hypothesis was consequently constructed: There will be a positive correlation to prior knowledge of the institution's policies and procedures on Internet usage and email communication and trust by the employee that the organization has the responsibility of monitoring Internet and email activities.

The analysis was completed using a two-tailed *t*-test to determine whether or not there was a significant difference between the mean response of men and women at *p*-value < 0.05. The Pearson Correlation Analysis was also used at *p*-value < 0.05 to test for a significant relationship between responses. The study found a gender difference in that men were more vociferous about their privacy thanwomen. Overall, there was a negative correlation between employees' psychological contract with their employers and trusting them to engage in unfettered electronic surveillance (statistical significance not reported). The study contradicts a prior research conducted by Samaranayake and Gamage (2012), which suggested that when employers are transparent, employees are encouraged to compromise their privacy. The study was limited because of the convenience sampling technique and cross-sectional data type. Recommendations included a longitudinal research that could explore exploring of trust, privacy in the context of a psychological contract.

Luther and Radovic (2012) conducted a phenomenological study to explore Japanese notions of privacy and perspectives on electronic surveillance carried out by companies and the government. The two-part study was conducted at a university in Japan. The first part included two focus groups (*N*=5; *N*=7) of graduate students in 2008, and the second part included professionals who participated in one focus group (*N*=5) and individual interviews (*N*=3) in 2010. The snowball sampling technique was used to recruit students and professionals who were from different areas of Japan, and they worked in different industries. The focus groups sessions lasted 90 to 120 minutes, while individual interviews lasted from 60 to 90 minutes.

The results were discussed under the themes derived from data analysis which were privacy, company monitoring of communication and behaviors, and governmental monitoring of communication and behavior. The authors pointed to a possible difference between the way Japanese and Americans view privacy rooted in their different histories prior to conducting the study. The study did reveal that Japanese viewed privacy as something very intimate such as that associated with a personal diary or keeping a secret from their parents. A distribution company employee reported that privacy to him was like hiding something from his wife and her hiding something from him. In terms of companies monitoring communication and behaviors, the participants voiced mixed opinions. One female ward office worker indicated that employees knew that they should not be using the company's computer during work hours for private use. Some participants had reservations about being monitored by cameras. A woman writer responded, "I would absolutely hate that […] it really would come across as surveillance" (Luther & Radovic, 2012, p. 270). A man employed by a distribution company agreed by adding, "If my company were to do that, I would vigorously protest" (Luther & Radovic, 2012, p. 270). Unanimity among groups was recorded regarding governmental monitoring of communication and behavior. Individuals and focus groups expressed belief that for security reasons the government must collect data on the citizens. One participant mentioned that he did not mind the government surveilling him because it was not "close," so it could embarrass him with his private secrets.

The notion of privacy is contextual; therefore, the investigators of these studies looked at privacy within the context of electronic surveillance. Ball, Daniel, and Stride (2012) conducted a mixed-method study to identify three notions of privacy at the

workplace that could be innovative in enhancing employee-employer workplace harmony. A progressive initiative taken by employees to meet employees' unique privacy needs in the e workplace around personal information privacy, architectural privacy, and solitude showed promising results. Coultrup and Fountain's (2015) correlational study identified participants who were very amenable to relinquishing some of their privacy to electronic monitoring because the employer was transparent about it. These participants did not believe any amount of transparency changed the way they felt about private information. Luther and Radovic (2012) conducted a phenomenological study highlighting the role culture plays in privacy. Despite being a phenomenological study, it revealed that Japanese culture could be less sensitive to surveillance than American culture, as the study participants endorsed government surveillance on the basis of national security. Privacy at the workplace has been one of the most contentious issues in the current electronic surveillance age, and these studies have highlighted why this is the case. However, the focus of this current study stands to add depth to the issue, since it is a study on the lived experience of CCTV surveillance of nurses working in the mental health units. The above cited studies have not addressed this particular phenomenon.

The Paradox of Workplace Surveillance

In a mixed method study of workplace surveillance, Allen, Coopman, Hart, and Walker (2007) conducted 154 interviews of managers and non-managers from a variety of organizations to identify the ways organizations, employees, and coworkers describe electronic surveillance and their privacy expectations in the San Francisco area of California. Some of the organizations were companies in the field of high-technology, financial, insurance, telecommunication, transportation, and education. Students enrolled

in a graduate course were trained to conduct from one to three interviews. Each student conducted from one to three interviews. The interview guide included six primary questions: “Tell me about the ways your organization uses technology to monitor employees at work?” “How did you learn about the monitoring?” “How did your organization explain why it needs to monitor employees at work?” “What do your coworkers say about the organization’s monitoring of employees?” “What have you heard others say about what they are doing to avoid being monitored?” and “How do you feel about being monitored?” The interviewers asked follow-up questions when necessary to encourage interviewees to elaborate. The study revealed two hypotheses.

Hypotheses one indicated that 49% of the employees believed that surveillance is a form coercion and control that protects the company from employee dishonesty and noncompliance and increases productivity by promoting efficiency. However, Hypothesis Two supported the opposite premise, as employees identified 39 strategies to circumvent electronic monitoring. These range from the use of personal equipment at work (e.g., cell phones or e-mail; 20%); avoid being seen (e.g., telling each other to stay out of camera’s view or be careful, wait until work is finished, and there are no customers around, and turn off volume of instant messaging); and taking into account that the company records personal e-mail, so that words and topics are accordingly monitored. This study underscores the dichotomous relationship some employees have with electronic surveillance. Employees believed surveillance was good to weed out dishonest employee, but at the same time, they try to circumvent the same monitoring system when they are the object of the monitoring. This study supported previous investigations, as it uncovered that employees who have been socialized early in the employment process into

believing that electronic surveillance is beneficial are willing to give up their privacy (Allen, Coopman, Hart & Walker, 2007). The study was limited in its scope because it used a convenience sample. The recommendation was for a follow-up longitudinal or ethnographic study to gather more substantive data.

Whalen and Gates (2010) conducted a qualitative study of eight individuals who reported having had a positive experience working under constant surveillance. These individuals maintain or have top-level security clearance, which was one of the inclusion criteria. The participants were chosen purposively; there were seven men and one woman who worked for the United States (U.S.) government in some national security capacity. The specific location of the study was not mentioned except it was conducted in the U.S. The participants were divided into two groups of four. Semi-structured phone interviews were conducted on each group eight months apart. The participants were asked questions about their experience with security screening, ongoing requirements for reporting, and any critical incidents in the workplace that affected their attitudes toward monitoring. The data was analyzed using thematic coding.

The findings consisted of major themes and subthemes. Major themes included: employee monitoring, compensating factors, complicating factors and aspects of the work and workplace. Subthemes included: personal security, catching mistakes or having a "second set of eyes," simplifying collaboration, audit trails and procedures, professionalism, openness, scope, and use of technology. The participants felt comfortable with the monitoring because of the high-security nature of their jobs. Participants additionally reported that once monitoring is transparent and open, it is not a problem for them. One participant said, "I trust my agency far more than the government

at large" (Whalen & Gates, 2010, p. 21). However, some participants expressed reservations. One participant mentioned that he could not have friends because they would be investigated. Another shared that he had a friend whose visa status was questionable, but he was obligated to report the contacts with a foreign national, so he did. The authors of the study recognized that their study presents a unique case and that most people do not have a similar experience at their workplace. Recommendations to employers included making an effort to be transparent, open, and not be unnecessarily intrusive with surveillance so that employees may be more accepting of it. For future research, they recommend a more extensive study with a large sample.

Samaranayake and Gamage (2012) conducted a correlational study in Sri Lanka at software companies that electronically monitored their employees to determine its effect on job satisfaction (dependent variable). The sample size was 380 participants. The independent variables were perceived level of infringement, relevance to work, rationale of employer, invasion of privacy, task satisfaction, and personal judgment of effectiveness. The data was collected via an online survey using a 75-point questionnaire. Sixteen hypotheses were developed for the study. Statistical testing was done using inferential analysis, regression analysis, and ANOVA. The study found mixed perceptions among employees in their relationship to electronic monitoring and their job satisfaction. The participants in the study did view surveillance as an advantage if it was relevant to uplift the quality of their work and help with job promotion ($p<.01$, .251**). However, if the employees perceived electronic monitoring as a means of coercion and invasion of privacy, they did not like it ($p<.01$, −.241**). The implication of the study is that when employees view electronic surveillance negatively, it is a source of stress to

them; however, if employers limit surveillance to only work necessity, they could decrease the risk of alienating the employees (Samaranayake & Gamage, 2012). The authors recommended additional studies in different geographical locations, age groups, and samples sizes.

Holland, Cooper, and Hecker (2015) conducted a correlational study of companies that performed electronic monitoring and surveillance (EMS) of their employees to examine the relationship between EMS and employee's trust in management. A total of 500 employees were randomly sampled from a residential telephone book for a telephone survey. The sample was further stratified to reflect geographical distribution of the population. A total of 54% of the respondents were men with a mean age of 41.16 years (*SD* =12.24). The mean number of hours worked per week was 36.72 (*SD*= 123.33). Respondents were asked to answer a four-point questionnaire that was found to be internally consistent (*a*= 0.86) reliable and valid. Each of the items on the questionnaire was rated on a five-point scale ranging from 1=strongly disagree to 5=strongly agree. Four hypotheses emerged from the data.

The analysis was conducted using *Probit* and *OLS* regression models. The results found that the greater the EMS of employees, the greater the distrust they had of management (manual employees *B*=-0.35 and non-manual *B* =-0.05). However, the result was mixed because non-manual employees had a very low level of distrust in management. The overall difference in manual and non-manual employees distrust for management was *(B* = -0.13). The study has limitations because of the cross-sectional nature of the data. The authors recommended a study of the decision-making process, and the level of collaboration management undertakes when it institutes EMS measures.

The above studies highlighted the ambivalence some employees have with electronic surveillance because of its advantages and disadvantages. For example, Allen et al. (2007) found that almost half the participants they had in the study believed that the employers should use electronic surveillance as a coercive tool to control and protect the company from dishonest employees. On the other hand, the same employees utilized a wide range of measures to circumvent electronic surveillance when it was directed at them. Equally interesting is Whalen and Gates (2010) study of employees who worked for national security agencies. The participants in the study seemed to have no problem with the government's constant surveillance of their activities, but they had reservations conducted by Samaranayake and Gamage (2012) found that participants liked electronic monitoring if it enhanced their job, but disliked it for opposite reasons. The correlational study conducted by Holland, et al. (2015) revealed the ambivalence between manual and non-manual employees. Non-manual employees had very little distrust in management, whereas manual employees had a high level of distrust in management. It follows that each group had a different relationship with management, which is reflected in the trust levels.

Employers electronically monitor workplaces because it is legal to do so. It enhances productivity, controls risk, and deters illegal activities in the process. Some, employees who work under electronic surveillance share some of the employers' goals, but at the same time, may also have competing needs. These studies have exposed a paradox in electronic surveillance at the workplace; however, none of them addressed the lived experience of nurses working under CCTV surveillance. Therefore, there is a need for a study of this magnitude.

Experiential Context

The experiential context is a depiction of the researcher's experience, involvement, background, knowledge, and connection to the topic. According to Heideggerian (1962) and Gamaderian (1998) philosophy, the researcher is as much an integral part to the research process as the participant. Both the researcher and participants have approached the study with per-understandings and the assumption that researcher and participants are inextricably linked throughout the study. Reflexivity in qualitative research is a tradition. Since the researcher and researched are individuals sharing the same space, it is necessary for the researcher to reflect on how that might influence data gathering and analysis (Shaw, 2010). The concern is that the researcher, who is attempting to understand the participants' experiences, could allow his own preconceived ideas to dominate the interpretation. However, the way the researcher deals with reflexivity is philosophically related. For example, researchers who underpin their studies with Husserlian phenomenology engage in reflexivity, but they also engage in bracketing of preconceive ideas (Lopez & Willis, 2004). Conversely, researchers adopting Heigedderian and Gamaderian phenomenology also engage in reflexivity, but their purpose is to identify the horizons from which the researcher is interpreting.

Heidegger's (1962) existential phenomenology state that individuals are inextricable linked to the world in which they live; they cannot step out of it, and they experience things as already interpreted. Given this perception, the researcher is proactively engaged in reflexivity from the start of the research to ensure the openness necessary in dialogue with participants that could revise the researcher's fore-understanding and lead to better understanding of the phenomenon. The researcher of this

study proactively resisted any tendency to be hegemonic and created an atmosphere of openness to invite conversation of the kind Gadamer recommends.

According to Gadamer (1998), the more experience one has, the more opened he or she is to more experience. Experiences are the basis of preunderstandings because that is where one's thoughts, ideas, and decision-making germinate. The researcher of the current study has worked in mental health units for greater than three decades in leadership, academia, and clinical nursing roles. I have experienced working in nursing units without CCTV surveillance cameras and units that had CCTV surveillance cameras. The experience has included being monitored by the cameras as a clinical nurse and being the nurse supervisor who examined and used footages captured by the cameras in decision-making. I have subsequently formed opinions about the conditions best for nurses to advance their role as caregivers in relation to CCTV surveillance. I have reflected on these experiences throughout the research as they form part of the pre-understanding Heidegger (1962) and Gadamer (1998) identified in their phenomenological constructs. Research on the effects of CCTV surveillance in the workplaces of other industries has cited stress, feelings of vulnerability, and change in professional practice among some employees.

The therapeutic environment in the inpatient mental health unit is also the work environment. It is potentially more susceptible to interferences and barriers than the usual work environment. At the same time, not much is known about nurses working under constant CCTV surveillance in the mental treatment environment because little research exists on the topic. However, the researcher is convinced that this hermeneutic phenomenological research approach has the framework to uncover the unknown about

the lived experiences of nurses working under constant CCTV surveillance mental health units.

Chapter Summary

The literature review for this study has been completed to help contextualize the phenomenon of registered nurses working under surveillance in mental health units. The content areas of this review were historical context, outcome of workplace electronic surveillance, workplace electronic surveillance and privacy, and the paradox of workplace surveillance. The literature review provided important information about what is and is not known about electronic surveillance. As a result, there is a better understanding of the gap in the literature on the lived experiences of nurses working under constant CCTV surveillance in mental health units. Chapter Three will follow with an outline of the methodology used to conduct the study.

CHAPTER THREE

METHODS

The purpose of this qualitative hermeneutic phenomenological study has been to understand the lived experience of nurses working in mental health units under constant Closed Circuit Television (CCTV) surveillance. This chapter provides a discussion on the research design, sample and setting, access and recruitment of the sample, inclusion and exclusion criteria, ethical considerations, data collection procedures, interview questions, demographic data, data analysis and research rigor. Qualitative research seeks to understand the meanings a particular group of participants attach to a phenomenon when they are absorbed in their natural setting- the lifeworld.

According to Creswell (2013), such pursuit begins with the adoption of certain assumptions related to reality, knowledge, value, and methodology. These assumptions lay the foundation and framework by which the inquiry may be guided in a systematic way. Qualitative studies approach humans as a whole that includes the context in which they operate, rather than individuals detached from their circumstances (Polit & Beck, 2012). This approach is naturalistic in that it enhances better reflective reconstruction of a phenomenon for understanding as the researcher is immersed in the data without the need for control and explanation. Such understanding is based on the natural setting and is a fundamental difference between a qualitative approach and other types of research approaches of a quantitative nature.

Qualitative research is data-driven instead of theory-driven (Creswell, 2013). The researcher, who is an instrument, uses emerging data gathering from the participants to

construct a theory or uncover the essence of a phenomenon. This approach contrasts with other types of research that start with a theory leading to hypothesis testing. Qualitative researchers engage in complex inductive and deductive reasoning procedures to arrive at themes gathered from the data (Creswell, 2013). The lived experience of nurses working under constant CCTV surveillance has been studied in this current research using a qualitative hermeneutic phenomenological approach based on Heideggerian and Gamaderian philosophy. The inquiry has an ontological focus on the lifeworld of the participants: What does it mean to work under surveillance? How do the participants view it? Despite the researcher's desire to see the phenomenon from the participants' point of view, he inevitably co-constructed the findings with them since he could not escape his own view (Heidegger, 1962). Ultimately, there were no findings of universal truths or facts. Instead, the themes that emerged from the data are callings and suggestions pointing to something meaningful and important that needs further exploration (Smythe et al., 2008).

Research Design

A researcher typically applies either a qualitative or a quantitative method. The choice of method must be dictated by the researcher interest, philosophy, type of study, and the type of question the researcher seeks to answer (Hoskins & Mariano, 2004). In a typical quantitative study, the researcher identifies the control and treatment variables, the method to control extraneous variables, the timing of data collection, data analysis method, and manner by which ethical issues are addressed (Polit & Hungler, 1999). Qualitative studies support a very different approach because the design is flexible, and

there is no attempt to control predetermined variables. It is therefore incumbent upon the researcher to allow a natural emergence of information (Mariano, 2004).

There are at least five qualitative research designs upon which a researcher can base a study. These are *ethnography*, *grounded theory*, *case study*, *narrative study*, and *phenomenology.* An ethnographic study was not considered good fit for studying nurses' experiences working under constant electronic surveillance in a mental health unit because such study requires the researcher to become more immersed in the natural setting of the researched environment (Creswell, 2013). This requirement could not be met because nurses who work in mental health under surveillance are scattered in various counties in the South Florida region.

Grounded theory also was not contemplated as an appropriate design for this study because its focus is to seek an explanation or theory behind the phenomenon (Locke, 2003). The researcher in this instance is interested in the nurses' experiences working under surveillance, not a theory related to it. It is arguable that a case study of nurses working under surveillance in mental health would constitute a robust collection of findings; however, a case study requires a typical individual (person) or a multiple bound (organization) case that meets the criteria (Simons, 2009). Accessing a nurse or an organization of nurses working in mental health facilities under surveillance would be difficult if not impossible, so a case study design was not selected.

A narrative research design is believed to be very flexible in telling the experiences of the lived and told stories (Creswell, 2013). However, these stories usually emanate from one or two individuals with a biographical and historical focus. Again, one

or two nurses working in mental facilities under surveillance cannot supply enough data to highlight the group's lived experience, so a narrative design was not selected. A phenomenological design was examined for its suitability in studying the lived experiences of nurses working under constant electronic surveillance in mental health units and was chosen by the researcher as the appropriate model for this type of study.

Selecting a method to conduct phenomenological research is fraught with controversies as critics (Annells, 1996; Flemings, Gaidys, & Robb 2003; McNamara, 2005; Munhall, 2012) weigh in on advantages and disadvantages. The argument is centered on how to construct a step-by-step approach to conduct a phenomenological study when the nature of the phenomenology is unknown. According to Munhall (2012), the phenomenological inquiry process unfolds throughout the study, and it cannot be known from the outset. Notwithstanding, it is agreed that phenomenological researchers, especially at the novice experience level need a step-by-step approach such as that of Moustakas, van Manen, or Fleming et al. to conduct inquiries. Fleming et al. (2003) produced a five-step approach that was deemed appropriate to conduct this hermeneutic phenomenological study. The method guided the collection and analysis of data of the lived experiences of nurses working under electronic surveillance in mental health units. The five steps of this method are: (1) Deciding upon a research problem; (2) Identification of researcher's preunderstandings; (3) Gaining understanding through dialogue with participants; (4) Gaining understanding through dialogue with text; and (5) Establish trustworthiness.

Figure 2: Phenomenological Conceptual Diagram

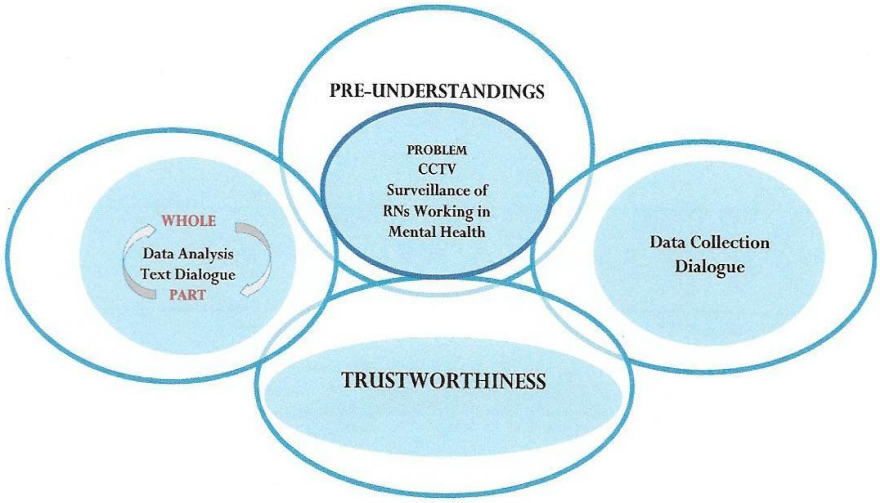


Figure 2. Rodney Wallace (2017). Hermeneutic Phenomenological Conceptualization Approach (Adapted from Fleming et al. 2003).

Fleming et al. (2003) acknowledge the delicate issue of using a method to conduct phenomenological research; however, they also recognize that researchers need guidance to conduct a realistic study, so they crafted the following steps designed loosely to provide the flexibility a phenomenological inquiry process requires (Fleming et al., 2003). Fleming et al. (2003) recommends the researcher must first decide on an area of interest to shape the research question/problem and that the area under study remains a focus of the participants and researcher throughout the research process. The area of

study in this case is nurses working under constant electronic surveillance in mental health unit to answer the underlying question: What is the lived experience of nurses working in the mental health units under constant Closed Circuit Television (CCTV) surveillance? This initial research question becomes the guiding force behind the whole research process, according to Gadamer (1990).

The method next requires the researchers to identify their own area of pre-understanding. Preunderstanding is an individual's preformed history and understandings of the world brought to the study (Fleming et al., 2003). Since the pre-understanding cannot be set aside Gadamer recommends that the researcher makes it explicit. Based on Gamaderian philosophy, identifying one's pre-understanding or prejudice of the topic is crucial because reflecting upon them will allow the researcher to move beyond them to understand the phenomenon. The researcher in the current study has had a wide range of experiences working in clinical, academic, and leadership roles in nursing. In each context, this researcher has worked with and without CCTV surveillance. He additionally has conducted extensive readings into electronic surveillance in other industries, noting the advantages and disadvantages of the technology. These opportunities have equipped the researcher with considerable pre-judgment about the environment best suited for nurses to advance their mission of caring for patients and promoting the profession.

The method next directs the researcher to gain understanding of the phenomenon through dialogue with the study participants (data collection) and come to an understanding of the meaning of the text. Dialogue with the participants is not just a conversation between the two persons, but also takes place between the reader and the

text. The researcher must remain opened to the opinion of others; in this case the nurses working under electronic surveillance in mental health unit. At this stage, the researcher immerses himself into the subject matter to gain deeper understanding of the phenomenon. Understanding evolves through a fusion of horizons as the researcher allows the participants' understanding to challenge the researcher's preunderstandings through the reflective process (Gadamer, 1990). A fourth step is to gain understanding through dialogue with text. Dialoguing with the text is not just with the written words but also with the taped words, written notes (journaling) about the interview situation, and observations that are verbal or non-verbal. At this stage, analysis is done using the hermeneutic circle to move back and forth from whole to parts of the text.

The fifth step involves the establishment of trustworthiness, or is the degree of confidence one can place in the data, method, and interpretation of the results to ensure quality (Polit & Beck, 2014). Trustworthiness of the research process was established in this study using Lincoln and Guba (1985) criteria of trustworthiness consisting of *credibility, dependability, confirmability, and transferability*. Each criterion was discussed in detail under Research Rigor.

Sample and Setting

According to Emmel (2013), sampling is generally associated with a defined population from which a representative group is selected. The two primary types of sampling techniques used in research are non-probability sampling and probability sampling. Non-probabilistic sampling technique does not give every member of a population a chance to be selected, while probabilistic sampling technique gives every

member of the population a chance to be chosen (Daniel, 2011). Quantitative and qualitative studies have different sampling guidelines. The aim of quantitative studies is to generalize to larger population so probabilistic sampling techniques are more conducive to this type of study. On the other hand, a qualitative study does not intend to generalize the findings, so the size of the sample is less meaningful and is usually small in comparison to quantitative samples.

The non-probabilistic purposive sampling technique was determined the preferred technique for this kind of qualitative research because it is attuned to the researcher's purpose and flexible in addressing constraints (Patten, 1990**).** A purposive sample is a very informed group of participants that can provide rich data to a researcher's particular question and research interest (Emmel, 2013). Snowball sampling is a procedure that researchers employ by accessing participants through contact information provided by other participants (Noy, 2008). This sampling procedure is complementary to purposive sampling, and they are widely used together. The researcher for this study utilized both purposive and snowball sampling techniques to recruit nurses who work in mental health units under constant CCTV surveillance. Experts recommend a sample size of between 5 and 25 participants to achieve data saturation in a phenomenology study; however, the researcher recruited a maximum of 20 participants (Creswell, 2013). The sample was obtained in the South Florida region from handing out flyers at professional networking activities to nurses who work in mental health units under constant CCTV surveillance. The setting was limited to South Florida.

Access and Recruitment of the Sample

After the study had been approved by the Barry University Institutional Review Board (IRB) (see Appendix A), the researcher recruited participants. The researcher obtained access (see Appendix C) to potential participants by submitting a letter to professional network organizations in South Florida seeking permission to hand out flyers (see Appendix D) to prospective participants. The sampling procedure employed was purposive and snowball sampling techniques to select the prospective participants. Prospective participants who contacted the researcher were screened to determine if they met the inclusion criteria. All participants received a $20.00 Walmart gift card as a token of appreciation for their participation in the research which was theirs to keep even if they withdrew from the study.

Inclusion Criteria

The participants interested in the study were Registered Nurses (RN) with a current Florida License for a minimum of two years. The RNs had had at least two years working experience in a mental health unit under CCTV surveillance in South Florida. The RNs also worked a minimum of 24 hours per week, performed direct patient care, and held a non-managerial or non- supervisory position. The RN had access to a telephone.

Exclusion Criteria

Registered nurses (RN) excluded were those who had not worked in mental health units for at least two years and who did not have at least two years working experience in a mental health unit under constant CCTV surveillance in South Florida. RNs who did not work a minimum of 24 hours per week and did

not perform direct patient care also were excluded. RNs who held managerial or supervisory positions and RNs without telephone access were excluded.

Ethical Considerations

Ethical considerations are of the highest importance in qualitative studies because of the intrusion into the participants' private lives (Punch, 1998). It is an obligation of the researcher to uphold the highest ethical principle grounded in respect for persons, beneficence, and justice. To ensure competency in research ethics, the researcher completed the National Institute of Health (NIH) web-based training course titled: Protection of Human Research Participants and received certificate of completion. Approval was sought from Barry University Institutional Review Board (IRB) (see Appendix A) to conduct the study.

Following Barry University Institutional Review Board (IRB) approval the study began. Access (see Appendix C) to participants was gained through professional networking activities. The flyer (see Appendix D) detailing the nature of the study, researcher's contact information, faculty sponsor, and Barry University IRB contact person were handed out to prospective participants during networking. The respondents to the flyers who met the inclusion criteria were provided all relevant information about the study by the researcher. Each participant who indicated interest in the study and met the inclusion criteria was contacted for a tape-recorded, face-to-face semi-structured interview at a mutually-agreed upon site, time, and place.

Prior to each interview, the participant was thanked by the researcher for agreeing to participate in the study. Next, each participant was given verbal and written

information about the study. This information included the purpose of the study, the role of the participants in the study, and how the study information would be distributed. The participants were informed of how their confidentiality was to be maintained, as interview transcripts and notes were labeled with the participant's pseudonym, and only the researcher knows the real names of the participants. Items with real names such as consent forms were locked in a separate file cabinet in the researcher's home-office away from data with pseudonym information. Each participant was informed that there would be one tape-recorded face-to-face semi-structured interview lasting a maximum of 55 minutes. The participants were reminded that they could withdraw from the study at any time, and refuse to answer any question (s) without any penalty. The participants were encouraged to ask question(s) about the study, and the researcher provided clear answers. Each participant was reminded that there were no known benefits or risks associated with the study. The consent form (see Appendix B) was reviewed with each participant and question(s) answered before signatures were obtained.

Each participant was asked to provide a pseudonym, which they placed on the demographic questionnaire (see Appendix E) and then filled out the demographic questionnaire lasting five minutes (total of 60 minutes study participant time). A token of appreciation for participation in the study of a $20 Walmart gift-card was given to each participant before the interview. The token of appreciation was theirs to keep even if they decided to withdraw from the research. Next, the interview began with the focus on the topic of their lived experiences working in mental health under constant CCTV surveillance. Upon completion of each interview, the participant was thanked for their

participation. No participants withdrew from the study. A transcriptionist, who signed a third-party confidentiality agreement (see Appendix G), completed the transcription within two weeks of each interview. The transcribed data was then stored on the researcher's password-protected computer in the researcher's home-office. The researcher will delete all tape-recorded interviews 90 days after transcription has been authenticated. All transcriptions, consents, and demographic data will be kept for five years upon completion of the study and then kept indefinitely in a locked file cabinet in the researcher's home-office.

Data Collection Procedures

Following Barry University Institutional Review Board (IRB) approval, (see Appendix A) the study began. Each participant was contacted for a face-to-face, tape-recorded semi-structured interview lasting 60 minutes inclusive of a five-minute demographic survey. Each participant who contacted the researcher and met the inclusion criteria had an interview at a mutually-arranged location. Prior to each interview, the participant was thanked by the researcher for agreeing to participate in the study. Next, each participant was given verbal and written information about the study. This information included the purpose of the study, the role of the participants in the study, and how the study information would be distributed. The participants were informed of how their confidentiality would be maintained in that interview transcripts and notes would be labeled with the participant's pseudonym, and only the researcher would know the real names of the participants. Items with real names such as consent forms were locked in a separate file cabinet in the researcher's home-office away from data with pseudonyms. Each participant was informed that there would be one tape-recorded face-

to-face semi-structured interview lasting a maximum of 55 minutes, and a demographic survey lasting five minutes for a total of 60 minutes. The participants were reminded that they could withdraw from the study at any time, and refuse to answer any question (s) without any penalty. The participants were encouraged to ask question(s) about the study, and the researcher provided clear answers.

Next, each participant was reminded that there were no known benefits or risks associated with the study. The consent form (see Appendix B) was reviewed with each participant and question(s) answered before signatures were obtained. Each participant was asked to provide a pseudonym which, they placed on the demographic questionnaire and then filled out the demographic questionnaire lasting five minutes (total 60 minutes). A token of appreciation for participation in the study of $20 Walmart gift-card was given to each participant before the interview. The token of appreciation was theirs to keep even if they decided to withdraw from the research. Next, the interview began with the focus on the Lived Experience of Registered Nurses Working in Mental Health under Closed Circuit Television (CCTV) Surveillance. Upon completion of each interview, the participants were thanked for their participation. Participants that withdrew from the study would have their information destroyed within 24 hours by the researcher. A transcriptionist, who signed a third-party confidentiality agreement (see Appendix G), completed the transcription within two weeks of each interview. To ensure accuracy of the transcription, the researcher reviewed the transcripts by listening to the recorded information. The transcribed data was stored on the researcher's password-protected computer in the researcher's home office. The researcher will delete all tape-recorded interviews 90 days after transcription authenticated by the researcher. All transcriptions,

consents, and demographic data will be kept for five years upon completion of the study and then indefinitely in a locked file cabinet in the researcher's home-office.

There was no member checking because it is inconsistent with Heideggerian and Gamaderian philosophy (Bradbury-Jones, Irvine, & Sambrook, 2010; McConnell-Henry, Chapman, & Francis, 2011; Crowther, Ironside, Spence, & Smythe, 2016). However, if there had been a need to clarify data, the researcher would ask clarifying follow-up questions during the actual interview. After the interview, the researcher engaged in writing notes about the interview related to non-verbal and other notable observations.

Interview Questions

When conducting Gadamerian and Heideggerian hermeneutic research, it is important that the researcher maintains openness, equality, and freedom without the hegemony (Liu & Sui, 2014). In particular, Gadamer (2000) directs the researcher to fall into or become involved in a conversation with the participants, not to "conduct interviews." Once the researcher has entered the participants' world to share their lived experience, the researcher and participant are inextricably linked throughout the process (Heidegger's fore-structure). Consequently, both researcher and participant in some subtle way contributed to the interpretation (co-construction) the participant has attached to the lived experience (Corney, 2008; Koch, 1995). The researcher in the current study used semi-structured open-ended questions that allowed participants to focus their response about their lived experience however they chose. The first question to the participant was: What does working under constant Closed Circuit Television (CCTV) Surveillance mean to you in the mental health unit? There were follow-up questions (see Appendix F).

Demographic Data

A researcher developed demographic questionnaire (see Appendix E) was used to collect data describing the participants. Out of the total time of 60 minutes allotted for the interview, five minutes was allotted to complete the demographic questionnaire. The data included gender, age, education level, length of time as a registered nurse, area of nursing specialty, and length of time working in mental health units under constant CCTV surveillance. The data was used to determine similarities and differences among the participants in this study.

Data Analysis

Qualitative data analysis is a daunting task of pouring over vast amounts of nonnumeric data (De, 2014). It gets even more difficult when there is a scarcity of clear guidelines to conduct data analysis (Gibson & Brown, 2009). Qualitative data analysis involves organizing text, reducing the data into themes, and presenting it for discussion (Creswell, 2013). The interviews provided by the nurses working under constant CCTV surveillance were the sources of data from which the researcher extracted the meanings attached to their lived experiences. However, in hermeneutic phenomenological data analysis, the themes derived from the study are not meant to be objects of a phenomenon. Instead, the themes are meant to point to something that seemed significant, meaningful and to spur the reader to explore further- they are not facts (Smythe et al., 2008). Gadamer suggests that understanding is never complete; it is evolutionary, so it is within that context the data analysis should be viewed. The data analysis for this study was guided by the following four-step process of the hermeneutic circle of understanding by Fleming et al. (2003).

1. All interview texts were examined to find an expression that reflects the fundamental meaning of the text as a whole. Gaining understanding of the whole text should be the starting point of analysis, because the meaning of the whole will influence understanding of every other part of the text. Already the first encounter with the text is influenced by a sense of anticipation, which has developed through the preunderstanding of the researcher.
2. In the next phase every single sentence or section was investigated to expose its meaning for understanding of the subject matter. This stage facilitated the identification of themes, which in turn led to a rich and detailed understanding of the phenomenon under investigation.
3. Every sentence or section was then related to the meaning of the whole text and with it the sense of the text as a whole is expanded. This is the significance of expansion of the unity of the understood sense (Gadamer, 1990). The hermeneutic circle, which is essential for gaining understanding, is only fully experienced if the movement back to the whole is included in research based on Philosophical Hermeneutics. With the expanded understanding of the whole text, meaning of the parts can widen.
4. This step involved the identification of passages that seem to be representative of the shared understandings between the researcher and participants. Such passages, which may appear in the research report, should give the reader insight into that aspect of the phenomenon, which is being discussed (Fleming et al., 2003).

Research Rigor

Rigor in qualitative research is the degree to which the findings of a research can be trusted (Polit & Beck, 2014). In other words, the issue is whether or not congruence exists between the concepts offered and the data collection, analysis, and interpretation. Are the arguments compelling and supported by the data? These are questions that challenge the trustworthiness of a research. The trustworthiness of qualitative research has provided a source of robust debate among experts (Sandelowski, 1993; Leininger, 1994).The argument is centered on whether or not qualitative research should have unique standards for trustworthiness based on its paradigm instead of any parallel criteria. Despite the debate, the criteria outlined by Lincoln and Guba (1985) remain the most widely-used test for qualitative research trustworthiness. The components of the criteria are *credibility, dependability, confirmability,* and *transferability.* They will be the focus of discussion in the following section as they relate to the study of nurses working under constant CCTV surveillance in mental health units.

Credibility

Credibility is considered to be one of the most important criteria of trustworthiness as it questions the congruency of the findings with reality (Shenton, 2004). The question is: "Was the study conducted using standard procedures typically used in similar qualitative studies?" The hermeneutic phenomenology study has remained faithful to the philosophical underpinning, sampling procedure, data collection procedure, and data analysis procedures (Ajjawi & Higgs, 2007) to ensure its credible trustworthiness. The researcher employed prolonged engagement with the data,

conducted reflective journaling, kept accurate audit trails, and described the context sufficiently so readers of this research can judge for themselves.

Dependability

Dependability speaks to the ability of others to replicate the finding of a study in a similar design, or reflect a stability of the findings over time (Bitsch, 2005). It is generally agreed among experts that because of the nature of hermeneutic phenomenology, it does not lend itself to such replication. However, others believe that the process followed in the research should have sufficient details to allow someone else to repeat the process (Shenton, 2004). The researcher for this study maintained an accurate audit trail, rich documentation, and proper description of the study design namely sampling techniques, data collection, and analysis in such a way that proximate results are likely to result in a similar study.

Confirmability

Confirmability is the extent to which the results represent the experiences and ideas of the informant (Shenton, 2004). In a Heideggerian and Gadamerian Hermeneutic Phenomenological study, it is debatable if not impossible to confirm the result. Inherent to hermeneutic phenomenology is the expectation that every interpretation of a text will yield new information. Nevertheless, experts (Bowen, 2009; Koch, 2006) believe that an accurate audit trail and reflexive journaling will allow any observer to trace the course of the research step-by-step. The researcher kept an accurate journal and audit trail to satisfy this requirement.

Transferability

Transferability is the ability of an independent researcher to use the research findings to be applied in a similar situation (Bitsch, 2005). Though there are reservations about the extent to which one can transfer the findings from one qualitative study to another, some experts believe it is possible (Tobin & Begley, 2004). To aid in transferability, the researcher of this study maintained an accurate paper trail, provided sufficient contextual information, and attained thick descriptions and evidence of purposeful sampling (Shenton, 2004; Anney, 2014).

Chapter Summary

This chapter provides a systematic outline of the qualitative approach employed to investigate the lived experiences of registered nurses working in mental health units under Closed Circuit Television (CCTV) monitoring. A Heideggerian and Gamaderian hermeneutic phenomenological approach was used to guide the study. Sampling and setting, access and recruitment of the sample, inclusion and exclusion criteria, ethical considerations, data collection procedures, interview questions, demographic data, data analysis, and research rigor were all delineated. Chapter Four follows with the results of the study.

CHAPTER FOUR

FINDINGS OF THE INQUIRY

The purpose of this hermeneutic phenomenological study is to understand the lived experience of registered nurses (RNs) working under constant closed-circuit television (CCTV) surveillance in mental health units. The aim of the study has been to have the participants explain what it has meant for them to be a RN working under constant CCTV surveillance, to interpret their meanings, and co-construct their narratives. A hermeneutic phenomenological approach based on Heideggerian and Gamaderian philosophy was used to explore this phenomenon; philosophically flexible procedure in allowing the researcher access to the participants' world of experiences and co-construct with them the meanings they attach to their experiences.

Electronic surveillance has become ubiquitous in the workplace. Its advantages and disadvantages have been well documented in the literature (Ball, 2010). However, there is a dearth of information regarding the lived experiences of nurses who work in mental health nursing units under CCTV surveillance. A hermeneutic phenomenological study provides a condusive framework by which the participants and the researcher are engaged in hermeneutic circle of understanding to bring life to the experience through imagination, self-reflexivity, interpretation, and language (Laverty, 2003). Such co-construction is an inherent, integral, inescapable feature of the research process (Gill, 2015). Heidegger's and Gadamer's phenomenological inquiry directs consideration about what it means to be in the world (Regan, 2012). Furthermore, Powers and Knapp (2011) explained that access to such deliberation involves having the participants return to their lifeworlds of experiences to describe its meanings. However, to remain philosophically

congruent to the Heideggerian and Gadamerian traditions means using analytical devices that exposed the ontological structure of the phenomenon (MacKey, 2005).

Heidegger and Gadamer recognized the hermeneutic circle to be one of such interpretive devices because human beings are always in an inescapable "circle" of understanding and interpretation as they make sense of their world. The circle or spiral movement, as it is sometimes called, is a process of moving back and forth between the whole and part of a text; one that goes inward and outward until the researcher reaches a fusion of horizon with the text (Taylor, 2010; Gill, 2014). Gadamer's assumption was that to arrive at a fusion of horizon the researcher engages the text with openness to flesh-out tensions between divergent perspectives shaped by one's fore-structure (Gill, 2014). Therefore, the researcher is required to engage each participant in the hermeneutic circle of understanding, interpretation, and self-reflexivity while maintaining vigilance on the local knowledge that could influence the analysis. The Fleming et al., 2003 four-step process of the hermeneutic circle of understanding was the model used in this study to get an understanding of the data.

Another ontological interpretive device postulated by Heidegger fundamental in explicating the lived experience used in this inquiry was temporality. Heidegger (1962) regards temporality as a grounding feature of all experiences. Those experiences are meaningful when there is coherence in temporal past, present, and future. A researcher should explore how a phenomenon has been experienced in the past, through the present, and how it will be experienced in the future. The researcher of this study has analyzed the participants' lived experience working under CCTV surveillance in mental health units to learn their past, present, and future understanding of the phenomenon.

A third Heideggerian interpretive device that this researcher used to analyze the participants' data for the ontological structure is called "modes of engagement." Heidegger identified three modes of engagement humans have with their surroundings namely *ready-to-hand, unready-to-hand,* and *present-at-hand.* According to Heidegger, the ready-to-hand mode of engagement is the most primordial. Heidegger contended that a human's relationship with equipment, life events, and the human mind and body are seamlessly embedded in a referential whole that is mostly taken for granted without the need for focal awareness (Paker, 1985). It is in this the ready-to-hand and preferred mode of engagement that Heidegger believed humans spend most of their day living. Humans enter the unready-to-hand mode of engagement when equipment, life events, or the human body are disrupted and fail to run smoothly (Parson, 2010). During the disruption, the problematic aspect of the activity is examined but not context-free, so the individual continues to function, albeit not seamlessly (Paker, 1985; Weick, 2002).

Heidegger further maintained that humans enter the present-at-hand mode of engagement when life events and other activities become problematic because of pauses and breakdowns. Such disruptions cause the individual to examine the activity theoretically for solutions (Parker, 1985). However, it is during the present-at-hand mode of engagement, Heidegger contends, that the phenomenon takes on its ontological existence as an entity as its awareness becomes evident through theoretical examination and embodiment (Weick, 2002). The phenomenon is not a detached object waiting to be discovered, but rather part of a complex web of activities that are constantly and contextually unfolding. The researcher of this study has gained valuable insight into how

the participants made meanings of the experience by analyzing the participants' experiences from the "modes of engagement" standpoint.

The data collection phase was an important aspect to the data analysis process over the course of this study. The participants' verbal responses to the researcher's questions were important, but their concurrent nonverbal responses were also significant in bringing life to their described experiences. Equally important was the researcher's familiarity with the environment in which the participants work, because he also participates in caring for the mentally-ill in similar environment under constant CCTV surveillance and navigates related issues as they became evident. The experience as an RN is not monolithic, but rather based on Heideggerian and Gadamerian philosophy which indicates that humans' fore-structure is pivotal to how people experience a phenomenon. The researcher expected some of the participants to share several commonalities in the meanings they attached to their experience, while others were likely to differ because of their varied backgrounds. It was within this context the researcher applied these philosophical underpinnings and reflexivity by which the narratives in this study was co-constructed.

After having receiving the Institutional Review Board (IRB) approval from Barry University (see Appendix A), the researcher began recruiting participants using purposive and snowball sampling techniques. Each participant was an RN with at least two years' experience working in mental health inpatient units under CCTV surveillance. The researcher scheduled all participants individually for face-to-face semi-structured interviews. Upon meeting and greeting the participants, the researcher provided them with explanations about the study, had them sign the consent forms, fill the demographic

questionnaire (see Appendix E), chose a pseudonym, then began interviews. The researcher maintained an atmosphere of collegiality and emphatic listening throughout each interview. The main research question was, "What does it mean to be working under constant closed-circuit television (CCTV) surveillance in a mental health unit?" Seven additional pre-planned questions for clarifications and prompts were also given during the interview (see Appendix F).

After each tape-recorded interview, the researcher wrote reflective notes to capture information not readily recovered from a recording such as the participants' mood, enthusiasm, and other non-verbal happenings. The researcher then repeatedly listened to the recordings to become more familiar with the data. Each time the researcher listened to the recordings of the participants' stories, "the what" he or she was saying became more vivid. Each recording was sent to a third-party transcriptionist (see Appendix G) who transcribed the data and returned it to the researcher. The researcher actively engaged in writing, rewriting, reflection, and returning to the recordings to have the data speak over and over repeatedly to him throughout the process of data analysis. The researcher employed the hermeneutic circle of reading the whole text, then parts of it, then returning to the whole until the meaning was interpreted and employed throughout the analysis of the data (Fleming et al., 2003). The researcher remained constantly immersed in the data to allow the themes and links between them to emerge. Concomitantly, the researcher also allowed the data to stand alone, and not be influenced by the literature. After 14 individual semi-structured face-to-face interviews and data analysis, data saturation was reached and the following themes emerged: *Disappearing Status Quo Ante, Deterring Litigation, Feeling Uneasy, Limiting Caring,* and

Normalizing the Present. Two additional individual face-to-face semi-structured interviews were completed to confirm data saturation yielding a total sample of 16 participants. This chapter presents the analyzed data of 16 RNs working at inpatient mental health units under CCTV surveillance in South Florida. It is noteworthy that the data presented by this researcher is merely a glimpse of something meaningful that is meant to spur the reader to investigate further, and there is no claim that the findings are either simplified or final (Smythe et al., 2008). This chapter purveys a discussion of the sample, results of inquiry, and a connection of the themes to Maslow's Motivational Theory.

Sample Description

The 16 participants represented in this study were registered nurses (RNs) working at inpatient mental health units under closed circuit television (CCTV) surveillance in South Florida. They were selected using purposive and snowball sampling techniques. The demographic characteristics were collected using a questionnaire (see Appendix E) constructed by the researcher. The questionnaire collected participant genders, age ranges, and educational levels, years as an RN, areas of specialization, and years as an RN working at inpatient mental health units under CCTV surveillance (see Table 1). Other characteristics were collected during the semi-structured interviews. Of the 16 participants, 11 were females and five were males. The youngest participant was 27 years and the oldest 63 years of age. Four participants had Associates Degrees in Nursing (ADN), nine participants had Bachelor of Science (BSN) Degrees in Nursing, and three participants had Master of Science Degrees in Nursing (MSN) (see Table 1). All 16 participants specialized in mental health nursing. Years as an RN among the

participants ranged from 3 to 40 years, but the range of years among RNs working in mental health under surveillance was 3 to 20 years. The individual characteristics of the research participants are presented in the next section.

Table 1

Characteristics of Sample Demographics

Gender	Age Range	Education Level	Years as RN	Area of Specialization in Nursing	Years as RN in Mental Health working under CCTV surveillance
M	30 - 39	Bachelors	3	Mental Health	3
M	40 - 49	MSN	5	Mental Health	5
M	20 - 29	Bachelors	4	Mental Health	3
M	40 - 49	Bachelors	4	Mental Health	3
M	40 - 49	Bachelors	8	Mental Health	5
F	40 - 49	Bachelors	20	Mental Health	8
F	20 - 29	Bachelors	4	Mental Health	3
F	60 - 70	Associates	7	Mental Health	20
F	60 - 70	Bachelors	30	Mental Health	14
F	60 - 70	MSN	40	Mental Health	20
F	40 - 49	MSN	25	Mental Health	10
F	20 - 29	Associates	6	Mental Health	6
F	30 - 39	Bachelors	7	Mental Health	3
F	60 - 70	Associates	27	Mental Health	20
F	30 - 39	Bachelors	8	Mental Health	2
F	50 - 59	Associates	25	Mental Health	20

Characteristics of the Participants

A brief description of each participant's characteristics added more contexts to their stories for a better understanding of their experiences. Each participant selected a pseudonym to protect their confidentiality and represent them in the study findings. Pseudonyms were also used to enhance the credibility of their stories which they eagerly

and voluntarily shared with the researcher. The following is a brief description of each participant in the study.

Nurse Jack is a Hispanic male in his 30s. He has been an RN for three years, has a BSN, and all his years as a RN have been spent working in mental health units under constant CCTV surveillance. **Nurse Jack** was modest about his nursing experience, but he was very emphatic about the need for CCTV surveillance in mental health. He stated:

> I understand that there is legal issues attached to it [CCTV surveillance] so I completely understand why they put cameras in there. I don't view it as a trust issue because I know like I said there is legal things […] the employer has to be careful that if something happens to the patient and we have to investigate or even employee we have to investigate so I completely understand why the cameras are there.

Nurse Josh is a male of Hispanic origin. He is in his 40s and has been an RN for five years. **Nurse Josh** already holds a MSN degree and has worked in areas where there were CCTV surveillance and in those where there were no CCTV surveillance. His experience working under CCTV surveillance in the inpatient mental health unit is five years. He is an adjunct instructor at multiple Universities. **Nurse Josh** had a lot of views about CCTV surveillance in the mental health units, and he was not holding back any of his comments. According to **Nurse Josh**, "Cameras symbolize that we are being watched, be careful what you do or don't do or say or don't say […] it symbolizes restriction, it symbolizes that your job may be on the line - bottom-line."

Nurse Maxime is an imposing male approximately 6'5" and over 250 pounds in his mid-20s. He is of Haitian heritage, a very jovial, and talkative RN. **Nurse Maxime**

has a BSN degree, and has been an RN for four years three of which he has been working under CCTV surveillance in the inpatient mental health unit. He thought the CCTV surveillance cameras could be a hindrance to nursing care. **Nurse Maxime** expressed, "I think sometime you are pressured because of the camera. I feel like I would be more effective […] especially when you are in a very high acuity setting."

Nurse Steve is a male and also of Haitian heritage. He is an RN in his 40s, has a BSN degree, has been a nurse for four years, and has worked at an inpatient mental health unit under CCTV surveillance for three years. **Nurse Steve** believes CCTV surveillance cameras were a necessity because of the patient population in mental health. He indicated, "I believe the surveillance camera is good is to protect the patients, and at the same time protect the employees, because it's always good to have extra eyes, especially when you work in a very volatile environment."

Nurse John is a RN male in his mid-40s of Haitian heritage. He was very animated, and showed a lot of confidence. **Nurse John** has been an RN for eight years. He has a BSN degree and has worked five years under CCTV surveillance in the mental health unit. **Nurse John** had no reservations about the need for surveillance cameras in the unit. He shared: "Well to me it means because we are dealing with patients who have psychiatric issues, it's a protection for us and for them, and also for safety […] if a patient says something happened this is your back up."

Nurse Michael is a female in her 40s who has been an RN for 20 years. She has a BSN degree, and most of her experience has been in the Intensive Care Unit (ICU). However, she had been working the inpatient mental health units for the past eight years under CCTV surveillance. She is Nigerian by heritage, and she has a very deep accent.

Nurse Michael believes that surveillance cameras are essential in mental health units because of the unpredictable nature of patients with mental illness. Here is a sample of her conviction:

> You know because ah you cannot predict psych patients at any given time. So with the cameras being monitored and you are able to see what's going on with your patients for safety because you don't want anybody to hang themselves, suicidal attempt, or hitting somebody, you don't want that to happen. And sometimes some of them attack the nurses too. So the other workers can also see what's going on and can come to your rescue. It's very good.

Nurse Mila is a RN female with four years' experience, three of them working under CCTV surveillance in a mental health unit. She has a BSN degree. **Nurse Mila** is of Hispanic heritage, very cheerful, but cynical about management's motive for CCTV surveillance. She reminded the researcher on more than one occasion that the CCTV cameras were set up to monitor the staff members not patients. **Nurse Mila** explained, "I think they are watching us more that the patients. I think they are really meant to be set up for the safety of the patients. However, I noticed that the nurses are being monitored than the patients themselves."

Nurse Sally is a female Caucasian American in her early 60s. She has been an RN for 37 years and has an Associate degree in Nursing. **Nurse Sally** has been working under CCTV surveillance for 20 years. She is petrified of CCTV surveillance, but still thinks it is necessary in mental health unit because of employees' misconduct. **Nurse Sally** declared her opinion about the CCTV camera with the following statement:

> It keeps me on my toes, making sure that I do what I'm supposed to do; knowing that I'm been watched makes me more, um it gives me some anxiety, but it also reinforces that the job needs to get done, and that I need to be monitoring as instructed and I need to be doing my job in a timely manner.

Nurse Sara is a female RN of Jamaican heritage. She is in her early 60s, has been an RN for 30 years, has a BSN degree, and has had extensive experience working under CCTV surveillance and without CCTV surveillance. **Nurse Sara** has 14 years' experience working under CCTV surveillance in inpatient mental units. She has also worked in forensic mental health where there is extreme CCTV surveillance of inmates and staff members. **Nurse Sara** explained, "I have worked in forensic facilities and surveillance is all over. So that's part of the forensic culture. So for me it wasn't anything unusual for me or anything new." She thought the staff made too much of CCTV surveillance.

Nurse Samantha is a nurse of Jamaican heritage. She is a female in her early 60s. **Nurse Samantha** has been a RN for 40 years and has a MSN degree. She has 20 years of nursing experience working under CCTV surveillance in the inpatient mental health unit. **Nurse Samantha** was very adept to the privacy issues surrounding surveillance, and found CCTV surveillance a hindrance to her caring for her patients. She commented, "I think it is invasive, I think it belittles me as a professional; it also prevents me from being effective in my interaction with my patients."

Nurse Bird is an American Caucasian RN in her 40s with extensive nursing experience. She has a MSN degree, and has worked in the mental unit under CCTV

surveillance for more than 10 years. Her tone was one of frustration as she described what it meant to be monitored by CCTV cameras. She explained:

> Yes, because not only do the administrators are watching, security is watching from home and they make it very clear that they watch the cameras from home. So our administrators and security are constantly watching what we do, so yes we are being watched- that's for sure.

Nurse Victoria is a female RN of Hispanic heritage. She is in her late 20s, has an Associate Degree in Nursing, and six years of nursing experience working on the mental health unit under CCTV surveillance. For **Nurse Victoria**, it was very simple; CCTV surveillance was about monitoring patients for safety and staff members for accountability. She illuminated:

> From my experience if you are able to use the cameras to monitor the patients, it's another set of eyes of what's going on the unit. And also monitoring the staff to make sure that they do what they are supposed to be doing. So really it's safety I identify with the cameras.

Nurse Kat is a female RN with Jamaican heritage. She has a BSN degree, 7 years working experience as a RN and three of them were spent working in the inpatient mental health unit under CCTV surveillance. **Nurse Kat** commented that prior to transferring to the mental health unit to work, she worked in the medical surgical units under CCTV surveillance, and the RNs used the CCTV surveillance cameras as an advantage. She explicated:

> I think at the other places I had more cameras, but I think we all reacted even slower, we go like wait I'm doing this for the cameras, and if we were like pulling

> medications we would pull it in front of the cameras, like if we were checking insulin we both would look at the camera to make sure they see that we were double checking it.

Nurse Kat found CCTV surveillance in the mental health unit was more of an issue than her previous workplace. She affirmed that in the inpatient mental health unit there were frequent incidents involving the nurses and patients that necessitated a review of the CCTV surveillance cameras by the management staff.

Nurse Evelyn is an RN of Hispanic heritage in her early 60s. She revealed that she grew up in a totalitarian state where surveillance was common. **Nurse Evelyn** has 27 years of nursing experience and an Associate Degree in Nursing. She has been working in a mental health unit under CCTV surveillance for 20 years. **Nurse Evelyn** remarked:

> It brings back actually personal memories where I lived in a place where, the country I was born, in this place was ah […] it was a lot of surveillance everywhere, so it brings back memories yes. It's, it's to me it's like all my life is like I'm cursed.

Nurse Betty is a mixed-race American female RN in her 30s. She has a BSN degree and has been an RN for eight years. **Nurse Betty** has been working in the mental health unit under CCTV surveillance for two years. She felt so monitored by the CCTV cameras that she could not even do little ordinary things she took for granted. **Nurse Betty** commented:

> It just feels like someone is like constantly watching […] I don't know it's little things like you're constantly being watched […] you can't even like pick a

wedgie [An uncomfortable tightening of the underwear between the buttocks] without it being recorded.

Even though **Nurse Betty** knew picking a wedgie in public was not considered socially acceptable, it underscored the pervasiveness of CCTV surveillance in the mental health unit.

Nurse Jane is a female RN of Jamaican heritage in her late 50s, she has an Associate Degree in Nursing, and has 25 years working as an RN, and 20 of them at mental health unit under CCTV surveillance. **Nurse Jane** thought that management lacked trust in the staff necessitating the electronic surveillance. She noted, "They don't trust you, and they want to see everything that you do; not that they are trying to help you to make the workload easier, but I think they are trying to see what you do wrong."

Emerging Themes

The primary aim of this research has been to flesh out what it meant to be a registered nurse (RN) working in the mental health unit under closed circuit television (CCTV) surveillance. These meanings are represented in the themes the researcher identified here as the most prominent in the text. According to Sutton and Austin (2015), a theme refers to "the drawing together of codes from one or more transcripts to present the findings of qualitative research in a coherent and meaningful way" (p. 229). It could be argued that there were other themes in the text that were also meaningful, but this representation was not intended as final, rather it is, according to Gadamer's directives, this presentation is just a glimpse of human understanding that is constantly evolving. During the writing and rewriting, back and forth reading, and repeated reflection, the researcher identified the following five themes: *Disappearing Status Quo Ante, Deterring*

Litigation, Feeling Uneasy, Limiting Caring, and *Normalizing the Present.* Each theme represents the overarching significance of the participants and their experiences working under CCTV surveillance. Together, all five themes formed the ontological structure of what it meant for these 16 RNs to be under constant CCTV surveillance while working in a mental health unit. These themes emerged within the context of Heidegger's temporality, modes of engagement, and the hermeneutic circle.

Temporality is, from Heidegger's standpoint, time seized as a unity of three dimensions namely the past, present, and future. Heidegger declared that things that meaningful experiences have time attached to them. Each emergent theme appeared did so within the context of the past, present, and future. The disappearing *status quo ante* emerged as the past, deterring litigation, feeling uneasy, and limiting caring emerged as the present**,** and normalizing the present as the future**.** At the same time, the themes emerged within the context Heidegger's three modes of engagement namely the ready-to-hand, unready-to-hand, and present-at-hand. Thus, *disappearing status quo ante* was primarily a ready-to-hand mode of engagement**,** with deterring litigation, feeling uneasy, limiting caring, and normalizing the present were unready-to-hand and present-at-hand modes of engagement. The researcher applied the hermeneutic circle of understanding to determine the relationship of the meaningful whole of the text to it parts and vice versa until each theme emerged.

Disappearing Status Quo Ante

Mutlu (2015), used the term *disappearing* to refer to researchers in the field of productive pedagogy who remove their foot print, such as "research design process and the ways in which empirical information was collected" from their research making it difficult to replicate. Mutlu (2015) exclaimed, "The act of disappearing, which has become the norm in the name of professional [ised] publications, robs the field of the productive pedagogical potential of research methods" (p. 932). The generic term *status quo ante* refers to a previous condition or status and is commonly used in contract dispute thus its use is prominent in the legal literature. For example, the U.S Court of Appeals for the District of Columbia heard a contract dispute case between "FALLBROOK HOSPITAL CORPORATION, DOING BUSINESS AS FALLBROOK HOSPITAL, PETITIONER v. NATIONAL LABOR RELATIONS BOARD, RESPONDENT" related to (Fallbrook Hospital Corp) refusing to bargain in good faith with it employees' representative (Nurses' Union). The court found for the respondent (Nurses' Union) and ruled that the petitioner return to the *Status Quo Ante*. The following is an excerpt from the U.S. Court of Appeals (2015):

> The purpose of the Board's order – which is 18 plainly stated in its decision – was to reimburse the Union for resources wasted by attempting in vain to bargain with Fallbrook, *and to restore the status quo ante – i.e.*, to place the Union in the same position it was in before the parties began bargaining. *See* BLACK'S LAW DICTIONARY 1633 (10th ed. 2014) ("*status quo ante*" defined as "[t]he situation that existed before something else (being discussed) occurred."

In the context if this study, the participants' experience of working in the inpatient mental health units without CCTV surveillance is the period referred to in this theme as the *Disappearing Status Quo Ante*. During the period of their employment, the participants practiced seamlessly in the mental health inpatient units within what Heidegger calls the ready-to-hand mode of engagement; even so, the environment without surveillance was not without problems as patients frequently made unsubstantiated allegations against the nurses and the hospitals. Frivolous malpractice and negligent lawsuits were sometimes filed against hospitals that were very expensive for them to defend (Studdert, et al., 2006). This period was the temporal *past* of ready-to-hand mode of engagement the participants experienced. The following is a sample of the participants' responses that formed the basis of the theme *Disappearing Status Quo Ante.*

Nurse Maxime was not happy with the advent of CCTV surveillance in the mental health unit because it placed constraints on him in the *present* that slowed his response time in a crisis situation and increased the risk of someone getting hurt. He remarked:

> I mean before [CCTV surveillance] you could just […] if you see something escalate, a situation escalate, a staff getting attack, or anything, you would just act instinctively […] still keeping your professionalism, but you would not think twice about how you [are] going, you know to act, because that second that you take to think twice could prevent somebody getting injured or a patient getting injured. So I feel like it [CCTV surveillance] definitely delays our response when it comes to anything that happens on the floor.

Nurse Sally did not think about CCTV surveillance in the mental health unit before its introduction and she went about her work without any fanfare. She explained:

> I didn't realize that there were no cameras. So if someone just told me that there was a camera, I know that someone from their house could be watching me. But prior to that [CCTV surveillance] I didn't really think there was camera or no camera; I just did what I needed to do.

Nurse Mila believes that she was a better nurse at providing nursing care to her patients before CCTV surveillance had been added to her work area. She said that under CCTV surveillance, she was too focused on not making mistakes which deterred her from using other caring options she knew could be beneficial. **Nurse Mila** stated:

> I honest believe that without the camera the patient got better care because we weren't so focus on the task that were assigned to us such as documentation, proper administration of medications, and making sure that you do you know your rounds every 15 minutes on the clock and you know that pressure takes away a lot of the things you can do for the patient.

Nurse Josh on the other hand, thought the past of nursing in the mental health unit without CCTV surveillance was better because he was able to provide meaningful care to his patients. He commented:

> I would say that I would feel more at ease and have more leisure to be able to incorporate the fundamental of nursing which is caring being out there talking with patients because that's what I enjoy doing […] that's why I enjoy psych nursing because I am able to talk to patients, give them advise and hear their story out […] I feel like I would be able to do that if I did not have the restriction of

surveillance that said that I should be in this area or should not be in that area and so forth.

Nurse Samantha felt she had a better relationship with her boss when she worked without CCTV surveillance. She articulated that the give-and-take between staff and management was better. **Nurse Samantha** described her feelings as follows:

> For years I worked in a hospital where there were no surveillance cameras. I didn't have to worry about anything. If I was late [or] early it was no big deal […] I had a better relationship with my boss. Sometimes I stayed late because of a family […] I did not have to explain to anyone why I stayed late. No with the cameras everyone is

Nurse Sara similarly compared the seamlessness of her work without CCTV surveillance with working under CCTV surveillance. She commented:

> Truthfully, there is a difference when there was no camera. I didn't have to focus on what I was doing […] come to think about it, and I didn't make mistakes. But now I am conscious of my posture to make sure my behavior is more appropriate.

On the contraire, **Nurse Bird** recognized that CCTV surveillance has positive attributes, though her experience with it was primarily negative. She explained:

> I think – that's a tough one because it can go both ways, but so far since I have been working I see it as negative for me. When I didn't have the cameras no one bothered me. I cared for my patients without any problem. Now security is calling you from home, supervisor on their laptop at home monitoring your every move. It is stressful.

Nurse Evelyn found CCTV surveillance to be an irritant. She recalled the time without them as peaceful. **Nurse Evelyn** explained:

> In terms of being a nurse and doing my nursing work, it definitely makes a difference. I didn't think of cameras when there was none. I did my work in peace and no one called me to the office to ask me why I did this or that.

Underlying the theme of *Disappearing Status Quo Ante* is the expression of nostalgia and delight. **Nurse Michael** did not like the past without the CCTV surveillance cameras. She thought there was more risk for everyone including nurses, hospitals, and patients. **Nurse Michael** uttered:

> Without the cameras there would be lots of lawsuits, people will not do the right thing when they come to work; people might maltreat the patients, the patient might abuse the nurse, and there will be no outcome. Anything can happen, if you don't have the cameras how are you going to back up your story? So you see the nurses [are] in legal jeopardy without the cameras.

Prior to the use of CCTV surveillance in their inpatient mental health unit the participants had enjoyed the flexibility to provide care to their patients. Their practice was mainly seamless in the *ready-to-hand* mode of engagement. However, since the introduction of CCTV surveillance, the participants recognized its benefits of enhancing their job security as more important than other consequences. The theme of *Disappearing Status Quo Ante* in relation to the participants' practice in the inpatient mental health is a thing of the past.

Deterring Litigation

According to Ball (1955) ‘‘deterrence’’ is a legal term that goes back to ancient time. Ball explained:

> Deterrence is usually defined as the preventive effect which actual or threatened punishment of offenders has upon potential offenders. The principle is of ancient origin. In antiquity torturous deaths and mutilations were exacted with the thought of making an example of the malefactor. It is for this reason that crucifixion was employed as a means of execution by the Romans. The deterrent principle has been prominent throughout history in systems of punishment. (p. 347)

Kerley, Hames, and Sukys, (2009), refer to “Litigation” as the process of resolving private disputes through the court system. In the context of the inpatient mental health unit, CCTV surveillance was used to *deter* risks spurred by patients’ and staff members’ misconduct. All study participants were in favor of some level of CCTV surveillance in the inpatient mental health unit because of its deterrent effect. Hence the theme *deterring litigation* emerged in this study as a significant experience. At the same time, the participants were aware that they were also objects of CCTV surveillance, although this fact was of secondary interest to them.

Within the context of Heidegger’s temporality, the theme *Deterring Litigation* emerged in the present. That is in the now the participants were experiencing the deterrent effect of CCTV surveillance in the inpatient mental health unit. Likewise, from Heidegger’s modes of engagement, *Deterring Litigation* is an unready-to-hand and present-at-hand experience according to Heidegger’s modes of engagement because the

CCTV surveillance brought the participants' actions into focal view. The following is a sample of the participants' comments supported the theme of *Deterring Litigation.*

Nurse Sara had no doubt that CCTV surveillance was a necessity on the mental health units. She had worked in forensic, private, and public mental health units. **Nurse Sara** believed it was an easy means of protecting the staff from dishonest patients who made false charges. She elaborated by stating:

> This happen recently […] a patient stated that a staff member spat in his face. He was in the quiet room where there is a surveillance camera. When the patient made the accusation, he wanted the management to be notified and the different people and so on. But when the administration rolled the tape, 24-48 hours later, the staff member was actually there, but there was no incident of any confrontation or any close proximity with the patient and the staff, so in that light there was no further action that needed to be done because it was non-founded. If there wasn't a camera, probably it would have to be more probing, more investigation into the accusation. It just stopped there because there was nothing to continue investigate.

Nurse Samantha thought nurses who were males in the mental health units were at grave risks for law suits and losing their licenses. Performing physical assessment and other one to one interventions with the female patients was personally risky. Therefore male nurses may not want to give complete care to their female patients. **Nurse Samantha** explained:

> Now, although it's still a minority, there are more men, and one of the things that I think is going to happen is that male nurses are going to be afraid to care

> appropriately for female patient because they are going to be afraid of, even if the patient might not complain that the male nurse gives her a back rub and went down too far, somebody might be looking at a camera somewhere and totally misinterpret. A male nurse might hold up a female's breast to examine it, somebody looking at it who doesn't have a clue, because bear in mind that the people monitoring these are not nurses; many times they are just people looking at films and if they see something that they have a text that there no grey area, there are just going to say oh I saw nurse John touching patient Mary's breast and it looked inappropriate to me.

Nurse Bird thought CCTV surveillance cameras were a good idea because it *deterred* staff members from causing *litigation* issues for the hospital. Her focus was on staff members' misconduct. **Nurse Bird** expressed, "Positively, I have seen people getting fired for injuring patients- they have been too rough with the patients, so yeah I have seen people getting fired because of the surveillance cameras." **Nurse Kat** similarly also had concerns for the nurses that were males. She did not see how they could recover from allegations of sexual misconduct patients are prone to make. Therefore, she believed they needed CCTV surveillance to help prove their innocence and communicated:

> I know like maybe for males, like if a patient said they were touched or like a male was in their room long, they can prove that the staff member came in the room and left in a second or two, you could not have been touched.

Nurse Betty believed that CCTV surveillance cameras were the nurses' friends in an environment where patients were constantly making allegations against them. She characterized it this way, "It works in our favor also if we're constantly being watched,

patients are constantly saying oh, ah […] this happen, that happen and I am like thank God for cameras."

In support of CCTV surveillance cameras, **Nurse Jane** stated that she had witnessed the patients' behavior being modified by the cameras. She said that after recognizing that patients had tried to claim falsely that they fell, the threat of reviewing the cameras got them to withdraw their claims. **Nurse Jane** verbalized, "I think the cameras can be bad and good because I see patients throw themselves on the floor, and a threat to review the cameras got them to withdraw their claim of a fall."

Nurse Josh conceded with reservation that CCTV surveillance cameras could be of help to him in the mental health unit. Being a male, he had concerns for sexual allegations charges against him. **Nurse Josh** indicated:

> On the positive aspect of surveillance let's say there is a patient that has a history of accusing others of sexual involvement. If I need to go into the patient's room, the fact that there is a camera watching me; I may be delivering a towel or asking the patient a question. The camera will document that I went in an out within 15 seconds; that's a good thing because the patient cannot claim that I was there for X amount of time harassing the patient and so forth. Basically, it's an in and out type thing, so I guess the camera can save me at that time.

Likewise, **Nurse Michael** believed CCTV surveillance in mental health units was long overdue. She said that patients got away with allegations of misconduct because their claims could not be disproved, but this could no longer be the case because encounters are surveilled. **Nurse Michael** explained:

> Yes, psych patients make serious allegations 24/7[…] oh he touched me, oh he had sex me, oh he fondled my breast, oh he did this, oh […] look at the camera. Camera doesn't lie. You play the camera everywhere in the court it exonerates you. Case closed! If it doesn't fit, you must acquit?

Nurse Jack believed that CCTV surveillance was a given because of its help in resolving problems. He further clarified this when he mentioned:

> I would say it's a necessary evil in today's society because a lot of things they have to monitor because that it's the only proof you have if something happen to a patient or to an employee; even away from work sometimes you install cameras yourself for protection; so I completely understand; putting myself in the employers' shoes why they do that, so it's natural I have to work around it, there is no avoiding it.

Nurse Steve also believes CCTV surveillance is the perfect solution to disprove false allegations. He illuminated:

> […] patients sometimes can create stories […] they make-up stories, they make-up stories that is not true. How you going to investigate? How are you going to prove it? Now, one review of the camera, right there, saves us a lot of hassle. So I think the camera has 99% more positive than negatives.

Despite having to practice in unready-to-hand and present-at-hand modes of engagement, the participants found working under constant CCTV surveillance in the inpatient mental health unit beneficial in enhancing their job security. CCTV surveillance inpatient mental health unit is the status quo *(*present*).* That is from Heidegger's

temporality, one of the participants' present experience working under CCTV surveillance is the *deterrence* of *litigation*.

Feeling Uneasy

"Uneasy" is an uncomfortable, anxious, apprehensive, or unsettled *feeling*. Yang and Yang (2013), conducted a grounded theory study to determine if Problem-Based Learning was extensively used in nursing education. One of the themes that emerged in the study was, *Feeling Uneasy*. *Feeling uneasy* is defined as, "The participants experienced very high levels of anxiety, stress, and uneasiness." The participants' anxiety and uneasiness were driven by the fact that they had little experience being so close to faculty members who were scrutinizing their actions. In this study, all 16 participants acknowledged that they had some level of discomfort or uneasiness working under the watchful eyes of the CCTV surveillance cameras in the inpatient mental health unit. The theme of *Feeling uneasy* when performing nursing care in the mental health unit under constant CCTV surveillance heightened these participants' awareness to the point that they felt unsure of themselves at times or even second-guessed themselves. The imagery the participants evoked in the researcher's mind with their descriptions of *feeling uneasy* was profound and underscored the power of CCTV surveillance cameras to influence individuals' perceptions and behavior.

Within the context of Heidegger's temporality, the theme of *feeling uneasy* was one of the participants' present experiences. Besides, such uneasiness propelled the participants into practicing in Heidegger's modes of engagement termed unready-to-hand and present-at-hand. The unready-to-hand and present-at-hand modes of engagement are

spurred by disruptions caused by CCTV surveillance. According to Heidegger, these are not the preferred modes of engagement.

The following section is a representation of the participants' stories that reflects the theme of *Feeling uneasy.*

Nurse Betty used what sounded like a childhood traumatic event to associate her experience working under CCTV surveillance in the mental health unit. She imparted, "Yeah, it's like ah […] I guess if it's like your child your parent is like over you with like a belt […] yeah, that's how it feels though […] like little black globes [it] feels like a parent holding a belt and you're just like trapped." Nursing tasks under CCTV surveillance in the mental health unit that evoke memories of childhood punishment or threats of any kind, not only disrupted the normal flow of things, but at times had the participants stop to question and even rehearsed mentally their actions before proceeding.

Nurse Samantha despite her 40 years of nursing experience still feels uneasy working under CCTV surveillance cameras in the mental health unit. She explained:

> Even as an expert nurse, you start saying well […] I um […] I supposed to- what do you do, do you put this there first or do you put that there first. Even though intellectually you know you are doing the right, but emotionally you are questioning whether you are doing the right thing, so you know it makes you pause, it makes you question yourself, you know. So it increases your stress level.

Nurse Maxime correspondingly, found being watched very uneasy when he had to attend crisis situations. He was not nervous about bystanders watching him; he was uncomfortable with the CCTV surveillance recording his nursing intervention. **Nurse Maxime** disclosed:

> Um […] whenever there is a confrontation on the floor. Like a code- like somebody going crazy, or somebody verbally abusive towards a staff or anything. If you see any elevated situation, first thing that comes to mind, ok I'm being watched […] so let's think about this for a minute now [laugh]! How am I going to handle this? That's the number one thing that always reminds me that hi, I'm being watched.

Nurse Jane did not like the idea of constantly being watched. She commented, "Very uncomfortable. You are sitting, people watching every single move you make. It's very uncomfortable man." **Nurse Sally** had the need to be reminded to focus on her work, so she did not mind some psychological uneasiness generated by the CCTV surveillance cameras to accomplish her responsibilities. She specified:

> Positively it keeps me on my toes [while working in the mental health unit] making sure that I need to do what I'm supposed to do; knowing that I'm been watched makes me more […] um it gives me some anxiety, but it also reinforces that the job needs to get done, and that I need to be monitoring as instructed and I need to be doing my job in a timely manner.

Nurse Jack found the CCTV surveillance cameras in the mental health unit somewhat unsettling, but he was willing to accommodate them for other more compelling reasons. He voiced, "Even though I can't say I feel a 100% comfortable about it, but I understand that there are legal issues attached to it." **Nurse Mila** engaged in a great deal of self-censoring of her behavior, second-guessed her actions, and was frequently consumed with what the "camera thinks." For **Nurse Mila**, the CCTV surveillance cameras took on human qualities. She described her feelings of uneasiness as follows:

> […] you know that pressure takes away a lot of the things you can do for the patient because you are constantly thinking about ok what did I do wrong what I could do better or did I do something that the camera might think was inappropriate.

Nurse Bird expressed ambivalence towards CCTV surveillance. She explained, "I don't I don't really like cameras, they make me feel uncomfortable, but sometimes they can help you and sometimes they can work against you; most of the times they work against you [laughs]." **Nurse Kat** identified crisis situations on the mental health unit as the moments when she experienced additional stress from the CCTV surveillance. She divulged:

> Yes, during a crisis situation that's when I remember it [CCTV surveillance] the most because I know everybody is nervous because you know they are going to review the tape [laugh] to criticize what you did from what you didn't do.

Stopping to pick up coffee and going to the bathroom could make **Nurse Victoria** *feel uneasy*. She explained:

> Oh when I have to move away from the desk, I get called to find out where I am. You know they are watching you. Sometimes I go to get a coffee and the line is long or I am in the bathroom too long. I get really uncomfortable when my phone starts ringing because I know they are monitoring me.

Working in an inpatient mental health unit under CCTV surveillance was not always a comforting experience. The participants verbalized what it was like to feel uneasy working under CCTV surveillance in the inpatient mental health units. Notwithstanding, *feeling uneasy* was experienced from the temporal present in the

inpatient mental health unit. *Feelings of uneasiness* reminded the participants that they were under CCTV surveillance, and such awareness occurred within the unready-to-hand and present-at-hand modes of engagement. Paradoxically, *feeling uneasy* allowed the participants to examine (the phenomenon) what it meant to be under constant surveillance in the inpatient unit. Heidegger contends that it is during these moments of disruption that the phenomenon is brought close-up into focus for examination for its meanings.

Limiting Caring

"Limiting" means preventing or restricting one from having many choices. For example, Michael Blumberg, former mayor of New York, a few years ago proposed a ban on sugar drinks greater than 16 fluid ounces because he believed they were contributing to obesity. In other words, he limited access to the drinks. Limiting in *limiting caring* is used with similar meaning, which is to regulate, or control access to certain caring options (Mariner, & Annas, 2013). Mayeroff (1971) described *caring* as, "helping another to grow" which involves among other things trust, honesty, and patience. "Caring" is an experience of the other as an extension of oneself as well as independent; both patient and nurse benefit from the caring relationship that is reflected as an improvement in their wellbeing (Mayeroff, 1971). While the participants worked under CCTV surveillance in the inpatient mental health unit, the theme of *limiting caring* emerged. The participants reported avoiding caring options that could be misunderstood by someone viewing the CCTV surveillance cameras. The caring options they omitted were neither unacceptable nor wrong, but performing them could risk earning a call to the management office to explain their actions, and no participant wanted to have to explain their caring choices.

Limiting caring is meaningful in the present from Heidegger's temporality of significance because it was a current experience in the inpatient unit working under constant CCTV surveillance. *Limiting caring* proved to have been one of the dissuading effects of CCTV surveillance in the inpatient mental health unit when the participants wanted to use their initiatives to provide complimentary care to their patients, but refrained because they were fearful of reprimand. Participants were consciously gauging their activities to ensure they did not break any rules thereby working under CCTV surveillance in the inpatient mental health unit meant the participants were always in the unready-to-hand and present-at-hand modes of engagement (Greaves, 2010). The following is a sample that represents the participants' sentiments reflecting the theme of *Limiting Caring*:

Nurse Josh discussed the restriction CCTV surveillance placed on him in the mental health unit with some frustration because he felt limited in what he could do. He commented:

> I would say that I would feel more at ease and have more leisure to be able to incorporate the fundamental of nursing which is caring being out there talking with patients because that's what I enjoy doing […] that's why I enjoy psych nursing because I am able to [patients], give them advise and hear their story out […] I feel like I would be able to do that if I did not have the restriction of surveillance that said that I should be in this area or should not be in that area and so forth.

Nurse Jane wanted to use her initiative and creativity to benefit the patient, but like **Nurse Josh**, she did not want to risk having a judgmental conversation with anyone over

patient care. Subsequently, she did what she thought was acceptable to the CCTV surveillance cameras. **Nurse Josh** explained, "Sometimes when you are under the camera, some things that you going to do that you know management doesn't agree with that you know is going to help the patient, you can't do it."

Nurse Jack eliminated techniques from his caring options that he believed could have been more effective in dealing with certain situations, but like the other participants his underlying concern was the threat of being called in the office to explain his caring intervention. He communicated his feelings this way:

> Like I said not a major difference, but maybe I would be a little more, maybe I would say more firm with the patient maybe, not that I am going to attack him, but you know establish a harsher boundary than I would normally if I was not being watched […] again, I am not trying to you no hurt the patient.

Nurse Evelyn wanted to use her initiative and creativity to benefit the patients, but she felt there was "a way" that the administration wanted things done, so she was restricted to this way of doing things. She remarked:

> Sometimes, yes […] sometimes it will be probably more effective to do it some other way and we know that because we have the experience. We are the ones with the patients […] we really are the ones caring for the patient. We doing the job but someone from above want you to look this way and it's unrealistic to meet the cameras unrealistic expectation of things.

Nurse Victoria felt the limiting effects of the CCTV surveillance in her work area. Her frustration with not being able to provide a wider range of care to her patients was palpable in her comments. **Nurse Victoria** expressed:

> I think sometimes it keeps me from going above and beyond, and it just makes me do the absolute […] just whatever I need to do to keep my job […] I am not going to do anything above and beyond that […] I don't want you calling me because I was not at my desk for two minutes.

Similarly, **Nurse Samantha** did not feel free to use her vast nursing experience to its fullest when caring for her patients while she was working under CCTV surveillance in the mental health unit. She explained:

> It restricts you because um […] you have to deal with each patient in a different manner. Some patients require firmer methods- not been ride- but firmer methods, strong conversation. That's how you get across to certain patients. In addition, you develop a rapport with certain patients because you've been with them over the years, you know them, you talk to them […] um you cannot be as opened to them as you would be, and it also restricts your interaction with your peers because what somebody sees or hears under surveillance might not be your intent […] it's subjected to their interpretation.

Nurse Mila felt limited in what she did for her patients when she is working under the CCTV surveillance camera in the mental health unit. She commented "[…] sometimes you do just enough to not get in trouble […] but maybe not enough to benefit the patient."

In the same token, **Nurse Kat** recalled how she felt restricted in caring for her patients**, "**[…] for a regular nurse that wants to help the patients, you feel restricted, you feel like a kid, baby sit, so I say ok what's the point." **Nurse Betty** believes the management team was misguided in their approach to treatment of the mentally ill. She explained, "They

[management] want you to walk around and monitor the patients and give them pills. Pills can't solve problem […] patients need to talk about their problems […] but that's not what they [management] want."

Working under CCTV surveillance in the inpatient mental health unit, the participants experienced the theme of *limiting caring* by being dissuaded from performing certain complementary caring activities. The omitted caring options were nursing initiatives that could have benefitted the patients. The participants reported their belief that someone viewing the CCTV surveillance cameras could not easily verify their activities so they omitted them. Considering that CCTV surveillance is a standard feature in the inpatient mental health unit in which the participants worked, the theme of *Limiting Caring* is a temporal present experience. Given the context of Heidegger's modes of engagement, the participants always found themselves in an unready-to-hand or present-at-hand situation each time they attempted a caring intervention. Ultimately, CCTV surveillance cameras reminded them of their limitations regarding caring.

Normalizing the Present

Jones (1996) argued that, "Normalization" is the disciplinary process by which norms are produced; it makes the rules about what is 'normal." Moreover, surveillance works hand in hand with normalizing as it makes humans want to be "normal" as they self-regulating their behavior (Jones, 1996). Thus, in the case of the workplace, normalization is an unbalanced power relationship between the owners of the business who introduce surveillance tools to instill discipline and the employees who are to be disciplined by it. The theme of *Normalizing the Present* emerged in the current study, but not because the participants felt oppressed by the owners of the businesses. The

participants instead believed the *status quo* in the inpatient mental health unit working under constant CCTV surveillance would and should continue into the future. That is the participants' present experience of CCTV surveillance *deterrent litigation*, it makes them feel uneasy, and limit caring options as they worked in the inpatient mental health unit under CCTV surveillance. The participants expressed their belief that CCTV surveillance would and should continue into the future. The modes in which nurses will engage their practice in the future working under constant CCTV surveillance in the inpatient mental health unit will be the unready-to-hand and present-at-hand. Hence, the theme *Normalizing the Present* speaks to the *future* projection of nurses working under CCTV surveillance. A sample of the participants' voices supports the theme of *Normalizing the Present* is presented in the next section.

Nurse Jack said he understood the need for CCTV in the mental health unit and believed it was in line with the times. He was also confident with CCTV surveillance going forward. **Nurse Jack** relayed:

> It's gonna be more surveillance [laughs] I don't think it's going anywhere […] I think it's just advancing. In general, I think it's a good thing […] it was more towards the positive side than the negative side. The challenge will be to don't overdo it, not overdo it in the sense that sometimes we have to give employees some freedom […] so they don't feel worse that their privacy is being taken away. So we have to be careful about that so we draw a line. But if we are careful and we factoring the ethics problem into it […] it's a positive thing.

Nurse Michael had no reservation about having CCTV surveillance cameras in the mental health units in the future. Her focus was on nurses' potential misconduct. **Nurse Michael** explained:

> I see it as a positive thing that should continue because with surveillance, there is little or no room for error, and there is little or no room for you to be doing the wrong stuff because you know some nurses are also drug addicts, they go and they take patients' medications, the camera is watching you and whatever you are doing […] you know you will be caught. You can't do it. If you are going to be caught stealing, why do it? It makes sure you do the right thing […] it protects you, it protects the patient, it protects the hospital that you are working for.

Nurse Mila was in her 20s and was temporally projecting into the future decades of nursing practice of which she will be a part. She characterized it as:

> I think there is not going to be any less surveillance. I think in the future there is always going to be more surveillance. They are going to find ways and loopholes into how they can quote "benefit the patient" in putting surveillance here and there. I don't think it's going to get any better. I think it's going to be completely monitored nursing in the near future.

Nurse John believes that CCTV surveillance could save the nurses' jobs. He was emphatic about the need to have them on the mental health unit. **Nurse John** remarked:

> Um […] we don't have a choice. With nursing especially in psych, I don't think the camera is going anywhere anytime soon. We know we cannot put cameras in the patients' rooms because of privacy concerns, but we need it in the communal areas. Not only that the patients sometimes get out of hand, staff can get out of

hand, the camera is what's going to save your job. So I think we need to co-exist. The cameras, there are there […] Uncle Sam is going to be watching you whether you like it or not.

Nurse Steve wants the CCTV surveillance in mental health unit to get even more sophisticated. He would like audio recording in addition to the video. **Nurse Steve** expressed:

> […] I don't know how the technology is moving where the camera could actually record the voices. I think in the future that might be happening. That's when we are going to see the benefits […] now it's going to be really strict […] it's like you are been recorded live. I'm sure there are some instances, some kind of jobs, high tech jobs, FBI security where people work like that, but as far as nursing I haven't see it implemented. I don't know if they are thinking about it. Maybe in the operating room or where there will be high risk procedures they may want to do, but uh I think eventually the cameras are already very advanced now, but in the future they are going to be very, very, sophisticated like a live picture. And I hope it gets there.

Nurse Sara could not see any end to CCTV in the mental health units in the distant future. In fact, she thought nursing will willingly integrate it into its practice. She reckoned:

> Nursing and surveillance are going to be partners because that's the new trend now and it's not going to change. If anything, they will improve on what they have now […] I see it in the future as here to stay.

Nurse Victoria believes CCTV surveillance in the mental health units was already very pervasive. She commented:

> […] it will probably be more surveillance in different areas of nursing. A lot more reporting, because I have worked in place where there was no reporting. At this point, our supervisors have access from home, everything is recorded, you can go back […] you can rewind and fast forward. The only thing left would be for them to actually sit there with me. I can't see it get any worse than this.

Nurse Betty had resigned herself to the reality or the CCTV surveillance cameras. She commented, "Yeah I guess it's because of the population we work with cameras will be here to stay […] so I make it work for my advantage." **Nurse Kat** was convinced that CCTV surveillance cameras were going to be part of the foreseeable future. She described her feelings accordingly:

> I think ultimately, I think there are going to be more cameras, cause even in our own lives you notice more cameras; more people have cameras on their dashboard when they drive, so know definitely at the workplace now, since cameras are new technically, if anything happens people want it caught on tape, so I know like for litigation purpose.

Nurse Evelyn believed new nurses will come to nursing already socialized to the presence of the CCTV surveillance. She illustrated this in the following statement:

> To be honest, maybe this ah […] the new nurses would just come out with this [CCTV surveillance] already done and they just take it as a normal part of nursing […] many of them may never know that really it's not part of nursing.

The theme of *Normalizing the Present* is what the participants' forecast for the nurses who will be working in the inpatient mental health unit under CCTV surveillance in the future as they anticipate more of the current experience. Future nurses working under CCTV surveillance at inpatient mental health units will engage their practice primarily from the unready-to-hand and present-at-hand modes as they do now.

The conceptual diagram (see Figure 3) is a representation of interpretive devices based on Heideggerian philosophy and the search for ontological understanding.

Temporality. Existence is structured around time as a horizon such that meaningful experiences time unity of the past, present, and future attached to them. The experience of this unity means that what is experienced in the present is coherent with the *past* and the *future*. The diagram illustrates what was meaningful. This temporal significance is showcased in the following comments by the participants of this study

Modes of Engagement. Modes of engagement constitute the manner in which humans engage with others and equipment. There are three modes which include:

1. Ready-to-hand
2. Unready-to-hand
3. Present-at-hand

The ready-to-hand mode is the preferred way to engage the world. It is seamless, embedded, and taken for granted. The unready-to-hand mode is engaged when there is disruption in the function that causes it to be visible. The present-at-hand is a more serious disruption or breakdown that disengages the activity from its context closer scrutiny and search for solution. The themes in the study were examined for modes of engagement to determine meaning.

Hermeneutic Circle. Humans exist within a hermeneutic circle of understanding. A new understanding is based on an already existing set of understanding. Hence, the whole is examined, then the part, the whole, until there is understanding.

Figure 3: Conceptual Diagram

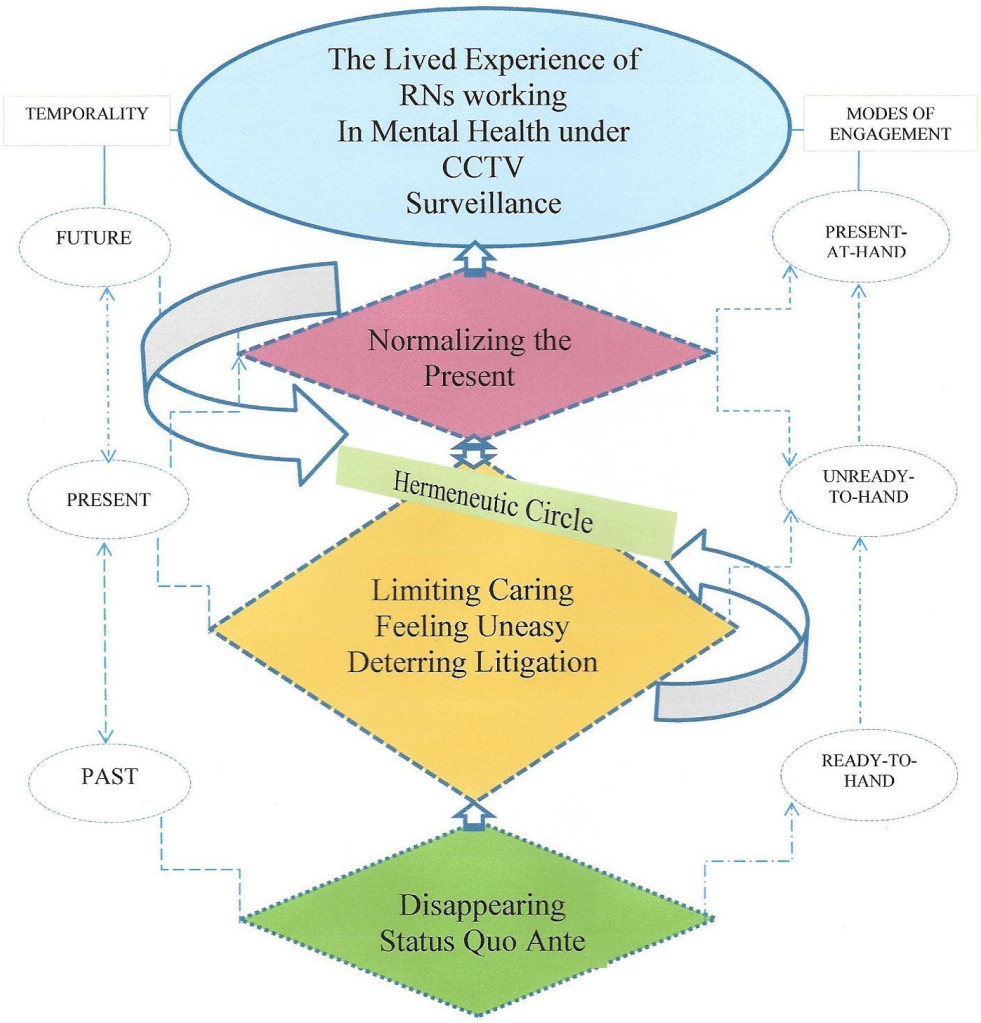


Figure 3. Wallace's (2018). Conceptual diagram of the ontological structure of the lived experience of RNs working in Mental Health Units under constant CCTV Surveillance.

Connection to a Theory

Nursing is primarily a caring profession. When practicing professionally, nurses embody five essential values of professional nursing namely human dignity, integrity, autonomy, altruism, and social justice (Fahrenwald et al., 2005). Nurses have the unique opportunity and ability to bond with individuals who are experiencing moments of health

deficit. The resulting outcomes of such engagement have the potential for earning an intrinsic reward such as emotional satisfaction. Working under closed circuit television (CCTV) surveillance in was reported by the participants in this study as having led to a curtailment of such reciprocal relationships between the patient and the nurse. The five themes of (*Disappearing Status Quo Ante, Deterring Litigation, Feeling Uneasy, Llimiting Caring,* and *Normalizing the Present*) that emerged from the study revealed a dichotomous relationship. Essentially, the participants would like to return to the *status quo ante* wherein they had enjoyed more flexibility to care for their patients in the inpatient mental health unit; however, the threat to their employment from potential *litigations* have them opting for CCTV surveillance with all its consequences (*deterring litigation, feeling uneasy,* and *limiting caring*). Maslow's Motivational Theory – Hierarchy of Needs (1970) was used to formulate a connection within these themes that emerged in this study.

Chapter Summary

Chapter four has described the ontological structure of what it meant for 16 nurses to be working under constant closed circuit television (CCTV) surveillance in mental health units. The data analysis was guided by Heideggerian and Gamaderian philosophy in addition to Fleming et al. (2003) four-step process. The sample description and characteristics of the participants were highlighted. Five overarching themes emerged from the data namely *disappearing status quo ante, deterring litigation, feeling uneasy, limiting caring,* and *normalizing the past.* These themes brought to light new insights into a phenomenon about which little has been known, and a connection was made between

the emerged themes and Maslow's Theory of Motivation. The meaning of the study will be interpreted in Chapter Five.

CHAPTER FIVE

DISCUSSION AND CONCLUSION OF THE INQUIRY

The purpose of this hermeneutic phenomenological study has been to understand the lived experiences of registered nurses (RNs) working in mental health units under constant closed circuit television (CCTV) surveillance. The aim of the study was to have the participants explain what it meant to be a RN working under constant CCTV surveillance in the inpatient mental health unit, to interpret their meanings, and co-construct the narrative. Hermeneutic phenomenology has provided the researcher with only limited access to the participants' world of experiences. With that in mind, the researcher recognizes that such pursuit was not meant to provide final answers, but to begin a conversation that will stimulate interest among readers to further explore the phenomenon. Excerpts from the literature were used to support and clarify the themes that emerged. The following is a discussion of the findings revealed in the emergence of five themes and their connections to Maslow's Hierarchy of Needs Theory. The significance of the study to nursing in the areas of nursing education, practice, research, health and public policy have been discussed. This chapter concludes with a discussion of the strengths and limitation of the study, and recommendations for future study.

Exploration of the Meaning of the Study

Using a qualitative hermeneutic phenomenological approach, the researcher's quest has been to understand what it meant to be a registered nurse (RN) working in mental health under constant closed circuit television (CCTV) surveillance. Such interest was sparked by the researcher's own extensive experience working in mental health under constant CCTV surveillance, and a scarcity of research reported on the

phenomenon. The researcher chose a hermeneutic phenomenological method based on a Heideggerian and Gamaderian philosophical approach because of its focus on the contextual "situatedness*"* of human experience and what it means to "be." This philosophy provided the researcher and participants with the flexibility to explore the meanings they attached to the experiences of working under constant CCTV surveillance at inpatient mental health units and co-construct the narrative. Hermeneutic phenomenology assumes that the researcher and participants are inextricably linked in a hermeneutic circle of understanding related to the "world of RNs working under CCTV surveillance in the mental health unit" familiar to both as meanings were interpreted (Gadamer, 1989). The participants, therefore, returned to their lifeworlds to recall the experience of what it means to be working under constant CCTV surveillance in a mental health unit.

Heidegegrian and Gamaderian hermeneutic phenomenology has an ontological focus. The participants' experience of working under constant CCTV surveillance at inpatient mental health units was interpreted within the context of a referential whole of connectedness and embodiment and not as a detached object waiting to be discovered (Greaves, 2010). Thus, to accomplish such task, the researcher applied three interpretive devices namely the hermeneutic circle, temporality, and modes of engagement.

The Fleming et al. (2003) four-step process was the model of the hermeneutic circle applied to the data analysis in this study. The researcher repeatedly read the whole text, then read the parts, then read the whole text until the meaning was understood. This approach is sometimes called the hermeneutic spiral or the spiraling process of understanding wherein the interpretation of a group of individuals is built on each other's

understandings overtime (Conroy, 2003). Heidegger proposed that things that were meaningful to humans were also temporally important such that there must be coherence with the *past, present,* and *future* in relation to the phenomenon. The participants' experience working under constant CCTV surveillance was examined in relation to its past, present, and future meanings.

Heidegger identified three modes of engagement namely ready-to-hand, unready-to-hand, and present-at-hand. As an ontological interpretive device, it is during the cycling through the modes of engagement that a phenomenon shows itself as an existential entity (Greaves, 2010). During the ready-to-hand mode of engagement, the participants' nursing practice in relation to working under CCTV surveillance should be seamless and taken for granted such that the phenomenon is not noticed. On the other hand, during the unready-to-hand mode of engagement, the participants experience minor disruption in their practice in relation to the phenomenon leading to close examination of the phenomenon as it shows itself. Major disruption of nursing practices relative to CCTV surveillance is a *present-at-hand* mode of engagement leading to even closer examination of the phenomenon. It was within the context of these three interpretive devices: the hermeneutic circle, temporality, and modes of engagement that the themes for this study emerged.

The five themes that emergent from the text were *Disappearing Status Quo Ante, Deterring Litigation, Feeling Uneasy, Limiting Caring,* and *Normalizing the Present.* These themes presented themselves after the researcher remained immersed in the data through reading, rereading, making notes, listening, reflecting, and revising.

Interpretive Analysis of the Findings

Five themes that emerged from the data during analysis revealed a coherent picture of what it meant for the 16 registered nurses (RNs) to work in mental healthcare units under constant CCTV surveillance. These themes were *Disappearing Status Quo Ante, Deterring Litigation, Feeling Uneasy, Limiting Caring,* and *Normalizing the Present.* Each theme formed a significant thread in each participant's story.

Disappearing Status Quo Ante

The *Disappearing Status Quo Ante* was identified as a period during which participants practiced autonomously to be creative and spontaneous in building and maintaining a therapeutic milieu in the mental health unit. The therapeutic milieu is defined as "a stable and coherent social organization" that provides patient centered care (Tuck & Keels, 1992). The ability to practice in the therapeutic environment is challenging but rewarding. The milieu provides healing to the patients, and validates the role of the nurse: not just as members of the team, but also as an autonomous agent of patient care.

Scholars have suggested that the shortened length of inpatient stay has contributed to the demise of the "therapeutic milieu," and refocused care from an interpersonal domain to one based primarily on "structure, limit setting, and safety" (Mahoney, Palyo, Napier & Giordano, 2009). Despite no evidence or correlation between the two conditions, patient and employee misconduct proliferates in the milieu as dishonest patients falsely allege staff misconduct, and some would even stage falls by throwing themselves to the floor with the intent to sue the healthcare facility for fault. Some staff members also were known to engage in unprofessional behavior and such behaviors

contributed to the introduction of CCTV surveillance in mental health units. A confluence of these factors of a past without CCTV surveillance that exposed what was of highest priority for the participants moving forward into a *future* working under CCTV surveillance. The study participants had mixed feelings since they all wanted to work under CCTV surveillance in the inpatient mental health unit for its benefits but also lamented on the *past* without it. The following sample of the participants' voices confirmed their interests yielding the theme of *Disappearing Status Quo Ante*.

Nurse Betty talked about her inability to provide therapy groups, which is a basic activity in the therapeutic milieu, to the patients because of CCTV surveillance. She expressed, "I would, […] really be doing nursing group as often as I umm […] that's the first thing that came to mind. I wouldn't be doing something that I found pointless." However, when the risk of *litigation* emerged, **Nurse Betty** would rather CCTV surveillance in the inpatient unit. She explained, "It works in our favor also if we're constantly being watched, patients are constantly saying oh, ah […] this happen, that happen and I am like thank God for cameras." **Nurse Samantha** saw the days without working under constant CCTV surveillance as a better time for staff and patient**.** In her words she disclosed, "I think that while nursing in general can be a very stressful profession, I believe that it was better […] we interacted differently with our patients and with our peers […] um because you were not totally monitored."

Likewise, **Nurse Maxime** believed the *past* of not working under constant CCTV surveillance provided more flexibility to prioritize nursing care. He vowed:

> I believe I would be more effective with patient care. I would focus more on patient care and not on what have to be done [be]cause you know some stuff can

be done five minutes later. If patient care is being done […] you can delay doing the Q [15 minute observation] with a tech [mental health technicians] the tech can do the round by himself because the round is still being done […] if you have to attend to someone in distress.

However, **Nurse Maxime** liked the CCTV surveillance when it exonerated the nurses of false allegations against them. He clarified:

> The good side of surveillance is that the setting that we work in, patient with mental health issues tend to say stuff that are very important. Like if a patient says hey that guy touch me they can always go back and look at the cameras that you didn't even interact with the patient.

Nurse Mila felt managed as she went through the day and did not seem to have the type of control she would like over her schedule. She added:

> Now, in the other scenario that I wasn't under surveillance, I felt like the day went smoother. We did have to do what we had to do with the patients however people weren't pressured to do certain things that were standard protocol. Nobody per say got affected negatively, but as staff wise I believed the day did go smoother when we weren't under surveillance.

Nonetheless**, Nurse Mila** liked the fact that CCTV surveillance protected the staff from unscrupulous patients. She shared, "The good thing about the cameras is that people can get less in trouble in some way. When patients complain the camera expose their lies."

Nurse Josh believed that without the CCTV surveillance cameras in the mental health unit the environment was safer for the staff and patient because the patients were aware

that the staff was not afraid to engage them in a crisis situation. **Nurse Josh** succinctly stated:

> […] when patients' behavior is controlled because of not having [CCTV] surveillance, everyone benefits […] staff, management, and patients. It becomes a more dangerous and unsafe situation for patient and staff when the patient realizes that the nurse is frozen because of surveillance, and he or she the patient can act with impunity.

Still, **Nurse Josh** liked the idea that the CCTV surveillance cameras protected the staff from sexual allegations. He explained:

> […] the positive aspect of surveillance let's say there is a patient that has a history of accusing others of sexual involvement. I may be delivering a towel or asking the patient a question. The camera will document that I went in an out within 15 seconds; that's a good thing because the patient cannot claim that I was there for X.

According to Bell (2010), some of the reasons employers introduced electronic surveillance is to protect the company from legal liabilities and prevent sabotage, employee bullying, and thefts. It is estimated that businesses lose billions of dollars each year because of their employees (Mello, Chandra, Gawande, & Studdert, 2010). Most of the participants corroborate the claim of employee misconduct necessitating CCTV surveillance in the mental health units. **Nurse Bird** agreed that some employee engaged in less than admirable behaviors that needed to be dissuaded. She remarked:

> I think if we didn't have cameras, I think people would […] do a lot of things that were not ethical. Probably would try to get away with more things. So in a sense

> it's a good thing there are cameras because people would do all sought of things and get away with it […] staff and patients**.**

Nurse Bird further revealed that she did not like the CCTV because most times they worked against her. She reported, "I don't I don't really like cameras, they make me feel uncomfortable, but sometimes they can help you and sometimes they can work against you- most of the times they work against you."

Nurse Michael shared similar sentiments when she echoed:

> Before there was no camera, they [patients] sued the hospital unnecessarily, the nurses, the doctors and got away with it. Now, it's good. If it's on camera what can you sue? The camera speaks loud for you in the court. You got to protect yourself […] I see it as protection.

Nurse Steve believed that without CCTV surveillance too much was left up for chance and things were ambiguous. He believed that the introduction of the CCTV surveillance in the mental health units was a necessary mediator when he uttered:

> Even with the staff that you work with […] in the event something happens, it's going to be he says she says, and there has to be a mediator. I think the camera would help to mediator because the person [mediator] would not be there to know what went on.

Using the self through interpersonal-relationship building is one of the primary therapeutic tools the psychiatric mental health nurse employs to help their patients recover from their illness. Interacting with the patient in the mental health has been was an embedded feature of the therapeutic milieu. However, the diminished use of the self as a therapeutic tool in the inpatient mental health unit has emerged as a significant factor in

the theme of *limiting caring*. Participants have lamented on the limited opportunity they have to engage in building therapeutic relationships as they did in the past. Spending time with patients, listening to their concerns, and providing support is a disappearing skill. **Nurse Josh** summed it up this way:

> I enjoy psych nursing because I am able to talk to patients, give them advise and hear their story out […] I feel like I would be able to do that if I did not have the restriction of surveillance that said that I should be in this area or should not be in that area and so forth.

The current literature supports **Nurse Josh's** point. For example, Kornhaber, Walsh, Duff, & Walker (2016) conducted an integrative review on the benefit of therapeutic interpersonal relationships between healthcare professionals and patients. The review was comprised ten studies, eight qualitative designs and two mixed methods. The findings of this interpretive review revealed the themes of building therapeutic relationship with patient, engaging in therapeutic listening, responding to patients' emotions and unmet needs, patient centeredness, and therapeutic engagement as very effective in patient recovery. The following is an excerpt from the study findings:

> Taking the opportunity to engage therapeutically was seen as crucial by one Registered Nurse: The opportunity to interact is the ultimate … it's a really important interaction … It can be the difference between life and death.
>
> The importance of therapeutic engagement was made clear by a patient in Lees et al study who stated: I wanted someone to sit down and talk with and go through it all … to just support me and ask me about it and how I was feeling … someone to make contact with me about it. (p. 543)

Thibeault (2016) used an interpretive phenomenological approach for another study with 15 participants who were psychiatric mental health nurses working in inpatient acute settings. The study findings revealed that even among acutely-ill patients who were in distress, the use of interpersonal relationships and self as a therapeutic tool can be effective as treatment. The following excerpt taken from this study represents the remarks of a nurse who had been verbally abused by a very ill patient:

> She was saying things like, "Oh, you're so stupid, you are the stupidest nurse I've ever met. Why aren't you dead? I could kill you." This woman was very, very angry; it just really got to me, and I thought, How much is too much? I think in psychiatry we are used to a little bit of verbal abuse because nobody wants to be here and they don't think they are ill. So there are those conflicts, right? (p. 5)

The nurse took the abuse personal, but she continued to care for her patient in a professional manner. The patient's comment underlines a safety concern these nurses must content with as they continue to care for psychiatric patient.

Unfortunately, some patients are successful in their intent to hurt the mental health staff member. **Nurse Maxime** shared an experience of a staff member having been knocked out by a patient. He explained:

> So when I got to the floor, I saw that the patient was on top of the staff member. So I reacted, I reacted, I grabbed the patient and I put him down, and I was on top of him […] he was punching the staff member and everything, so he [staff member] was in bad condition.

In a recent incident at a mental health facility in Augusta, Georgia a mental health patient who habitually assaulted staff members was sent to prison for four years for her

most recent assault on a hospital employee. A news reporter Adams (2017, October 18) commented on the case:

> The defendant assaulted Sally from behind – it was a totally unprovoked attack on a defenseless woman," Katz wrote in an email sent Tuesday. "The defendant had some mental health issues but clearly knew just what she is doing. Sally has some lasting and permanent health issues now and the defendant bears responsibility." The lawsuit says that as a result of assault, Nichols was injured seriously and now suffers from "continuous headaches that range anywhere from 6-9 on a scale of 10." She says she takes up to10 ibuprofen a day for headaches (para.4).

Another incident of staff member misconduct in Orlando, Florida was reported as having taken placeat a behavioral health facility. The employee was arrested for allegedly sexually assaulting a19-year-old woman while she was a patient at the hospital (WFTV9, 2017 Nov 15). CCTV surveillance footage of the accused entering the patient's room was cited.

These reports add some clarity to the findings of *disappearing status quo ante* that while the participants missed the inpatient mental health unit of the temporal past they would rather embrace the present. Participants found it much easier to use interpersonal relationship as a therapeutic skill to help their patient recover in the past. The participants felt more autonomous in caring for their patients, and they practiced nursing in the inpatient mental health unit seamlessly and in the ready-to-hand mode of engagement. However, they also recognize that incident and employee misconduct have helped to herald in the era of CCTV surveillance in the inpatient mental health unit. The participants commended it fortuitously.

Deterring Litigation

Inpatients mental health facilities provide a great service to the community as patients in the most acute phases of the illness are routinely stabilized and returned home. Nevertheless, inpatient mental health facilities are ripe for litigations of all kinds. One of the primary reasons employers identify as being in favor of installing electronic surveillance including CCTV is to decrease risks (Rosenblat & Kneese, 2014). Patient abuse claims is one category of risk those who work in mental health facilities encounter. Such liability can financially-ruin a mental health facility or even lead to closure of the service (CCHR International, 2018).Then there are other kinds of employee misconduct such as sleeping on the job, stealing, and incivility that also could have legal ramifications. Not surprisingly, the 16 participants of this study gave similar reasons for vouching for CCTV surveillance in the mental health unit. The relationship between the participants and the mental health environment in which they worked seemed adversarial such that they welcomed CCTV surveillance as a partner to combat what seemed like injustice.

Nurse John believed CCTV surveillance in the mental health unit is a necessity to protect patients and staff. He contended that patients frequently make allegations that must be verified. **Nurse John** made his point when he mentioned:

> Well to me it means because we are dealing with patients who have psychiatric issues, it's [CCTV surveillance] a protection for us and for them, and also for safety. Now sometimes you may not see something let me just playback the tape the video and you can catch something that the naked eye didn't see. And also if a patient says something happened this is your back up.

Nurse Steve believed in the CCTV surveillance cameras. He commented that they were his back-up; they exonerated him according to what he disclosed:

> The patient likes to throw herself on the floor […]. At the same time I know the patient likes to get nurses into trouble. I had just come on the unit, and the patient threw herself on the floor, and she was a heavy patient. And she was like not well covered with her gown […].The next day she went to complain to the director of nursing of the situation. When they reviewed the camera; they saw everything […]. So it definitely helped me and reinforced my position and also my judgment.

Nurse Kat said that she took no chances: When she is working under CCTV surveillance she always plans for the worse. She verbalized:

> […] it's going to be, you know, it's going to be a call on a hindsight basis, whereas you know you should have done this differently, so I start to try to think ahead before I react in a crisis situation. Yeah, I tried to plan for the litigation in advance.

Nurse Betty related a situation with which she was familiar that got some nurses in legal problems. She conveyed, "Yes, some of the nurses are still like reeling from depression from having to go to *litigation*." **Nurse Jane** also liked the fact that CCTV surveillance can exonerate her if there is a false claim:

> The good part is if the patient tries to do something or say something that you didn't do they can look back at the camera and see that you didn't do it and where you were at that time and what you were doing.

Incidents in which the mental health staff member abuses the patients entrusted in their care also occur. South Carolina RN working in an inpatient mental health facility

was charged with sexual misconduct with an inpatient that was in her care (FITS News, 2017). Another case in Connecticut involved staff misconduct that was so egregious the police had to be called. In this particular case, they arrested nine staff members, and 31 were suspended. Collins (The Associated Press, 2017, Sep 17) described:

> At Connecticut's only maximum-security psychiatric hospital, staff members put a diaper on a patient's head, threw food at him, poured water over him, put salt in his coffee, kicked him and placed a mop on his head after cleaning a floor, according to a state report (para.1).

It is understandable that **Nurse Michael** insisted that some nurses working in mental nursing needed to be under CCTV surveillance. She explained:

> I see it [CCTV surveillance] as a positive thing that should continue because with surveillance, there is little or no room for error, and there is little or no room for you to be doing the wrong stuff because you know some nurses are also drug addicts, they go and they take patients' medications, the camera is watching you and whatever you are doing […] you know you will be caught. You can't do it. If you are going to be caught stealing, why do it? It makes sure you do the right thing […] it protects you, it protects the patient, it protects the hospital that you are working for.

According to **Nurse Maxime:**

> The good side of surveillance is that the setting that we work in, patient with mental health issues tend to say stuff that are very important. Like if a patient says hey that guy touch me they can always go back and look at the cameras that you didn't even interact with the patient. That's one of the good sides of it.

Nurse Michael shared similar sentiments:

> Before there was no camera, they [patients] sued the hospital unnecessarily, the nurses, the doctors and got away with it. Now, it's good. If it's on camera what can you sue? The camera speaks loud for you in the court. You got to protect yourself […] I see it as protection.

As **Nurse Michael** has described, having CCTV surveillance in the inpatient mental health unit *deters litigation*, and ultimately decreases risks for everyone. A case in point is that in 2014 at a Naples Florida facility, a patient committed suicide by hanging himself in his bathroom. CCTV surveillance footage revealed that the protocol of checking the patient every 15 minutes had not been followed. The family filed a lawsuit against the hospital that has had legal problems in its short history. Carpenter (2016, Jan 09) of the *Naples Daily News* reported:

> The troubling details of Ousback's death are the subject of a recently filed lawsuit in Lee County against Park Royal Hospital and Landers. They also represent another black eye for the four-year-old hospital, which has already seen one employee sent to prison for sexually assaulting several patients and has had documented issues with failing to check on patients (para.3).

CCTV surveillance did not prevent the death; however, it made solving the problem of who was at fault a lot easier, which the participants of this study affirmed. **Nurse Sara's** observation supported this point. She explained:

> It [CCTV surveillance] helps in *litigation* when there is a law suit or a case that a patient might accuse a staff of any abuse or so, the camera will be there to kind of direct, and you know, you can look at the camera and see exactly what took place.

In the following case involving nurse misconduct in a hospital in New South Wales, no CCTV surveillance cameras were involved. A male patient claimed that a male nurse touched him inappropriately sexually, including his genitalia, and offered him back and shoulder rubs during his shift (HPCS3, 2012). The initial complaint was dismissed for insufficient evidence. The participants in this study made similar claims that without CCTV surveillance there is too much ambiguity. **Nurse John** concurred with the comment, "The camera doesn't lie; it records what happens." Fortunately, for this patient he was vindicated on appeal. However, by then, he was suffering from emotional stress.

Yet another case of employee misconduct caught on CCTV surveillance cameras resulted in the termination of a nurse for falling asleep at the nurses' station on her break. Her case was extreme in that she was taking her 30-minute break at the last 30 minutes of her (7:00 am to 7:30 am) shift. Her supervisor approached and informed her of the violation, whereupon she was subsequently terminated. The nurse filed a lawsuit against the hospital and lost, but she took her case to the appeals court, where she explained that the hospital was guilty of double standard for not having terminating a lab technician for similar conduct. Latner (2017), the legal reporter provided the following excerpt:

> Ms N had just finished a busy 7 pm to 7 am shift, so busy that she had not been able to take her half-hour break. It was 7 am, but she had a staff meeting at 7:30 am, so she remained on the clock and took her break from 7 to 7:30 am. She sat at the nurse's station and closed her burning eyes for a moment. The next thing she knew, her supervisor was standing over her, loudly and pointedly saying "Good morning, Ms N." The appeals court agreed with the lower court that a nurse is very different from a lab technician. "Nurses—unlike technologists—have a

> responsibility to respond with immediacy to patient needs," wrote the court. "Moreover, a nurse sleeping in a public area could undermine the public's confidence in the hospital, which has an interest in putting forth a professional image." The court found that the differences in responsibilities between Ms N and the lab tech made it an unsuitable comparison (para.5-7).

The nurse lost her job under an unfortunate circumstance, but CCTV surveillance ensured that the conversation was about the reasonableness of the hospital and not about whether or not she was sleeping. The CCTV surveillance made things simple.

Nurse Steve alluded to a similar point in reference to a co-worker's complaint. He commented:

> Even with the staff that you work with […] in the event something happens [without CCTV surveillance] it is going to be he says she says, and there has to be a mediator. I think the cameras would help the mediator because the person [mediator] would not be there to know what went on.

The participants embraced CCTV surveillance in the inpatient mental health unit because of its ability to *deterring litigation*. *Deterring litigation* enhanced the participants' job security by protecting their licenses, saving the business from financial demise, and ensuring patient safety. The theme is in the temporal present, and because CCTV surveillance actively mediated the participants' activities in the inpatient unit, they engaged their practice in unready-to-hand and present-at-hand modes.

Feeling Uneasy

Feeling uneasy is a theme that brings to light potential negative consequences for the participants' psychological and physical wellbeing when they work under constant

CCTV surveillance in a mental health unit. Such negative consequences are well-documented in the literature by other industries. For example, *feeling uneasy* is stress, an unhealthy physical condition, and a contributor to progressive lack of job satisfaction resulting from electronic monitoring (Watson, 2001; Lee & Kleiner, 2003). Most of the participants in this study acknowledged some level of discomfort, anxiety, or stress working under the CCTV surveillance. Some participants reported having been frozen at times; others second-guessed their actions, and some lost their confidence in what had been previously taken for granted routine behavior. Some participants in more than one way described this unsettling feeling. **Nurse Samantha** revealed how *feeling uneasy* affected her relationship with her patient and the quality of care she gave while working under CCTV surveillance. She regretted being monitored. She shared:

> My anxiety level would go down [without CCTV surveillance] and you know really, when you are a care giver, your nurse is anxious it sometimes carries over to the patient. If I am taking care of the patient, and I am constantly looking at my watch because I know that I have this to do or that to do, or you know they give me an hour to between when I give the medication and when to chart it, then I'm going to be more anxious, so if you come to talk to me, I am probably going to say to you, you know Mr. Brown, Ms. Jones, I have to put this in the computer can I tell you when I'm done, and by that time you lose the momentum, you know the patient doesn't want to talk, they get upset sometimes, they say if you don't want to talk to me, I don't want to talk to you, so you lose that connectivity with the patient.

Nurse Josh felt like his anxiety level lessened over time as he worked under CCTV surveillance. He commented, "I guess when I just started working I felt it, [CCTV] but after a while I feel less of it. There is always an element of discomfort. It decreases with time, but it never disappear 100%." **Nurse John** also acknowledged the discomfort he felt working under CCTV surveillance, but he was willing to go along with it. He unveiled that:

> [CCTV surveillance]- is not something that I am really comfortable with, but since it's there and you work for a […] business, when you signed on the dotted line, you have to follow the instruction of the place where you work.

Nurse Jack is a proponent of having CCTV surveillance in the mental health unit. However, when he worked under CCTV surveillance and had to participate in crisis situations in which he would ordinarily have been comfortable, he got unsettled and nervous. He articulated:

> […]sometimes you are in the middle […] you are in the heat of the whole thing, but you have to be careful not to hurt yourself or the patient, but sometimes things get really messy and that when you have to think about your CPI [Crisis Prevention Institute] and try to do your best, and try to get the best out of what you learn because things can get badly quickly, and you are being watched at the same time [laugh]so it's something very uncomfortable.

Nurse Sally found doing little things such as peeking at her cellphone or the day's paper while working under CCTV surveillance in the mental health unit heightened her anxiety level. She mentioned:

> Ok I tell you so we have some downtime ok and I pick up the newspaper and I want to look at the Sunday paper so I'm hesitant like what if, I'm been watched and I'm looking at the newspaper and I am going to get called out […] you were looking at the newspaper, so that gives me anxiety […] or, looking at my phone, checking email like I'm just real anxious about that because I don't know if […] at that moment […] might be just zooming in on me at that moment and call me and says […] you were looking at your cellphone when you should have been working and that's where the anxiety settles in.

Whereas, **Nurse Sally** characterized her feeling of uneasiness and anxiety, **Nurse Mila** called hers paranoia. Harper (2008), in Surveillance & Society, referred to paranoia as a general sense of heightened self-consciousness and suspicion or an indication of a form of delusion. **Nurse Mila** described her feelings of paranoia working under CCTV surveillance as follows:

> I know exactly what it's [CCTV] meant for, but the way that it makes me feel […] it honestly make me feel paranoid. It makes me watch every step that I make, and to see how that step can be interpreted in their eyes.

It follows that any electronic surveillance is a potential occupational hazard leading to a host psychological and physical problems. According to Levy (2006), studies in other industries of workers working under a wide range of electronic surveillance including CCTV were exposed to the following:

> The pathophysiologic effect of chronic stress (strain), resulting from work related stress, contribute to a wide range of unhealthy behaviors and illnesses, including

> mental disorders, CVD and its risk factors (hypertension, obesity, diabetes, and the metabolic syndrome), and musculoskeletal disorders. (p. 334)

Rafnsdóttir and Gudmundsdottir (2011) conducted a mixed study to measure six high-technology companies to determine their psychological work environment under electronic performance monitoring (EPM). There were 984 employees divided into two groups. Some employees worked under EPM, and some did not work under EPM. The result showed statistical significance that employees that worked under EPM had a worse psychological work environment that those that did not work under EPM. The following is an excerpt from the findings:

> The results show that our hypothesis that employees working under EPM technology reported a worse psychosocial work environment than their colleagues is true. On the other hand, the male employees working under EPM technology showed significantly more stress than their male colleagues at the companies. But even though the monitored women did not demonstrate more stress in the survey than other women, the interviewed women did complain about increased stress while working with the EPM. (p. 218)

Similar to the aforementioned study findings, **Nurse Bird** felt intense pressure to perform and follow protocol to avoid a call to the management office. She explained:

> I [know I] am being watched, and I could possibly, and at any time be called into the office and asked questions about my job performance, maybe what I was doing or maybe what I was not supposed to be doing so yeah it has a big significance the cameras […] they are constantly there and so you just have to know that they are there and you are doing what you are supposed to be doing.

Nurse Victoria had similar sentiment. She shared, "I am being micromanaged, decreased job satisfaction […] it [CCTV surveillance] makes me feel uncomfortable being watched so much, so heavily."

Suri and Rizvi (2008) conducted a comparative study to determine the stress level of the workers on a life Stress Scale and a Mental Health Inventory scale. The study was conducted at a domestic and international call center in India where men and women worked under intense electronic monitoring. Both call centers had high stress levels among the employees. The stress level was the same at international center for both men and women, but at the domestic call center, men's stress levels were higher than women's. Even though this study did not measure stress levels among the participants, both groups reported *feeling uneasy.* In this current study, **Nurse Jack** said, "I don't feel 100% confident working around them [CCTV surveillance cameras]. Similarly, **Nurse Kat** admits to different levels of *uneasiness*. She clarified, "I do get nervous and stressed especially when something [an incident or crisis situation] happens."

Feeling uneasy was a significant theme for the temporal present as it helped highlight what it meant to work under constant CCTV surveillance in mental health units. Its discomforting feature was meaningful in helping to identify what it meant for the participants to work under constant CCTV surveillance. *Feeling uneasy* was identified as also meaningful because the participants were frequently in the unready-to-hand and present-at-hand modes of engagement.

Limiting Caring

Limiting caring emerged to represent the participants' beliefs that they could not use their initiative and creativity in various caring situations for the betterment of their

patients for fear of disciplinary actions under surveillance. The literature has identified such limitations as an unintended consequence of managing the perceived risk of dangerous patients by overemphasizing physical security measures including CCTV surveillance. In a case study, Curtis, et al. (2013) stated, "The growing emphasis on security [in the mental health unit], prompted by responses to specific incidents in other hospitals, was thought by a matron to reduce the scope for therapeutic activities" (p. 207). The study identified that the value of physically-managing the mental health environment of care using electronic tools has been viewed as more important than the interpersonal model of care. This includes activities such as group therapies, individual counseling, and peer modeling which have been displaced or relegated to a lower status rather than making sure a patients' behaviors do not lead to liability for the organization.

The participants in this case study (Curtis, et al., 2013) did not address the underlying reasons for why CCTV surveillance *limited* their *caring* activities, some of the caring activities; however, they reported not being able to perform were of the interpersonal model mentioned in the case study. **Nurse Josh** talked about not being able to sit and spend a little time with his patients when he expressed:

> I enjoy psych nursing because I am able to […] patients, give them advise and hear their story out […] I feel like I would be able to do that if I did not have the restriction of surveillance that said that I should be in this area or should not be in that area and so forth.

Nurse Evelyn felt competent to care for her patients, but she felt dissuaded to do what she thought was right because of the CCTV surveillance. She verbalized:

> Sometimes it will be probably more effective to do it [care for the patient] some other way and we know that because we have the experience. We are the ones with the patients […] we really are the ones caring for the patient […] we doing the job but someone from above [management] wants you to look this way and it's unrealistic to meet the camera's unrealistic expectation of things.

Nurse Samantha was more specific in how she had been affected in performing a basic task such as educating a patient about medication. She commented:

> So I would probably spend maybe […] I have a difficult patient who probably needs 10 or 15 minutes to explain his medications […] to encourage him into taking his medications and then because they are monitoring your time […] they are monitoring your length of time on a certain task […] then you have to be watching yourself […] you spend 2 minutes to make this patient's bed for example, when you should do it in 5 minutes. So it also monitors your productivity […] so there becomes the issue of quantity instead of quality work.

Unfortunately, **Nurse Victoria** has lost affection for her employment. Kassim and Marzukhi (2014) conducted a correlational study to determine employees' commitment to an organization. The three categories of employees identified were those with *affective commitment*, *normative commitment*, and *continued commitment*. Affective committed employees had belief in the goals of organization and were willing to work toward meeting them. Normative committed employees had feelings of duty and obligation to the workplace. Continued committed employees were vested only because nowhere else needed their skill set. The study found that continued committed employees were the

most threatening to the organization because their interest in the organization was based on reward and not identity.

The issue is reflected in the current study. **Nurse Victoria's** voice was one of frustration that she had been limited in what she wanted to accomplish for her patient. According to the study by Kassim and Marzukhi (2014), **Nurse Victoria** seemed to fit the category of a *continued committed* employee who had not left her organization because she had not yet received another job offer. **Nurse Victoria's** stated:

> I think sometimes it [CCTV surveillance] keeps me from going above and beyond, and it [CCTV surveillance] just make me do the absolute […] just whatever I need to do to keep my job. Ok, you want to watch me I am going to do just what you want to see me doing […] I am not going to do anything above and beyond that […] I don't want you calling me because I was not at my desk for two minutes. So don't expect anything more of me than what's expected.

Nurse Mila also gauged her actions to save her job. She explained, "Um […] sometime you kind have to be on the paranoia side […] and you have to […] sometimes you do just enough to not get in trouble, but maybe not enough to benefit the patient." **Nurse Jane's** experience with *limiting caring* was a serious matter. She said, "Sometimes the staff ignores stuff [patient on patient violence] that they should engage and address because they are afraid of being told they did the wrong thing. So they say let them do what they want to do." In the case of this study, CCTV surveillance was viewed as counterproductive because it prevented the RNs from protecting a patient during violent incidents. Desai (2010) has suggested in an editorial that there was a manipulation at play on the part of the patients and nurses related to the CCTV surveillance cameras. That is,

the patient realized that the nurses were also under CCTV surveillance and were *limited* in how they could respond to the situation. Nurses consequently avoided the violent situation with the excuse that there was insufficient staff. The outcome could be serious injuries to staff as well as patients.

This is borne out in the current study. **Nurse Maxime's** experience of trying to help a fellow staff member who was being beaten by a patient turned out to be deflating when the supervisor reviewed the CCTV surveillance recording and reprimanded him for his effort. He explained:

> So when I got to the floor, I saw that the patient was on top of the staff member. So I reacted, I reacted, I grabbed the patient and I put him down, and I was on top of him. Mind you, the staff member was bloody, cause he was punching the staff member and everything, so he was in bad condition […] he had to go to the ER […]The next day I got called to the office [laughs] the patient said that you know […]that I slammed him on the floor […]patient is suing […]they look at the camera, the said why didn't I wait for the rest of the staff to get to the floor, you know you could have apprehended the patient better […] now really realize that hay, before you do anything, think twice because you are being watched.

Nurse Maxime felt betrayed by the administration. He expected credit for his quick reaction to save the life of his colleague, but based on the surveillance evidence the administration second-guessed his technique instead of focusing on his effort to save the employee. Such lack of support by the administration potentially left the staff left the staff unclear as to the precise boundaries required in emergencies when peoples' lives are

on the line. Individual self-censor consequently influences behavior based on perception of a risk.

Penney (2016) conducted a case study of the online site Wikipedia to determine the search habits of individuals after Edward Snowden revealed that the government had been monitoring online activities in 2013. The study found that there was a 30% drop in search words such as "suicide attack," or "dirty bomb" among others. The author concluded that people avoid these topics in fear of being misunderstood. The author was more concerned with the self-censorship the users engaged in, preventing them from sharing unpopular and minority ideas characteristic of a free and democratic society. One could argue that the workplace is neither a free or democratic society, but nurses working under constant CCTV surveillance at the inpatient mental health units had similar experience as the online individuals.

Nurse Kat explained that when she was going about her work, she was careful not to behave in a certain way to avoid being singled out for any special attention by the management. **She** remarked:

> You don't want to attract attention so you do what they [supervisors] want. If you are passing medications, let them [supervisors] see you passing medications. No hanging out with patient chit chatting. If not you risk getting a call from them [supervisors].It's reality TV you know [laughs].

Paradoxically, the medication administration time is an ideal situation to have patient conversation and teaching, but **Nurse Kat** was deterred from engaging in any lengthy discussion with the patient for fear of being misunderstood. **Nurse Betty** declared that she plays for the cameras a great deal because it covers everything. She clarified:

> It's like Disney if you are seen happy they [supervisors] think everything is well. Don't mind that what you really want to do is sit with a patient and talk with them and see what you can do for them. I know it's silly [laughs] but that's how it is.

Nurse Maxime also had concerns about his limitations in caring for his patients. He described:

> I think it's the main thing really, if you are a nurse it's all about caring, you know, and if you can't provide topnotch care, because of something [CCTV surveillance] that's *limiting* your response or your effectiveness is delayed, I think that's a big problem.

Limiting Caring emerged as a theme because CCTV surveillance creates uncertainty and threat in the minds of the participants. Such uncertainty spurred them to engage in self-censorship and curtailment of caring options available to them. Hence, the theme of *Limiting Caring* is meaningful from the standpoint of the temporal present and the unready-to-hand and present-at-hand modes of engagement.

Normalizing the Present

> Norms encourage subjects to become highly efficient at performing a narrowly defined range of practices. This is the case with gender, where subjects are divided into two mutually exclusive groups, the appropriate behaviors of which are predetermined and which these subjects are encouraged to repeat over and over again. In time, the repeated behaviors become embedded to the point where they are perceived not as a particular set of prevailing norms, but instead simply as "normal" inevitable, and therefore immune to critical analysis. (Taylor, 2009, p. 47)

Foucault (1977) in his book *Discipline and Punish* describes "normalization" as an instrument of social control through disciplinary power. A populous that is influentially-weak, will yield to the ideas of the powerful few to increase efficiency (Sheridan, 2016). The industrialized era with the factory system and Taylorism or Scientific Management enabled employers to utilize a form of normalization of workers into a system that was efficient for production (Littler, 1978). Electronic performance monitoring including CCTV surveillance has enhanced the normalization of workplace behavior (Vorvoreanu & Botan, 2001). According to Lippert and Scalia (2015) article review, the industry of Hollywood movie studios provide part of the explanation of why CCTV surveillance has been normalized in our lives. The following except clarifies their argument:

> Hollywood expresses that video surveillance can identify and locate people to advantage and need not raise privacy concerns or be resisted by citizens. Only some kinds of people are competent to use video surveillance and everyone neglects its products and "malfunctions" at their peril. These dominant discourses in Hollywood films help facilitate normalization of video surveillance by assigning it positive attributes, albeit not blithely so. Hollywood also expresses that video surveillance can be used to great advantage, usually coupled with other means; it can be resisted (albeit crudely by criminals or immoral persons with something to hide); and it does not deter. However, overall our results support the notion that Hollywood film conveys video surveillance as a necessary and inevitable component of everyday life; surveillance is typically experienced by characters as largely benign and unobtrusive. (p. 35)

Normalizing of the present in the context of mental health facilities refers to a combination of three themes of the present namely *Deterring Litigation, Feeling Uneasy,* and *Limiting Caring* that the participants believe will carry over into the *future* of RNs working under constant CCTV surveillance. The themes emerged within the context of Heidegger's temporality of the future, and the unready-to-hand and present-at-hand modes of engagement. *Normalizing the Present* speaks to a projected future of nurses working in mental health unit under constant CCTV surveillance. This is premised on the idea that the inpatient mental health unit is an inherently-risky workplace, and that electronic surveillance technology would help to decrease the risks. However, what accompanies CCTV surveillance in the inpatient mental health unit is *deterring litigation, feeling uneasy,* and *limiting caring.* The following sample of the participants' comments is representative of *normalizing the present.*

Nurse John explained**:**

> Ah, we don't have a choice. With nursing especially in psych, I don't think the camera [CCTV] is going anywhere anytime soon. We know we cannot put cameras in the patients' rooms because of privacy concerns, but we need it in the communal areas. Not only that the patients sometimes get out of hand, staff can get out of hand, the camera is what's going to save your job. So I think we need to coexist. The cameras, they are there. Uncle Tom is going to be watching you whether you like it or not.

Nurse Sally agreed that CCTV surveillance is necessary in the mental health unit. She remarked**:**

> I think it [CCTV surveillance] needs to be there because it's easier to slack-off, you know, nurses or anybody, techs, nurses, any employees can get very distracted by the cellphone with the television you know you can easily become distracted by so many things that are going on the unit. Knowing that there is a camera and being watched, it keeps everybody more on their toes.

Nurse Steve added a supporting comment**:**

> Anybody comes with allegation of sexual assault, or offending someone or this guy touched me inappropriately. A specific date, tell me the date, tell me the time, we review and everything. So I think surveillance camera is there to stay.

Nurse Sara believed that nursing would support CCTV surveillance in the future. She clarified:

> Nursing and surveillance are going to be partners because that's the new trend now and it's not going to change. If anything, they will improve on what they have now […] I see it in the future as here to stay.

Dašić, Dašić, & Crvenković (2017) explained a new and innovative trend in CCTV surveillance that is being introduced into the inpatient mental health unit in the editorial titled: *Improving Patient Safety in Hospitals through Usage of Cloud Supported Video Surveillance*. The technology is called Video Surveillance as a Service (VSaaS). This technology utilizes an existing cloud service provider to perform video surveillance management, and in turn free-up the unit staff to perform other duties. The authors believe the service is efficient because it interfaces well with existing technology, and it has an enormous storage space in cloud technology. This represents the future of surveillance. **Nurse Maxime** had mixed feelings about CCTV surveillance and the

future, but he agreed it was necessary because of the risks in the inpatient mental health unit. **Nurse Maxime** made the following observation:

> So I think that it will be bad for patient and nurses, but good for corporate. That's how I feel, I feel like patient care is being degraded because of cameras [CCTV]. But satisfaction when it comes to corporate and all that surveys and rating is going to go up. So cameras is good for corporate, but bad for nursing. So it will be here for the long hall.

Nurse Bird believed CCTV surveillance is necessary in inpatient mental health units; she just wished others would take them serious. She explained**, "**I just think that, I don't think people take these cameras serious. I think that they are going to use them more and more in the future." **Nurse Jane** believed CCTV surveillance will get even more obtrusive. She clarified this in her explanation:

> It's going to get worse because now they only have it in certain. If you look every single year they put more cameras; so can you imagine 10 years from now! If you are not careful, I think they are going to put cameras in the bathroom [laughs].

Nurse Josh believed CCTV is the way of the future. He clarified this in the following statement:

> I think surveillance in nursing will become normative because; I cannot speak by experience because I have not been a nurse for a really, long time; I have had a nursing license for the last 5 years, but from talking to others more and more hospitals have been adding surveillance as the years have elapsed. And as new generations of nurses come into the workforce, this is what they are exposed to, this is what they are used to and this is part of the status quo. It is what it is.

Nurse Josh's comment support the trend that it is becoming widespread for hospital to use CCTV surveillance to monitor handwashing as a measure of combating hospital-acquired infection (HAI) (Armellino et al., 2013; Khan & Nausheen, 2017). **Nurse Kat** believed trust had deteriorated between management and staff, making CCTV surveillance an imperative into the future for job security. She commented:

> We definitely are going to see more [CCTV surveillance] in nursing even if they are not fully on the medical floor. In my other job, they even had cameras in the patients' rooms […] so there will be a lot more. As far as the med room […] but that's going to be the way it is […] they don't trust us so there will be more cameras. If it ever helps a *litigation* case […] then more jobs for me.

Nurse Mila shared similar sentiments when she explained:

> So I honestly believe that there will always be more opportunities for people [management] to place cameras and they will be more surveillance so there are no loopholes or no dark um […] no unknown areas in nursing that they cannot know what's going on or find an answer to a patient's complaint or find an answer to a staff complaint.

Normalizing the Present is a theme forecasting the *future* experience of RNs working in the inpatient mental health unit under constant CCTV surveillance. This theme emerged because the participants overwhelmingly supported the need for CCTV surveillance. Foucault (1977) in his book *Discipline and Punish* suggested that surveillance (especially CCTV) is the means that makes it possible for an entity to gain control and exert power over an individual because of its omnipresence. The fact that participants in the current study had been coerced and managed within their organizations

according to this observation did not seem apparent to them. Instead, the security of their employment and the survival of the organizations seemed to be their primary concern. The participants' modes of engagement working constantly under CCTV surveillance have been primarily unready-to-hand and present-at-hand. These modes of engagement are associated with psychological discomfort such as stress. The themes of *Deterring Litigation, Feeling Uneasy,* and *Limiting Caring* resulted from such modes of engagement. Heidegger has suggested that humans' preferred mode of engagement with their environment is ready-to-hand.

Maslow's Hierarchy of Needs Theory

Abraham Maslow was an American Psychologist who lived from 1908 to 1970 and wrote, "A Theory of Motivation." The theory was published in the Journal of *Psychological Review* 1943 and reprinted many times since then (Adair, 2006). Maslow's Theory of Motivation has five hierarchal levels. A traditional conceptual diagram depicts the theory as a pyramid (see Figure 4) with five levels of needs arranged in a hierarchal ascending order starting, with basic physiological needs, then safety, belonging, esteem, and self-actualization at the apex. The following list that identifies these needs:

1. Physiological (air, food, drink, shelter, warmth, sex, sleep).
2. Safety (protection from elements, security, order, law, stability, freedom from fear).
3. Belonging (affiliating, being part of a group, friendship, trust).
4. Esteem (dignity, achievement, mastery, independence, respect from others (i.e., status, prestige).

5. Self-actualization (self-fulfillment, seeking personal growth and peak experiences).

Maslow's Hierarchy of Needs Theory suggests that individuals are behaviorally-motivated by their needs in a ranking manner beginning with their basic physiological needs and progressing one by one through the higher needs up to self-actualization (Tay & Diener, 2011). The concept is that humans are innately motivated to grow psychologically and develop themselves. However, humans tend to work to meet the unmet needs at the lower level of the pyramid first and only after those needs are met the upper ones are pursued (Adair, 2006). Maslow's theory has been used in many disciplines, such as business, education, and healthcare; specifically, in nursing to improve patient care and the work environment (Groff Paris & Terhaar, 2010; Thielke, Harniss, Thompson, & Patel, 2012).

Regis & Porto (2011) conducted a mixed study involving 18 participants at a 203-bed hospital to gauge the rate of job satisfaction among nurses using Maslow's Motivational Theory as the satisfaction scale. The findings revealed that the nurses were grappling with issues having to do with their physiological and safety needs because they were not readily-attended to by the organization. The following excerpt from the findings provides further insight:

> The needs displayed […] show that the nursing team members' dissatisfaction is concentrated in *physiological and safety needs*. These needs found in the results from the field diary and questionnaire point towards the person with a lack of evolution in terms of basic needs. Nursing team members are trying to attend to and consolidate compliance with their most primary needs, involving access to

> water, food, relaxation and sufficient staff numbers, after which they will be apt to reach their maximum potential regarding the higher needs for self-esteem, self-accomplishment and transcendence. Thus, the nursing team's dissatisfaction can interfere in the achievement of other needs (autonomy, recognition and professional growth), compromising full satisfaction and adequate development at work. In this sense, the nurse [and other team members] use not only individual and informal (omission, adherence and innovation), but also formal and collective (establishment of alliances, claims and manifestations) resistance mechanisms and strategies, as opposed to the relations of domination that exist in their work. (p. 336)

Budd and Bhave (2010) suggested that the primary reasons individuals seek employment is to earn income to maintain their basic survival. This study found that the 16 participants who had worked in the inpatient mental health units under CCTV surveillance primarily concentrated their energy around job security and personal survival. Despite the disadvantages of working under constant closed circuit television (CCTV) surveillance such as *feeling uneasy* and *limiting caring* options, the participants accepted it because of its collateral benefit of increased job security. Table 4 is an adaptation of Maslow's hierarchy of needs to the themes that emerged from what it meant for these study participants to work under constant CCTV surveillance in the inpatient mental health unit. The following represents the adaptation of the needs to the themes that emerged in the study:

1. Physiological- Secured employment supported by CCTV surveillance, guaranteed - food, water, shelter, sleep, sex (survival needs).

2. Safety - CCTV surveillance enhances job security by *deterring litigations*, false allegations, and the removal of any danger from the workplace to make it a safe work environment for the nurse.
3. Belonging - the need to form alliance and work with others to change working condition such as those that led to *feeling uneasy* and *limiting caring*, and *deterred* access to the positives of the *status quo ante*.
4. Esteem - the personal reward from the enhanced status for helping to accomplish the change.
5. Self-actualization - achieving individual potential growth and fulfillment from engaging the forces that are changing the nursing practice and help to direct the change for the betterment of the profession. For example, work towards bring back the positive attributes of the *disappearing status quo ante.*

The theme of *normalizing the present* refers to the acclimatization to three themes namely *Deterring Litigation, Feeling Uneasy*, and *Limiting Caring* in the future. *Normalizing the Present* was not assigned a particular rank among Maslow's hierarchy of needs because it is a future projection that is uncertain. However, since it encompasses themes (*deterring litigation, feeling uneasy, and limiting caring)* that are already ranked and discussed below in the present, the focus is placed on how CCTV surveillance in the inpatient mental health unit might be normalized in the future.

Figure 4: Conceptual Diagram

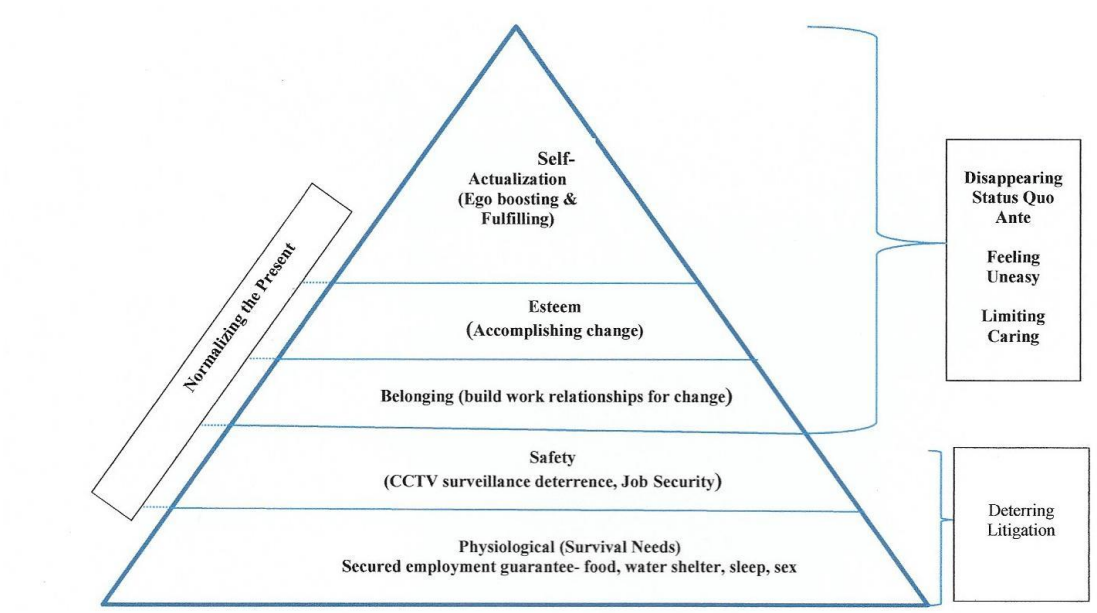


*Figure 4.*Wallace's (2018) Adopted from Maslow's Hierarchy of Human Needs Theory (1970)

Four of the themes that emerged from the study namely *Disappearing Status Quo Ante, Deterring Litigation, Feeling uneasy,* and *Limiting Caring,* were arranged in ascending order according to Maslow's hierarchy of needs.

Deterring Litigation was at the physiological and safety needs levels because the participants viewed CCTV surveillance as an immediate benefit that could decrease threats to their job security. The three themes of *Disappearing Status Quo Ante, Feeling Uneasy, and Limiting Caring* were consigned to upper level needs namely belonging, esteem, and self-actualization because the study participants had no immediate interest in pursuing them. *Normalizing the Present* was a theme that projected the *future* and was

incorporated into all five needs of Maslow's theory. The next section presents the connection made by this researcher between the themes that emerged from this study and Maslow's Hierarchy of Needs Theory.

Physiological and Safety (Survival needs) - Deterring Litigation

As revealed in the study, the 16 participants who worked under CCTV surveillance in inpatient mental health unit were preoccupied with their job security because CCTV surveillance led them to believe that their supervisors were always monitoring their work habits without being seen. The threat of job termination therefore compelled these study participants to monitor their own activities to ensure they did not break any protocol. Patients in the inpatient mental health unit occasionally falsely-accused the staff of misconduct including those of a sexual nature. Such serious allegations could be career-ending starting, with job termination and loss of nursing license. A safety concern arose because it was not unusual for patients to perpetrate physical violence on the staff members. Such situations made the inpatient mental health work environment very unpredictable, potentially dangerous, and stressful to work. Al-Rjoub, Zabian, and Qawasmeh (2008) conducted a quantitative study to determine employees' points of view on electronic workplace surveillance. The study found that job security was the most important thing to them. The following excerpt elucidated this finding:

From the employees' point of view the most devastating effect of employees' monitoring is the fear of losing their jobs. In addition, to ethical and social issues […] and many other negative consequences some of them are:

1. Lowest interest in the job that transforms the workplace to become mistrust and hostile work environment. That makes the employees feel less satisfied with their job and start looking for other secure job opportunities
2. Absenteeism that means the number of people taking off of work for personal reasons is on the rise
3. Privacy invasion: employees of many organizations are exposed to many types of privacy invasive monitoring while earning a living. However, these activities may diminish employment moral and dignity and increase stress and may lead to lawsuit case. (p. 191)

Participants in the current study in an unexpected way found that CCTV surveillance in the inpatient mental health unit supported them, because it helped to exonerate them from false charges and monitor, record, and *deter* violent confrontations between patient and staff. Based on Maslow's Hierarchy of Needs, *Deterring Litigation* was a physiological and safety need the study participants were primarily trying to meet to the exclusion of others. The following participants' comments reflect the sentiments of the theme. **Nurse Jane** believes CCTV surveillance is helpful to vulnerable staff members. She specified:

> Yeah the cameras can clear you if they said you did something wrong and you know you didn't do it. Especially the male nurses and techs [technicians]. They are the ones that have to be careful. You know how devious some of these patient are?

Nurse Steve was convinced the CCTV surveillance cameras were there for everyone's protection. He enlightened the researcher by stating, "The camera presents the body

language and clarifies what is going on. This is the best weapon against patients that try to say you do this or that, […] not only patients, visitors and staff alike." **Nurse Betty** was concerned that the patient population in the mental health units was unpredictable and one should not take any chances. She mentioned, "With our population we're often not […] I rather have those cameras there […] yes, some of the nurses are still like reeling from depression from having to go to litigation." **Nurse Victoria** could not be more specific about her focus related to the CCTV surveillance cameras. She commented, "I am not going to do anything stupid that could get me in trouble. I'm afraid of losing my job […] yes, it's the only one I have." **Nurse Jack,** on the other hand was also concerned about not losing his job. He imparted, "I'm not about to lose my job because some patient says I touch her. In this country everybody wants to sue you. I don't have any money but I need protect my license and my job."

Nurse Jack's fears have been realized in the following report. CCHR International (2018, Jan 22), a mental health watchdog group, reported on the closure of multiple inpatient mental health facilities because of employees' misconducts. The reporter commented:

> Timberlawn psychiatric hospital in Dallas, Texas, owned by Universal Health Services (UHS), announced it is closing its doors, following state officials threatening to shut it down in the wake of allegations of patient sexual assault, including the rape of a 13-year-old girl under its care […] In 2017, the Massachusetts Department of Mental Health (DMH) also closed Westwood Lodge psychiatric hospital due to "issues concerning patient safety and quality of care," amid a sexual assault investigation (Psychiatric Hospital Rife With Sexual

> Assault Allegations Finally Shuts Down While Another Faces Lawsuit over Teen Rape. para. 1-10).

One can only imagine the problems the former employees and their families underwent because of the closure of these facilities; it is therefore understandable that the participants of this current study were trying to avoid such demise. **Nurse Maxime** spoke about his job security in relation to the CCTV surveillance cameras in the inpatient mental health unit. He clarified:

> Yes, absolutely, they [CCTV surveillance cameras] help the patient, and they help you too to not losing your job. You know, even we are in the business of *caring*, we still have to pay bills […] you still have a family to feed, you got to eat, so you can't […] if they tell you […] that camera is there, if we see you doing something wrong we are going to fire you. We have to keep that in mind.

Nurse Michael related a tragic experience one of her colleagues had that caused her to lose her livelihood. The colleague had been beaten by a patient in an inpatient the mental health unit. **Nurse Michael** remarked:

> This nurse had a bleed [subarachnoid] and she is no longer working. This nurse cannot work up to now. Her husband has to be the one taking care of her. It [the injury] affected her livelihood, it affected everything she has worked for as a nurse or her education, everything comes to a stop because she no longer can work […] she is […] because of the bleed in the brain, she became very sick.

Nurse Michael's experience underscored the high safety-risk of working in inpatient mental health units. A similar incident happened in Buffalo N.Y. (WIVB, 2016 March 2) reported an encounter at a mental health facility in which a patient went on a rampage,

grabbed a nurse by her neck, slammed her to the floor, and potentially caused her life-threatening injuries. The CCTV video clip clearly showed that in the Buffalo case, the staff was poorly-trained and there was not enough protection to avoid the incident. According to Maslow's Hierarchy of Needs, safety at the workplace must be guaranteed before individuals employees can move to higher level needs. Such incident as the one cited above potentially made other nurses feel insecure and vulnerable.

Nurse John's experience with patient violence in the inpatient mental health unit was not reassuring either. He commented:

> Sometimes patients get violent and they attack their fellow patients or they attack the staff. It can gets messy […] you try to do your best to control the situation. You not going to look good all the times on the camera, but it's what it is. Hopeful when everything is over you are not hurt.

In a systemic review conducted by Iozzino et al. (2015), the level of violence in a mental health unit was as high as 20% and reflects the danger involved in working in that environment. The following citation from the study denotes some of the findings:

> The main finding was that […] almost 1 in 5 patients admitted to acute psychiatric wards in high-income countries commit an act of physical violence while in hospital. While this figure might be an important benchmark for psychiatric services, the high level of heterogeneity in the rates of inpatient violence indicates that the result does not apply to all acute inpatient settings. Wards with higher proportions of males, involuntary patients and patients with alcohol use disorders had higher proportions of patients who committed acts of violence. This finding is consistent with findings from studies on the associations with violence at

> individual patient level. For example, male sex and substance use disorders have been found to be reliably associated with aggression both in individual studies. (p. 12)

Nurse Victoria believed the CCTV surveillance cameras helped her prevent serious injuries as she worked in the inpatient mental health unit. She explained:

> That they are another set of eye out there. For example, I am at the station and a patient confronted the staff in the lounge, I would not have seen it if it were not for the cameras. So I called for help. If I did not have the camera who know what would have happened?

Stevenson, Jack, O'Mara, and LeGris (2015) conducted an interpretive descriptive study of 12 nurses who worked in acute care psychiatric facilities to determine the level of patient violence in the facilities. The results found that nurses were frequently exposed to different levels of violence ranging from verbal, physical, and emotional. One of the nurses in the study summed it up in the following comment:

> I never thought I would sign up to be…assaulted as a career path. That was something that I never realized that happened so frequently and that it was almost okay for nurses to be beat up all the time or verbally or physically assaulted and I guess that's normal practice and it's going to take a lot longer to change that. (p. 9)

Inpatient mental health units are not inherently-safe places to work, judging from the study participants' comments. It is understandable that they found CCTV surveillance helpful in their effort to enhance their job security. The theme of *Deterring Litigation* is a physiological and safety requisite based on Maslow's Hierarchy of Needs because

participants concentrated most of their efforts on their personal safety and job security. According to Heidegger, the preferred mode of engagement is the ready-to-hand (Greaves, 2010). Moreover the theme of *Deterring Litigation* is experienced in the present as based on Heidegger's temporality. Despite the benefits surveillance measures offer of helping participants secure their jobs, they are mainly engaged in unready-to-hand and present-at-hand modes of engagement.

Belonging, Esteem, Self-Actualization - Disappearing Status Quo Ante, Feeling Uneasy, Limiting Caring

Maslow's Hierarchy of Needs indicates s that upper-level needs such as belonging, esteem, and self-actualization do not constitute a primary focus of concern until the lower-level needs such as physiological and safety needs have been met. In this study as based on Maslow's Hierarchy of Needs, the themes of *Disappearing Status Quo Ante, Feeling Uneasy, and Limiting Caring* were not of primary interest to the participants.

The theme *Disappearing Status Quo Ante* represented the time working in the inpatient mental health unit without CCTV surveillance. The participants had mixed feelings about the time. For example, they had the freedom to practice autonomously; the leisure to build therapeutic interpersonal relationship with their patients and use their initiative to seamlessly introduce a variety of caring techniques. Despite such positive attributes, the inherent risks for violence and litigations in the patient care environment attracted the use of CCTV surveillance to help mitigate such risks, even though CCTV surveillance dissuaded the participants from practicing as they should. Participants felt uneasy and curtailed in the amount of time they would like to spend with their patients;

they also felt *limited* in what *caring* options they had. *Disappearing Status Quo Ante* (returning to the *past*) was not a goal the participant showed any interest in pursuing because it was incompatible with CCTV surveillance in the present inpatient mental health unit, a theme at Maslow's hierarchy of needs upper levels (Belonging, Esteem, and Self-Actualization) to be suspended. The following participants' words highlight their commitment to having CCTV surveillance in the inpatient mental health unit with no return to the past.

Nurse Jane believed CCTV surveillance was good in the aftermath. She explained:

> The good part is if the patient tries to do something or say something that you didn't do they can look back at the camera and see that you didn't do it and where you were at that time and what you were doing.

On the other hand, **Nurse Betty** believed that with the CCTV surveillance cameras in place there was no need for a conversation before looking at them, because she insisted that they exonerate. **Nurse Betty** related an incident she had in the emergency room (ER):

> So I had an issue with this patient who was giving me a hard time and he reported me. So they [management] called me and I am like why are even having this conversation […] I honestly don't wanna have this discussion. I rather you just pull the camera and see for yourself.

Nurse Sara thought the CCTV surveillance made the investigation of incidents much easier. She confirmed:

> It [CCTV surveillance] helps in litigation when there is a law suit or a case that a patient might accuse a staff of any abuse or so, the camera will be there to kind of direct […] and you know, you can look at the camera and see exactly what took place. It also helps the employees to get out of situations when they are accused of different things.

As **Nurse Sara** explained, CCTV surveillance footage can be very helpful in a lot of situations. Take for instance when the *Tampa Bay Times* made public some videos titled CLOSED-CIRCUIT CHAOS (2015, OCT 29) showing gruesome violence in mental health facilities in Florida causing serious injuries even death. The following represents three such incidents:

1. Oct. 20, 2012: North Florida Evaluation and Treatment Center. An orderly is left alone with 27 mental patients on the ward. She was beaten badly.
2. Aug. 13, 2010: North Florida Evaluation and Treatment Center. Help is so far away, this attack goes on for more than 2 minutes before staff can respond. The patient survived after an emergency room visit that left the state with a $60,000 bill.
3. Sept. 19, 2013: North Florida Evaluation and Treatment Center. This patient beat a worker so badly she now uses a cane to walk

These are only three of the many videos that have been made available to the public. The media used them to make a case for increased mental health funding because it was believed that cuts in the budget contributed to the steep increase in the violence in these facilities.

Nurse Steve thought the CCTV surveillance was good to protect everyone. He described:

> One of the main reasons I believe the surveillance camera is good is to protect the patients, and at the same time protect the employees, because it's always good to have extra eyes, especially when you work in a very volatile environment. In case something happens, "the what if" and there is always something that can be reviewed.

In support of **Nurse Steve's** point, a DuPage County judge ordered a hospital to turn over CCTV surveillance footage that purported to show the male RN downloading private sexual images from a patient's cellphone to his phone (Kmitch, 2017, Nov 21). The hospital had already terminated the RN's employment, and he bonded out of jail for $150,000. This RN happened to be on the wrong side of the litigation issue, but that was supported by some participants who said that a RN of his character was a threat to the organization and should be removed. **Nurse Michael** shared similar sentiment. She commented, "You know some nurses are also drug addicts, they go and they take patients' medications, the camera is watching you and whatever you are doing; you know you will be caught."

Nurse Josh understood the need for the CCTV surveillance. He commented, "The hospital, from my notion, my opinion puts it out there like it's for the patients' safety and for our safety, but I think in the end is to reduce the liability to the hospital." At the same time, **Nurse John** did not want to take any chances. He said that the CCTV surveillance was his backup. He informed the researcher:

> I was trained by previous nurses, when we are doing the body check; if it's a female of course, we get a female to do it. I'll go with the tech [mental health technician], we do it under the camera, so there is no issues that is hidden, whatever happen we could say ok view the camera, this is what happened […] of course we try to give the patient some kind of dignity, but I think it's best for the patient and for us.

The theme of *Feeling Uneasy* was consequential in limiting the participant's caring options, but in terms of Maslow's Hierarchy of Needs, it was in the category of upper-level needs (Belonging, Esteem, and Self-Actualization) because the participants showed no interest in pursuing. The following participants explained what it meant to feel uneasy working under CCTV surveillance in an inpatient mental health unit.

Nurse Mila's experience of having to position herself in a way so that the CCTV surveillance cameras could view her face was horrible. She explained:

> I was reading off the monitor because I was in school, and I was reading for a while because it was a book, and they [management] told me that I looked like I was sleeping, and in the future if I was reading because I explained myself that I was reading […] in the future try to move or try to, to change the angle that you are looking at the camera, and I felt like really! Like that's what I need to do for you guys to think that I am not sleeping?

Nurse Mila's feeling was not isolated as the following study revealed similar sentiments. A literature review completed by West and Bowman (2016) analyzed the ethics of workplace surveillance and found that surveillance can "Negatively affects morale, increases stress, lowers motivation, one of the results of which could be worse

productivity. When monitoring backfires, it can result in resistance, non-compliance, and retaliation." (p. 636)

Nurse Bird recalled an instance in another situation when a patient was found not breathing and the initial staff members who found her, including **Nurse Bird**, were so nervous and uncertain about the proper procedure to follow that they froze and did not provide immediate help to the patient. She explained:

> […] the fact of the matter is that [we] were all on video that nobody had started CPR. None of us had initiated CPR […] um we froze […] we all went into this lady's room, and none of us had initiated CPR. And, wow the first person that went in there was supposed to initiate CPR, but she came out and said I think there is something wrong with this lady, and you are taught in school when you go into a patient's room and she is not breathing you are supposed to start CPR.

It was not that **Nurse Bird** did not know what to do when a patient was found not breathing; rather, she got caught up into second-guessing herself because of the CCTV surveillance and stood back waiting for someone else to act.

Nurse Josh compared his uneasiness working under the CCTV surveillance cameras as someone breathing over him. He recalled a situation:

> I am actively aware that I am being surveilled. You know, it's like having someone breathing over your shoulder. It's a little uncomfortable […] but I am actively cognizant of it, and in fact sometimes I even remind the patients that […] if you decide to throw that chair, it's going to be caught on camera, if you decide to attack staff you know, there is a possibility law enforcement will be involved and all that.

A qualitative study was conducted at Alto University (2012) titled "Negative effects of computerized surveillance at home: Cause of annoyance, concern, anxiety, and even anger," to understand the effect of continuous surveillance using video cameras, microphones, and logging software for personal computers, wireless networks, smartphones, TVs, and DVDs at home. All of the participants but one complained of negative changes including anger and anxiety. The following is an excerpt from the study findings:

> […] the ever-observing "eye," the video camera, deprived the participants of the solitude and isolation they expect at home. The surveillees felt particularly strong the violation of reserve and intimacy by the capture of nudity, physical appearance […] -- Psychological theories of privacy have postulated six privacy functions of the home, and we find that computerized surveillance can disturb all of them (para.5).

Even though the surveillance was at home, the effects of being constantly monitored were the same. **Nurse Kat** felt annoyed at having been constantly monitored. She recalled childhood experience of her parents' supervision. **Nurse Kat** explained: "I feel like there is always somebody watching you and not trusting you to do what you are supposed to do on your own. It's like your parents at home guiding and watching you. It's annoying and nagging." **Nurse Betty** thought she should able to have a little fun with her co-workers. It's her way to relief stress. However, she felt stressed not being able to it. **Nurse Betty** commented, "You can't even really relax or joke around with your co-workers, I guess you're not supposed to, I don't know you can't really like relax, or goof, I don't know. I feel stressed."

Nurse Victoria wanted to think that she might have gotten used to working under CCTV surveillance in the inpatient mental health unit, but she conceded she felt uneasy. She explained, "I still feel watched, but it's a feeling I think I was already used to but it still bothers me. Knowing that you are being watched is not comforting." **Nurse Sally** was reminded what it was like to feel uneasy working under CCTV surveillance in an inpatient unit. She commented, "Just knowing that someone is watching you through the cameras just make you anxious." **Nurse Jane** remarked, "It's very uncomfortable [monitored by CCTV cameras], I can't sit still. It makes me nervous." Despite the objection by the participants to *feeling uneasy* under CCTV surveillance in the inpatient mental health unit, they made no intimation of wanting reverse that experience. The only explanation for why they did not address it was that the benefits of CCTV surveillance were greater than its disadvantages. *Feeling Uneasy* was therefore a theme that occupied the upper-levels (Belonging, Esteem, and Self -Actualization) of Maslow's Hierarchy of Needs. The theme was experienced in the temporal present, but it also served as the psychological feedback to the participants that they were cognizant of being under CCTV surveillance in the inpatient mental health unit while they worked. Such uneasiness is component of the unready-to-hand and present-at-hand modes of engagement that the participants experienced.

Limiting Caring was another theme that emerged as a consequence of working under CCTV surveillance. It was assigned to the upper-levels (Belonging, Esteem, and Self-Actualization) of Maslow's Hierarchy of Needs because it was not an essential need the participants' were trying to attain. At no time did the participants mention any effort to change the fact that they were limited in caring for their patients. The subsequent

section provides comments from the participants' about their experience with *limiting caring*.

Nurse Jane was uncertain what management would do if she took her initiative to give complementary care; therefore, she did not engage in it. She explained, **"**Yeah there is limitations […] there are some good things I would like to do for the patients and I can't do them because the cameras are there and somebody may question it so you don't do it." **Nurse Jane's** comments reflected other participants' experiences of *limiting-caring* for their patients which seem to dramatically contrast with other psychiatric nurses' experiences in other inpatient units.

Hawamdeh, and Fakhry (2014) conducted an interpretive phenomenological study of 17 participants in two hospitals with capacities of 80 and 120 beds respectively. The study was designed to gain the psychiatric nurses' perspectives on how they build therapeutic relationship with their patients. The themes were Provision of Physical Care, Conveying Safety and Security, Protection, and Companionship. The study participants seemed relaxed and matter-of-fact as they went about building relationships with their patients and meeting their needs. One participant remarked:

> I have to be the person my client is expecting to see—to be listening and attentive. Yes, we are like friends and . . . I usually see it like that; it feels good to sense that your client treats you as a friend . . . a friend you can talk to, tell you anything.

Nurse Maxime described that he became tentative and slowed down because he was afraid of being caught on CCTV surveillance cameras not following protocol. He recalled, "So I feel like it [CCTV surveillance] is definitely delaying our response when it comes to anything that happens on the floor […] you know, I don't want them say I did

the wrong thing." Another participant in the study (Hawamdeh & Fakhry, 2014) remarked about approaching a crisis situation. The participant made the following comment:

> I protect them because the clients are in a vulnerable position; they are here because they are either harmful to themselves or to others; . . . I just keep my eye on them almost all the time. I think there is a protective component to my therapeutic relationship with clients it has to do with maintaining the safety of the person. (p. 182)

Nurse Samantha believed CCTV surveillance put her in a state of indecisions and led to loss of confidence. She expounded:

> […] being monitored is, is almost like a daily struggle, even when you know that you hold up a needle and put the thread through it when you start to look, and you use a forceps to pick up the needle and put it through the thread you are going to start thinking, well, do I put the needle down and put the forceps the thread through it of do I pick up the forceps first or the thread- you know.

Nurse John was concerned with the risk for litigation that limited his caring options. He described:

> You took an oath to do no harm, and as a nurse you are nurturing, but because now you know there is a camera there […] oh you like oh […], wait if I do this even though I wanted to do this because it's something good, but because of litigation, I can be sued, I can be reprimanded, it paralyzes you in a sense.

Nurse Josh shared a similar concern. He commented:

> I enjoy psych nursing because I am able to [patients], give them advise and hear their story out […] I feel like I would be able to do that if I did not have the restriction of surveillance that said that I should be in this area or should not be in that area and so forth.

Nurse Josh's concern is not unique as some Journalists, Lawyers, and non-profit organization have expressed similar concerns about being monitored. Some have chosen to limit their activity through self-censorship. In a *Huffington Post* article, Ridout (2014, AUG 26) reported on a worrying trend:

> In the United States, we have already been seeing the chilling effects of self-censorship due to mass surveillance. Some American writers are opting not to research and explore certain sensitive topics, cowed by fear of retribution. This is because trying to fully comprehend and meaningfully convey different perspectives and realities requires intellectual immersion in a subject matter… Historical examples demonstrate that the mere suspicion of being watched is often enough to silence individuals or disrupt their thought processes. When Ernest Hemingway was monitored by the Federal Bureau of Investigation (FBI), he found it impossible to do any creative work. For John Steinbeck, merely depicting the bleak reality of poverty in a way that resonated with the public earned him the dreaded "Communist" label, which meant he was also targeted by the FBI (para. 11).

Nurse Kat recalled how she felt restricted in caring for her patients**.** She said **"**[…] for a regular nurse that wants to help the patients, you feel restricted, you feel like a kid, baby sit, so I say ok what's the point." **Nurse Mila** felt limited in what she did for

her patients when she is working under the CCTV surveillance camera in the mental health unit. She commented "[…] sometimes you do just enough to not get in trouble […] but maybe not enough to benefit the patient." **Nurse Betty** shared an experience she had with her staff. She commented, "Due to a prior negative experience he had where a patient accused him of wrong doing, he refused to go close to any patient without security present."

Nurses pride themselves as caring agents. Thus, a theme of limited caring is a threat to their stature. The participants experienced limited caring in the present temporally, but the theme also reflected their engagement in the unready-to-hand and present-at-hand modes as they had difficulties deciding the boundaries of care.

All three themes namely *Disappearing Status Quo Ante, Feeling Uneasy,* and *Limiting Caring* were placed in the category of Maslow's upper-level needs of Belonging, Esteem, and Self-Actualization because the participants did not pursue them as essential. There were no easy means for the participants to reverse the themes *Disappearing Status Quo Ante, Feeling Uneasy, Limiting Caring* because they were dichotomously related to those CCTV surveillance attributes in the participants liked. The theme of *Disappearing Status Quo Ante,* is of the past and when the nurses in the inpatient mental health unit practiced mainly in the ready-to-hand mode of engagement, and the themes of *Feeling Uneasy* and *Limiting Caring* were experienced in the present with modes of engagement primarily unready-to-hand and present-at-hand.

Physiological, Safety, Belonging, Esteem, and Self –Actualization - Normalizing the Present

Normalizing the Present is a theme that emerged within the context of Heidegger's temporality as the *future* relative to other themes namely *Deterring litigation, Feeling uneasy,* and *Limiting caring* that emerged in the present of Heidegger's temporality. However, this theme was not given a particular rank within Maslow's Hierarchy of Needs in the current study, because it was a future prediction. Nevertheless, normalizing CCTV surveillance in the inpatient mental health unit of the future meant it would be habitual for the nurses to work under CCTV surveillance. **Nurse Evelyn** explains how it might happen. She explained:

> Yeah in the future they umm […] they will have cameras all over the place[…] I think the new nurses may not realize that nursing wasn't like this umm […] they will be born baptized into surveillance so they may not think of anything else.

Even though the participants were confident that CCTV surveillance would be normalized in the inpatient mental health unit of the future, it was unclear how it would happen. Foucault (1977) has suggested that it would occur through the power relationship between the employee and the employees as it refers to a systemic, bureaucratic, and structural arrangement that is not always obvious to the employees. CCTV surveillance in the inpatient mental health unit is one of such elements of power. **Nurse Josh** views it as oppressive. He stated, "When I see cameras initially, I think of […] what I think of I am going to tell you exactly, no filter […] an oppressive environment." **Nurse Samantha** reflected on this as dark time in our history for comparison. She expressed, "Well, coming from my background historically, slaves were permanently watched all time […]

they were punished for whatever they thought were indiscretion, and so I just see like this is another […] so it's called electronic slavery."

Lee and Cook (2014) conducted a qualitative study of 17 Generation Ys (Gen Y) and provided an alternate view of this issue. The study found that Gen Ys grew up on the internet where immediacy is a premium. However, to conduct business online, Gen Ys had to give up some privacy through surveillance for the speed and convenience of shopping, banking, and social media. Online activity is not without risks, but Gen Ys were also willing to forego some risks because of the benefits. Gen Ys are therefore understood as having been conditioned into trading some privacy for access so long as the benefits are perceived to outweigh the risk of the surveillance (Lee & Cook, 2014). **Nurse Josh** contributed to the *normalization* of CCTV surveillance in the inpatient mental health unit when he focused his attention on the benefits of CCTV surveillance more than *feeling uneasy,* and *limiting caring.* **Nurse Josh's** explained:

> They do it for a purpose; that is to protect their business and to reduce liability. Whereas they have certain procedures and policies in place that allow them to enforce disciplinary action when individuals are caught on camera "not doing their job," or if it is a patient situation the cameras help them to defend against litigation. The camera is a tool the hospital uses to protect itself. It's their back-up. Those are the eyes for administration.

Nurse Jack said he would trade *feeling uneasy* and *limiting caring* more for CCTV surveillance deterrence. He remarked, "I completely understand […] putting myself in the employers' shoes why they do that [CCTV surveillance], so it's natural I have to work around it, there is no avoiding it." The *Normalizing* Process Theory (May,

et al., 2014), argues that the normalizing process occur when an organization focuses on the things that individuals and groups do to accomplish the task. The proponents of this theory contends that *normalization* is accomplished when individuals and groups seek out ways to deliberately embed, personalize, and attempt to sustain certain behavior (May et al., 2014). In this study, the participants identified occasions when management embarrassed them by showing video footage of in-artful performance to the entire staff under the pretext of education. Such shaming was meant to *normalize* CCTV surveillance in the inpatient mental health unit and also remove any doubts that participants may have had about the purpose of CCTV surveillance cameras. **Nurse Bird** recalled one such occasion as embarrassing. She explained, "Oh they say they were going to use it [CCTV surveillance footage] as a learning tool. But the person involved look like a complete idiot. And the person [management] doesn't even ask can we show this?" **Nurse Jane** believes that management did not use CCTV surveillance to educate. Instead, she said feedback was given to employees only when something went wrong. **Nurse Jane** described:

> I have never seen they come and say something positive that happen on a camera yet, it's always something negative […]they never come to you and tell you anything positive that they see on the camera it's everything is like they are sitting there waiting watching the camera for something to go bad to come to the staff.

These accounts effectively contributed to the normalization of CCTV surveillance the intent was to convince everyone that someone is watching the camera, and they ought to be careful.

In an article titled, “Taken for granted: normalizing nurses' work in hospitals,” Urban (2014), has suggested that normalization in nursing working condition result of a combination of ruling patriarchal power and nurses’ altruism. Overcapacity, cost containment, and staffing shortage have resulted in a culture of accommodation by the nurses (Urban, 2014). **Nurse Kat** was being altruistic to her employer’s bottom-line when she made the following observation:

> I thought that at least having it [CCTV surveillance] in the med [medication] room at least, people having a lot of med errors, or medications going missing, so I just know

Nurse Samantha supported the theme as she expounded:

> Also I guess you could say they [CCTV surveillance] prevent lawsuits. You know some patients make false accusations and try to get away with it. They [patients] look for opportunities to sue the hospital. So the cameras are good in that sense to prevent them from getting away with it.

Nurse Michael would like to see the hospital save money by deterring lawsuits. She clarified, “Hospital should be able to defend itself against false lawsuits. Some patients come to the hospital to make money. They try to hurt themselves and blame the hospital. That’s not right.”

One of the interesting mysteries of CCTV surveillance in the inpatient mental health unit is that none of the participants knew of any policies or documents in the organization stipulating what should, or should not be done regarding patient care. The participants determined where to draw the limit based on their perceptions of the situation. Such behavior is not without explanation. Shaw (2017, Jan-Feb) wrote about

surveillance, self-censorship, and limits individuals place on their behavior in an editorial in *Harvard Magazine*. He remarked:

> The fact that you won't do things, that you will self-censor, are the worst effects of pervasive surveillance," reiterates security expert Bruce Schneier, a fellow at the Berkman and in the cybersecurity program of the Kennedy School's Belfer Center for Government and International Affairs. China bases its surveillance on this fact. It wants people to self-censor, because it knows it can't stop everybody. The idea is that if you don't know where the line is, and the penalty for crossing it is severe, you will stay far away from it. Basic human conditioning (para. 3).

The theme *Normalizing the Present* emerged within the context of Heidegger's temporal future that captures one's prospective outlook. Heidegger suggested that humans were always "ahead of themselves," clearing the way and situating themselves for the next possibilities. Things that are significant have future possibilities attached to them. The participants in this study believed that nurses will work under CCTV surveillance in the inpatient mental health units of the future. They stated that it is practical to assume that the nurses of the future working in inpatient mental health units will experience *deterring litigation, feeling uneasy*, and *limiting caring* since they are all products of CCTV surveillance. Nevertheless, CCTV surveillance spurs unready-to-hand and present-at-hand modes of engagement such that future nurses working in inpatient mental health units will be expected to engage their environment in these modes. Normalizing CCTV surveillance in the mental health inpatient units is expected to occur based on the bureaucratic and systemic forces embedded within the organizations the

nurses will work. However, by accepting CCTV surveillance in inpatient mental health units, these nurses will make the process of normalizing less problematic.

Summary

Maslow's Hierarchy of Needs Theory was used to provide further clarity to the themes that emerged from the study. The five themes namely *Disappearing Status Quo Ante, deterring litigation, Feeling Uneasy*, *Limiting Caring*, and *Normalizing the Present* were arranged in ascending order as needs of the study participants were accomplished based on Maslow's assumptions. These study participants expressed having been trapped at the physiological and security needs reflecting the theme of *Deterring litigation* because it was associated with the job security and safety. *Disappearing Status Quo Ante, Feeling Uneasy, and Limiting Caring* occupied the upper-level needs of Belonging, Esteem, and Self –Actualization because the participants showed little interest in achieving them. The theme of *Normalizing the Present* was not assigned any special rank among needs because it is uncertain and in the *future*, but it was discussed from the standpoint of how it would occur.

All the themes in this study derived their significance within the context of Heidegger's temporality and modes of engagement. The theme *Disappearing Status Quo Ante* was the past of the study participants practicing in the inpatient mental health unit without CCTV surveillance. The experience was mainly in the seamless or ready-to-hand mode of engagement. The themes *Deterring Litigation, Feeling Uneasy,* and *Limiting Caring* were experienced in the temporal present through unready-to-hand and present-at-hand modes of engagement. The theme of *normalizing the present* is a future projection

of nurses working in the inpatient unit under CCTV surveillance and engaged with the milieu in unready-to-hand and present-at-hand modes of engagement.

Significance of the Study

This study of the lived experience of registered nurses (RNs) working in mental health under constant closed circuit television (CCTV) surveillance was conducted to bring focus to potential barriers to patient care and nursing practice. The evidence from studies of employees' working under surveillance in other industries identifies disadvantages such as stress, fear, and vulnerability among them. Surveillance is also known to limit creativity and exploration of innovative ideas. The findings in this study confirmed some of what is already known about how CCTV surveillance promotes psychological discomfort and disrupts normative function. A better understanding of what it is like to be working under CCTV surveillance in the inpatient mental health unit has been established through this study. The findings from this study have implications for nursing education, practice, research, and health/public policy that can help to create a better work environment for the nurses as they strive to provide optimal care to the public.

Significance of the Study to Nursing

Working under closed circuit television (CCTV) surveillance at inpatient mental health units is sharply becoming normative experience for nurses. The literature has identified psychological problems such as stressor, anxiety uncertainty, and sense vulnerability as some of its adverse effects (Vorvoreanu & Botan, 2001). The current study has identified *Feeling Uneasy* working under CCTV surveillance, and limitations in their caring options as additional deficiencies also surfaced. Despite these adverse effects,

nurses were willing to incorporate CCTV surveillance into their practice because it enhanced their job security. Nurses are on the frontline of promoting a healthy nation, and they should not have to endure psychological discomfort and curtailment in caring initiatives, spurred by CCTV surveillance, to maintain employment. The inclusion of CCTV surveillance at inpatient mental health units has negatively-affected the nurses' wellbeing and quality of care they provide to the public. A review of the literature has produced no studies of this kind. The current study subsequently has filled a gap in the nursing literature that needed empirical data on nurses working under CCTV surveillance.

Implications for Nursing Education

Nursing education has a unique opportunity to shape the values and ethics of the professional nurse. The new graduate nurse is confronted with barriers when he or she begins clinical practice for which they have not been unprepared. One such barrier to fulfilling effective clinical is having to work under constant CCTV surveillance. Some participants in the study speculated that the new generations of nurses may not care about electronic surveillance because they are used to being monitored. However, such notion has been dispelled by other participants accustomed to being electronically monitored as inaccurate. Nursing education is the place to enlighten nurses about such conditions. Contesting such barriers takes a high level of sophistication because the employers have a vested interest in having employees working under CCTV surveillance beyond the need to deter misconduct.

CCTV surveillance at the workplace is legal, and the only effective way to challenge it is during a labor union contract negotiation. Few nurses have union

representation, and one of the tools employers use to deter union activity at the workplace is CCTV surveillance. The last place a nurse without representation would want to challenge the barrier of working under CCTV is at his or her place of employment. Therefore, the most ideal place for the nurse to begin learning about how to organize to build a safer workplace and promote the profession is throughout nursing education.

Implications for Nursing Practice

Without proper representation within a healthcare organization, the nurse's practice is fragmented and directed by the power source within the organization which is able to introduce CCTV surveillance into the work environment without consultation or transparent check and balances. Nurses are forced to accept the new technology unless access to alternate employment that does not use CCTV surveillance is available. Those nurses chose to work under constant CCTV surveillance, such as those in this study, have provided extensive details of some of the disadvantages of been constantly monitored. Some of the participants complained of feeling nervous and uncertain during certain therapeutic interventions, while others felt restricted in providing certain care for fear of misunderstanding. All these effects are consequences of CCTV surveillance designed to coerce the nurse into self-censorship under the threat of job termination. The result is an unsettled nurse who provides limited care to the patients.

Implications for Nursing Research

There is a dearth of research on nurses working under CCTV surveillance in the inpatient mental health unit. This qualitative hermeneutic phenomenological study has provided a better understanding of it, and has closed a gap in the literature. This study revealed that the participants lacked job security; CCTV surveillance could be a

workplace hazard and the participants were helpless in resolving the problems. Electronic monitoring of the medical workplace is growing rapidly, and it is becoming more sophisticated. Nursing scholars should not sit by passively and allow the imposition of such technology on the profession without input. Moreover, there needs to be empirical data about the effects of electronic surveillance on the psychological and physical wellbeing of the nurse and the quality of nursing care they provide patients under such condition.

Implications for Health and Public Policy

Closed circuit television (CCTV) surveillance in the inpatient mental health unit has become routine. The current study has revealed that it has disadvantages in psychological wellbeing and limitations in patient care delivery. This revelation is not unique, as studies in other industries have identified similar findings such as stress, anxiety, and vulnerability among workers. Such working condition are not conducive to job satisfaction and work retention. For instance, Chang, Lee, Ma, and Yang (2009) conducted a study and found that nurse job satisfaction was a predictor for whether or not a nurse remains on the job. Hinshaw (2008) additionally reported that many nurses leave their job because of factors in their work environment out of their control that they perceive as making it difficult for them to provide safe patient care.

Nurses seem helpless in effecting any meaningful changes in their workplace condition as it is negatively-influenced by the effects of CCTV surveillance. Such stalemate has implications for the nursing profession and the public. Many nurses' workplace representation is limited to the corporate agenda as the employers ask the nurses to buy into their organizational decisions and trust that they are good for nurses,

nursing, and the public. This study has found that such agenda is not always in the interest of the nurse and patient care. Policy-makers who are stakeholder in the medical profession should have the resources to ensure that nurses have the appropriate work environment conducive to meeting the public's interest.

Strengths and Limitations of the Study

The purpose of this study has been to understand the lived experience of nurses working in mental health units under constant closed circuit television (CCTV) surveillance. The strengths as well as the limitations are inherently methodological. The strength of this qualitative hermeneutic phenomenological study is that it provided the researcher and the participants, who were registered nurses (RNs) with a face-to-face opportunity to discuss what it means to be working under CCTV surveillance at an inpatient mental health unit. The researcher asked questions with follow-ups to clarify any ambiguity. Being the sole researcher allowed for complete immersion in the data from collection to analysis and provided the clarity necessary to connect codes and ultimately themes. Co-construction of the narrative between researcher and participants was also a strength because of the researcher's close familiarity with the environment and context in which the participants had their experience.

A weakness of the study is that the researcher has no guarantee that the participants were candid with their answers. The literature identifies a host of reasons why a participant may not be sincere. It is possible that the themes presented in the study were not exhausted, but they were the researcher's best interpretation, given that Gadamer (1998) has suggested that interpretation is evolutional and never final. The researcher's novice level of experience could be a factor in decision-making through the

study. It is recognized that the results from the study might not be transferable to other settings.

Recommendations for Future Studies

The researcher was surprised that the participants would embrace CCTV surveillance at their workplace instead of viewing this as a workplace inequity that suppressed their professional growth. The recommendation is for a quantitative study that address more specific issues related to nurses working in inpatient units under CCTV surveillance. The question could be how CCTV surveillance relates to job security, advocacy, professional growth, and job satisfaction. In this study it seemed as though the nurses were only about securing their jobs, and there were no obvious alternatives. The ideas of collaborating and lobbying organizations to address the issues limiting patient care and causing uneasiness did not seem to register on any level. Another recommendation might be for an institutional case study to understand how the nursing agenda is set within the organization, who sets it, and how the nurses make input and work towards achieving this agenda. There was no mention of a nurse representative throughout the study. The participants seemed to have had no individuals, groups or organizations to address their concerns. An employer who is vested with unlimited power in an organization assumes more power when the employees "buy into" CCTV surveillance because of necessity. A systemic study is recommended to demonstrate the benefit of employee decision-making representation in terms of professional growth, job satisfaction, and job security.

Summary and Conclusions

Chapter Five discussed the lived experience of registered nurses (RNs) working under constant closed-circuit television (CCTV) surveillance at inpatient mental health unit in South Florida. The participants were 16 RNs who volunteered for face-to-face semi-structured interviews to share their experiences with the researcher. The study design was qualitative with a hermeneutic phenomenological approach that allowed for methodological flexibility to gain a good understanding of the participants' lived experiences. The study yielded the following five themes: (a) *Disappearing status Quo Ante;* (b) *Deterring Litigation*; (c) *Feeling Uneasy;* (d*) Limiting Caring;* (e) *Normalizing the Present.*

The theme of *Disappearing Status Quo Ante* represented a past the participants liked and disliked, but a *past* nevertheless, to which they did not want to return. In the *past*, the study participants had practiced seamlessly while they worked in the inpatient mental health unit without CCTV surveillance. Such seamless engagement is what Heidegger called the preferred ready-to-hand mode. The study participants' *past* working in the inpatient mental health unit without CCTV surveillance enhanced therapeutic nursing relationships, but it lacked job security.

The theme of *Deterring Litigation* was an imperative of CCTV surveillance in the inpatient mental health unit. The participants embraced it despite its adverse consequences. *Feeling Uneasy* was one of the adverse consequences of CCTV surveillance that contributed to the nurses' negative psychological wellbeing. *Limiting Caring* was a direct result of *Feeling Uneasy* as participants did no engage in certain therapeutic activities that they thought could have attracted undue scrutiny from

management. Al three themes emerged in Heidegger's temporal present. Additionally, all three themes obligated the study participants primarily in the unready-to-hand and present-at-hand modes of engagement. Finally, *Normalizing the Present* is a theme that emerged within Heidegger's temporal *future*. The participants projected nurses to be working under CCTV surveillance in the inpatient mental health unit of the future with the accompanying consequences namely *Deterring litigation*, *Feeling Uneasy*, and *Limiting Caring*.

Maslow's Hierarchy of Needs Theory explained the dichotomy in the themes. The participants supported CCTV surveillance in the inpatient mental health unit because it *Deterred Litigation* that was a threat to the participants' job security a physiological and safety need. The three themes, *Disappearing Status Quo Ante, Feeling Uneasy,* and *Limiting Caring* were Maslow's upper level needs the participants did not pursue. The theme *normalizing the present* was assigned not particular rank among Maslow's need because of the uncertainty of the future, but its potential normalizing process was explained. The study provided useful information regarding nurses' reaction towards elements in their work environment that affected their practice.

References

Aalto University. (2012, October 8). Negative effects of computerized surveillance at home: Cause of annoyance, concern, anxiety, and even anger. *ScienceDaily*. Retrieved from www.sciencedaily.com/releases/2012/10/121008101646.htm. February 22, 2018.

Adair, J. (2006). PART 2. Maslow and Herzberg - chapter 4. Maslow's hierarchy of needs. London: Kogan Page Ltd. Retrieved from https://search-proquest-com.contentproxy.phoenix.edu/docview/288406806?accountid=134061. October 1, 2017.

Adam, B. (2017, October 18). Ex-Riverview patient sued over assault on worker. *Morning Sentinel*. Retrieved from https://www.centralmaine.com/2017/10/18/ex-riverview-patient-sued-over-assault-on-worker/. October 18, 2017.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Lake, E. T., & Cheney, T. (2008). Effects of hospital care environment on patient mortality and nurse outcomes. *The Journal of Nursing Administration,* 38(5), 223.

Ajjawi, R., & Higgs, J. (2007). Using Hermeneutic Phenomenology to Investigate How Experienced Practitioners Lear n to Communicate Clinical Reasoning. *The qualitative report,* 12(4), 612-638.

Alasuutari, P. (2010). The rise and relevance of qualitative research. *International Journal of Social Research Methodology, 13*(2), 139-155.

Allen, M. W., Coopman, S. J., Hart, J. L., & Walker, K. L. (2007). Workplace surveillance and managing privacy boundaries. *Management Communication Quarterly: McQ,* 21(2), 172-200.

Allen, N.J. & Meyer, J.P. (1990). The measurement and antecedents of affective, continuance and normative commitment to the organization. *Journal of Occupational Psychology* 63(1), 1-8.

Al-Rjoub, H; Zabian, A, & Qawasmeh, S (2008). Electronic monitoring: The employees' point of view. *Journal of Social Sciences, 4*(3), 189-195. doi: 10.3844/jssp.2008.189.195.

Annells, M. (1996). Hermeneutic phenomenology: philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing, 23*(4), 705-713. doi:10.1111/1365-2648.ep8543536.

Anney, V. N. (2014). Ensuring the quality of the findings of qualitative research: looking at Trustworthiness Criteria. *Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS, 5*(2): 272-281.

Armellino, D., Trivedi, M., Law, I., Singh, N., Schilling, M. E., Hussain, E., & Farber, B. (2013). Replicating changes in hand hygiene in a surgical intensive care unit with remote video auditing and feedback. *American Journal of Infection Control, 41*(10), 925-927. doi:10.1016/j.ajic.2012.12.011.

Arutunyan, A. (2013). Russia expels U.S. diplomat for alleged spying. *USA Today*

Aveyard, H. (2014). *Doing a literature review in health and social care: A practical guide*. McGraw-Hill Education (UK).

Baker, G., Morris, K., & Baker, G. (2002). Descartes' dualism. Retrieved from https://ebookcentral-proquest-com.contentproxy.phoenix.edu. May 10, 2017.

Bakir, V. (2015). "veillant panoptic assemblage": Mutual watching and resistance to mass surveillance after Snowden. *Media and Communication, 3*(3), 12-25. doi:10.17645/mac.v3i3.277.

Ball, J. C. (1955). Deterrence Concept in Criminology and Law, The. J. Crim. L. *Criminology & Police Sci.*, 46, 347.

Ball, K. (2010). Workplace Surveillance: An Overview. *Labor History, 51*(1), 87-106

Ball, K; Daniel, E. M. & Stride, C. (2012). Dimensions of employee privacy: an empirical study. *Information Technology & People*, *25*(4).

Barrett, D. (2014). One surveillance camera for every 11 people in Britain, says CCTV survey. *The Telegraph*, 10. Retrieved from http://w3.salemstate.edu/~pglasser/One_surveillance_camera_for_every_11_people in_Britain__says_CCTV_survey_-_Telegraph.pdf. May 10, 2016.

Bassett, C., & Bassett, J. (2003). The importance of research in nursing practice. *British Journal of Perioperative Nursing*, *13*(1), 30

Berge, P. L., & Luckmann, T. (1967). *The social construction of reality*. New York: Anchor.

Bharucha, A. J., London, A. J., Barnard, D., Wactlar, H., Dew, M. A., & Reynolds, C. F. (2006). Ethical considerations in the conduct of electronic surveillance research. *The Journal of Law, Medicine & Ethics, 34*(3), 611-619. doi:10.1111/j.1748-720X.2006.00075.x.

Bitsch, V. (2005). Qualitative Research: A Grounded Theory Example and Evaluation *Criteria. Journal of Agribusiness*. *23*(1), 75-91.

Bourgeault, I., Dingwall, R. & De Vries, R. (2010). *Phenomenology.* In Bourgeault, I., Dingwall, R. & De Vries, R. The SAGE handbook of qualitative methods in health research (pp. 229-248). London, SAGE Publications Ltd doi: 10.4135/9781446268247.n13.

Bowen, G. A. (2009). Supporting a grounded theory with an audit trail: an illustration. *International Journal of Social Research Methodology*, 12(4), 305-316.

Bradbury-Jones, C., Irvine, F., & Sambrook, S. (2010). Phenomenology and participant feedback: convention or contention? Caroline Bradbury-Jones, Fiona Irvine and Sally Sambrook consider the use of member checks to improve the rigor of phenomenological research. *Nurse researcher*, 17(2), 25-33.

Brinkmann, S. (2012). *Qualitative inquiry in everyday life: Working with everyday life materials.* Sage.

Brooke, M. (2013). Which research paradigm for TESOL? Theory and Practice in Language Studies, 3(3), 430.

Bryant, S. (1995). Electronic surveillance in the workplace. *Canadian Journal of Communication*, *20*(4), 505-521.

Budd, J. W., & Bhave, D. (2010). The employment relationship. The SAGE handbook of human resource management, 51-70.

Burns, A. (2003). Protecting infants in healthcare facilities from abduction: a facility's search for a sound infant security system. *Journal of Perinatal & Neonatal Nursing*, 17(2), 139-149.

Burr, V (1995). *An introduction to Social Constructionism*. London Routledge

Campbell, S. (2014). What is qualitative research? *Clinical Laboratory Science*, *27*(1), 3.

Carpenter, J. (2016).Park Royal Hospital faces more trouble with lawsuit over suicide of psychiatric patient Theodore Ousback Jr. Naples Daily News. Retrieved from http://archive.naplesnews.com/news/health/park-royal-hospital-faces-more-trouble-with-lawsuit-over-suicide-of-psychiatric-patient-theodore-ous-364745521.html/. November 11, 2017.

Carter P. (2007).The importance of research in nursing. *Journal of Research in Nursing, 12(*3), 207-208.

CCHR International (2018). Psychiatric Hospital Rife With Sexual Assault Allegations Finally Shuts Down While Another Faces Lawsuit over Teen Rape. Retrieved from https://www.cchrint.org/2018/01/22/psychiatric-hospital-rife-with-sexual-assault-allegations-finally-shuts-down/. January 22, 2018.

Chambers, M. and Gillard, S. (2005). Review of CCTV on John Meyer Ward, 19 July 2005. Agenda Item 9, Trust Board Meeting, 28 July 2005, South West London and St George's NHS Mental Health Trust. Retrieved from http://www.swlstgtr.nhs.uk/about/board_meeting.asp. January 17, 2017.

Chang, S. E., Liu, A. Y., & Lin, S. (2015). Exploring privacy and trust for employee monitoring. *Industrial Management & Data Systems, 115*(1), 88.

Chang, W., Lee, P., Ma, J., & Yang, Y. (2009). Predicting factors related to nurse's intention to leave, job satisfaction, and perception of quality of care in acute care hospitals. *Nursing Economics*, 27(3), 178.

Cho, J. S. (2014). Video Surveillance Systems and Future Requirements of the Security Market in United Kingdom and Korea. *International Journal of Trends in Economics Management & Technology (IJTEMT), 3*(5).

Cleary, M., Hunt, G. E., Walter, G., & Robertson, M. (2009). Locked inpatient units in modern mental health care: Values and practice issues. *Journal of Medical Ethics*, *35*(10), 644-646. doi:10.1136/jme.2008.027888.

Closed-Circuit Chaos (2015, OCT 29). Florida makes surveillance videos from inside its mental hospitals secret. Here's what it won't let you see. Tampa Bay Times. Retrieved from http://www.tampabay.com/projects/2015/investigations/florida-mental-health-hospitals/surveillance-videos/. November 10, 2017.

Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: controversies and recommendations. *Annals of Family Medicine*, *6*(4), 331-339. doi:10.1370/afm.818.

Collins, D. (2017). Abuse allegations and arrests mount at Connecticut mental hospital. Retrieved from https://www.boston.com/news/local-news/2017/09/17/abuse-allegations-and-arrests-mount-at-connecticut-mental-hospital. September 30, 2017.

Corney, B. (2008),"Aggression in the workplace", *Journal of Health Organization and Management, 22*(2), 164 – 177. http://dx.doi.org/10.1108/14777260810876321

Conroy, D. E. (2003). Representational models associated with fear of failure in adolescents and young adults. *Journal of Personality*, 71(5), 757-784.

Coultrup, S., & Patrick D "Pat" Fountain, P. D. (2012). Effects of electronic monitoring and surveillance on the psychological contract of employees: An exploratory study. *ASBBS Proceedings*, *19*(1), 219.

Creswell, J. W. (2013). *Qualitative inquiry and research design. Choosing among five approaches.* Thousand Oaks, CA: Sage Publications.

Crotty, M. (1998). *The foundations of social research*. London: Sage.

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2016). Crafting stories in hermeneutic phenomenology research: A methodological device. *Qualitative Health Research,* 27(6), 826-835. doi:10.1177/1049732316656161.

Curtis, S., Gesler, W., Wood, V., Spencer, I., Mason, J., Close, H., & Reilly, J. (2013). Compassionate containment? Balancing technical safety and therapy in the design of psychiatric wards. Social Science & Medicine, 97, 201-209.

Dallas Morning News. (2010). The big story: Russian spies-like-us farce or something more serious? *Dallas: Newstex.*

Daniel, J. N. (2011). *Sampling essentials: Practical guidelines for making sampling choices* SAGE Publications.

Dašić, P., Dašić, J., & Crvenković, B. (2017). Improving Patient Safety in Hospitals through Usage of Cloud Supported Video Surveillance. *Open Access Macedonian Journal of Medical Sciences*, 5(2), 101–106.

Davies, T. S. (1962). Closed-circuit television in A mental hospital. *The British Medical Journal, 2*(5318), 1531-1532. doi:10.1136/bmj.2.5318.1531.

Dawidowicz, P. (2010). *Literature Reviews Made Easy: A Quick Guide to Success*. Charlotte, NC: Information Age Publishing.

Debesay, J., Nåden, D., & Slettebø, Å. (2008). How do we close the hermeneutic circle? A Gadamerian approach to justification in interpretation in qualitative studies. Nursing Inquiry, 15(1), 57-66. doi:10.1111/j.1440-1800.2008.00390.x.

De, C. M. (2014). *Nursing Research Using Data Analysis*. New York: Springer Publishing Company.

Deisman, W, Derby, P Doyle, A et al., (2009) A Report on Camera Surveillance in Canada - Part One, Surveillance Camera Awareness Network (SCAN), The Surveillance Project, Queen's University, Kingston. Retrieved from http://www.sscqueens.org/sites/default/files/SCAN_Report_Phase1_Final_Jan_30_2009. Pdf. July8, 2017.

Denzin, N.K. & Lincoln, Y.S. (2003), *The Landscape of Qualitative Research - Theories and Issues*, Sage, Thousand Oaks, CA.

Desai, S. (2010). Violence and Surveillance: Some Unintended Consequences of CCTV Monitoring within Mental Health Hospital Wards. *Surveillance & Society*, *8*(1), 85-92.

Desai, S. (2011). Violence and surveillance in mental health wards: Suki desai considers the negative impact on vulnerable people. *Criminal Justice Matters, 83*(1), 4. doi:10.1080/09627251.2011.550146.

Dietrich, S. J. (2015). Protecting DHS component pre-9/11 functions: improving visibility in budget exhibits (*Doctoral dissertation, Monterey, California: Naval Postgraduate School).*

Emmel, N. (2013). *Theoretical sampling. In Sampling and choosing cases in qualitative research: A realist approach* 11-32. London, SAGE Publications Ltd doi: 10.4135/9781473913882.n2.

Estryn-Béhar, M., Van der Heijden, B. I., Ogińska, H., Camerino, D., Le Nézet, O., Conway, P. M., & Hasselhorn, H. M. (2007). The impact of social work environment, teamwork characteristics, burnout, and personal factors upon intent to leave among European nurses. *Medical Care*, 939-950.

Fahrenwald, N. L., Bassett, S. D., Tschetter, L., Carson, P. P., White, L., & Winterboer, V. J. (2005). Teaching core nursing values. *Journal of Professional Nursing*, 21(1), 46-51.

Findlay, P., & McKinlay, A. (2003). Surveillance, electronic communications technologies and regulation. *Industrial Relations Journal*, *34*(4), 305-318.

FITSNews. (2017). Woman Arrested For Having Sex With Mental Health Patient Retrieved from https://www.fitsnews.com/2017/09/27/woman-arrested-for-having-sex-with-mental-health-patient/. September27, 2017.

Fitzpatrick, J. J. (2010). The future of nursing: Leading change, advancing health. *Nursing Education Perspectives*, *31*(6), 347-348.

Fleming, V., Gaidys, U., & Robb, Y. (2003). Hermeneutic research in nursing: developing a Gadamerian-based research method. *Nursing Inquiry*, *10*(2), 113-120. doi:10.1046/j.1440-1800.2003.00163.x.

Foucault, M. (1977). *Discipline and Punish*, trans. Alan Sheridan (New York: Vintage, 1979), 242.

Fuchs, C. (2013). Political economy and surveillance theory. *Critical Sociology*, *39*(5), 671-687.

Fuchs, C. (2015). Surveillance and critical theory. *Media and Communication*, *3*(2), 6-9.

Gadamer, H. G. (1998). *Truth and method* (2 nd, revised). Trans. J. Weinsheimer & D. Marshell. New York, NY: Continuum.

Gadamer, H. G. (1990). *The hermeneutical problem*. In Gayle Ormiston & Alan Schrift (Eds.), *The hermeneutic tradition: From Ast to Ricouer* (pp.273-297). New York: State University of New York Press.

Gadamer, H. G. (2000). *Beginning of philosophy.* Bloomsbury Publishing USA.

Gelling, L. (2015). Qualitative research. *Nursing Standard*, 29(30), 43-47.

Gergen, K. J. (1985). "The Social Constructionist Movement In Modern Psychology". *American Psychologist*. 40(3), 266-275.

Ghoshray, S. (2013). Employer surveillance versus employee privacy: the new reality of social media and workplace privacy. *Northern Kentucky Law Review*, *40*(3), 593-626.

Gill, M. J. (2014). The possibilities of phenomenology for organizational research. *Organizational Research Methods*, 17(2), 118-137. doi:10.1177/1094428113518348.

Gill, M., & Hemming, M. (2006). CCTV: does it work?. *Safer Communities, 5*(1), 35-36.

Gill, S. (2015). "Holding Oneself Open in a Conversation"–Gadamer's Philosophical Hermeneutics and the Ethics of Dialogue. *Journal of Dialogue Studies*, 3(1), 9-28.

Gibson, W. J. & Brown, A. (2009). *Introduction: qualitative data analysis in context. In Working with qualitative data (*pp. 1-14). : SAGE Publications Ltd doi: 10.4135/9780857029041.d1.

Gjesdal, K. (2006). Hermeneutics and philology: A reconsideration of Gadamer's critique of Schleiermacher. *The British Journal for the History of Philosophy, 14*(1), 133-156.

Goldkuhl, G. (2012). Pragmatism vs interpretivism in qualitative information systems research. *European Journal of Information Systems,* 21(2), 135-146.

Gomez-Mejia L. R., Balkin D. B., Cardy R. L. (2004). Managing human resources (4th ed.). Harlow, UK: Pearson Education. Google Scholar.

Greaves, T. (2010). Starting with Heidegger. Bloomsbury Publishing.

Groff Paris, L., & Terhaar, M. (2010). Using Maslow's Pyramid and the National Database of Nursing Quality Indicators™ to Attain a Healthier Work Environment. *OJIN: The online journal of issues in nursing*, 16(1).

Guba, E.G. (1990). *The alternative paradigm dialog. In Cuba EG (Ed) The Paradigm Dialog*. Sage Publications, Newbur)' Park CA.

Guba, E. & Lincoln, Y. S. (1998). *Competing Paradigms in Qualitative Research*, in: N. K. Denzin & Y. S. Lincoln (eds), The Landscape of Qualitative Research:Theories and issues.Thousand Oaks, CA, Sage Publications, (pp. 195–220).

Habermas J .(1968). *Knowledge and human interests (*Shapiro J J, , Trans.). Boston, MA: Beacon Press.

Haley, L. M; Flint, D & McNally, J. J. (2012). The effects of employee perceptions of monitoring procedures on turnover. *Problems and Perspectives in Management*, *10*(3), 75-82.

Hayes, L. M. (2013). Suicide prevention in correctional facilities: Reflections and next steps. *International Journal of Law and Psychiatry*, 36(3), 188-194.

Heidegger, M.(1962). *Being and Time*. Blackwell, Malden MA.

Harper, D. (2008). The politics of paranoia: Paranoid positioning and conspiratorial narratives in the surveillance society. Surveillance & Society, 5(1), 1-32.

Hawamdeh, S., & Fakhry, R. (2014). Therapeutic Relationships From the Psychiatric Nurses' Perspectives: An Interpretative Phenomenological Study. *Perspectives In Psychiatric Care,* 50(3), 178-185. doi:10.1111/ppc.12039.

Hinshaw, A. (2008). Navigating the perfect storm. Balancing a culture of safety with workforce challenges. *Nursing Research, 57*(1), S4-10.

Hogg, M. K., & Maclaran, P. (2008). Rhetorical issues in writing interpretivist consumer research. Qualitative Market Research: An International Journal, 11(2), 130-146.

Holland, P. J., Cooper, B., & Hecker, R. (2015). Electronic monitoring and surveillance in the workplace: The effects on trust in management, and the moderating role of occupational type. *Personnel Review, 44*(1), 161-175.

Holroyd, A. E. M. (2007). Interpretive hermeneutic phenomenology: clarifying understanding. *Indo-Pacific Journal of phenomenology*, *7*(2), 1-12; DOI: 10.1080/20797222.2007.11433946.

Hoskins, C. N., & Mariano, C. (2004). *Research in nursing and health: Understanding and using quantitative and qualitative methods (*Vol. 23). Springer Publishing Company.

HPCS3(2012).Health Practitioner Tribunal case Summaries. Australian Health Practitioner Regulatory Agency. HCCC v Santos [2012] NSWNMT 8.

Iozzino, L., Ferrari, C., Large, M., Nielssen, O., & de Girolamo, G. (2015). Prevalence and Risk Factors of Violence by Psychiatric Acute Inpatients: A Systematic Review and Meta-Analysis. PLoS ONE, 10(6), e0128536. http://doi.org/10.1371/journal.pone.0128536.

Jenkins, N. (2015). IHS: 245 million video surveillance cameras installed globally in 2014. *Market Insight*. SecurityInfoWatch.com.

Jeske, D., & Santuzzi, A. M. (2015). Monitoring what and how: psychological implications of electronic performance monitoring. New Technology, Work & Employment, 30(1), 62-78.

Johansson, G., Sandahl, C., & Hasson, D. (2013). Role stress among first-line nurse managers and registered nurses–a comparative study. *Journal of nursing management*, *21*(3), 449-458.

Joh, E. E. (2016). Beyond surveillance: Data control and body cameras. *Surveillance & Society*, *14*(1), 133.

Johnson, M. E. (2000). Heidegger and meaning: Implications for phenomenological research. *Nursing Philosophy*, *1*(2), 134-146.

Jones, A., Powell, T., Watkins, D., & Kelly, D. (2015). Realizing their potential? Exploring interprofessional perceptions and potential of the advanced practitioner role: a qualitative analysis. *BMJ Open*, *5*(12).

Jones, D. (1996). The Equitable Public Servant: Regulating Equal Employment Opportunities (EEO) in the New Zealand Public Service. The Journal of New Zealand Studies, 6(2).

Jung, H. Y. (1974). The Structures of the Life-World. By SchutzAlfred and LuckmannThomas. Translated from the German by ZanerRichard M. and EngelhardtH. TristramJr.,(Evanston, Illinois: Northwestern University Press, 1973. Pp. xxxvi, 335. *American Political Science Review*, *68*(3), 1319-1321.

Kassim, E. S., & Marzukhi, N. A. (2014). Surveillance compliance: examining employee commitment and intention to comply with electronic monitoring system. *Journal of Technology Management and Business*, *1*(1), 40-52.

Keiber, J. (2015). Surveillance hegemony. *Surveillance & Society*, *13*(2), 168.

Kelly, U. A. (2011). Theories of intimate partner violence: From blaming the victim to acting against injustice: Intersectionality as an analytic framework. *Advances in Nursing Science,* 34(3), E29-E51.

Kennedy, S. L. (2014). *Understanding Hermeneutics*. Durham, GB: Routledge.

Kerley, P; Hames J.B, & Sukys P.A. (2009). Civil Litigation, Fifth Edition Publisher: Cengage Learning ISBN: 9781428318397.

Khan, A & Nausheen, S. (2017). Compliance of surgical hand washing before surgery: Role of remote video surveillance. *J Pak Med Assoc. 67* (1), 92-96.

King, N. J. (2003). Electronic monitoring to promote national security impacts workplace privacy. *Employee Responsibilities and Rights Journal, 15*(3), 127-127.

Kmitch, J. (2017, Nov 21). Judge allows viewing of hospital surveillance video in case against ex-nurse. Daily Herold. Retrieved from http://www.dailyherald.com/news/20171121/judge-allows-viewing-of-hospital-surveillance-video-in-case-against-ex-nurse. November10, 2017.

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of advanced nursing*, 21(5), 827-836.

Koch, T. (2006). Establishing rigor in qualitative research: the decision trail. *Journal Of Advanced Nursing,* 53(1), 91-100. doi:10.1111/j.1365-2648.2006.03681.x.

Kornhaber, R., Walsh, K., Duff, J., & Walker, K. (2016). Enhancing adult therapeutic interpersonal relationships in the acute health care setting: an integrative review. Journal of multidisciplinary healthcare, 9, 537.

Langdridge, D.(2007). *Phenomenological psychology: Theory, research, and* Method. (1st ed.). Pearson Prentice Hall. Canada.

Laverty, S. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 1–29.

Latner, A. W. (2017). A nurse fired for falling asleep on the job. Clinical Advisor. Retrieved from https://www.clinicaladvisor.com/legal-advisor/fired-for-falling-asleep-on-the-job/article/669037/. November1, 2017.

Lee, S., & Kleiner, B. H. (2003). Electronic surveillance in the workplace. *Management Research News*, *26*(2-4), 72-81.

Lee, A., & Cook, P. S. (2014). The conditions of exposure and immediacy: Internet surveillance and Generation Y. *Journal of Sociology* 51, (3), pp. 674 – 688.

Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. *Critical issues in qualitative research methods*, 95-115.

Levy, B. S. (Ed.). (2006). *Occupational and environmental health: recognizing and preventing disease and injury*. Lippincott Williams & Wilkins.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lippert, R. K., & Newell, B. C. (2016). Introduction: The privacy and surveillance implications of police body cameras. *Surveillance & Society*, *14*(1), 113.

Lippert, R. K., & Scalia, J. (2015). Attaching Hollywood to a surveillant assemblage: Normalizing discourses of video surveillance. Media and Communication, 3(3).

Littler, C. R. (1978). Understanding Taylorism. *British Journal Of Sociology*, *29*(2), 185-202.

Liu, C., & Sui, X. (2014). Understanding the Platonic dialogue from the perspective of Gadamer's hermeneutics. *Theory and Practice in Language Studies*, *4*(4), 758-765.

Locke, K. (2003). *Situating the discovery of grounded theory within the tradition of qualitative methods. In Sage Series in Management Research: Grounded theory in management research* (pp. 2-19). : SAGE Publications Ltd doi: 10.4135/9780857024428.d3.

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative health research, 14*(5), 726-735.

Luther, C., & Radovic, I. (2012). Perspectives on privacy, information technology and company/governmental surveillance in Japan. *Surveillance and Society,10*(3-4), 263-275.

Lyon, D. (1993). An electronic panopticon? A sociological critique of surveillance theory. *Sociological Review*, 41(4), 653-678.

Lyon, D. (2001). *Surveillance society: Monitoring everyday life*. McGraw-Hill Education (UK).

Lyon, D. (2010). *Surveillance, power and everyday life. In Emerging Digital Spaces in Contemporary Society* (pp. 107-120). Palgrave Macmillan UK.

Ma, F. (2015). A review of research methods in EFL education. Theory and Practice in *Language Studies*, 5(3), 566.

Mackey, S. (2005). Phenomenological nursing research: Methodological insights derived from Heidegger's interpretive phenomenology. *International Journal of Nursing Studies,* 42(2), 179-186. doi:10.1016/j.ijnurstu.2004.06.011.

Magubane, Z. (2008). The mammy and the panopticon African American women in the self-help movement. *Race, Gender & Class, 15*(1/2), 220-236.

Mahoney, J. S., Palyo, N., Napier, G., & Giordano, J. (2009). The therapeutic milieu reconceptualized for the 21st century. *Archives of Psychiatric Nursing*, 23(6), 423-429.

Mariner, W. K., & Annas, G. J. (2013). Limiting "sugary drinks" to reduce obesity—who decides?. New England Journal of Medicine, 368(19), 1763-1765.

Marx, K. (1867). [1867] *Capital: A Critique of Political Economy*. New York: International.

Maslow, A. H. (1970). Motivation and Personality. (2nd Ed0. New York: Harper and Rowe.

May, C., Sibley, A., & Hunt, K. (2014). The nursing work of hospital-based clinical practice guideline implementation: an explanatory systematic review using Normalisation Process Theory. *International Journal of Nursing Studies,* 51(2), 289-299.

Mayeroff, M. (1971). On caring. Oxford, England: Harper & Row.

Mello, M. M., Chandra, A., Gawande, A. A., & Studdert, D. M. (2010). National costs of the medical liability system. Health affairs, 29(9), 1569-1577.

McConnell-Henry, T., Chapman, Y., & Francis, K. (2011). Member checking and Heideggerian phenomenology: a redundant component. *Nurse researcher*, 18(2), 28-37.

McCormick, M. R., & Kuchuris, C. G. (2013). The danger of relativism in reason. *International Journal of Arts & Sciences, 6*(3), 397.

McIntyre, S. L. (2000). The failure of Fordism. *Technology and Culture, 41*(2), 269.

McNamara, M. S. (2005). Knowing and doing phenomenology: The implications of the critique of 'nursing phenomenology 'for a phenomenological inquiry: A discussion paper. *International journal of nursing studies, 42*(6), 695-704.

Meier, K. A. (2014). Removing the Menacing Specter of Elder Abuse in Nursing Homes through Video Surveillance. *Gonz. L. Rev., 50*(29).

Meisenhelder, T. (1979). A Further Investigation of the Life-World. *Human Studies*, *2*(1), 21-30.

Merecz, D; Rymaszewska, J; Moscicka, A; Kiejna, A; & Jarosz-Nowak, J. (2006). Violence at the workplace--a questionnaire survey of nurses. *Eur Psychiatry*, 21(7), 442–50.

Merleau-Ponty, M. (1945). *Phenomenology of Perception (Original: Phénoménologie de la perception 1945).* D. Tiemersma & R. Vlasblom). Boom.

Merleau-Ponty, M., & Smith, C. (1962). *Phénoménologie de la Perception. Phenomenology of Perception...* Translated... by Colin Smith. London; Humanities Press: New York.

Merleau-Ponty, E. M. (2016). Perception, Reversibility, "Flesh": Merleau-Ponty's *Phenomenology and Leadership as Embodied Practice*. Perception.

Miles, M., Francis, K., Chapman, Y., & Taylor, B. (2013). Hermeneutic phenomenology: A methodology of choice for midwives. *International Journal of Nursing Practice, 19*(4), 409-414.

Miller, R. S. (2007). Preventing infant abduction in the hospital. *Nursing2016*, 37(10), 20-22.

Miller, S., & Weckert, J. (2000). Privacy, the Workplace and the Internet. *Journal of Business Ethics*, *28*(3), 255-265.

Moran, D. (2002*). Introduction to Phenomenology*: Taylor and Francis.

Moustaka, E., & Constantinidis, T. C. (2010). Sources and effects of work-related stress in nursing. *Health Science Journal*, *4*(4), 210-216.

Munhall, P. (2012). *Nursing research: A qualitative perspective* (5th ed.). Sudbury, MA: Jones and Bartlett leaning.

Munhall, S. (1993). *On Being in the World.* New York: Routledge.

Mutlu, C. E. (2015). How (Not) to Disappear Completely: Pedagogical Potential of Research Methods in International Relations. Millennium, 43(3), 931-941.

Norris, C; McCahill, M; & Wood, D. (2004). The Growth of CCTV: A global perspective on the international diffusion of video surveillance in publicly accessible space. *Surveillance & Society*, *2*(2/3): 110-135.

Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. *International Journal of Social Research Methodology, 11*(4), 327-344.

Nyst, C., & Crowe, A. (2014). Unmasking the Five Eyes' Global Surveillance Practices. *Communications Surveillance in the Digital Age*, 51-54.

Oermann, M. H., & Heinrich, K. T. (2005). *Annual review of nursing education Volume 3*, New York, NY, USA: Springer Publishing Company.

Oliver, P (2012). *Succeeding With Your Literature Review : A Handbook For Students*. Maidenhead: McGraw-Hill Education. eBook Collection.

Packer, M.J. (1985) 'Hermeneutic inquiry in the study ofhuman conduct'. *American Psychologist*, 40(10), 1081–1093.

Paris Jr, M., & Hoge, M. A. (2010). Burnout in the mental health workforce: A review. *The Journal of Behavioral Health Services & Research*, *37*(4), 519-528.

Parsons, K. (2010). Exploring how Heideggerian philosophy underpins phenomenolgical research: Karen Parsons considers the use of Heidegger's philosophy and the methodological implications resulting from its application in the phenomenological study of the daily lives of people who experience memory loss. *Nurse Researcher*, 17(4), 60-69.

Patton, M. (1990). *Qualitative evaluation and research methods* (pp. 169-186). Beverly Hills, CA: Sage.

Penney, J. W. (2016). Chilling effects: online surveillance and Wikipedia use. Berkley *Law Review*, 3(1), 117-182.

Pivčević, E. (1970). *Husserl and phenomenology*. London: Hutchinson.

Polit, D. R., & Hungler, B. P. (1999). *Nursing research. Principles and methods* (7th ed.). New York: Lippincott.

Polit, D.F., & Beck, C.T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Polit, D.F., & Beck, C.T. (2014*). Essentials of nursing research: Appraising evidence for nursing practic*e (8th ed.). Philadelphia, PA: Wolters Kluwer/Lippincott Williams & Wilkins.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*(2), 126-136.

Powers, B. A., & Knapp, T. R. (2011). *Dictionary of Nursing Theory and Research:* (4th ed.). New York: Springer Publishing Company.

Price, D. H. (2014). The New Surveillance Normal. *Monthly Review*: *An Independent Socialist Magazine*, *66*(3), 43-53.

Proctor, K. (2013). The great surveillance boom. *Fortune Magazine, April, 26.*

Punch, K. F. (1998). *Introduction to Social Research: Quantitative and Qualitative Approaches.* SAGE Publications.

Rabun, J. B. (2014). For healthcare professionals: Guidelines on prevention of and response to infant abductions. *National Center for Missing & Exploited Children*. (10th Ed).

Rafnsdóttir, G. L., & Gudmundsdottir, M. L. (2011). EPM technology and the psychosocial work environment. *New Technology, Work & Employment*, *26*(3), 210-221.

Rastegar, D. A. (2004). Health Care Becomes an Industry. *Annals of Family Medicine*, 2(1), 79–83.

Regan, P. (2012). Hans-Georg Gadamer's philosophical hermeneutics: Concepts of reading, understanding and interpretation. *Research in Hermeneutics, Phenomenology and Practical Philosophy,* 4(2), 286-303.

Regis, L. F. L. V., & Porto, I. S. (2011). Basic human needs of nursing professional: situations of (dis) satisfaction at work. *Revista da Escola de Enfermagem da USP,* 45(2), 334-341.

Riedy, M. K., & Wen, J. H. (2010). Electronic surveillance of Internet access in the American workplace: implications for management. *Information & Communications Technology Law*, *19*(1), 87-99.

Riffkin, R. (2014). Americans rate nurses highest on honesty, ethical standards. *Gallup Social Issues.*

Robinson, S. G. 2014. True presence: Practicing the art of nursing. *Nursing 44*(4), 44-45.

Roche, M., Duffield, C., & White, E. (2011). Factors in the practice environment of nurses working in inpatient mental health: A partial least squares path modeling approach. *International Journal of Nursing Studies*, *48*(12), 1475-1486.

Rothstein, L. E. (2000). Privacy or dignity? Electronic monitoring in the workplace. *New York Law School Journal of International & Comparative Law*, *19*(3), 379-412.

Ridout, T. A. (2014). Surveillance and Creative Minds. *Huffington Post*. Retrieved from https://www.huffingtonpost.com/t-a-ridout/surveillance-and-the-creative-mind_b_5706145.html. October1, 2017.

Rosenblat, A., & Kneese, T. (2014). Workplace surveillance. Retrieved from https://www.datasociety.net/pubs/fow/WorkplaceSurveillance.pdf.

Sadala, M. A., & Adorno, R. F. (2002). Phenomenology as a method to investigate the experience lived: a perspective from Husserl and Merleau-Ponty's thought. *Journal Of Advanced Nursing,* 37(3), 282-293. doi:10.1046/j.1365-2648.2002.02071.x.

Samaranayake, V & Gamage, C. (2012). Employee perception towards electronic monitoring at the workplace and its impact on job satisfaction of software professionals in Sri Lanka. *Telemat. Inf. 29*(2), 233-244.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advanced Nursing Science*, *16*(2), 1-8.

Schaufeli, W. B., & Buunk, B. P. (2003). Burnout: An overview of 25 years of research and theorizing. *The handbook of work and health psychology*, 2, 282-424.

Schmitz, P. W. (2005). Workplace surveillance, privacy protection, and efficiency wages.

Scotland, J. (2012). Exploring the Philosophical Underpinnings of Research: Relating Ontology and Epistemology to the Methodology and Methods of the Scientific, Interpretive, and Critical Research Paradigms. *English Language Teaching*, *5*(9), 9-16.

Sewell, G., & Barker, J. R. (2006). Coercion versus care: Using irony to make sense of organizational surveillance. *The Academy of Management Review*, *31*(4), 934-961. doi:10.5465/AMR.2006.22527466.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. Qualitative research in psychology, 7(3), 233-243.

Shaw, J. (2017, Jan-Feb). The Watchers. Assaults on privacy in America. Harvard Magazine. Retrieved from https://harvardmagazine.com/2017/01/the-watchers. November 1, 2017.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, 22(2), 63-75.

Sheridan, C. (2016). Foucault, Power and the Modern Panopticon. Retrieved from http://digitalrepository.trincoll.edu/cgi/viewcontent.cgi?article=1564&context=theses. November2, 2017.

Simons, H. (2009). *Evolution and concept of case study research. In Case study research in practice* (pp. 12-27). London, SAGE Publications Ltd doi: 10.4135/9781446268322.n1.

Smith, D. V, & Burg, J. (2012). Privacy and confidentiality. What are the limits of employee privacy? *American Bar Association*, *29*(6).

Smythe, E. A., Ironside, P. M., Sims, S. L., Swenson, M. M., & Spence, D. G. (2008). Doing Heideggerian hermeneutic research: A discussion paper. International *Journal of Nursing Studies*, 45(9), 1389-1397.

Sokolowski, R. (2000). *Introduction to Phenomenology*. Cambridge, UK: Cambridge University Press.

Sousa, W. H., Coldren, J. R., Rodriguez, D., & Braga, A. A. (2016). Research on body worn cameras: Meeting the challenges of police operations, program implementation, and randomized controlled trial designs. *Police Quarterly*, *19*(3), 363-384.

Sprague, R. (2007), 'From Taylorism to the Omnipticon: Expanding Employee Surveillance beyond the Workplace,' *John Marshall Journal of Computer & Information Law 25*(1), 1–35

Steedman, P (2000). *On the relations between seeing, interpreting and knowing*. In Steier, F. (Ed.), Research and Reflexivity 53-62. London: Sage.

Stevens, P. E. (1989). A critical social reconceptu

alization of environment in nursing: Implications for methodology. *Advances in Nursing Science, 11*(4), 56-68.

Stevenson, K. N., Jack, S. M., O'Mara, L., & LeGris, J. (2015). Registered nurses' experiences of patient violence on acute care psychiatric inpatient units: an interpretive descriptive study. *BMC Nursing*, 14, 35. http://doi.org/10.1186/s12912-015-0079-5.

Sutton, J., & Austin, Z. (2015). Qualitative Research: Data Collection, Analysis, and Management. *The Canadian Journal of Hospital Pharmacy*, 68(3), 226–231.

Stolovy, T., Melamed, Y., & Afek, A. (2015). Video Surveillance in Mental Health Facilities: Is it Ethical? *The Israel Medical Association Journal: IMAJ*, *17*(5), 274-276.

Stross, R. (2013). Wearing a badge, and a video camera. *The New York Times*, 1.

Studdert, D. M., Mello, M. M., Gawande, A. A., Gandhi, T. K., Kachalia, A., Yoon, C., & Brennan, T. A. (2006). Claims, errors, and compensation payments in medical malpractice litigation. New England journal of medicine, 354(19), 2024-2033.

Suri, S & Rizvi, S (2008). Mental Health and Stress among call center employees. *Journal of the Indian Academy of Applied Psychology*, *34*(2), 215-220.

Swartz, M. K. (2014). Critical theory as a framework for academic nursing practice. *Journal of Nursing Education*, *53*(5), 271.

Swanson, E. (2013). Boston Bombings Prompt Mixed Support for Increased Surveillance, HuffPost/YouGov Poll Finds. *Politic*s.

Tay, L., & Diener, E. (2011). Needs and subjective well-being around the world. *Journal of Personality and Social Psychology*, 101(2), 354-365. doi:http://dx.doi.org.contentproxy.phoenix.edu/10.1037/a0023779.

Taylor, B. (2010). Reflective practice for healthcare professionals: a practical guide. McGraw-Hill Education (UK).

Taylor, D. (2009). Normativity and normalization. Foucault Studies, (7), 45. doi:10.22439/fs.v0i7.2636.

Thielke, S., Harniss, M., Thompson, H., & Patel, S. (2012). Maslow's hierarchy of human needs and the adoption of health-related technologies for older adults. Ageing International, 37(4), 470. 10.1007/s12126-011-9121-4.

Thibeault, C. (2016). An Interpretation of Nurse–Patient Relationships in Inpatient Psychiatry: Understanding the Mindful Approach. *Global qualitative nursing research*, 3, 2333393616630465.

Thomas, S. P. (2005). Through the lens of Merleau-Ponty: Advancing the phenomenological approach to nursing research. *Nursing Philosophy*, *6*(1), 63-76.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigor within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388-396.

Townsend, M. (2014). *Psychiatric Nursing*. (9th ed.). F. A. Davis Company.

Trujillo, J. (2014). Time, temporality, and the scientific investigation of reality. Meta : *Research in Hermeneutics*, (2), 445-462.

Tuck, I., & Keels, M. C. (1992). Milieu Therapy: A Review of Development of This Concept and its Implicats for Psychiatric Nursing. *Issues in Mental Health Nursing, 13(1), 51-58.*

United States Court of Appeals - D.C Circuit (2015). FALLBROOK HOSPITAL CORPORATION V.. NATIONAL LABOR RELATIONS BOARD. Retrieved from https://www.cadc.uscourts.gov/internet/opinions.nsf/F34DF80E8B80A91585257E3F00517D12/$file/14-1056-1551461.pdf. December10, 2017.

Urban, A. M. (2014). Taken for granted: normalizing nurses' work in hospitals. *Nursing Inquiry*, 21(1), 69-78.

van Manen, M. (1990). *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy.* Althouse Press, Ontario.

Van Mourik, M. S., van Duijn, P. J., Moons, K. G., Bonten, M. J., & Lee, G. M. (2015). Accuracy of administrative data for surveillance of healthcare-associated infections: a systematic review. *BMJ Open, 5*(8), e008424.

Vorvoreanu, M & Botan, C. H (2001). Examining electronic surveillance in the workplace: A review of theoretical perspective and research findings. *Paper presented at the Conference of the International Communication Association, Acapulco, Mexico.*

Vygotsky, L.S. (1975). *Mind in Society*. U.S: Harvard College.

Warnke, G. (2011). The hermeneutic circle versus dialogue. *The Review of Metaphysics*, *65*(1), 91-112.

Watson, Nathan (2001) "The Private Workplace and the Proposed "Notice of Electronic Monitoring Act": Is "Notice" Enough?" Federal Communications Law Journal: Vol. 54: Iss. 1, Article 5.
Available at: http://www.repository.law.indiana.edu/fclj/vol54/iss1/5

Weick, K. E. (2002). Essai: real-time reflexivity: prods to reflection. Organization Studies, 23(6), 893-898.

West, J. P & Bowman, J. S. (2014).Electronic Surveillance at Work. *Administration & Society. 48*(5), 628 – 651. 10.1177/0095399714556502.

WFTV9 (2017, Nov 15).Mental health worker accused of sexually assaulting patient at Central Florida Behavioral Hospital. Retrieved from http://www.wftv.com/news/local/mental-health-worker-accused-of-sexually-assaulting-patient-at-central-florida-behavioral-hospital/648192338.

Whalen, T., & Gates, C. (2010). Watching the watchers: "voluntary monitoring" of InfoSec employees. *Information Management & Computer Security*, *18*(1), 14–25.

Williams, C. A. (2003). Police surveillance and the emergence of CCTV in the 1960s. *Crime Prevention & Community Safety, 5*(3), 27-37.

Williamson, K. (2002a). *Research methods for students, academics and professionals: Information management and systems* (2nd ed.). Wagga Wagga, NSW: Centre for Information Studies, Charles Sturt University.

Wiskow, C., Albreht, T., & De Pietro, C. (2010). How to create an attractive and supportive working environment for health professionals. *World Health Organization.*

WIVB4 (2016, March 2). Caught on Camera: ECMC's psychiatric patient's rampage. Buffalo, N.Y. Retrieved from http://wivb.com/investigative-story/caught-on-camera-ecmcs-psychiatric-patients-rampage/. November2, 2017.

Wood, A. M. (1998),"Omniscient organizations and bodily observations: electronic surveillance in the workplace," *International Journal of Sociology and Social Policy, 18*(5/6).

Wood, D. M., & Webster, C. W. R. (2009). Living in surveillance societies: The normalization of surveillance in Europe and the threat of Britain's bad example. *Journal of Contemporary European Research, 5*(2), 259-273.

Wright, N., & Losekoot, E. (2010). Interpretative research paradigms: points of difference. In ECRM2012-9th European Conference on Research Methods in Business Management: ECRM 2012 (pp. 416-422). *Academic Conferences Limited*.

Yang, J. H., & Yang, B. (2013). Nursing students' experiences with facilitator in problem-based learning class. *Asian Nursing Research*, 7(4), 198-204.

Appendix A
IRB Documents
Barry University

Barry University
Division of Academic Affairs

Institutional Review Board
11300 NE 2nd Avenue
Miami, FL 33161
P: 305.899.3020 or 1.800.756.6000, ext. 3020
F: 305.899.3026
www.barry.edu

Research with Human Subjects
Protocol Review

Date:	September 27, 2017
Protocol Number:	170807
Title:	"The Lived Experience of Registered Nurses Working in Mental Health under Surveillance."
Meeting Date:	September 2017
Researcher Name:	Mr. Rodney Wallace
Address:	13499 Biscayne Blvd. Apt 1701 North Miami, Florida 33181
Sponsor:	Claudette R. Chin, PhD, ARNP

Dear Mr. Wallace:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the convened IRB on September 27, 2017 have been made.

It is the IRB's judgment that the rights and welfare of the individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with requirements and that the potential benefits to participants and to others warrant the risks participants may choose to incur. You may, therefore, proceed with data collection.

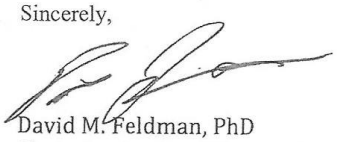
As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires on September 30, 2018. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with and IRB Application for Continuing Review (Progress Report) summarizing study results to date. The IRB will request a progress report from you approximately three months before the anniversary date of your current approval.

Ifyou have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Jasmine Trana at (305)899-3020 or send an e-mail to jtrana@barry.edu Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,



David M. Feldman, PhD
Chair, Institutional Review Board
Barry University
11300 NE 2nd Avenue
Miami Shores, FL 33161

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

***Appendix* B**
Barry University
Informed Consent Form

Your participation in a research project is requested. The title of the study is, "The Lived Experience of Nurses Working in the Mental Health under Surveillance." The research is being conducted by Rodney Wallace, RN, MSN/ED, a doctoral student in the College of Nursing and Health Sciences at Barry University. The researcher is seeking information that will be useful in the field of nursing. The study's purpose is to understand the lived experience of nurses working in the mental health unit under constant Closed Circuit Television Surveillance. Tape-recorded, face-to-face semi-structured interviews will be scheduled. The anticipated number of participants will be a maximum of 20 or until data saturation is reached. If you decide to participate in this research, you must meet the following criteria:

- Be a registered nurse with a Florida License for a minimum of two years
- Be a registered nurse who have at least two years working experience in a mental health unit under constant CCTV surveillance in South Florida
- Be a registered nurse who work a minimum of 24 hours per week performing direct patient care and hold a non-managerial or non-supervisory position
- Be a registered nurse who has access to a telephone.

If you decide to participate in this research, you will be asked to complete the following: a demographic questionnaire, which will take five minutes, and a 55 minute tape-recorded, face-to-face semi-structured interview to discuss your experience of working in mental health under constant CCTV. Your total time requirement for the completing demographic questionnaire and the interview and will be 60 minutes.

Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, there will be no penalty. There are no known benefits associated with this study, and there are no known risks associated with this study. As a token of appreciation for participating in the study, the researcher will give you a $20 Walmart gift card at the beginning of the interview after signing the consent. You may keep this even if you withdraw from this study.

As a research participant, information you provide will be held in confidence to the extent permitted by law. Any published results of the research will be presented in the aggregate and identified with pseudonym. Data will be kept in a locked file cabinet in the researcher's home-office and on a personal, password-protected computer that is accessible only by the researcher. The consent will be kept separate from the data, in a separated locked file cabinet in the researcher's home-office. Tape recordings will be destroyed by deleting the information 90 days after the recordings and transcriptions have been reviewed for clarification by the researcher. All data will be kept separate and personally secured in locked file cabinet in the researcher's home office for five years after completion of the study, and then indefinitely in a locked file cabinet in the researcher's home office.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Rodney Wallace ([redacted]; my supervisor Dr. Claudette R. Chin, at [redacted] or the Institutional Review Board point of contact, Estela Azevedo, at (305) 899-3021, email eazevedo@barry.edu. If you are satisfied with the information provided and are willing to participate in this research,

please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this study by Rodney Wallace and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this experiment.

_____	_____
Signature of Participant	Date
_____ _____	_____ _____
Researcher Date Witness	Date

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present).

***Appendix* C**
Barry University
Letter of Request for Access

Rodney Wallace, MSN/ED, RN
Date:

Name and Address of Professional Network Organization
Dear _____,

My name is Rodney Wallace, and I am a doctoral student at Barry University College of Nursing and Health Sciences, in Miami Shores, Florida. I am conducting a study entitled: *The Lived Experience of Registered Nurses Working in Mental Health under Surveillance.* The study is a partial fulfillment of my PhD dissertation requirements. The purpose of the hermeneutic phenomenological study is to understand the lived experience of nurses working in the mental health unit under constant CCTV surveillance.

This letter is to seek permission and assistance in gaining access to nurses during their attendance to meetings after approval by the Institutional Review Board (IRB) of Barry University in Miami Shores, Florida. I will be sending you the flyer that will be used to recruit potential participants to participate in this study. Recruitment flyers will handed out to prospective participants before and after meeting if permission granted. The participants that meet the inclusion criteria will be asked to consent to a tape-recorded, face-to-face semi-structured 60-minute interview that includes filling out a five-minute demographic questionnaire.

Participants will engage in the study voluntarily, and they can withdraw at any time without penalty. Each participant will be given a $20 Walmart gift card as a token of appreciation. The anticipated date to begin this study will be on September 1, 2017. I will comply with all the requirements of your establishment.

Please contact me at ([redacted] me at [redacted] for any questions or concerns. You may also contact my faculty sponsor, [redacted] at [redacted] or email [redacted] The IRB point of contact is Estela Azevedo who can be reached at (305) 899-3021 or email eazevedo@barry.edu. I look forward to your response at your earliest convenience.

Respectfully Yours,

_____
Rodney Wallace, MSN/ED, RN
Barry University, PhD Student

Appendix D
Barry University
Flyer for Recruitment of Sample

BARRY UNIVERSITY

Requesting Volunteers For Study

Are You an RN with a Florida License and meeting the Following Criteria?

- ✓ RN with a Florida License for a minimum of two years
- ✓ RN who has at least two years working experience in a mental health unit under constant CCTV surveillance in South Florida
- ✓ RN who works a minimum of 24 hours per week performing direct patient care and holds a non-managerial or non-supervisory position
- ✓ RN who has access to a telephone.

I am inviting you to participate in a study titled: The Lived Experience of Registered Nurses Working in Mental Health under Surveillance.

What to Expect:

- ✓ You will participate in one tape-recorded, face-to-face, semi-structured interview lasting 55 minutes
- ✓ Fill out a demographic form for 5 minutes (total time 60 minutes)
- ✓ You will receive a token of appreciation of $20 Walmart gift card

Contact Information:

Researcher: [redacted]

Faculty: [redacted]

Institutional Review Board Contact: Estela Azevedo Tel: 305-899-3021 Email: eazevedo@barry.edu

[redacted]

***Appendix* E**
Barry University
Demographic Questionnaire

Instructions: Please fill in or circle your response for each question.

Date / Time: _____

Pseudonym: _____

1. What is your gender? Male, Female, Other----------
2. What is your current age?

   20-29

   30-39

   40-49

   50- 59

   60 or more

   Prefer not to disclose
3. What is your educational level?

   Diploma

   Associates

   Bachelors

   Graduate- MSN, DNP, PhD
4. How long have you been an RN? _____
5. What is your area of specialty in nursing? _____
6. How long have you been working in a mental health unit under constant CCTV surveillance? _____

Appendix F
Barry University
Interview Questions

Primary Question: What does working under constant closed circuit television surveillance in the mental health unit mean to you?

Follow up questions:

What does the surveillance camera symbolize to you?

What aspect of your work reminds you the most that you are under surveillance?

How does surveillance contribute to your work positively or negatively?

Related to your role as a nurse in the unit, what difference would it make if you did not work under surveillance?

Identify and explain a specific incident, or situation that stands out, and captures for you what it means to be under surveillance.

Any additional thoughts would like to share?

The researcher will ask follow up clarifying questions if necessary.

***Appendix* G**
Barry University
Third Party Confidentiality Form

Confidentiality Agreement

As a member of the research team investigating _____,
I understand that I will have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my obligation to maintain confidentiality and agree to the following:

I understand that names and any other identifying information about study participants are completely confidential.

I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study

I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information unless specifically authorized to do so by office protocol or by a supervisor acting in response to applicable protocol or court order, or otherwise, as required by law.

I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.

I understand that a breach of confidentiality may be grounds for disciplinary action, and may include termination of employment.

I agree to notify my supervisor immediately should I become aware of an actual breach of confidentiality or situation which could potentially result in a breach, whether this be on my part or on the part of another person.

Signature Date Printed Name

Signature Date Printed Name

Appendix H
Barry University
Curriculum Vitae

Rodney Wallace, MSN/ED, RN

EDUCATION

2018	**Doctor of Philosophy in Nursing (Student)**
	Barry University
	Miami, FL
2012	**Masters of Science in Nursing/Education**
	University of Phoenix
	Phoenix, AZ
2010	**Bachelor Science in Nursing**
	University of Phoenix,
	Phoenix, AZ
1980	**Diploma in Nursing**
	Kingston School of Nursing
	Kingston, Jamaica

WORK EXPERIENCE

2006 – Current	**Charge Nurse, Behavioral Health Nursing**
	Aventura Hospital & Medical Center
	Aventura, FL
2014 – 2016	**Adjunct Nursing Faculty**
	Miami-Dade College of Nursing
	Miami, FL
2014 – Current	**Adjunct Nursing Faculty**
	Barry University

	Miami, FL
1989 – 2006	**Charge Nurse, Behavioral Health Nursing**
	University of Miami
	Miami, FL
1987 – 1989	**Staff Nurse, Jewish Memorial Hospital & Rehabilitation Center**
	Roxbury, MA
1980 – 1987	**Staff Nurse, Behavioral Health Nursing**
	Bellevue Hospital
	Kingston, Jamaica