Mental health nurse identity at the interface of psychological therapies: Commencing the journey toward emotionally intelligent nurse training

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A Dissertation submitted by

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ABSTRACT

With the expectation that MHNs now embrace psychological therapies, as well as new roles in prescribing and mental health law, a strong need exists for a discipline specific response to the inherent challenges of assuming these new responsibilities effectively. However, whether MHNs now engaged in these roles are identifying themselves as nurses or aligning themselves with the medical, social and psychological professions who historically have delivered these interventions is unknown. This study sought to offer some constructive contributions to the discourses framing the challenges related to psychological therapies through representations of the voices of MHNs situated at the interface of this role expansion and possible identity diffusion.

The study was conceptually framed by social constructionism, a theory that places high value on the power of social discourses both to inform and to form current and future realities. A qualitative research orientation with a direct phenomenological method was adopted. Data were collected through in-depth interview, and then thematically analysed with the support of NVivo 7 software.

Key findings commenced with clarification of the lifeworld in which MHNs are engaging with talk based therapies. This lifeworld was themed with low perceived worth, obstacles to success and uncertainty. Despite these challenges distinctive MHN contributions to delivering talk based therapies emerged. Most distinctive was a generic expanse of capabilities, argued as being a specialist characteristic of MHNs. Other themes included MHNs utilising their personal selves, having a

profound service user focus and displaying innovations in delivering talk based therapies. Additional themes were that MHNs spent elongated times periods with users, deployed everyday attitudes and had transferable skills to engage effectively with delivering talk based therapies.

A powerful resonance was identified between emotional intelligence and the participants' constructions of MHN identity. This resonance was also evident in the literature and policies examined within this study. The emotionally intelligent aspect of MHN identity was shown to be at least partially performed before entering the profession, and powerfully influenced by work based learning and formal education.

CERTIFICATION OF DISSERTATION

I certify that the ideas, experimental work, results, analyses, software and conclusions reported in this dissertation are entirely my own effort, except where otherwise acknowledged. I also certify that the work is original and has not been previously submitted for any other award, except where otherwise acknowledged.

_____ _____

Signature of Candidate Date

ENDORSEMENT

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Signature of Supervisor/s Date

_____ _____

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GLOSSARY OF TERMS

Community settings: This term is used in this study to refer to any non-hospital or institution based site where mental health care is offered.

CPN: Community psychiatric nurse.

In-patient settings: This term is used within this study to refer to any hospital or institution based site where mental health care is offered.

IPCU: Intensive psychiatric care unit.

National Health Service (NHS): The British organisation responsible for the delivery of health services, free at the point of entry, within the United Kingdom.

Nursing Midwifery Council (NMC): The UK regulatory body for nursing with primary responsibilities for maintaining the professional register and maintaining professional standards.

LIST OF RELATED PUBLICATIONS AND PRESENTATIONS

Barrett, P., & Hurley, J. (2007). 'Being with' without becoming a technician of the mind: The immediate and future challenge for mental health nursing. In *1st RCN international mental health nursing conference, 7th & 8th February* (pp. 38-39). Cardiff, United Kingdom: Cardiff City Hall.

Hurley, J. (2008). Invade your own privacy. *International Journal of Pedagogies and Learning*, *4*(1), 5-13.

Hurley, J. (2008, November 5-9). *Mental health nurse identity: A social construction in the United Kingdom.* Paper presented at the European Festival of Psychiatric Nursing conference.

Hurley, J. (2008). The necessity and barriers for enhancing emotionally intelligent mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 15*(5), 379-385.

Hurley, J. (2009). Mental health nurse identity: Responding to Crawford et al. *International Journal of Nursing Studies, 46*(2), 291-293.

Hurley, J., & Barrett, P. (2006, July 17-18). *A call for the messy pottage of therapeutic pluralism within mental health nursing.* Paper presented at the national mental health nursing conference, Robinson College, Cambridge.

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Hurley, J., & Linsley, P. (2006). Proposed changes to the Mental Health Act of England and Wales: Research indicating future educational and training needs for mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 13*(1), 48-54.

Hurley, J., & Linsley, P. (2007). Changes to the MHA: An opportunity for professional growth or a missed opportunity. *Journal of Psychiatric and Mental Health Nursing, 14*(6), 535-541.

Hurley, J., & Linsley, P. (2007, October). *The application of emotional intelligence to mental health nursing.* Paper presented at the 33rd ANZCMHN international conference, Cairns, Qld.

Hurley, J., & Mears, A. (2007, September 2-4). *Which me am I today: The complexities of professional identity.* Paper presented at the *11th* international philosophy of nursing conference, Westpark Conference Centre, Dundee.

Hurley, J., & Ramsay, M. (2008). Mental health nursing: Sleep walking toward a chasm of non-existence? *Mental Health Practice, 11*(10), 14-17.

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Hurley, J., & Rankin, R. (2008). As mental health nursing roles expand is education expanding mental health nurses: An emotionally intelligent view toward preparation for psychological therapies and relatedness. *Nursing Inquiry, 15*(3)199-205.

CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Chapter introduction

Mental health nurses (MHNs) in the United Kingdom (UK) represent the largest professional group caring for people who are experiencing mental health difficulties. This active caring role has roots stretching back to the Victorian era in Britain, with mental health nursing roles and identities gradually evolving over time (Chatterton, 2004). Despite this numerical and historical presence, the roles and professional identities of mental health nurses have been externally influenced, historically from the psychiatric profession and increasingly from policy sources and disciplines such as psychology and social work (Hurley & Ramsay, 2008; Royal College of Psychiatrists, 2008). Arguably, the degree of this influence supersedes that of the mental health nursing profession itself, potentially rendering it being seen as a large, malleable workforce to meet the changing needs of all other stakeholders in mental health service provision. Contextually, mental health nursing, as with wider health service provision, is facing a future exacerbation of workforce shortages whilst simultaneously service demand is expected to expand (Forster Committee, 2005; Royal College of Nursing, 2005). Responses to these challenges must incorporate the voices and views of MHNs not only to ensure an effective response to new roles and responsibilities, but also to generate an internally articulated future for mental health nursing.

Within the text of this study the terms ‘MHN identity’ and ‘MHN identities’ are used. Indeed, such subjectivities can be contended as underpinning the tensions within mental health nursing in the UK, with the multiplicity of MHN identities being arguably viewed as problematic. Within the context of the study the term ‘identity’ is assumed as being a multiple, multi-faceted and evolving construct rather than one that is fixed. Even the term ‘MHN’ can be argued as being a homogeneous and limiting label with not only a wide variation on specialities in mental health nursing, but also individual interpretations of what it means to be a MHN. Within this study the term ‘MHN’ is used to refer to mental health nurses within the United Kingdom, unless otherwise stated.

As I elaborate throughout this study, mental health nursing is currently the focus of a raft of policies and role expansion, all impacting upon the identities of MHNs. The profession recently underwent extensive Chief Nursing Officer reviews in Scotland, England and Wales (Department of Health, 2006a, 2006b; Scottish Executive, 2006a). The outcomes of these reviews are far reaching, with the future roles of MHNs being increased in both the breadth and the depth of expected service quality. Of particular significance to this study are the following:

- Inter- and intra-personal relating is foundational to mental health nursing, with the development of capabilities to enhance relating being identified as a core role of nurse education.
- The expected values, roles and attitudes of MHNs, all sources of identity markers, are influenced from outside the MHN profession.

- The range of roles for MHNs is highly inclusive, stretching from health promotion to acute serious illness, all in the absence of a clearly articulated core role or professional identity.

Additional policies emanating out of the UK that impact upon mental health nursing and that are relevant to this study direct MHNs toward increasing the delivery of psychological therapies (Department of Health, 2008; Mental Health Foundation, 2006; National Education Scotland, 2008). Key points from these policies include that all mental health staffs are expected to have basic psychological literacy and that alterations to MHN education and training programmes are required. At this point it is worth noting that the terms 'psychological therapies' and 'talk based therapies' are synonymous within the context of this study, and are used to refer to an all inclusive range of psycho-therapeutic interventions. For the purposes of this study, psychological or talk based therapies are terms used to describe the structured utilisation of therapeutic verbal and non verbal communication skills by a trained professional to treat mental and emotional distress. There is further clarification on what talk based therapies are in this chapter and Chapter 2.

While these points link mental health nursing to psychological therapies, additional policies simultaneously widen expectations of MHNs beyond this boundary. In outlining the best practice competencies and capabilities of MHNs, the Department of Health (2006b, 2008) articulates a massive array of specialist knowledge and performance competencies which are expanded upon in Chapter 2.

Arguably one point of clarity that does exist amidst this complex policy picture is that the capabilities and competencies required of MHNs within these documents have a resonance with emotional intelligence (EI). This study of 25 MHNs' experiences and perceptions of their professional identity, unique contributions to talk based therapies and perceived links with EI has sought to incorporate the views and voices of MHNs about the impact of policy implementation and educational provision on new mental health nursing roles.

1.2 Justification of the study

MHNs in the UK are currently occupying a challenging position. This positioning is one that offers a view of expanding roles and responsibilities in both mental health legislation and the delivery of psychological therapies. Furthermore, expectations of improved quality of service delivery are also being increasingly expressed (Department of Health, 2006a). Whilst the view from this position is not without challenge and internal discipline dispute, such role expansion can offer growing professional influence and respect from other health disciplines, as well as the wider public. Conversely, if the training, education and strategic enactment for new MHN roles are formulated and delivered from predominantly non-MHN axiomatic and epistemological stances, already opaque MHN identities can be further diminished.

With the expectation that MHNs now embrace psychological therapies, a strong need exists for a discipline specific response to the inherent challenges of achieving this outcome. However, whether MHNs engaged in those roles are identifying

themselves as nurses rather than therapists is unknown, as is the impact of any fundamental shift in their professional identity. This study sought to offer some constructive contributions to the discourses framing these challenges through representations of the voices of MHNs situated at the interface of role expansion and possible identity diffusion. With the recent Chief Nursing Officer's review of MHNs (Department of Health, 2006a, 2006b; Scottish Executive, 2006a) being heavily informed by government policy documents and supported by other government policies, the views of these MHNs, including those responsible for delivering relevant education and training programs, are left largely unspoken. This study offers a medium for some of these views to be heard, consequently allowing implications for learning to be potentially incorporated into future education and training.

Primarily this study has been focused on exploring MHN identities through attempting to identify distinctive nursing contributions to the role of delivering psychological therapies. Consequently, the study has also made a contribution to the debate on what constitutes, differentiates and therefore ultimately defines the profession (Clarke, 2006). The study explored this MHN–therapies interface within the context of EI, in itself a complex concept. It was apparent from the data arising from the literature review, analysis of policy documents and participant interviews that, while shared themes exist between mental health nursing and EI, little attention has been paid to this relationship (Hurley, 2008a).

There has been minimal impact by MHN education and training providers in leading the delivery of psychological therapies training for MHNs. Arguably, English policy which is highly restrictive of who can deliver such training, is influencing this apparent lack of initiative. Consequently, there is potentially a vacuum out of which other disciplines may assume training leadership, an issue expanded on later in this study (Department of Health, 2008). This study offers a launching platform from which to commence an evidence based educative and training response from the perspective of those either experienced in delivering, or expected to deliver, psychological therapies. Consequently, the study provides a rare focus on those delivering therapies rather than on the efficacy levels of differing therapy approaches. This attention to MHNs firmly places data arising from the study as being contextualised in the lifeworlds of those MHNs. The study also demonstrates strong links among education, training and practice through drawing on the experiences of MHNs to commence informing curricula, which will potentially then loop back into improved practice for those with mental health problems. Thus, at least a beginning point to populating MHN influenced curricula, as well as adding to the knowledge base of how to incorporate EI into a learning framework within nurse education, can be achieved.

1.3 Research questions

Three research questions were articulated to guide this exploration of the lived experiences of MHNs at the interface of delivery psychological therapies:

1. What, if any, are the perceived unique qualities, abilities and behaviours of MHNs engaged in the delivery of psychological therapies in the United Kingdom?

This initial research question sought to explore what MHNs may add to the delivery of psychological therapies. The previously mentioned policy documents focus almost exclusively upon what educational and training inputs MHNs will require, consequently minimising both the current and the future worth of the nursing profession. Searching for MHN contributions to providing psychological therapies not only highlighted the value of nursing service delivery, but also contributed to the search for MHN identities. Additionally, through MHN perceptions of their difference from other mental health professionals and other nurses having been sought, a shift of focus toward internal rather than external identity discourse was achieved.

2. What, if any, are the thematic resonances of MHN experiences with the construct of Emotional Intelligence?

The second research question sought to establish if there is any resonance between EI and mental health nursing engagement with delivering psychological therapies. While searching for such resonance was undertaken throughout the entirety of the literature review and data collection processes, participants were also directly asked to contrast their capabilities with Goleman's' framework of emotional competencies (Consortium for Research on Emotional Intelligence in Organisations, 1998). This framework is explored and discussed at length in Chapter 2 of this study.

It is of interest not only to establish whether such resonance exists, but also to compare and contrast the perceptions of MHNs with the focus of policy toward which EI capabilities may be integral to deliver psychological therapies. Additionally, through seeking a deeper understanding of how participants developed their own perceived EI capabilities, the beginnings of forming an educational and training response to MHNs undertaking psychological therapy roles can be established.

3. What journeys through structures of social rules and processes did MHNs undertake to reach their current identities, both personally and professionally?

Research question three sought to gain insight into the processes by which MHNs form and perform their professional identities. The purpose of posing this question was multiple. As is evident from the literature review in Chapter 2 and theoretical discussions in Chapter 3, mental health nursing has a poorly articulated professional identity, necessitating clarification from MHNs. Highlighting the journeys that MHNs have undertaken to develop their identities promotes such an articulation. Additionally, making the influences upon identity formation more explicit maximises the opportunity for incorporating such influences into education and training processes, which potentially enhances the effectiveness of MHNs engaging with delivering psychological therapies. In turn, this enhanced effectiveness may increase the perceived worth of mental health nursing, consequently contributing to MHNs continuing to identify with mental health nursing rather than with another discipline.

1.4 Social constructionism: A brief introduction

As is discussed extensively in Chapter 3 and applied to the research methodology in Chapter 4, social constructionism is the conceptual framework adopted for this study. It is worthwhile to highlight briefly the key elements of social constructionism at this early stage to strengthen the justification of the study and the research questions stated above, as well as the literature review in Chapter 2. Social constructionism proposes that discourse within socially enacted relationships formulates the very fabric of meaning (Berger & Luckmann, 1966, p. 13). Focusing upon social interaction as the point of this meaning generation assigns a central position to relationships. In rejecting the presence of a single absolute truth, social constructionism offers a view that a multiplicity of truths abounds but that through power, tradition and privilege some discourses and hence meanings exercise authority over others. Where such imbalances of power can be negated, social constructionism highlights that, as we describe and represent through language within relationships, traditions are both sustained and evolved. Constructionists also place high value on reflexivity that questions premises and that seeks empathic understandings of others' positions of reality and taken for granted positions to evaluate outcomes from multiple other positions (Gergen, 1999, pp. 47-49). The adoption of such a lens through which to view the findings of this study, as well as the literature and policies relevant to the topic under investigation, enables the presentation of the voices of a range of stakeholders in mental health nursing engaging with psychological therapies. Additionally, through the facilitation of the voices of the MHN participants in generating their own professional identities, a

counternarrative is essayed in relation to the texts and descriptions of MHNs derived from policy alone.

1.5 Overview of the dissertation

While this chapter introduces the study, subsequent chapters explore and expand upon the key elements of the topic of investigation. Chapter 2 offers an extensive review of the literature to provide an in-depth critical review of important constructs in the study. In examining mental health nursing's engagement with psychological therapies, MHN identities and EI, Chapter 2 delineates the context of the study, that of global nursing workforce shortages and expanding expectations of MHN capabilities and roles. Mental health nurse education and training provision is also examined, particularly in relation to preparing nurses for psychological therapies and EI capabilities. Showing that these have traditionally been areas that nurse education has struggled to excel in reveals the depth of the challenge to prepare MHNs successfully for these expanding roles. Chapter 2 also addresses the range of available psychological therapies, and then examines the construct of EI. EI capabilities are argued as being highly congruent with multiple stakeholders' expectations of MHN capabilities, and as being amenable to development through education and training. Finally, Chapter2 provides an analysis of recent and relevant policies and documents that impact upon MHNs, psychological therapies and MHN identities. Again, connections are argued as being evident between desired MHN capabilities and those of EI. It is also arguably apparent from this review of the policies that the MHNs have been in the background of forming these policies and the future roles that impact upon their own professional identities.

Chapter 3 presents a deeper examination of the key theoretical constructs of this study, namely those of social constructionism, identity and mental health nursing, as well as educational theories relevant to the expanding roles of MHNs. Social constructionism is offered as a highly congruent lens through which to view the study owing to its emphasis on meaning generation at the point of social contact, a point of importance to both mental health nursing and psychological therapies. The theoretical underpinnings of social constructionism are then critically analysed and applied to other key constructs of the study. Identity, central to the study, is also critically examined in Chapter 3 and applied to mental health nursing. This examination shows that MHNs blend their personal and professional identities into their work roles, that MHN identity lacks clarity and that MHN role expansion challenges current understandings of MHN identity. The chapter moves on to explore the epistemological underpinnings of mental health nursing and concludes with an analysis of heutagogy as an appropriate educational model to apply to MHNs and EI. Whilst expanded upon in Chapter 3, heutagogy can be understood as an emerging and hence still contestable self-determined approach to learning, which incorporates the unpredictability of how and when learning needs arise (Hase & Kenyon, 1999).

Chapter 4 briefly revisits social constructionism as a research paradigm, paying particular attention to the congruent relationship that constructionism holds with both the topic under investigation and the qualitative research orientation adopted for this study. This research orientation is used to frame an examination of

qualitative approaches generally, and then focuses upon phenomenology, direct phenomenology and the research techniques employed to enact direct phenomenology. Issues of research rigour and trustworthiness are then explored through discussing issues of credibility, transferability, confirmability and dependability. Finally in Chapter 4 the ethics and politics of the study are explored, with a focus on the power differentials existing within the research contexts.

The final chapters of this dissertation offer the reader an opportunity to examine the findings and implications of the research process described in Chapter 4. Reporting these findings commences in Chapter 5 where the MHN lifeworld in which the other findings are contextually placed is described. Subsequent chapters are then dedicated to addressing each of the three research questions. Finally, Chapter 9 summarises the main findings, identifies key points of learning and highlights areas for future possible research.

1.6 A personal positioning

While this study was geographically situated in the UK owing to my current residence there, potential exists for findings to have at least some potential interest to other cultural contexts. Having worked in Australia, England and Scotland I have experienced more commonalities than variances in mental health nurse roles, identities and approaches across these international settings. Certainly, given that I have worked in both Australia and the UK in psychiatric crisis and psychological therapy services for many years, this study has for me a sense of natural progression.

This progression continues in that my own journey into the field of education and training for MHNs is also crucial to the study. With MHN identity being central to the study, I have experienced a growing sense of disquiet that, despite working as a MHN for 21 years, and in common with many other MHNs, I struggle to articulate clearly my professional identity. Indeed, my own positioning in the study is that of training as a gestalt psychotherapist in Sydney and then undertaking a degree in counselling. These qualifications added significantly to my own perceptions of being able to help those with mental health problems, underpinned my career progression and attracted what I would describe as more credibility from other disciplines. Despite these qualifications, I have always called and identified myself as a MHN, whatever that is or means.

These work and educational experiences can be seen woven throughout the fabric of this study. The research design that included social constructionism, direct phenomenology and in-depth interviews was a partial product of gestalt epistemological curiosity encapsulated in the question of "What is going on here?" The interview process utilised to collect data drew on counselling and communication micro-skills and reflected the partially shared journey of therapy and phenomenological research to uncover hidden personal meanings. My interest in undertaking this research has actually grown throughout the progress of the study, a growth fuelled by an increasing understanding of the impact of discourse upon agency, change and power, an understanding clarified by looking through the lens of social constructionism.

The policy drivers in the UK that seek to move MHNs toward psychological therapies and to shape the underpinning values of the profession offer what I perceive to be an excellent opportunity for MHNs to develop their practice. Yet witnessing the processes of such changes being undertaken with arguably minimal MHN involvement has highlighted the hegemonic relationships in which MHNs exist within service delivery and policy formation. Also witnessing the growing influence of other professions to claim ownership of and to direct the work of MHNs within the context of talk based therapies motivated a response from me to clarify who MHNs are professionally, and what MHNs do from the perspective of MHNs.

1.7 Chapter summary

This first chapter introduced the main thrust of this study as being directed toward MHN identity within the context of policy initiatives to assume greater participation in delivering psychological therapies. Such role expansion not only offers opportunities for professional development, but also challenges the future of the MHN profession. Chapter 2 commences an in-depth examination of both literature and policy that demonstrates the educational and training considerations required to integrate successfully mental health nursing and psychological therapies.

CHAPTER 2: THE CONTEXT OF THE STUDY

2.1 Chapter introduction

As evident from the research questions detailed in Chapter 1, this study examines MHN identities within the context of psychological therapies. However, this expansion of traditional MHN roles does not occur in isolation. A wider view of connected issues and events is therefore required to gain a broad understanding of this topic of investigation. This wider view shows that this period of time is one of immense policy driven change and consequently challenge for MHN clinicians, as well as the educators and trainers responsible for preparing MHNs for new roles in the UK.

To provide a context for both this study and its key constructs, a brief overview of the pilot study to this research commences this chapter. While brief, the pilot study demonstrated that MHN role expansion and the consequent need for education and training may be associated with EI. An in-depth critical review of both literature and relevant policies is then undertaken. This review of the literature and policy highlights global nursing workforce shortage pressures generating the need for both expanding MHN roles and increasing the flexibility of the nursing workforce. The role of education and training as the primary vehicles through which these workforce changes are envisioned to be carried by is also critically discussed. Consequently, an overview of MHN education and training in the UK is offered.

The literature highlighting the difficult relationship that mental health nursing has had with delivering psychological therapies is also reviewed. This focus upon therapies shows that the breadth of available therapies offers a range of responses to varied service users' needs, as well as reflecting a significant array of values and assumptions about reality. Cognitive Behavioural Therapy (CBT) is argued as being offered a privileged position through Department of Health (2008) policy, and the difficulties associated with MHNs adopting mono-therapy approaches and principles are consequently explored. Regardless of therapy approach, the literature review on EI highlights its relationships with mental health nursing, talk based therapies and helping relationships.

It is also argued that current policy and other documents related to mental health nursing reflect the capabilities and competencies of EI. In the critical review of recent policy and other relevant grey literature related to this study, the drive for influencing EI capabilities of MHNs becomes increasingly clear. The critical review of the grey literature also identifies a range of other key issues related to this study, as well as emergent themes which are then synthesised into a construction of what mental health nursing is from this policy based perspective. MHNs are presented as having minimal influence upon these constructions of their identities. Through highlighting both the impact of these policies and the muting of MHN voices in forming and influencing their current and future identities, it is hoped that the worth of this study that places the voices of MHNs at the foreground will be heightened.

2.2 The pilot study: Understanding the issues

The pilot study to this research was a qualitative study focused upon role expansion for MHNs in England and Wales who have been recently empowered to enact Mental Health Act legislation (Hurley & Linsley, 2005, 2006). The pilot study had the aim of seeking a better understanding of the impact that enacting mental health law may have had upon the therapeutic relationship. The study consisted of questionnaires and interviews of staffs from a health trust in England. 22 staff returned questionnaires with 8 of those indicating a willingness to be interviewed.

While paying attention to the possible impact of assuming Mental Health Act roles on the therapeutic relationship, this earlier study raised questions surrounding EI, MHN identity, and education and training for these new responsibilities. With drivers for MHNs to assume these Mental Health Act roles arising from sources that are external to MHN clinicians, stemming instead from staff shortages among the existing professional groups assuming those roles, resonance exists with underlying themes in this study. The pilot study, which adopted a similar design to this study through utilising interviews and thematic analysis, identified the following relevant themes from eight participants in 2005:

1. Relationship

Findings from the interview data suggested that the therapeutic relationship is affected through applying Mental Health Act legislation within community settings. However, the nature of the impact was directed at achieving user centred benefits and relationship building. All respondents reported that proactive intervention was

required to avoid a negative impact upon the therapeutic relationship and that in turn potentially beneficial changes to the relationship were achieved. Collectively respondents identified honesty, communication and listening skills, an established trusting relationship, individual user personality, non-judgemental approaches and maintaining a relationship as the building blocks of the quality of the pre-existing relationship.

2. Skills and knowledge

The most frequently reported theme in the data obtained was that of the required skills and knowledge to ensure a high quality user centred care package as opposed to custodial and punitive responses. Participants reported that advanced skills, gleaned from either practice or education were important to devise and maintain alternatives to sectioning service users under mental health law.

3. Emotion

An emotional strand arose from the data. Keywords expressed by all respondents within the context of considering restrictive care were those of hostility and emotional challenge. Five respondents identified conflict among users, carers and other professionals and the burden of responsibility as being significant within this role. Three respondents identified stress and anxiety in undertaking this responsibility, with loneliness also being expressed. All respondents communicated an emotional component across a broad spectrum.

4. User centeredness

Unanimously, considerations of restrictive care were expressed within the context of maintaining a client centred, needs based approach. Participants identified that their actions and hence interventions under mental health law were entirely driven by the needs of the service user and those caring for them (Hurley & Linsley, 2005, 2006).

It is evident from the brief synopsis above and the preceding outline describing this study that links and commonalities exist between the new roles of MHNs engaging with the Mental Health Act and new roles with psychological therapies. As expanded upon later in this chapter, capabilities such as communication skills, relationship formation and other awareness, as well as emotional self-management and utilising complex and creative thinking, all pertain to EI. It is also of significance that future training for Mental Health Act roles is based heavily upon current programs directed solely at social workers to ensure a non-medical perspective (Department of Health, 2006c). While evidence demonstrating medical paternity over nursing exits in abundance, nursing is progressively adopting more independent roles and values (Torjuul & Sorlie, 2006). Training could incorporate nursing axioms as being as non-medical as those of social work, whilst also reflecting the shared values and the experience that social work has in this field (Hurley & Linsley, 2007a). Additionally, nursing has a growing body of knowledge and established skills, particularly within the context of the therapeutic relationship, yet these are effectively dismissed as not being worthy of contribution to education and training for such roles.

Both changes to mental health law and the drives to assume roles in talk based therapies clearly demonstrate how understandings of what mental health is change in response to the influence of policy and politics. As this study discusses expanding roles for MHNs there is worth in briefly identifying what current roles are. MHNs represent the largest single mental health profession in the UK, and while they are increasingly occupying community based roles, MHNs still predominantly work within in-patient settings (Department of Health, 2006a). Typical nursing roles include medication management, assessment of mental health need and long term management of users with serious mental health issues within community settings. In more recent times, and in line with implementation of increasingly innovative services, MHNs will also be responding to those in crisis, engage in non-medical prescribing and lead assertive community care. MHNs will also have physical health care concerns as well as intervening on social and psychological levels (Department of Health, 2006a). These multifarious roles highlight not only the fluid nature of MHN identity, but also that the impact of policy, service user expectations and expanding knowledge on mental health makes this identity problematic. These issues are expanded upon in Chapter3.

The influence of education and training, which often responds to the above influences, on professional identity formation is important. As is expanded upon in Chapter 3 and Chapter 4, this study adopts a framework of social constructionism that identifies the central role of discourse within social settings in creating shared reality meanings (Berger & Luckmann, 1966, p. 13). Exclusion of nurse based discourse will inevitably further diminish MHN identity. Finally, MHNs who assume

Mental Health Act roles are not identified as nurses but as Mental Health Officers, potentially distancing them further from their professional identity. Nurses who assume roles in psychological therapies potentially face identical challenges through being guided toward education and training grounded in the psychology discipline and through having multiple professional titles.

The rising call for MHNs to expand their roles in talk based therapies originates from primarily political and Department of Health sources (Department of Health, 2007, 2008; Layard, 2005; National Education Scotland, 2008). Documentary supports from these calls either were drawn almost exclusively from within their own department (Barker, 2006) or addressed the urgency for assuming the roles in terms of economic rationalisation. A political dimension is woven throughout the proposed role expansion, with links being made between MHNs delivering therapies and fewer persons receiving state benefits for anxiety and depressive conditions that in turn will also increase tax revenue through these people re-joining the workforce (Layard, 2005).

This political dimension of discussing nursing roles exists within the context of longstanding political passivity by the nursing profession (Robinson, 1991). It is important to clarify at this juncture that there is no published mental health nursing literature resisting calls for this role expansion, nor is my own positioning against such progressive change. Ultimately, expanding the delivery of psychological therapies is for the benefit of the consumers of services. Rather, at issue is that mental health nursing can influence the change agenda and the discourses being

undertaken that shape its future identities as MHNs engage more intensely with talk based therapies.

Psychology and medical disciplines, as well as risk adverse health bureaucracies, are heavily bound to empirically based interventions. Consequently, training for psychological therapies concentrates almost exclusively on CBT (Department of Health, 2008), with its own set of axioms and reality assumptions, at least partially incongruent with many MHN ones (Hurley, Barrett & Reet, 2006). Again, as with Mental Health Act roles, nurses already engaging in CBT can be situated in psychology departments and have non-nursing titles. The impact of this is significant in terms of identity. As identity is influenced within social action and settings, MHNs seeking new roles, responsibilities and challenges as well as knowledge and skills may be effectively moved out of the profession, not just physically, but also through the perceptions of others and the individual MHN (Berger & Luckmann, 1966, p. 118). The perceived worth of being a MHN is consequently potentially diminished as those with more valued psychological therapy skills are assigned to other disciplines, leaving mental health nursing associated with passive and custodial roles alone.

The pilot study also identified themes about knowledge and skills as well as the emotional burden associated with assuming increasingly complex and demanding roles. This draws us to two questions inherent within the research questions in this study. What do MHNs have to offer to the role of psychological therapies? How should MHNs be prepared for assuming such roles? The first of these two questions

immediately invites exploration of MHN identities while the second offers potential for the integration of EI into knowledge and skills development, as well as informing MHN identities. These constructs are critically explored in the following sections of this chapter as well as in Chapter 3.

2.3 Literature review

2.3.1 Workforce issues

In terms of gaining an understanding of the drivers behind role expansion for mental health nursing and the challenges facing the profession, a view that moves beyond the UK is required. This view shows a potential global shortage of nursing staffs with fewer entrants over the past 20 years, and up to half of the current nursing workforce being eligible for retirement in the next decade across Australia, the UK and the USA, as well as Canada (Forster Committee, 2005; Health Resources and Services Administration, 2002; Royal College of Nursing, 2005). Elsom, Happell and Manias (2009) highlight that these shortages coincide with nurses assuming additional roles such as nurse prescribing and ordering diagnostic testing.

In searching for reasons for this shortage in a UK context, Levenson (2000) highlighted a variety of factors, including wider career options for women and the perceived low status of nursing as an academic pursuit. Of those who commence nurse training, significant percentages drop out, with reported attrition rates in the UK being around a quarter of all entrants (Scottish Executive, 2005). Other possible reasons for this workforce shortage include a diminishing vocational attitude toward employment (White, 2002), generational intolerance to inequality in

employment conditions and an increasing preparedness to change professions over a lifetime (Cowin & Jacobsson, 2003). Additionally, the hospital work environment characterised by stress, uncertainty and increasing responsibility can be seen as less appealing than better paid and less personally demanding occupations. When considered in the context of nurses' perceptions of being undervalued and lacking opportunities for career progression, it is unsurprising that many of those who do qualify as nurses also quickly leave the profession (Levenson, 2000).

These influences, while pertaining to all nursing branches, have an additional impact upon mental health nursing. With a nursing shortage that is global and across all branches, an obvious human resources response is to have fewer nurses being more capable of undertaking wider roles (Scottish Executive, 2006a, 2006b). Hence, generic training for nurses offers the potential for a flexible workforce in the future, while expanding the roles and capabilities of current MHNs addresses the current demands upon service delivery. When this is supplemented by allocating less technically demanding MHN roles to alternative human resources, a plausible response to nursing shortages can be argued.

While the move by the Nursing Midwifery Council (NMC) to switch to generic training for 2015 was rejected in a recent UK wide survey of nurses, the original proposal document appeared to support abolishing branch training. With support for generic training coming from the national body regulating the nursing profession the likelihood of alternative attempts to increase generic education remains (Nursing Midwifery Council, 2007). Appendices A and B support such a

view by showing nurse leaders and the NMC continuing to construct dialogues that confront a future MHN identity. Appendix A shows a UK nurse leader debate topic on abolishing the MHN as a mental health practitioner while Appendix B, an NMC document, describes the UK wide survey result as not being a vote and the survey result as being unfairly biased toward smaller nursing branches.

2.3.2 Nurse education and training

Given the study's focus on MHN identity and the preparation of MHNs to undertake psychological therapies within UK settings, an examination of issues surrounding possible educative avenues to enhance these is indicated. Within a UK context of curriculum design a number of overarching principles must be initially considered.

The first of these is that MHN curriculum must not only be developed from the 'ground up' through reflecting meaningful service user and carer input, but also be accurately reflecting the wider strategic directions of mental health care delivery (Forrest, Risk, Masters & Brown, 2000). Additionally, mental health services increasingly seek innovative services that by necessity are multi-disciplinary, hence requiring the input of other disciplines into MHN curricula. The emerging picture is one of multiple stakeholders in MHN curricula who must coherently contribute to the Nursing Midwifery Council, who ultimately own and administer nurse curricula in the UK. Underneath these issues dwell other considerations.

As Forrest et al., (2000) identify conflicts can arise between differing views between service users and professionals as to what constitutes an effective MHN.

Additionally, strategic concerns for education and training can become restricted to ensuring the learners, in this case MHNs, are simply 'transmitted' the knowledge to achieve pre-determined end products (Hayes, 2009). MHN curriculum design in the UK was proceeded by large scale professional reviews, that amongst other priorities sought to scope what the current workforce capabilities were, and contrast these against the capabilities required for emerging and future MHN roles (Department of Health, 2006a; Scottish Executive, 2006a). Curriculum design for MHNs must also take account of emergent research and evidence, as well as consider the capabilities of nurse education faculties to deliver the content, and how this will be achieved. Issues of assessment in both clinical and non-clinical settings must also be considered, as well as ensuring that quality standards which are set through legislation are also being maintained (NMC, 2009). All the above issues are currently being undertaken by the Nursing Midwifery Council (2009) through their ongoing re-design of nurse education.

Nurse education has historically approached curriculum models in the manner described above, that is with the intent to address specific problems (Morse & Corcoran-Perry, 1996). Commonly, these problems relate to the eclectic nature of nursing knowledge that requires melding from a variety of disciplines whilst nurse educators maintain authority on essential content (Morse & Corcoran-Perry, 1996). Consequently, a curriculum reflects an eclectic element seen within the nursing discipline itself. Both pre- and post-registration education and training curricula are set out as descriptive plans that intend nursing students to learn the product of core competencies combined with process issues of critical reflection and the

recognition of multiple perspectives. The descriptive component is so identified as the curriculum objectives are stated in behavioural actions rather than as preferred ideals (Smith & Lovat, 1990).

Pre-registration nurse education and training operate under curriculum that places emphasis on the role of health service users and carers within the students' learning experience, as well as balancing developing knowledge with attaining nursing skills (Department of Health, 1999). Students from all nursing branches spend their education and training shared equally between classroom and practice based settings, and must pass set assessment in both settings to be fit to practise as nurses under the NMC, which holds approval powers across the entire breadth of UK nurse based education and training curricula (Nursing Midwifery Council, 1999). Increasingly pre-registration training places emphasis on clusters of skills competencies. These skills clusters are deemed as being essential by the NMC and cut across all branches of pre-registration nurse training (Nursing Midwifery Council, 2006). These skills clusters are put forward by the NMC as not being a syllabus, yet obviously require education providers to prepare students to enable attainment.

The proficiency standards for post-registration education and training can also be described as an eclectic conception reflecting a predominantly humanistic approach with features of cognitive processing (Nursing Midwifery Council, 2004). Humanistic elements are evident in the very purpose and hence the content and assessment of the curriculum in that it seeks to develop safe, competent nurses enabled to

provide care to others. With an increasing emphasis on health communication and relationship formation, nurse learners are offered the opportunity to self-reflect that in turn promotes personal growth, a characteristic of humanistic purpose (Print, 1988). Humanism, which places high concern toward ethical understandings, human dignity and rationality, clearly represents an essential educational thread for the preparation and development of MHNs. This importance is enhanced through the understanding that humanism, and hence education that seeks to enhance humanistic values, seeks to develop and enhance the experience of others (Print, 1988). In question for MHN education, and indeed nurse education generally, is whether traditional approaches that focus upon the transmission of knowledge alone fully addresses the range of pedagogic requirements stretching from knowledge and skills through to humanistic values and capabilities. Arguably, the requirement for MHNs who can communicate respect, kindness and compassion, as well as enact evidenced based interventions suggests transformational learning approaches will be a significant component of educational programmes (Mezirow, 2000).

This integration of affective, psychomotor and cognitive domains is evident throughout nurse education and training programs (Nursing Midwifery Council, 2004, 2006). Learners are asked to explore issues of self and reflect on personal qualities in addition to engaging in cognitive style analysis and evaluation, all key characteristics of EI (Mayer & Salovey, 1997). McQueen (2004), along with other authors such as Freshwater (2004) and Freshwater and Stickley (2004), communicates considerable disquiet that inadequate attention is given to this. In

doing so they echo the concern expressed in the previous paragraph that questions the capacity of traditional educational approaches to achieve the range of MHN capabilities. Additionally, curriculum has been identified as either ignoring this aspect of training or presenting constructs such as EI as rationalistic competencies, rather than as elements of individual growth (Freshwater & Stickley, 2004).

Greater attention is paid later in this chapter to the relationship between EI and mental health nursing; suffice for the moment to recognise the shared inter- and intra-personal underpinnings of EI, mental health nursing and psychological therapies. Given this relationship such curriculum oversights should arguably be rectified, if only from a service user perspective. Applications of cognitive skills combined with research skills are also demonstrated throughout education and training programs, evidenced by asking learners to analyse, utilise theory and address rationales (Nursing Midwifery Council, 2004, 2006). An integration of these aspects reflects that nursing skills are bound to attitudes, values and factual knowledge (Burton, 2000). Consequently, a unity of these aspects is sought within the learner.

At this point it should be noted that MHN training currently enjoys specialist branch pre-registration training. While learners spend one year of the three year training in a common foundation settings, the remaining years are spent receiving specialist mental health preparation. This specialist approach to mental health nurse training is in contrast to the majority of other countries where once specialised training is now generic (Hurley & Ramsay, 2008). The Australian

experience of such generic training is that the undergraduate curriculum is not adequately preparing students to work in mental health settings (Queensland Health Ministerial Taskforce, 1999; Wynaden, Orb, McGowan & Downie, 2000). This lack of preparation is recognised by universities, clinicians and, importantly, the students (Wynaden et al., 2000). Poor integration of mental health theory and practice, students identifying themselves as general nurses and low confidence by students in mental health practice, as well as underdeveloped beliefs about mental illness, are key areas contributing to poor preparation (Wynaden et al., 2000). Consequently, the importance of specialised pre-registration training in preparing nurses for subsequent and more advanced roles such as engaging with talk based therapies is made apparent.

As a small branch of nursing directed toward health issues that society struggles to acknowledge comfortably, mental health nursing arguably experiences hegemonic relationships with more populous and influential nursing branches. Consequently, curriculum can be shaped from outside the mental health nursing profession, hence influencing the end product of the education and training process, the MHN. Indeed, mental health nursing fails to have a separately named education committee with the registration board, the NMC. Instead mental health nursing is a sub-group of adult and child nursing, along with learning disabilities nursing and prison nursing, on the Nursing Committee. Their role is to advise the NMC on all educational matters pertaining to adult and children's nursing care (Nursing Midwifery Council, 2004). Within the current curriculum re-design this point of tension is most clearly manifested through the creation of 'generic' and 'branch

specific' capabilities (NMC, 2009). Generic capabilities were the first to be articulated consequently narrowing mental health nursing responses to these pre-determined general capability sets from a mental health perspective. The Australian experience of adult nurse domination of education is that fewer nurses enter MHN practice following the heavily oriented adult program, and that those who do enter MHN practice lack specialist skills and knowledge (Stuhlmiller, 2005). Within the context of this study, this suggests educational discourse has influence in forming how pre-registration nurses identify with specialist nursing branches.

The mode of delivery of curricula for either pre-registration or post-registration/graduate training must also be considered within this study. Considering that half of MHN education and training occurs within clinical settings, and that preparation for assuming psychological therapies roles will also be heavily reliant upon learning in clinical settings, a case for distance learning exists. In presenting a more detailed overview of the varied constructs of EI it will be highlighted that communication and socialisation are important components of either enacting or enhancing EI. To be seen as an effective mode to enhance EI, distance education must be evidentially credible in both of these components.

Webb, Barker and Van Schaik (2004) offer a study exploring this issue after initially strongly arguing the necessity for higher education to utilise distance education. Their findings showed that communication and learning outcome achievement had an identifiable relationship within a distance or e-learning context. Faison (2003) strongly echoes the pressures upon nurse education to

provide distance education and the necessities of utilising distance education to meet future demand for trained nurses. Faison proposes an argument that the level of professional socialisation is equitable between distance and onsite students. Distance education is shown through this study as effective in achieving learning outcomes and facilitating professional socialisation, an EI construct.

Christianson, Tiene and Luft (2002) also found support for web based nurse training. In their examination of tutor perceptions of web based learning, barriers such as time demands and role expansion were overcome with tutors overwhelmingly experiencing the course as both effective and enjoyable. Additionally, communication was reported as improved, as was the fact that tutors could be more pointed and egalitarian in their communication with students. Significantly this succinct and less personalised communication was presented as a benefit of web based delivery. Arguably this finding indicates how poorly web based communication reflects the challenges and required interpersonal skills of health communication in a clinical environment. Christianson *et al.* (2002) paid no attention to EI constructs or to the emotional demands of clinical nursing, implying a lack of applicability of web learning. However, given that findings strongly suggested that communication and interactivity occurred in a web based learning environment, a holistic approach to learning is indicated.

In a study specifically exploring Internet use and its impact upon social skills, Engelberg and Sjoberg (2004) identify a concerning link among high Internet use,

loneliness, deviant values and lower EI scores than those of less frequent users. In the identification of lower emotional competence with high Internet use, the argument for a blended approach to nurse education is strengthened. This argument is supported by Freshwater (2004) in highlighting socialisation rather than isolation as a means to advance emotional maturity. The mixed view of the efficacy of distance education to reflect the breadth of nursing is also apparent in the work of Hyde and Murray (2005). Their qualitative research findings showed distance education as being socially isolating yet attracting a positive student attitude. However, critical reflection was found to be largely absent from the distance mode, hence raising debate as to the purpose of education being transformational or objectives driven. These wider challenges for nurse education and training are heightened when examining mental health nursing's engagement with talk based therapies.

2.3.3 Psychological therapies and mental health nursing

The recent professional reviews of mental health nursing across the UK strongly emphasise the need for nurses to assume additional roles in delivering psychological therapies (Scottish Executive, 2006a). However, the quality of learning provided by nurse education for counselling has been poor, leaving nurses feeling unskilled to cope with this challenging and intimate one to one therapeutic encounter (Stickley, 2002).

Considering the longstanding attachment that mental health nursing has to the therapeutic relationship, and the pivotal position of the therapeutic relationship to

psychological therapies, it seems astounding that MHNs and therapies have not naturally achieved even stronger links than what they have already formed. Authors such as Brooker and Butterworth (1994), Paley et al., (2003) through to Barrett (2009) all detail how MHNs have been positively influencing psychological therapies in the UK for many years. Arguably however, factors such as the sheer range of roles undertaken by MHNs and the barriers to delivering such therapies within in-patient settings have contributed to a stunting of this otherwise natural association (Van Den Berg, Shapiro, Bickerstaffe, & Cavanagh, 2004). Even benefits for MHNs have been reported, with those MHNs who have received training in psychological therapies being less prone to stress or low morale (Cameron & Kapur, 2005). The interpersonal relationship is the key transactional tool for mental health nursing to effect service user positive change, and as such is well supported in nursing theory as being fundamental to mental health nursing (Peplau, 1987). With perhaps the strongest predictors of positive change across psychological therapies being the ability of the therapist to construct a high quality therapeutic alliance, the axioms and capabilities of MHNs to be successful in delivering psychological therapies appear promising (Department of Health, 2001).

Currently the majority of the MHN talk based therapy work appears to be the utilisation of counselling skills rather than conducting formal counselling sessions (Koehn & Cutcliffe, 2007; McCardle & McKenna, 2007). This suggests that barriers may exist for nurses wishing to undertake more formal talk based therapy roles, especially within in-patient settings. Typically barriers pertinent to in-patient settings include limited therapist numbers, multiple role demands and the negative

attitudes of either patients or staff (Landeen, Kirkpatrick, & Woodside, 1996; Van Den Berg, et al, 2004). In-patient settings can be diminishing of patient empowerment, autonomy and individuality through factors such as the physical environment, restricted access and exit, and unquestioned disempowering traditional practices by staffs (Higgins, Hurst, & Wistow, 1999). Additionally, the therapeutic relationship supporting psychological interventions is much more likely to be based upon enforced care under mental health law. As discussed at the beginning of this chapter, the pilot study to this research examined the issue of the therapeutic relationship and enforced care. What is pertinent here is the finding that coerced care improved the therapeutic relationship in a third of cases explored, had no impact on the other third and was viewed as at least temporarily damaging in the remaining cases. This offers some insight into delivering therapies within in-patient settings, particularly as pilot study participants identified the quality of the pre-existing therapeutic relationship, influenced at least in part by EI, as pivotal in affecting these outcomes (Hurley & Linsley, 2006).

Post-registration learning has focused on psychosocial interventions that develop family intervention skills and those of CBT (O'Carroll, Rayner, & Young, 2004). Course curricula seek to inform a breadth of interventions and have been largely unchanged since the late 1990s (Bradshaw, Butterworth, & Mairs, 2007). The one exception to this static post-registration curriculum has been the expansion of CBT. The National Institute for Clinical Excellence (NICE) recently identified CBT as the evidence based approach for schizophrenia and depression (National Institute for Clinical Excellence, 2004). Not only have other psychotherapeutic interventions

been indirectly marginalised but also, if CBT is universally adopted, mental health nursing potentially risks a narrowing of its skill base and a corruption of the values underpinning the profession itself (Barrett & Hurley, 2007; Hurley, Barrett, & Reet, 2006). However, Binnie (2008) offers a more positive view of integrating CBT into MHN practice through identifying CBT as a means to gain autonomy and as an escape from medical model dominance.

Closer examination of documents such as ‘‘We Need To Talk” (Mental Health Foundation, 2006) and “Commissioning a Brighter Future” (Department of Health, 2007) shows that, while they strongly support CBT owing to its quantitative evidence base, support for a wider array of psychological therapies, and increasing research into alternatives to CBT, are also present. Counselling, psychodynamic therapies and interpersonal therapy as well as motivational interviewing are all recommended approaches. Given the primacy of pre-registration training to produce safe, competent and generalist practitioners, specialist training in any one therapy appears contraindicated. Instead, the interpersonal nurse-client/others relationship and the intrapersonal relationship with self, each laden with its own therapeutic potential and broadly applicable for contemporary continuing professional development, should be the focus (Hurley & Rankin, 2008).

2.3.4 Psychological therapies: An inclusive view

Social constructionism and therapies share an emphasis on the primacy of relationship in generating meaning. However, social constructionism ignores best practice considerations among CBT, counselling and psychodynamic therapies in

favour of seeing each as a community of practice that generates meaning. Each generated meaning will in turn positively impact upon some of the population (Gergen, 2001, p. 98). Social constructionism therefore does not adopt a 'disciple approach' to any therapy, but rather places emphasis on therapy that works for the individual.

The privileged descriptive position of the professional therapist whose interpretation of mental health problems supersedes those of the common culture is also questioned. Within a framework of social constructionism a therapist would be required to be a therapeutically skilled non-privileged eclectic, capable of incorporating the entire range of social constructs into her or his practice. Additionally, a more diverse description of what constitutes a positive outcome or mental wellness is another end product of a social constructionist view of therapy, one that includes the traditional approaches and diagnostic descriptions, but also one that includes competing ones.

The social constructionist shift toward a collaborative therapeutic approach does resonate with both contemporary mental health policy such as the "Ten Shared Essential Capabilities Framework" (Sainsbury Centre for Mental Health, 2004) and MHN emphasis on therapeutic relationships (Peplau, 1987). As such, MHNs are perhaps well placed to assume collaborative therapeutic working with mental health service users as the MHNs would not find the step down from a power position as radical as those of the medical or psychology professions. Additionally, contemporary mental health nursing models such as the tidal model (Barker, 2000)

espouse collaborative narratives underpinned by phenomenological naivety rather than explaining away another's experience. This emphasis on the narrative resonates with a shift of emphasis in therapies away from the internal mechanisms of the mind and toward therapy discourse where meaning is co-constructed through linguistic exchange within therapeutic relationships (Gergen, 2001, p. 104).

A highly inclusive view of what constitutes psychological or talking based therapies has been taken in this study. While this study places emphasis on the association between the MHN and talk based therapies, it is fundamentally vital to clarify that the purpose of exploring this topic is for the ultimate benefit of the service user. Psychological therapies offer the service user highly important alternatives from biological treatments alone, and place the user in a more empowered position to respond to their own health needs, as distinct from being passive recipients of medications (Department of Health, 2008). Additionally, by helping to alleviate the disabling impact of conditions such as depression and anxiety, service users have greater opportunity to experience a better quality of life, return to the workforce, and be less marginalised or stigmatised within their social communities (Department of Health, 2008). Given these powerful outcomes for service users it is arguably essential for MHNs to be increasingly effective within new roles of delivering psychological therapies. A brief review of some of these therapies highlights the skills, knowledge and capabilities required of MHNs to undertake these roles.

As identified by Koehn and Cutcliffe (2007), MHNs engage with counselling on two levels, namely those of counselling skills and counselling sessions. The former pertains to health communication skills and the latter to formal mutually negotiated therapy sessions. Additionally, O'Carroll *et al.* (2004) identified family intervention skills, psychosocial interventions and CBT as well as motivational interviewing as other commonly taught psychologically based interventions for MHNs.

Health communication is a rapidly expanding field of health studies that incorporates all spoken, written or non-verbal communication that occurs in health care settings. With evidence noting that poor communication in health care is a significant source of patient dissatisfaction, this expansion appears indicated (Caris-Verhallen, Kerkstra, & Bensing, 1997). The wide variety of theoretical health communication models and frameworks available to guide interventions reflects the enormous diversity of the topic that extends well beyond MHNs and into virtually all health related education and training.

Increasingly communication has been viewed as central to nursing and that nurses of all branches communicate under challenging conditions, often with powerful emotional themes such as anger and joy, as well as with challenging communication presentations such as psychosis and dementia. Inclusive of cognitive, affective and psychomotor domains, health communication is seen as the foundation upon which the therapeutic relationship is built and as being an essential component of best practice (Barry, 2007; Burnard, 2003; Riley, 2008, p. 18). In turn, this relationship

offers therapeutic value to users by its own worth, as well as acting as the basis upon which more formal approaches to psychological therapies are built.

Health communication is also seen as the vehicle upon which caring, central to nursing, is responsibly communicated. Within the context of mental health nursing, the attainment of communication skills is an outcome of pre-registration training and can act as a basis for more advanced therapy specific skills post-registration. Typically, such training will involve learning and utilising communication micro-skills, self-awareness and work on understanding communication models of transmission. Additionally, issues such as assertiveness, empathy and problem solving as well as use of self, deescalating aggression and self-awareness are important capability areas (Burnard, 2003; Riley, 2008). The relationship between the EI capabilities outlined in the following section and health communication capabilities is overt.

When does health communication suddenly transform into a counselling session? Perhaps the most effective means to distinguish this changeover point is that both the counsellor and the client must explicitly contract to enter into a counselling relationship; otherwise it is simply the use of counselling or health communication skills (British Association for Counselling and Psychotherapy, 2002). Counselling, as with mental health nursing, is a formal helping activity embedded within a therapeutic relationship that seeks to have the client's needs met. Although muddied by the multiplicity of schools and varied approaches, counselling remains an initially simplistic three stage process: identify where the client is now, where

s/he would like to be and a means of getting from one to the other. Although not a universal view, counselling can be arguably presented as an eclectic approach to problem management (Eagan, 1998, p. 14). The British Association for Counselling and Psychotherapy (BACP) define counselling as:

> Counselling takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be 'sent' for counselling. (British Association for Counselling and Psychotherapy, n.d.)

By listening attentively and patiently the counsellor can begin to perceive the difficulties from the client's point of view and can help her or him to see things more clearly, possibly from a different perspective. Counselling is a way of enabling choice or change or of reducing confusion. It does not involve giving advice or directing a client to take a particular course of action. Counsellors do not judge or exploit their clients in any way (British Association for Counselling and Psychotherapy, 2002).

Central to the BACP definition of counselling is a focus on skills, an emphasis shared by Eagan (1998), who devised a skill based problem solving approach to counselling training that underpins many formal educational and clinical approaches. Typically, generic or eclectic counselling will be underpinned by counsellors adopting

Rogerian principles of unconditional positive regard, empathy and genuineness. The self-aware counsellor will then employ a variety of micro-skills to help the client move toward her or his preferred life scenario. Typically these skills will include listening, the use of questions and summarising, as well as paraphrasing, empathy and the reflection of feelings (Eagan, 1998, p. 89). When the capabilities associated with EI are reviewed in the next section of this chapter the similarities between EI and the attitudes and skills required for counselling as well as mental health nursing emerge.

2.3.5 Psychological therapies: Divergent views

While health communication and counselling can be seen as overarching approaches to talk based therapies there is obviously a multiplicity of specific approaches. Through briefly describing four divergent approaches, those of Gestalt Therapy, Family therapy, Solution Focused Therapy and at greater length CBT, in addition to the previous discussions on health communication skills and counselling, it is hoped that the breadth of available therapies is communicated.

Contemporary Gestalt Therapy aims to integrate mind, emotion, body and spirit in a client directed search for wholeness within her or his social environment. This aim is achieved through emphasis on process over content within an existential framework of working (Clarkson, 1993, p. 17). As such, Gestalt Therapy differs from generalist counselling and from the more positivistic CBT approach to therapies. Clients are encouraged to adopt a phenomenological perspective rather than

having a determinist explanation being given to them by the therapist. In order to achieve the goal of phenomenological exploration, insight or self-awareness must be reached to achieve clarity of experiences. Achieving insight or personal awareness is absolutely central to the therapy process. By paying attention to how insight was achieved, an individual road map for clients is created to return to when insight is lost or diminished. Full personal awareness within sequential existential moments allows individuals to experience themselves fully in relationship to their environment. Being true or authentic to oneself is directly linked to awareness. Though self-awareness, individuals become more capable of choice and therefore responsibility for their own behaviour is reinforced.

Solution focused brief therapy offers an arguably radical departure from traditional ways of viewing mental health problems, as well as being highly congruent with recovery approaches. Solution focused therapy focuses not on solving problems, but upon generating solutions, and as such the problem may never be discussed. Therapy is time limited and looks with particular interest upon times when the problem is absent or less overt in the service user's life. Therapy focuses upon identifying the service user's strengths, coping skills and ability to generate solutions (Hosany, Wellman, & Lowe, 2007). In common with other therapies, solution focused therapy requires the therapist to have strong engagement and narrative capabilities and is being increasingly utilised within in-patient settings by MHNs, as well as other professionals (Hosany, Wellman, & Lowe, 2007).

Family therapy, as with many other psychological approaches, has variant schools of therapy existing under the one umbrella term. Despite these divergences, family therapy is arguably united through its focus upon the family as being a singular distinct organism, rather than being made up of separate individuals. A family is usually considered within a three generational overview, and can include in it those who share close bonds, rather than simply being tied by blood or marriage. Family therapy will use cognitive, behavioural and learning theory to seek therapeutic changes within individuals who dwell within a family. A major goal is to unblock family processes, often within crisis presentations so that they can effectively support each other again (Taibbi, 2007, pp. 16-24). Family therapy is usually a major component within Psycho-Social-Intervention training courses for MHNs within the UK as it enables the MHN to work effectively with the carers of those with mental health issues (O'Carroll et al., 2004).

Comparatively, the CBT approach to therapy is that the individual has erroneously interpreted her or his experiences that in turn generate emotions and behaviours that are unhelpful (Trower, Casey & Dryden, 1994, p. 1). As such CBT seeks to challenge the schemata or map that individuals have about the world, themselves and the future through assuming that cognitive activity affects behaviour, that these cognitive events can be monitored and altered and that emotions and behaviour will change by changing cognition. CBT places value on a collaborative therapeutic relationship and upon a robust initial assessment and subsequent formulation of the individual's problems. The individual is instructed in the CBT

model and will have her or his schemata challenged via Socratic questioning, which while leading her or him toward a therapist defined end point also allows for some self-direction (Trower, Casey & Dryden, 1994, p. 88).

While this point is expanded upon later in this chapter, it is worth noting that documents such as “We Need to Talk” (Mental Health Foundation, 2006) and even “Commissioning a Brighter Future: Increasing the Availability of Evidence-Based Psychological Therapies in Scotland” (National Education Scotland, 2008) acknowledge that a range of therapy approaches is both evidentially indicated and needed. Additionally, these documents acknowledge that research priority has been given to CBT, entrenching its privileged position over other approaches that in turn restricts access to alternatives for users or practitioners wishing to utilise or train in alternative approaches. Additionally, the evidence base of CBT has been established primarily through randomised control trials (RCTs) that are the gold standard of positivistic medicine, but are detached from the arena of practice. Consequently, its effectiveness in the clinical lifeworld is less certain (Holmes, 2002).

Given that CBT has utilised RCTs as its vehicle toward therapy dominance, it is ironic that CBT is in itself a wide and imprecise label covering increasingly diverse therapy approaches with a varied epistemological basis and as such lacks internal validity (Hardcastle, 2006). Additionally, even senior CBT nurse therapists acknowledge that the over generalisation of RCTs findings and the presentation of its being a panacea for all conditions are concerning (Allen, 2006). Regardless of these concerns, it is

arguably clear that CBT provides an effective intervention. On the basis of CBT's presuming to be able to quantify human experiences and to demonstrate effective change within relatively short treatment periods, government can plan service provision with more solid presumptions of treatment time and efficacy that at any prior time (Hurley, Barrett & Reet, 2006).

As a result of accepting these presumptions the UK Government launched a funded policy drive for expanding CBT service delivery in February 2008: "Improving Access to Psychological Therapies Implementation Plan: National Guidelines for Regional Delivery" (Department of Health, 2008). A key indicator of the success of this initiative is the removal of 25,000 people from sickness benefits by 2010/2011 achieved through the establishment of an additional 3,600 therapists (Department of Health, 2008, p. 3). Education and training to achieve this are tightly controlled through the therapy approach being only CBT, the curricula being national with minimal training institutes and a hierarchical structure of clearly articulated CBT competencies being put into place.

Roth and Pilling (2007) outline the competency framework upon which CBT therapist training will be provided by the "Improving Access to Psychological Therapies Implementation Plan". These competencies contain generic and CBT specific knowledge, skills and behaviours, with the CBT approach to therapy being obviously dominant. Andrews (2008) challenges Steve Pilling who holds senior responsibility for identifying effective psychological therapies in the UK. Despite starkly challenging the evidential basis upon which CBT's current dominance is

based, the policy direction adopted by Roth and Pilling (2007) continues unabated. Of central interest to the main focus of this study, MHN identities at the interface of psychological therapies, is that staff who have been CBT trained will be placed in therapist teams under the supervision of a therapist director, most probably from the psychology discipline (Department of Health, 2008). Such moves may further challenge the already fragile MHN identity in terms of both role and professional association.

2.3.6 Emotional Intelligence

EI represents one area in which this fragile MHN identity may be strengthened. As identified by Freshwater (2004), and Freshwater and Stickley (2004), EI has significant relevance to the roles that MHNs undertake, and yet does not have a significant place within MHN curricula or training. Additionally, the tutors who potentially lead educational programmes have themselves been identified as lacking EI (Cadman & Brewer, 2001). Such is the relevance of EI to nursing, regardless of branch, authors such as Cadman and Brewer (2001) and Bellack et al., (2001) suggest that EI measures should be used for the selection of nursing candidates, consequently restricting entry into the profession to those with the best capacity for empathy and self awareness. Arguably emergent from this section on EI, and the subsequent section of 2.4 that critically explores mental health policy, is that EI resonates with the needs of service users and the outcomes sought from policy toward MHNs.

Salovey and Mayer (1990) first used the term "EI" in 1990, and moved to establish a research evidence base that showed personal and social advantages for participants with high emotional clarity. Daniel Goleman (1995) moved EI into a wider public awareness with emphasis on organisations and leadership in particular. As identified at the beginning of this dissertation, EI is argued as having links to both mental health nursing and talk based therapies. EI is now widely accepted as a viable model of intelligence, although there remain those who contend that EI is nothing more than a component of the larger construct of personality (Helund & Sternberg, 2000; McCrae, 2000). What follows is a brief look at three prominent EI models, their approach to testing and selecting the model that has the 'best fit' with mental health nursing.

Mayer and Salovey (1997) and Mayer, Salovey and Caruso (2004) offer a foundation upon which agreement about EI can at least commence through offering a narrow perspective of EI, heavily defended by empirical psychological testing. Focusing upon the cooperative relationship between emotion and intelligence, they identify EI as being restricted to the following components: (1) The ability to perceive emotions accurately, involving the capacity to recognise emotions through non-verbal behaviour; (2) The ability to access and utilise emotions to assist cognition; (3) The ability to understand emotions by analysis and prediction; and (4) The ability to reflect on and regulate emotions to enhance both intellectual and emotional growth. Central to this view is that EI is an ability that enhances the relationship between emotion and cognition. Mayer, Salovey and Caruso (2000) offer empirical support for their EI model through their Mayer, Salovey, Caruso

Emotional Intelligence Test (MSCEIT). Mayer *et al*. (2000) identify EI as ability, and view other competence EI models that include leadership or assertiveness as failing in content validity with their measures. Additionally, Mayer *et al.* (2000) reject the measurement approach of self-reporting in favour of performance measures as this directly connects intelligence to ability.

By contrast, Bar-On (2000, p. 365) identifies EI constituents such as assertiveness, stress management, self-awareness and flexibility. Indeed, Bar-On (2000) extends EI into a 15 aspect model arranged in a hierarchical structure:

(1) Intrapersonal EI, including emotional self-awareness, assertiveness, self-regard, self-actualisation and independence.

(2) Interpersonal EI, including empathy, interpersonal relationships and social responsibility.

(3) Adaptability EI, including problem solving, reality testing and flexibility.

(4) Stress management EI, including stress tolerance and impulse control.

(5) General mood EI, including happiness and optimism.

Bar-On (2000) appears to adopt a wider view of EI than that of Mayer *et al*. (2000), a view that incorporates emotional and social intelligence. Central to Bar-On's (2000, p. 373) position is that EI is of its very essence the ability to understand, be aware of and also express emotions, and that while very closely related to social intelligence is separate from it. Bar-On's self-report measure, the Emotional Quotient Inventory (EQ-i), culminates in a global EI score as well as individual scores for each composite item that constitutes Bar-On's model of EI.

Goleman (1995) offers an even wider perspective on what EI constitutes in addition to supporting the model with empirical measures. These broader interpretations include self-motivation, empathy and relationship skills as well as impulse control, problem solving and social responsibility (Goleman, 1995, p. 26). The evidence offered by Goleman, who first popularised EI as a construct, is gleaned from the Emotional Competence Inventory, a self-reporting measurement tool that is reported as both reliable and valid (Boyatzis, Goleman, & Rhee, 2000). As with the other EI models the measurement tool was worked outwards from the model, strengthening the validity of outcomes.

So do these or other competence models in any way reflect mental health nursing or what service users want from MHNs? The application of EI is evident in a diversity of occupations, including customer relations (Ornstein & Nelson, 2006), law (Keeva, 2005) and politics, as well as trade based industry (Butler & Chinowsky, 2006) and education (Perry & Ball, 2008). Corporate United States of America is also embracing EI, particularly as a workforce improvement tool (Cherniss, 2000). Nursing is also starting to look, even if less robustly, at EI when considering factors such as organisational commitment and job satisfaction (Güleryüz, Güney, Aydın & Aşan, 2008). Table 2.1 offers a review of the main competencies within the varied EI models, highlighting areas of commonality. Table 2.2 then compares these commonalities with desirable abilities sought from MHNs as identified by both service user focused research (Rydon, 2005; Welch, 2005) and the professional

reviews into MHNs across the UK (Department of Health, 2006a, 2006b; Scottish Executive, 2006a).

Table 2.1: Variable EI components

Bar-on (2000)	Goleman (1995)	Mayer & Salovey (1997)	Shared capabilities
assertiveness	self-awareness	perceive emotions	awareness
stress coping	self-management	utilise emotions	responsiveness
self-awareness	empathy	understand emotions	self-management
flexibility	self-control	reflect/regulate emotions	relatedness
self-regard	adaptability		self and others
interpersonal	self-confidence		reflection
impulse control	collaboration		communication
problem solving	leadership		unstated morality
empathy	communication		
flexibility	initiative		

Table 2.2: Sought MHN capabilities compared with EI shared values

Sought capabilities - Reviews	Sought capabilities - Patients	Shared EI capabilities
Enhanced empathy	Empathy	Self and others
Inspiration and hope	Acceptance	Responsiveness
Purposeful relationship building skills	Autonomy	Unstated morality
Advanced communication skills	Listening	Communication
Purposeful engagement	Relationships	Relatedness
Respect	Respect	Reflection
Enhanced levels of self-awareness	Self-awareness	Awareness
Psychologically based therapies	Maturity	Self-management

An examination of Table 2.2 arguably shows a resonance between EI capabilities and those sought by current policy and user based research. Welch (2005) supported earlier advocates of the therapeutic relationship such as Carl Rogers and Hildegard Peplau through his contemporary study into the nurse–client therapeutic relationship. His thematic findings of critical constructs of that relationship included trust, power, mutuality, self-revelation, congruence and authenticity. Such constructs mandate the utilisation of a totality of self that extends beyond how mental health nurses are currently prepared for entering practice. Rydon (2005) equally demonstrates the underlying complexities of preparing nurses for therapeutic engagement in her user based study of required attitudes. This study identified the need for intrapersonal constructs of resilience and hardiness, self-knowledge and openness, as well as a raft of interpersonal abilities, including warmth, attending and counselling. Weng (2008) reflects the findings of both Welch

(2005) and Rydon (2005) by identifying a relationship between EI and the therapeutic relationship between physicians and service users.

Values based nursing, enhanced empathy and self-awareness, as well as social awareness and instilling hope, are identified in the professional reviews as requirements for mental health nursing and hence nurse education (Department of Health, 2006b; Scottish Executive, 2006a). Additionally, leadership and collaborative qualities are actively sought within a MHN who is also expected to be an expert communicator able to develop those around her or him. Links with EI capabilities appear evident, offering a further justification for the value of this study.

Regardless of which EI model is used to discuss MHNs within this study, both professional reviews and service users seemingly link MHNs to the shared capabilities of EI. From this comparison, the model of EI by Goleman is proposed as the most suitable for use to compare and contrast with the experiences of MHNs. While this is not a quantitative study, it remains essential to ensure that the construct of EI has evidentiary foundations, which Goleman's research as the first EI model has (Boyatzis, Goleman, & Rhee, 2000). Additionally, this study seeks to find congruence among the adopted research framework, the selected methodologies and the topic of investigation. Goleman's model, through being the most expansive, captures more of the complexities inherent in the working lives of MHNs. The model reflects not just the potential clinical application of EI in relation to psychological therapies, but also the governance and management aspects. Finally,

Goleman's model highlights the relational aspect between the self and others that is central to mental health nursing and to psychological therapies. This model, as with that of Mayer, Salovey and Caruso (2000), identifies EI as the bedrock and learning tool for emotional competencies that are the personal and social skills that lead to superior performance. A closer examination of the model will clarify the above points.

Table 2.3 below offers an overarching view of Goleman's EI model (adapted from Consortium for Research on Emotional Intelligence in Organisations, 1998). The framework breaks EI into both self-focused and other focused competencies that are in turn recognised and then utilised. Table 2.4 then expands upon the aspects of EI presented in Table 2.3.

Table 2.3: A framework of emotional competencies (adapted from Consortium for Research on Emotional Intelligence in Organisations, 1998)

	Self: Personal Competence	**Other: Social Competence**
Recognition	**Self-awareness** • Emotional self-awareness • Accurate self-assessment • Self-confidence	**Social Awareness** • Empathy • Service orientation • Organisational awareness
Regulation	**Self-Management** • Self-control • Trustworthiness • Conscientiousness • Adaptability • Achievement drive • Initiative	**Relationship Management** • Developing others • Influence • Communication • Conflict management • Leadership • Change catalyst • Building bonds • Teamwork • Collaboration

Each subheading within the framework also has descriptive capabilities that when viewed together give a more accurate picture of the complexity that is EI. This expanded framework is partially displayed below and is drawn from research by the Consortium for Research on Emotional Intelligence in Organisations (1998).

Table 2.4: An expanded view of the framework of emotional competencies (adapted from Consortium for Research on Emotional Intelligence in Organizations, 1998)

Self: Personal Competence
Self-awareness • Emotional self-awareness - Know which emotions they are feeling and why; have a guiding awareness of their values and goals • Accurate self-assessment - Show a sense of humour and perspective about themselves; reflective, learning from experience • Self-confidence - Able to make sound decisions despite uncertainties and pressures; present themselves with self-assurance
Self-Management • Self-control - Manage their impulsive feelings and distressing emotions; think clearly and stay focused under pressure • Trustworthiness - Build trust through their reliability and authenticity; admit their own mistakes and confront unethical actions in others • Conscientiousness - Meet commitments and keep promises; hold themselves accountable for meeting their objectives • Adaptability - Smoothly handle shifting priorities and rapid change; adapt their responses and tactics to fit fluid circumstances • Achievement drive - Are results-oriented, with a high drive; set challenging goals and take calculated risks • Initiative - Pursue goals beyond what's required or expected of them; mobilise others through unusual, enterprising efforts

Other: Social Competence

Social Awareness

- Empathy - Show sensitivity and understand others' perspectives; help out based on understanding other people's needs and feelings
- Service orientation - Gladly offer appropriate assistance; grasp a customer's perspective, acting as a trusted advisor
- Leveraging diversity **-** Respect and relate well to people from varied backgrounds; understand diverse worldviews

Relationship Management

- Developing others - Identify people's needs for development; mentor and offer assignments that challenge and grow a person's skill
- Influence - Use complex strategies to build consensus and support; orchestrate dramatic events to make a point effectively
- Communication - Listen well, seek mutual understanding; foster open communication and stay receptive to bad news as well as good
- Conflict management - Handle difficult people and tense situations with diplomacy and tact; spot potential conflict and deescalate
- Leadership - Guide the performance of others while holding them accountable; lead by example
- Change catalyst - Recognise the need for change and remove barriers; challenge the *status quo* to acknowledge the need for change
- Building bonds - Cultivate and maintain extensive informal networks; seek out relationships that are mutually beneficial
- Teamwork - Model team qualities like respect, helpfulness and cooperation; draw all members into active and enthusiastic participation
- Collaboration - Balance a focus on task with attention to relationships; collaborate by sharing plans, information and resources

What is highlighted by the competencies in the above tables is that the application of EI extends beyond clinical considerations alone into the dynamic environment in which mental health nursing is enacted. This environment is one characterised by frequent randomly episodic discontinuity that has challenged health organisations to blend structures designed to respond fluidly to change with existing rigid structures that allow accountability and bureaucratic governance (Hurley & Linsley, 2007b; Limerick, Cunnington & Crowther, 2002, p. 83). It is from within this challenging environment that MHNs must have the intrapersonal and interpersonal capabilities to respond to their clients' needs for psychological therapies, as well as their own needs. Mikolajczak, Menil and Luminet (2007) demonstrate through their study that EI traits are highly effective protective factors in these stressful environments. In their study of over 100 nurses those with high levels of EI traits showed markedly lower levels of stress or somatic problems.

2.3.7 Education and training for EI

It is vital within the context of this study to examine not only the construct of EI but also the question of how to enable and impact positively upon an individual's EI through education and training. This imperative to explore how to influence EI positively is apparent through the need for MHNs to be prepared for delivering psychological therapies. Cherniss *et al*. (1998) sought responses to this question through a robust exploration of literature primarily based around counselling, psychotherapy and behavioural change. As apparent from the synthesised training outlined below, this is a multi-faceted approach that requires an incremental educational approach. As a result of reviewing the educational and training

programs it emerges that the process of developing emotional and social competence, or EI, is similar to that of undergoing psychotherapy. Both require motivation to change and that the change sought is the change within and about oneself, and oneself in relation to others.

The initial stage focuses upon preparation that determines both the individual's and the organisation's levels of EI competence, and seeks congruence between competency development and the overall culture and strategies of the organisation. These assessments are carefully fed back, allowing maximum learner choice to set change targets and to influence how they will participate in the competency development. Ensuring that the organisation allows these developmental efforts to be successfully undertaken is vital as perceived training effectiveness acts as a motivator. Motivation is further enhanced within this approach through highlighting where the change fits with individuals' personal values and hopes. Where the individual is not motivated, efforts remain focused on promoting readiness.

The second stage immediately recognises the necessity for trainers to be warm, genuine and empathic for EI capabilities to be successfully developed in others. Also necessary for the leaning to be successful is that it is individually packaged and self-directed, individual learning styles are catered for and the learner is in charge of the program. Subsequent steps within stage two, which focuses upon the actual educational and training interventions, include:

- Setting specific behavioural goals that are clear and challenging
- Breaking these behavioural goals into achievable chunks
- Practising the behavioural goals over a period of months both at work and in life utilising naturally occurring opportunities
- Focusing sustained feedback as the learners practise new behaviours from as wide a range of people as possible such as trainers, supervisors and peers as well as friends or family
- Utilising experiential methods that are active and concrete and that engage all the senses as these are the most effective strategy, particularly when enhanced with the use of modelled behaviour through live role play or video. Genuine modelling from high status persons within on the job contexts also greatly enhances successful change
- Enhancing self-awareness that is central to developing EI is the cornerstone of emotional and social competence
- Generating an organisational culture that is safe for experimentation with the new behaviours (Boyatzis, 2002; Cherniss *et al.* 1998).

The final stage of the training is the evaluation stage, which seeks to evaluate lasting effects and the impact of the training upon job performance. Boyatzis (2002) affirms that this approach to education and training for EI can have a lasting effect

on behaviour, mood and self-image. Through citing multiple influential longitudinal studies Boyatzis, a highly significant contributor to EI research and EI outcome measures, offers valuable insights into education and training for EI development. It is significant that retained behavioural change is intentional, and within the context of EI necessitates a clear formulation of an 'ideal self'. The development of EI capabilities is consequently change that must be self driven toward that which a person is inspired to become.

When taken within the context of the mental health nursing professional reviews and the wider capabilities focused government policy directed at MHNs, idealised self-directed change for MHNs appears lacking. Rather MHNs are being directed toward what their idealised selves should be, potentially negating effective education and training interventions. Boyatzis (2002) highlights the profound personal implications of these education and training 'headlines' through seeing them more as an evolution of the self than as receiving training. Additionally, while Cherniss *et al.* (1998) focused heavily on change, self-evolution that commences with potentially uncomfortable self-scrutinisation must also involve stasis, or parts of the self that the person wants to remain unchanged. This communicates the immeasurable worth, value and vulnerability of the 'target' of EI education and training, the self. The risks associated with forcing behavioural changes that are incongruent with a MHN's values and self-image both real and ideal necessitate careful ethical attention. Arising from the work of both Boyatzis (2002) and Cherniss *et al.* (1998) is that skilled, ethical and considered approaches are required, rather

than simply achieving policy driven outcomes. Brett and VandeWalle (1999) advocate that a learning orientation as distinct from a performance orientation is one such approach. Their well supported study showed that a learning orientation clarified ideal self-imaging and generated hope for self-improvement.

2.4 Data from policy and document review and analysis

The delivery of health services in the UK is influenced by policy, thereby necessitating an examination of policies relevant to mental health nursing and the delivery of psychological therapies. This element of data analysis is presented in Chapter 2 to provide a continuation of reviewing the literature, as well as offering an opportunity for contrasting government and academic sourced documents. Arguably, it is the policy documents that have most impact upon the identity construction of MHNs when compared with academic journals and even educational interventions. The basis for such a position is that these policies influence both clinical practice and education, and as such reflect the lifeworlds of MHNs, educational provision and MHN identity.

Through assuming a research framework of social constructionism, the utilisation of such texts can be argued as an essential data collection source. Social constructionism places great value upon the use of language within the contexts of relationships (Berger & Luckmann, 1966, p. 13) and contends that meanings, both current and future, are generated by texts within social relationships (Gergen, 1999, pp. 47-49). The utilisation of texts for research when using a framework of social

constructionism is also unambiguously supported by McLeod (2001, pp. 28-29), who identifies the importance of opening all avenues of the interpretation of a phenomenon. Additionally, the affinity between phenomenology and hermeneutics, the interpretation of texts, is advocated by the phenomenological philosopher Heidegger (1962, as cited in McLeod, 2001, p. 59).

The selection criteria for such documents were that they were from either government or departmental sources in the UK [non–statutory organisations seeking to influence government], that they related to the topic of investigation in this study and that they had been published in the past five years. Each policy has undergone both a thematic analysis that searched for the themes of the dominant discourses and a critical analysis of the document as a whole. Themes were sought through repeated reading of the texts and identifying key points related to this study. This process was then expanded to comparing and contrasting major points and themes across the policies. This analysis process, as with the entirety of the study, is framed by the pillars of social constructionism and as such seeks to highlight what truths are being generated from the text, what relationships the truths are being generated through, what futures are being fashioned and whether outcomes evaluated from the perspectives of multiple others are present (Gergen, 1999, pp. 47-49).

A critical evaluation of each document is followed by a summary of the key points. Section 2.4.1 then distils the identified MHN capabilities within the documents, applies these to the EI model and then describes emergent themes constructed from the documents.

Document 1: Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland (Scottish Executive, 2006a).

This review of mental health nursing was conducted under the leadership of the Chief Nursing Officer for Scotland. This widely ranging review moves well beyond the boundaries of mental health nursing to incorporate much wider mental health service delivery reforms. These reforms focus upon establishing in-patient and community services that will meet people's needs, as well as reflect upon service user and carers' strengths. Shifts toward enhanced community services, improved whole systems of working and enhancing the delivery of psychological therapies make this a noteworthy document for seeking to improve mental health care in Scotland. Additionally, the necessity of linking higher education and clinical services is given priority. Service deficits within acute and age specific services are identified and aspirational goals articulated within the document. Arguably, however, barriers to attaining these aspirations such as in-patient care environments are approached not with expensive increases in staff levels or rebuilding projects, but with less expensive workforce capacity measures such as education toward leadership and values. What this document does achieve is communicating the breadth and depth of the education and training that the MHN workforce requires to meet the needs of service users and carers effectively. Such expansive visioning offers MHNs the

potential to adopt more active and responsible roles in delivering mental health care than what they currently experience.

Narrowing the review of the document solely toward the topic of this study moves it from being predominantly progressive and reforming to also being prescriptive and political. In setting out the purpose of such a review, the report highlights that it seeks to address the challenges of contemporary mental health services while empowering MHNs. Ironically, while MHN empowerment is stated as a goal, the participants engaged in the review of mental health nursing ranged through the breadth of mental health stakeholders, arguably culminating in MHNs having a minority and disempowered voice. Numerically significant MHN participation can be identified through the practitioner reference group and in focus group participation. However, the practitioner reference group, the only group with a MHN majority, held only facilitating roles. By contrast, the project steering group of 25 members holding deciding powers for the shape, final version and strategic guidance of the review had 15 members affiliated outside the profession and only two with a MHN professional title. Additionally, there is no documentary evidence within the report that substantiates the final reported findings and outcomes as being connected to those voiced by the MHNs. Interestingly, of the referenced documents supporting this report 38 were from government or statutory bodies, while only four were from academic journal sources. These influences upon the document strongly suggest an internal generation of meaning from within government and statutory organisations, rather than a generation of meaning for mental health nursing from inclusive relationships that challenge policy formation.

Key points relevant to this study include:

- The values, roles and attitudes of MHNs, all profound sources of identity markers, are being externally formulated and communicated.
- Despite MHNs being broadly identified as failing to meet the above expectations, nurse delivered interventions are briefly identified as generating positive service user outcomes.
- Nurse training programs should focus equally upon the development of clinical skills and more generic skills associated with relationship building, engagement and communication.
- MHN education is the dominant proposed vehicle to generate the identified skills, values and attitudes of MHNs.
- While evidence exists that a range of talk based therapies are effective, CBT is promoted above others.
- MHNs require the following:

  Capabilities to work with others

  Capabilities to facilitate engagement

  Capabilities to facilitate relationship formation

  Capabilities of having other awareness

  Capabilities of demonstrating respect for others

  Capabilities of empowering others

  Capabilities of advanced communication

  Capabilities of warmth, empathy and compassion co-existing with therapeutic clinical skills

  Leadership capabilities within the mental health nursing profession

Capabilities of engagement in evidence based, talk based therapies

Greater resilience to stress and burnout

Better attitudes toward carers and users

Capabilities to engage intensively with clinical supervision.

Document 2: The Chief Nursing Officer's Review of Mental Health Nursing: From Values to Action (Department of Health, 2006a).

This review of mental health nursing was conducted under the leadership of the Chief Nursing Officer for England. The review identifies pivotal areas of service development, training and education, and workforce development, as well as required developments to meet the needs of service users and carers. As such it can be seen as a potentially progressive document that seeks to progress mental health care delivery to ensure that it is modern, evidence based and effective to those who utilise it.

Focusing upon the topic of the study through the lens of social constructionism shifts the above descriptive terms toward the document away from being solely progressive. With over 50 of the 63 references being drawn from government sources, and a consequent paucity of academic or practitioner based recognition being evident, the meaning generations of this document can be argued as being internally generated. Indeed, while recognising receipt of 300 written responses, the consultation document also identifies that there are over 47,000 MHNs across the UK, emphasising minority participation. Very little meaning generation within the document is given to positive roles or impacts that MHNs could be currently

performing. Where the Scottish review stated its aims as improving health services, service user outcomes and mental health nursing (Scottish Executive, 2006a), this text acknowledges only improving health service delivery and service user/carer outcomes. While these are totally laudable, for a review of mental health nursing the absence of mental health nursing from the stated aims appears to be a startling omission. Also omitted is how nurse education will help prepare MHNs for the diverse roles identified in this document. While establishing what the 'end product MHN' should be capable of, the process of achieving this is absent. Wider discussions on preparing MHNs for new roles that demand technical capability underpinned by values and attitudes are in Chapter 9, as well as Section 2.3.2 of this chapter.

Key points relevant to this study include:

- The values, roles and attitudes of MHNs, all profound sources of identity markers, are being externally formulated and communicated.
- The formation and development of the therapeutic relationship were widely recognised as the platform from which MHN roles are delivered.
- MHN education is identified as the vehicle through which to create skills, values and attitudes, as well as to address skills and knowledge gaps.
- Clinical supervision is a highly visible construct running through the breadth of this consultation document.
- New professional roles for MHNs are both abundant and ill defined.
- The unambiguous articulation of the core role and distinct contribution of mental health nursing to these roles is absent.

- MHNs were identified as requiring the following:

  Capabilities to demonstrate positive and trusting relationships

  Capabilities to demonstrate collaborative and respectful relationships with users and carers

  Advanced communication capabilities

  Widely recognised capabilities to provide psychological therapies

  Capabilities to reduce stigma, prejudice and discrimination in mental health

  Capabilities to act as role models.

Document 3: We Need to Talk (Mental Health Foundation, 2006).

Unlike the previous two documents, this document was commissioned by the leading mental health charities in the UK to promote the need for greater access to psychological therapies. Its inclusion in a review of policy is because it was commissioned for the purpose of informing policy. What is seemingly apparent is a shift away from government sources to support the document, with a wide range of evidence based references being utilised. Despite being commissioned by charities, this document remains palpably political given its primary purpose of influencing policy. What is established is that both NICE and the general public are demanding greater utilisation of talk based therapies. It is also established that utilisation and access to these therapies are poor, despite a wide community need for them. The moral, economic and health benefits and imperatives of implementing greater access to talk based therapies are powerfully communicated. Arguably, this document reflects issues discussed in other sections of this study addressing CBT and its domination of therapy delivery within the UK. This document suggests alternate therapies are also valid, and that CBT has been given preference merely

through being amenable to measurement. This valuing of outcomes that are comparatively less tangible reflects the literature review findings from the review of mental health nursing (Department of Health, 2006a) which identified that while users valued MHNs for proving comfort and support, that these outcomes were difficult to measure and quantify.

Key points relevant to this study include:

- 12 approaches to psychological therapies are recommended.
- CBT remains the most evidence based in terms of RCT outcomes.
- Other approaches are recognised as having an evidence base, but this has been understated in comparison to CBT owing to preference being given to RCT evidence.
- Research into the efficacy of alternative approaches to CBT has been under funded owing to preference being given to RCT evidence.
- An additional 100,000 therapists are required in the National Health Service (NHS) to meet both current and projected need.
- Significant education and training are needed both to recruit the required numbers and to prepare therapists for speciality areas.

Document 4: Commissioning a Brighter Future: Improving Access to Psychological Therapies (Department of Health, 2007).

This document outlines the intended approach to achieve greater delivery of psychological therapies, primarily within the current workforce. Whilst broadly ranging, the response is primarily a scoping and strategic exercise with a heavy

focus on establishing competency based education and training. There are no supporting references and documents, and the identity of participants in the formation of this strategic approach is left anonymous.

Key points relevant to this study include:

- All mental health staffs are seen as requiring basic psychological literacy.
- All mental health staffs are seen as requiring effective inter-personal and communication skills.
- Training for psychological therapies must be at externally validated levels, ranging from basic to advanced competencies.
- Clinical supervision is the key to maintaining skills.
- CBT is given privilege over all other forms of therapy.
- CBT training will be expanded owing to its evidence base and work on quantifying national competencies.
- Psycho-dynamic therapies, associated with psychiatrists, will be expanded after CBT interventions have been embedded.
- Existing education and training are poorly and ineffectively organised, with no clear picture of what competencies and qualifications are held within the current workforce.
- There are few qualified supervisors.
- Individual staff members undertaking self-funded training in therapies of their own choice are seen as a problem owing to being non-strategic and non-CBT.

- Mental health nursing is the only profession identified within the document as requiring alterations made to its education and training programs.
- Mental health nursing is the only profession identified within the document as increasing its engagement with psychological therapies.

Document 5: The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce (Sainsbury Centre for Mental Health, 2004).

Although brief, this document forms the platform for all mental health training. As such it is the identified platform for informing pre-registration MHN training and is the precursor of education and training directed toward increasing psychological therapy literacy. The other item of note is that the shared capabilities are repeatedly put into relationship with other competency framework documents such as the Capable Practitioner (Sainsbury Centre for Mental Health, 2001) and Skills for Health (2008) competencies.

Key points relevant to this study include:

- As with previous documents this lays down the underpinning values which MHNs will hold and as such is seeking to influence the identity construction of the profession.
- The capabilities reflect EI capabilities.
- While the standards are entirely laudable, the formation of these standards was facilitated by the following professional bodies with the exclusion of mental health nursing or any other nurse representation:

  Royal College of Psychiatrists

General Practitioners

British Psychological Society

Primary Care

College of Occupational Therapy

British Psychological Society.

Document 6: Delivering for Mental Health Scotland (Scottish Executive, 2006b).

This document is a policy document that seeks to set the direction, values and structures of mental health services for Scotland over the forthcoming decade. As such while it makes many references to evidence and experts there are no academic sources or contributors identified.

Key points relevant to this study include:

- Cultures, behaviours and attitudes as well as values of staffs are identified as needing to be improved.
- Education and training are seen as the means of achieving the above changes.
- There is specific commitment to increasing the availability of psychological therapies.
- Increasing current workforce capacity and changes to service structures are seen as the means to achieving this end.

Document 7: Nursing: Towards 2015 (Nursing Midwifery Council, 2007).

This paper was commissioned by the NMC to inform the discussion of the options for change to the existing frameworks for the pre-registration education of nurses. It seeks through broad and inclusive literature reviews to make informed future assumptions about pre-registration nurse education. The authors, two generalist nurses and one with a health policy background, offer three probable scenarios open to nurse education:

- Scenario A represents minimal change to the present state.
- In Scenario B there is increased demand for specialist staff in a wide variety of roles.
- In Scenario C nursing has increasing specialisation by all registered nurses becoming specialists at a more advanced level.

The NMC took key issues arising from this report and translated these into a consultation exercise across the UK. This consultation placed strong emphasis on a flexible workforce, a degree exit level of pre-registration qualification and clinical supervision. Generic nurse training was a key discussion point to achieve this flexible workforce and to attain higher academic nurse qualifications. The positioning and power of nursing to influence its own future were put into stark relief with policy identified as directing healthcare that in turn dictates nursing and consequently nurse education. However, the processes of how nurse education will meet the identified educational objectives was absent, with no discussion offered on the different priorities of clinical work based and academic based educational programmes.

Key points relevant to this study include:

- Mental health problems are identified as being the largest cause of disability, with dementia and substance use related to mental illness in the top four reasons for disability.
- Policy directed toward regulation will increase and 'earned freedom' from these restrictions arising from longitudinal good performance is the only possible release from this.
- Currently there are poor definitions of nursing roles, titles and educational needs.
- Titles are less important than descriptors of the roles carried out by MHNs.
- Generic training is the most common world model of nurse training.
- Adequate post-registration funding must be available to support specialist training if the generic approach is adopted.
- Pre-registration education needs to prepare nurses for expanding roles such as the Mental Health Act, psychosocial interventions, and the values and attitudes required for a recovery approach.
- Pre-registration education needs to prepare nurses for being enabled to work across a diversity of roles requiring skills and knowledge underpinned by values.

Document 8: Modernising Nursing Careers: Setting the Direction (Scottish Executive, 2006c).

This government document announces its intention through its very title: to direct the future shape and identification of nursing from a departmental view of the profession. Of the 50 text documents referenced as supporting these changes, all

are policy documents. Of the 25 members of the directing board for the project, all identified as nursing leaders, but there was only one identifiable mental health representative.

Key points relevant to this study include:

- Changes in healthcare settings influence the future direction of nurse careers.
- Reforms to nursing roles and conditions have been overwhelmingly positive.
- Generic working for nurses is preferential to specialist working.
- A flexible, principle-based curriculum with a strong academic foundation is promoted.
- Nursing roles and titles are currently blurred and should be attached to patient need.
- Nurses are currently hierarchically managed and should be more accountable.
- Nurses are currently giving care decided by others and should be directing care.
- Melding academic and clinical career pathways to enhance education and training is needed to achieve the required changes in nursing.
- UK nurses are widely assuming new roles and working across professional boundaries.
- The competency based work system directs and will continue to direct nursing.
- Nurses will display the following competencies:

Collaborative leadership

Self and other leadership

Flexible working across work settings

Flexible working across work roles

Seeking ongoing education and training to gain specialist skills

Holding and developing a range of advanced skills

Entrepreneurial skills

Being aware of the needs of others

Being capable of patient empowerment.

Document 9: Best Practice Competencies and Capabilities for Pre-registration Mental Health Nurses in England: The Chief Nursing Officer's Review of Mental Health Nursing (Department of Health, 2006b).

Following from the Chief Nursing Officer's review of mental health nursing core competencies and capabilities for mental health nursing were established. The document identifies poor values and attitudes toward service users by MHNs as needing rectifying. Consequently, the document also identifies values, attitudes and inter-personal relating as crucial. The identified competencies are communicated as acting in conjunction with other competency frameworks such as the Ten Shared Capabilities (Sainsbury Centre for Mental Health, 2004).

Key points relevant to this study include:

- There are three broad competencies with 103 supporting knowledge criteria and 130 performance criteria cross referenced in part with other competency frameworks.
- EI constructs are evident throughout the knowledge and performance criteria; for example:

1.1.1K) the importance of self-awareness in monitoring your own practice.

1.1.2K) the engagement processes, designed to optimise user, carer and representative involvement in care and treatment (p. 7).

2.1.9P) identify and articulate your own emotional and psychological responses to situations with colleagues or with clients in a professional manner (p. 9).

3.2.8K) the evidence base about emotional intelligence/literacy and how this relates to mental health nursing work (p. 22).

2.4.1 Discussion of policy and document themes

A social constructionist view of emergent themes from the analysed documents is that the identities, roles and values of MHNs are largely a monological representation characterised by privilege. The voices and views of clinical MHNs about their own identity, roles and behaviours, both past and future, are a distant background throughout the documents. Conversely, the presence and influence of non-MHN professions hold a position of descriptive privilege toward MHNs. Previous policy is uncritically utilised to advocate the necessity for new and evolving policy that seeks to influence the shaping of the MHN. From the perspective of the work of Boyatzis (2002), who highlighted EI education and training as evolution of

the self, the policy documents fail to highlight the strengths or parts of MHN behaviours (selves) which should or could remain un-evolved.

Given the assumption that relationships are prior to meaning, as it is only through relating that meanings are generated by the way in which language and other representations are used (Gergen, 1999, pp. 47-49), one must ponder the policy/MHN relationship, and the MHN/service user relationship. Both relationships function as generators of social meaning and both relationships have been characterised by, and are therefore generators of, power differentials and partially disrespectful representations. While the themes arising from the texts establish EI, skills and knowledge foundations upon which the MHN/user relationship can address these issues, the power differentials and partial disrespectful representations of MHNs within the examined documents remain unaddressed. Fashioning a future for MHNs is therefore challenged. The dominant theme within the examined documents remains the absence of a shared descriptive language and voice between MHNs and policy makers in relation to self and truth, particularly in relation to the future well-being of mental health nursing. Social constructionism suggests that, in the absence of a universally accepted 'good' construction, good evidence and good reviewing of change, implications are usually undertaken to reach the 'best' outcome by those who hold most influence (Gergen, 1999, pp. 47-49).

Arguably, social constructionism would view the policy approach to knowledge generation outlined in the examined policy documents as stemming from a

hierarchical model characterised by authority driven knowledge production (Gergen, 2001, p. 125). MHNs within this view are simply the recipients of pre-determined and packed parcels of knowledge with MHN educators sitting only one rung above as the delivery mechanism. Educators can thus be argued as being at least to some degree silenced, as their knowledge has been generated by 'better' minds further up the knowledge generation hierarchy. Social constructionism would propose a heterarchy of knowledge generation that by its dialogical underpinnings would necessitate the inclusion of service users within learning environments. In turn this would support the equally valued constructionist priority of uniting discourse and practice, a value apparent in the themes of policy that seek to generate linkages between knowledge and its practical application in lifeworld settings. Policy themes and social constructionism meet at the point of aspiring to 'de-discipline' knowledge.

From a service user and carer perspective, the tradition being challenged is that of historically disempowering MHN behaviour, values and attitudes toward those under their care. As such, the targeting of EI capabilities toward the relationship management section of the EI framework represents a platform from which to challenge this assumed tradition of poor relating. Through relationship formation and the creation of equality within that relationship, a new tradition of collaboration leading to service user and carer empowerment can be argued as being achieved.

EI competencies are a theme across the examined documents. Table 2.5 below displays the competencies and capabilities found within the examined documents that can be directly attributable to EI. These have been expressed within Goleman's (1995) framework of EI which shows that the primary policy emphasis influencing MHN identity is directed at relationship management, followed by social awareness, both under the section of "social or other competence". Conversely, self-awareness is least targeted by policy despite arguably being the very foundation upon which all other competencies rest. This may be due to a presumption either that self-awareness is already established within the workforce or that policy priority is directed toward the recipients of care rather than those who deliver it. This first table simply lists the capabilities as indicated in the policy documents as a means of highlighting the volume of expected capabilities, and the relevance of EI to MHN education and mental health nursing, finally highlighting areas of commonality among the documents in terms of their future expectations of MHNs. As such there are repetitions within the lists. However, when these competencies and capabilities are synthesised into themes as displayed in Table 2.6, a greater emphasis on self or personal competence becomes apparent, despite relationship management remaining the most targeted area.

Table 2.5: EI competencies identified in and across the policy documents

	Self: **Personal Competence**	**Other:** **Social Competence**
Recognition	**Self-awareness** • self-awareness • ethical behaviour • reflection • self-assessment • promoting engagement • reflective practice • self-appraisal • reflecting on values • capabilities of warmth and compassion co-existing with therapeutic clinical skills • engaging intensively with clinical supervision • critically thinking	**Social Awareness** • other awareness • working effectively with others • team worker • empathy (5) • partnership working • self-management • respecting diversity • acknowledging power differentials • respecting diversity • being organisationally aware • promoting equality • capabilities of having other awareness • being respectful of others • leadership capabilities • leadership • cheap productivity • collaborative leadership • self and other leadership • flexible working across work settings • flexible working across work roles • leadership
Regulation	**Self-Management** • openness • flexibility • assertiveness (3) • self-responsibility • honesty with self and others • being ethical • integrity • flexibility • self-responsibility • role model • resilience to stress and burnout • capability to act as role models • flexibility • being entrepreneurial	**Relationship Management** • engagement with others • raising hope and dignity • empowering others • generating change • relationship formation • counselling skills • communication skills • conflict resolution inter-personal skills • generating change • empowering the person • conflict resolution • developing and maintaining relationships

	• being independent • being autonomous	• working in partnership • enabling service users • working with others • collaboration • self and other leadership • reducing conflict • empowering others • effective communication • enabling people • developing therapeutic relationships • challenging injustice and inequalities • working with others • capabilities to work with others • capabilities to facilitate engagement • capabilities to facilitate relationship formation • capabilities for empowering others • capabilities for advanced communication • capabilities for engagement in evidence based talk based therapies • holding high values toward therapeutic relationships • capabilities to demonstrate positive and trusting relationships • capabilities to demonstrate collaborative and respectful relationships with users and carers • advanced communication capabilities • capabilities to provide widely recognised psychological therapies • empowering marginalised groups • empowering others

Table 2.6: Themed competencies drawn from the policy documents

	Self: **Personal Competence**	**Other:** **Social Competence**
Recognition	**Self-Awareness** Critical reflection Self-assessment Self-awareness Being autonomous Being self-responsible	**Social Awareness** Empathy Leadership Flexible working Respecting diversity
Regulation	**Self-Management** Assertiveness Flexibility Being role models	**Relationship Management** Relationship formation Engagement Empowering others Advanced communication Counselling Collaboration Conflict management Generating change

Synthesising the EI capabilities and competencies for MHNs in Table 2.6 into a construction of meaning and truth toward MHN identity suggests mental health nursing as being the following:

"Therapeutically targeted ethical use of a critically reflective self for the empowerment of diverse and disempowered others".

Excluding the listed competencies, there were four major themes across all eight documents:

1. Mental health training and education

"Training" has been specifically placed before the word "education" as it received priority within the texts and in the remainder of this theme section will be

expressed in that order accordingly. However, each was expressed in close relationship to the other and as such has been taken as one rather than two separate themes. Sitting just below the thematic headline of training and education is that of competency based training, identified as underpinning MHN educational interventions. The intended product of such competency based training and education appears to be specialised advanced practice underpinned by principle based care. In turn this principle based care is informed by EI competencies. MHN training and education are identified as the vehicle by which MHN values and attitudes will be delivered, hence influencing MHN identity.

MHN training and education are also identified as being responsible for developing a MHN population who can deliver an expansion of psychological therapies. MHNs are identified as requiring training in CBT, although MHN training and education have been identified only as needing to build platforms in pre-registration education and training for later CBT educationalist interventions to be built on.

2. Silos of change politics

Both change and politics can be constructed as running through the policy agenda influencing the roles, axioms and behaviours of MHNs and MHN educators, consequently influencing MHN identity formation and identity standards. While a degree of cross policy compatibility can be identified, the paradoxes among policies and the exclusion of outside texts more strongly suggest silos of change policies. Indeed, as proposed by Ritzer (1983), the systemic over rationalisation of mental health care delivery can be argued as generating irrationality. The need for

additional specialist MHN skills co-exists with attempts to move to generic nurse training, while themes of increasing regulation and control are constructed simultaneously with wanting increased accountability, professionalism and autonomy.

3. Opaque MHN identity

As will be outlined in Chapter 4, social constructionism can be argued as being a radical lens through which to understand MHN identity as it views the generation of self as being achieved through social action. Through adopting such a view of identity, the focus on understanding MHN identity is therefore drawn toward neither MHNs nor their work environments in isolation, but rather toward the point where these two collide (Gergen, 1999, p 133). At this level of collision MHN identity can be thematically described as opaque. Externally driven with minimal self-identity generation, mental health nursing is repeatedly identified as a profession with blurred boundaries, multiple professional titles and widely ranging roles. Future meaning generation for MHN identity seeks advanced specialist skills within a framework of flexible role diversity. Assuming roles in psychotherapy (CBT), medication prescribing and mental health law, historical roles of psychology, medicine and social work respectively appears to be generating further identity blurring. Additionally, historical MHN identity markers are implied as being unacceptable. Consequently, an unacceptable past identity characterised by poor values, attitudes and behaviours is being replaced with current role, title and boundary blurring. Consequently, MHN identity can be constructed as moving

toward an externally prescribed future identity of advanced diverse specialist practice, at least partially indistinguishable from other mental health professions.

4. EI

Whilst evident in the listed capabilities and explored in some depth in the preceding section, the theme of EI must also be acknowledged within the main text of the documents. The inter- and intra-personal relating that encapsulates EI is constructed as being foundational to mental health nursing within the examined documents.

2.4.2 Policy and document responses to the research questions

In returning to the three research questions guiding this study the themes and main points from the examined documents begin to offer some insights into possible outcomes that are taken up in greater depth in the data analysis chapters.

1. What, if any, are the perceived unique qualities, abilities and behaviours of MHNs engaged in the delivery of psychological therapies in the UK?

Taking data solely from the examined policies and documents would indicate that the only example of unique qualities, abilities and behaviours that mental health nursing has to offer the expansion of psychological therapies is their numerical capacity to respond to population demand. While inter- and intra-personal relating are foundational to mental health nursing, other professions such as social work and psychotherapy can make similar claims, negating any uniqueness for MHNs. The expansive capabilities education and training, themed with EI as well as

knowledge and skills, indicated a perceived need to prepare MHNs rather than to seek what they may have to offer as a professional group.

2. What, if any, are the thematic resonances of these MHN experiences with the construct of Emotional Intelligence and how have they been developed?

The explored policies and documents appear to construct a relationship between mental health nursing and EI. As discussed earlier, this connection is most apparent in the relationship management section of the EI framework and specifically identified advanced communication, psychological interventions and therapeutic relationship formation. MHN education and training are identified as the means to develop these EI capabilities with little reference to the settings in which this education and training should or could occur.

3. What journeys through structures of social rules and processes independent of each participant did MHNs undertake to reach their current identity, both personally and professionally?

These examined document and policy data have highlighted that the identity journey undertaken is influenced by non-MHN stakeholders. Additionally, the point of identity destination is pre-determined, as is the means by which to reach it. Competency based education and training, heavily underpinned by EI competencies, are apparently this means. Future roles, titles and ways of working have been identified within the context of requiring greater depth, breadth and sophistication of MHN roles. Generic nurse training coexisting with nurse preparation for literacy in psychological therapies (CBT) is presented as the future

way of preparing nurses to work in mental health fields, possibly without being MHNs.

2.5 Chapter summary

Chapter 2 has sought to provide an in-depth critical review of important constructs in this study by examining within the relevant literature mental health nursing's engagement with psychological therapies, MHN identities and EI. This engagement with talk based therapies has been placed within the context of wider MHN role expansion and a global impending shortage of nurses. This package of influences upon MHNs preparing to deliver psychological therapies contains additional challenges of historically poor preparation by nursing, in-patient barriers to successful implementation and diversity between the therapeutic approaches. Mental health policy seeks at least to reduce that diversity through a strong emphasis on preparing MHNs for CBT. The raft of policies examined in this chapter demonstrates not only a widely ranging reform of mental health service provision but also that MHN identities are being transformed within the context of MHNs having minimal influence upon these changes.

The development of MHN capabilities being pursued through policy has connections to EI. Indeed, EI appears to form the principled base for care delivery within a capabilities driven educational framework, and yet is not mentioned by name. Social awareness and relationship management appear to be the main policy target areas within the EI capabilities framework. What is implicit and indeed at times made overt within the examined policies and documents is that MHNs have

been identified as being historically poor at enacting EI capabilities. EI enhancement is consequently required to engage successfully in the delivery of psychological therapies. EI enhancement training was shown as closely mirroring psychotherapy, with requirements of change motivation and preparedness to alter personal ways of being and relating. The examined literature arguably fails to uncover any nurse educational strength in this field, rather offering quite the opposite. Consequently, the worth of this study can be argued as having been enhanced, through its explication of these themes as well as its identification of potentially powerful counterpoints to them.

This study links with the literature in a number of different ways. Firstly, the study acts as a counternarrative to MHN identity formation being constructed predominantly from outside the profession. Through seeking MHN views about their roles, education and training, as well as their EI capabilities, a mental health nursing generative discourse is potentially achieved. Additionally, the study seeks MHN identity performances primarily through exploring difference and uniqueness compared with other mental health professionals and other nursing branches. This creates another counternarrative, this time toward the discourses promoting generic working. This study also seeks to relate to the explored literature through not only points of tension but also areas of harmonious discussions. The identified poor quality of education and training for MHNs engaged in talk based therapies is one such area, as is identifying a means to enhance the development of MHN EI capabilities.

Chapter 3 moves from the contextualising of this study described in this chapter to offer a much more focused and detailed examination of key constructs. Social constructionism, identity and mental health nursing are theoretically explored, as are educational theories relevant to the expanding roles of MHNs. This theoretical view is then applied to the lifeworld considerations of MHNs engaging or preparing to engage in delivering psychological therapies.

CHAPTER 3: THEORETICAL CONSIDERATIONS

3.1 Chapter introduction

While Chapter 2 offered an examination of the literature and policies that influence and inform this study, Chapter 3 offers both an expansive and an in-depth examination of social constructionism, identity and MHN epistemology, as well as relevant educational epistemological underpinnings. Social constructionism is the overarching framework of the study and, while presented and explored extensively within this chapter, it is also found woven throughout the entirety of the text. The wider application of social constructionism, as well as its emphasis upon meaning generation at the point of social contact, make this a highly appropriate and thought provoking lens through which to view both the constructs within the study and its findings. Identity, as well as mental health nursing and education, are all examined from the perspective of social constructionism to demonstrate the multiple ways in which they can be understood.

This chapter commences with a brief rationale for the choice of social constructionism as the research framework. The examination of social constructionism successively explores its four core principles and then applies these principles to mental health nursing, identity and EI as well as psychological therapies, all central constructs of the study. Following this exploration of social constructionism, identity is examined from a range of perspectives including social, temporal and psychological views, as well as from a personal perspective. The focus

is then shifted away from identity being in the foreground to having mental health nursing's epistemological underpinnings in focus. This focus shows a divided profession with tension points being clustered primarily around medical model and tidal model explanations of mental illness and mental health nursing roles. As this study seeks to commence informing education and training for MHNs engaging in talk based therapies, the chapter concludes with an exploration of the educational approaches of transformational learning, work based learning and heutagogy, the latter being seen as an extension of transformational learning and as having application to MHN work based learning environments.

3.2 Why social constructionism?

Choosing a conceptual framework for the study required a search for congruence between that framework and the topic under investigation (Taylor, Kermode, & Roberts, 2006, p. 23). A continuation of this congruence was then sought between the conceptual framework and the adopted research method, which is discussed in detail in Chapter 4. Any conceptual framework broadly seeks to provide a lens through which to view the phenomena under investigation, and can be seen as underpinning the entire study. Given the central constructs of mental health nursing, identity and EI, as well as educational considerations about those constructs, the chosen framework for this study must reflect the core themes of each. The themes of relationship and otherness represent such threads, particularly with mental health nursing placing an emphasis on the therapeutic relationship (Peplau, 1987). Additionally, relationship and otherness can be equally applied to identity, through the core consideration that identity can be viewed through the

perspective of comparative difference. As discussed in Chapter 2, EI also has resonance with both the themes of relationship and otherness. Relationship can be seen in EI not only through relating to others via constructs such as empathy, but also within the view of how individuals relate to themselves. Additionally, education embedded in teaching and learning contains connections to each of the identified themes through approaches such as heutagogy (Hase & Kenyon, 1999) and transformational learning (Mezirow, 1994) that are expanded upon later in this chapter.

As this study adopts a qualitative paradigm through utilising the direct phenomenological research method, any chosen conceptual framework must sit comfortably within these parameters. With data collection being predominantly undertaken through one to one interviews and data analysis through focusing upon the verbal responses of participants, the previously identified themes of relationship and otherness remain congruent. Social constructionism, with its emphasis on linguistic discourse within socially enacted relationships, appears to reflect accurately the focus of each of those two themes (Berger & Luckmann, 1966, p. 13; Van Langenhove & Bertolink, 1999). The importance of this conceptual framework with regard to MHN identity is that the profession's identity standards are being socially altered through policy, evidence based practice and role expansion, consequently altering what it means to be a MHN. These discourses of managerialism and evidence based practice dictate what can be considered as valid professional identity and, by implication, what is not. The normally temporally

changing MHN professional identity can therefore be seen as being shaped in the absence of voices from participants within the profession.

3.2.1 Social constructionism as theory

In seeking to grasp an understanding of the nature of knowledge, being and ultimately ourselves, humanity has contemplated and embraced varied philosophical viewpoints. Dualism, whereby an internal conscious self simultaneously exists with the external world, functions well as a philosophical model when considering each part in isolation, or when seeking internal causal relationships. For example, cognitive therapies' basic tenets of belief lie in the causal relationship between thought and feeling (internal self) and external behaviour. However, social constructionism argues that identifying causal links between the internal psychological world and the external material world remains problematic in terms of supporting such an explanation. Despite this, it is such a stance that underpins western modernism, regardless of the lack of definitive ability to separate the internal and external world (Gergen, 1999, p. 8). Expanding this causal problem, how can we be certain that the acquired knowledge of the external world has been accurately registered in our internal world of self? While idealism deals with this issue by retreating into the belief that nothing exists outside the mind (effectively reducing human experience to being nothing more or less than an individual projection), this retains little support in a contemporary world framed by materialism.

Certainly, social constructionism and the realist paradigm which is dominant in the MHN work lifeworld can be identified as being mutually antagonistic. At the centre of this conflict is the case of the physical world, seen by realists as representing the undeniable limit of constructionist argument with constructionist counter arguments of varying conviction offering how physical beauty or models of illness vary with cultural construction (Gergen, 2001, p. 11). Whilst antagonistic debate on the differing realities of each position offers little progression, value can be held in seeking whatever common ground may exist between the two positions. Each offers a truth and perhaps more importantly utilises language, text and relationships to convey meaning to communities (Gergen, 2001, p. 15).

Without question social constructionism places great value upon the use of language within the contexts of relationships (Berger & Luckmann, 1966, p. 13). This value is emphasised by identifying that language does not mirror life (Gergen, 1999, p. 35); rather it is the doing of life. It does not contest or deny the material world and merely accepts 'what is'. Once we begin to articulate the objective, social constructionism argues that we engage in discourse, in itself constructed by tradition and taken for granted values. Language is not seen as an accurate reflection of the world and neither is the language of one given rank over that of the other; indeed, multiple descriptions can exist for a single event. However, this generates problems in terms of being able to create shared meaning among one another. The generation of shared meaning through language consequently assumes rules to apply to the usage of words within the contexts in which they are uttered, and it is from within this context that the meaning is generated. Truth and

knowledge are considered by social constructionism to exist in the same manner. Social constructionism propounds that there is nothing in the mental life of an individual that has not been performed within the context of social interaction (Stetsenko & Arievitch, 1997). Rather than seeking an 'absolute truth', social constructionism places 'a truth' within the context of the rules within a specific social setting. Language does not depict the world, but rather functions as truth telling within the rules of certain conventions or groups.

Social constructionism postulates four primary working assumptions:

1. The terms by which we understand our world and ourselves are neither required nor demanded by "what there is".
2. Our modes of description, explanation and/or representation are derived from relationship.
3. As we describe, explain or otherwise represent, so do we fashion our future.
4. Reflections on our forms of understandings are vital to our future well-being. (Gergen, 1999, pp. 47-49)

Examining these in turn offers insight into the application of social constructionism to the world of mental health nursing, talk based therapies and EI.

1. The terms by which we understand our world and ourselves are neither required nor demanded by "what there is".

The key principle underlying this assumption is that language fails to represent an independent world. Inclusive of all forms of representation, this postulates that for any phenomenon there are an infinite number of possible descriptions, none of

which holds privilege over any other. Through being released from any convention of understanding, wider and more inclusive views of illness, learning and intelligence as well as gender, race and ethnicity become possible. Power, exhibited through the use of knowledge and discourse, can thus be altered from subrogation by those claiming possession of the 'absolute truth' to a position of shared appraisal of truths. Central to this study is that the lifeworld of many MHNs is one of dominant medical model language and understandings of illness, truth and worthwhile knowledge. A key issue is how to influence the power imbalances to promote shared truth appraisal.

2. Our modes of descriptions, explanation and/or representation are derived from relationship.

Within this assumption relationships are prior to meaning, as it is only through relating that meanings are generated by the way in which language and other representations are used. In this manner, meaning generated through language/text is embedded within human communities and thus negates meaning being reduced to nothing more than syllables and markings. Of central interest to this study is how the meaning of MHN identity is generated and through what relationships.

3. As we describe, explain or otherwise represent, so do we fashion our future.

Shared language and description are the major constituents of social life and these shared descriptions represent traditions which bind cultural life. These traditions, inclusive of self, truth and morality, are sustained and evolved through continual

processes of meaning generation that require shared language. Only through relationship formation and the creation of rationality within those relationships can these traditions thrive. Engaging in such meaning generation can not only sustain traditions but indeed also offer the platform from which to challenge them, enabling progressive change through new ways of relating, new language forms and new world interpretations. This places enormous importance on the conversations and writings being conducted about mental health nursing and roles, such as delivering psychological therapies, as it is these representations that will impact on the future, or lack of it, for the profession and those under their care. Not only being aware of the importance of these representations, but also asking core questions such as about their repercussions and who is being silenced or advantaged by them are vital points from which to commence shaping a future for MHN identity.

4. Reflections on our forms of understandings are vital to our future well-being.

Challenging existing traditions to enable new futures also creates tensions and resistance from within the tradition. In the absence of a universally accepted 'good' construction, good evidence, good morals and good reviewing of change, implications are usually undertaken to reach the 'best' outcome. However, the meaning interpretation of 'good' and 'best' usually arises from those within the tradition who are the focus of the generative discourses. With pre-existing constructions and subsequent rejection of alternatives from the outside, the tradition maintains an opposition to alternative possibilities. Constructionists place high value on reflexivity that questions our own premises, seeks empathic

understandings of others' positions of reality and suspends taken for granted positions to evaluate outcomes from multiple other positions. It is essential here to avoid placing values such as good/bad/right/wrong upon any group within this discourse. The use of such binary language is a superficial reinscribing rather than a generating of new narratives and hence futures.

These simply stated premises of social constructionism hide a fundamental challenge. To position self one must know where one is, to reflect one must know what to reflect upon and to be empathic one must know self and the 'other' as they temporally evolve. Learning about our values, attitudes and engagement with an external phenomenon demands first an internal engagement with the totality of self. Such engagement is itself potentially bound by cultural and societal influences.

Within a contemporary western context, self-engagement is most frequently dominated by cognitive reflection, with the emotional self relegated to a secondary identity and the spiritual self kept quarantined from all academic pursuits (Pfeifer & Cox, 2007). This narrowing of self-reflexivity fails to respond to the requirements of engaging with others, often culminating in stressful and disharmonious human relations and resulting in conflicting needs and values (Szasz, 1983, pp. 21, 23).

3.2.2 Social constructionism in the context of study constructs

Gergen (1999, p 40) offers a brief critique of the impact of language as creating power differentials in relation to mental health. Through holding a privileged position through evidence based science, mental health professionals identify and

communicate about increasing mental illnesses. This is then filtered through social, educational and public policy that informs the populace of how to understand their subjective and objective experiences (grief is no longer grief but depression or anger is a 'negative' emotion). Individuals then seek out mental health professionals to treat their newly identified illness, creating the need for additional mental health professionals who then have an even greater voice in determining the construction of mental illness. Indeed, the very generation of 'fact' can be argued as being at least partially embedded within socially constructed frameworks.

Latour (as cited in Gergen, 1999, p 55) postulates that fact is reached through a conscription process whereby support for the truth is maximised and resistance negated. What is important here is that fact or truth is seen through the eye of the paradigm in which it dwells. Consequently, truths from outside that dominant paradigm are deemed immeasurable and consequently irrelevant in today's evidence based practice MHN world. Typical means to achieve this conscription include enrolling supporters and utilising existing knowledge to support the current position. The truth is then established through disseminating it via influencing outlets such as respected journals. This presents an influential and highly complex system toward which challenge is difficult because each stage is self-fulfilling from within the rules of its own paradigm. Mental health care delivery and consequently MHNs and the roles that they assume dwell within such a system and must be contextually viewed from this basis to gain a wider understanding.

In relation to the identity formation of MHNs, social constructionism looks at the generative texts that fashion identity, importantly shifting identity formation away from a locus of self-generation toward that of external influence and external perception (Berger & Luckmann, 1966, p. 194). However, identity formation through external influence can also be seen as not occurring within a vacuum or – to apply the phenomenological tenets of experiential psychotherapy to the construct of projection – all projections must have a hook upon which to rest. How easy is it to refrain from critical self-examination that authentically notices and then purposively responds to faults or errors when the alternative is righteously (and with 'a truth') to decry criticisms as misrepresentations by already powerful groups seeking only to establish further advantage over a weak and marginalised group?

The same arguments and critical concerns can be applied to self-representations of identity. Rather than rebelling or engaging in conflict with the identity representations of others, with consequent emphasis on a perceived societal negative of 'conflict', self-identity representation permits a textual emphasis on perceived positives such as the strengths of self-determination. Again, however, can this be authentically achieved without self-deception and without subgroups simply assuming the vacated privileged positioning? Underneath political or influential manoeuvrings lie other considerations in relation to identity and MHNs. The move toward treating a social category as standing for a set of intrinsic qualities or characteristics shifts identity away from a point of difference toward that of sameness.

Goffman (as cited in Gergen, 1999, p 77) emphasises that the creation of a public identity is primarily a social task. Constructing this identity is achieved not only through the language utilised, but also by a full range of social actions inclusive of gestures and personal possessions. However, for all that is overtly presented in constructing this identity, much is left hidden from observers, most frequently that which the individual perceives would diminish the public standing of her or his identity. Goffman's stance is echoed by others who dwell in psychotherapy fields. This dichotomy of adoption and repression was noted by Jung (1928), who introduced the concept of the persona or masks that humans adopt in undertaking our social roles. These roles are predominantly, but not entirely, congruent with our true 'inner selves', allowing an emotional ease and fluid behaviours within our adopted masks that are mutually understood by those around us. However, when emotions and behaviour are in conflict with those personas, or when the inner self has become lost within the multiplicity of adopted masks, authenticity with self and others is challenged. This challenge is further complicated when the myth of consistency or permanency is pulled back to reveal that self is characterised by constant change with each contact that we have with both ourselves and the external environment (Perls, Hefferline & Goodman, 1973, p. 282). Brookfield (1995, pp. 228-235) proposes a similar concept to that of Jung called the impostor syndrome. Focusing upon teachers Brookfield (1995, pp. 228-235) explains that a false mask of control is adopted to hide internal feelings of job related inadequacy. This inadequacy is most frequently internally perceived rather than externally substantiated through means such as job evaluations. The outcome is that the

individual is constantly in fear of being 'found out' as pretending to be a competent teacher.

Table 3.1 displays the key constructs of the study as seen through the lens of social constructionism.

Table 3.1: A social constructionist view of key constructs in the study

STUDY CONSTRUCTION	SOCIAL CONSTRUCTIONIST VIEW
Identity	An active process of 'self-generation' through either empowering or disempowering social interaction.
MHN	A professional internally and externally ascribed social identity hegemonically situated within a dominant realist relationship.
EI	One of many equally valid ways linguistically to generate meaning and understanding with others about the construct of the self.
Talk based therapies	A therapeutically skilled, non-privileged, eclectic approach capable of incorporating the entire range of social constructs into practice.

3.2.3 Limitations of social constructionism

However postmodern the underpinning values of social constructionism might be, as an approach to understanding phenomena it is as reductionist as the rationalistic approaches that it criticises. Rather than reducing human behaviour to chemical and electrical sources as in the medical model approach, social constructionism reduces the self to a participant in discursive exchange (Stetsenko & Arievitch, 1997). Additionally, social constructionism struggles to explain clearly how generative discourses can be successfully implemented so that traditions can be challenged in the absence of extremist positioning and conflict. Certainly engagement in such discourses appears to rely upon not only voluntary

participation but also a shared desire for, and a vision of, an agreed need and general direction for change. Within the context of mental health nursing it can be displayed that such preconditions are absent. As highlighted when discussing MHN epistemology later in this chapter, dualism is the dominant theme, with the two major professional voices – some would argue guru figures – flagrantly combating between extremists positions: one Gournay (2003), postulating that all MHN interventions need to be embedded in evidence based medical model approaches, while the other Barker (2008), arguing that all such treatments should be withheld and calling upon the profession instead to focus entirely on caring and listening to patients (Ramsay, 2006).

While Gergen (1999) offers dialogical potentials as a remedy for such positioning, they arguably remain precisely that – potentials. While possibilities such as relational responsibility, discourse ethics and other affirmations are offered, each of these requires a shared decision to move from individual positioning toward that of prioritising a shared relational approach. Extending this difficulty outwards brings in a primary theme within mental health generally, MHN identity and psychological therapies: the power of the rationalistic discourse position. Through its dominance and consequent influence, not only can the discourse agenda be set, but also alternative views and voices are dismissed. Permeating through avenues such as policy, curriculum formation and professional literature, the dominant views and voices generate self-perpetuating confirmation of their own correctness.

Pragmatic stances may also contribute to limited participation in generative discourses. If my voice will not be heard, or if heard ignored, why speak? Where my view differs, why attract conflict or potential repercussions for my career advancement? Also MHNs in the UK can retire at the age of 55, arguably an age when their discourses are potently enhanced with experience, and a drive to contribute to the enhancement of mental health nursing prior to leaving. When given the choice of engaging in potentially futile conflict or simply quietly marking off days till departing, many influential voices may decide to remain silent. What is less pragmatic yet no less influential of minimal generative discourse is that those who dwell within mental health service worlds are immersed in the dominant culture. To challenge that culture first it is required to know that it is at least partially oppressive or potentially incongruent with the individual's beliefs and values. Where the individual is a product of the culture, moulded by education, policy and modelling, such awareness is difficult to achieve. Such challenging of existing traditions to enable new futures requires reflexivity that questions these premises, greater engagement in meaning generation through textual discourse and shared truth appraisal by all. While these behaviours that form the building blocks of social constructionism promise progressive movement, their successful enactment in the lifeworld of service delivery can be questioned.

3.3 Identity

Through seeking to locate a unique MHN contribution to the delivery of psychological therapies by the mental health nursing profession, this study focuses upon MHN identity. This section of the chapter examines identity firstly through the

lens of social constructionism, and then highlights the non-permanent nature of identity. The ramifications of being required to present a fixed identity are also discussed with particular application to mental health nursing and users of their services. This application shows that professional identity is not only bound in multi-disciplinary power struggles, but also intertwined with personal identity, itself influenced by an array of cultural, spiritual and philosophical forces. Through the demonstration of the complexity of the construct of identity, the challenges facing mental health nursing through role expansion are made clearer.

Defining identity as a construct offers some insights into the current influences upon MHN identity. The sociologist Giddens (1997, pp. 582-583) defines identity as:

> … the distinctive characteristics of a person's character or the character of a group. Both individual and group identity is largely provided by social markers. Thus one of the most important markers of an individual's identity is his or her name. The name is an important part of the person's individuality. Naming is also important for group identity.

While Giddens focuses upon the social importance of a named identity, it is the communicative social arena that constructs, dismantles and reconstructs identity through the discourses of individuals with wider social collectives (Eisenberg, 2001). The emphasis on the social underpinnings of identity is echoed by Gee (1999), who offers not only a socially constructionist view of identity but also puts forward the view that there is a multiplicity of identities held by an individual (Gee, 1999, p. 39). Central to this view of identity is that, while a fixed perceived view of self exists as a

core identity, individuals also assume less central identities in response to the contexts of their lives. This informs us that individuals undertake identity self-construction in response to their lived experiences.

From the perspective of social constructionism, identity can be viewed as an active process whereby individuals participate in their own identity formation, hence drawing in defining constructs such as agency and choice. Comparing this with 'recipient' approaches to describing identity such as identity being biologically pre-determined, the individual assumes a degree of responsibility and possibilities for change. Indeed, returning to Gergen (1999, p. 133), social constructionism can be argued as being at the radical extreme in relation to such passive positioning toward identity through viewing the generation of self as being achieved through social action. Through adopting such a view of identity, the focus on understanding MHN identity is therefore drawn toward neither MHNs nor their work environments in isolation, but rather toward the point where these two collide. This collision point is society, the source from which identity is drawn through social interactions that are in turn underpinned by language. It is this social interaction that draws identity away from being simply a 'self-construction' and toward being a 'co-construction' achieved through discourses with other societal members.

Table 3.2 below contrasts the principles of social constructionism with the current social discourses as derived from the literature review and policy documents discussed in Chapter 2 that are then applied to MHN identity.

Table 3.2: Social constructionism and MHN identity (adapted from Gergen, 1999, pp. 47-49)

Social constructionist principle	Application to MHN identity
The terms by which we understand our world and ourselves are neither required nor demanded by "what there is".	Finite descriptions of MHN identity are being conducted with privilege being situated through positivist understandings of MHNs' roles by those outside the profession. Power is hence static in subrogation through claiming possession of the 'absolute truth' rather than a shared appraisal of MHN identity.
Our modes of descriptions, explanations and/or representations are derived from relationships.	Through hegemonic relating, meanings that are unrepresentative of MHNs are created.
As we describe, explain or otherwise represent, so do we fashion our future.	Shared language based in relationships constitutes social life, generates meaning and maintains traditions. Current policy discourses about MHNs seek to sustain traditions of dominance through controlling the interpretations of MHN identity.
Reflections on our forms of understandings are vital to our future well-being.	Performative discourses, which create or perform an action through saying, need to be undertaken by MHNs to shape their own identity.

3.3.1 Temporary identity

This view of fixed and temporary identities is echoed by Howard (2006), who expands upon this concept to emphasise the temporal aspect connected to this multiplicity of identities. While fixed or permanent identity refers to unchangeable characteristics such as ethnicity, temporary identity is associated with changing social contexts and ambiguous identity is associated with an identity orientation containing both permanent and temporary orientations simultaneously. This multiplicity of ebbing and flowing individual identities suggests that self-awareness, accurate self-assessment and adaptability, as well as self-control, are required to inform professional and personal identity development – in short, key features of EI.

Of importance to this study is the future of MHN identity. The future trajectory of permanent identity characteristics would by definition remain unchanged, while those of temporary or ambiguous orientation remain open to influence and moulding. However, even apparently permanent characteristics of mental health nursing are not immune to alteration as they remain open to re-labelling, and re-ascribing of meaning from social sources such as other professionals, within the MHN profession itself, or from government departments. This social construction of identity, achieved through narratives within social settings, not just is externally inscribed, but also has an autobiographical component. This autobiographical account is heavily influenced by interpreting the past and anticipating the future, each temporal account heavily influenced by cultural narrative restraints within the present moment (Howard, 2006). Findings from this study tap into these autobiographical accounts of MHN identity while internally minimising any narrative restraints. However, once these or any other social narratives about MHN identity are forwarded into the professional arena, narrative and interpretive restraints occur. This study's findings while thematically analysed have a dual existence of also being an individual's subjective autobiography with an additional future orientation.

3.3.2 Identity – is it 'right' or required?

While such subjective individualism avoids the rigid categorisation and lumping together of perceived 'type-like things', it is arguably exactly such a labelling activity that the positivist culture of health service provision engages in. Through seeking a

recognisable professional identity within such a positivist culture MHNs would therefore require to present themselves as a homogeneous group articulating a collective professional identity with minimal individual variation. This suggests firstly that all professional groups if placed under such an expectation could present with any sustainable force such an identity to scrutiny. It must also be considered that any homogeneous narrative is by its nature a facade erected to hide a truth. All behind the facade must through either pressure or choices enact this homogeneous 'beingness'. All looking into the facade must be deceived; otherwise the messy truth of a temporally changing, subjective and objective, individual and partially shared identity will be exposed. Only a narrative that exposes a truth about identity as not being a socially constructed 'all-or-nothing' will truly liberate MHN professional identity.

Identity can be seen as an object being different from comparable phenomena. As such, the focus of this study, that of MHN identity, can be seen as an exploratory task to locate difference against other mental health disciplines and other branches of nursing. It is the lack of such articulation of difference that is a driver for eradicating pre-registration training in favour of generic nurse training (Hurley & Ramsay, 2008). Uncovering difference, then, not only assumes urgency but also becomes an imperative for the well-being of an established profession, and for those who attach value to MHNs, such as the recipients of their care and MHNs themselves. Consequently, subjective language attached to such an identity search may include references to terms such as "right", "good" or "just". However, is difference beneficial, benign or even required? Avoidance behaviours exist toward

those whose difference generates discomfort or threatens existing comfortable ways of relating or being (Gergen, 1999, pp. 148-149). Such avoidance obviously negates the possibility of sharing experiences, understandings and, perhaps most significantly, challenges to the existing comfortable traditions of being. Change and the full potential for growth are consequently stunted, resulting both in a simplified understanding of that which is different and in the potential for extremist positioning.

MHN identity or difference within the context of this study can be seen as separateness from other nursing groups and from other disciplines who offer psychological therapies. However, the validity and even the morality of separation from other mental health disciplines can be questioned. If mental health nursing remained separate from other disciplines offering therapies, would the delivery of such therapies and the therapeutic impact upon service users be enhanced or negated? While not the focus of this study, the rhetoric of the efficacy of multidisciplinary working unambiguously informs us that such joint working enhances both the quality and the efficiency of care delivery (Department of Health, 1994). More pertinent considerations are whether multidisciplinary groups work in reality and whether mental health nursing is working toward a chosen position of identity or is being taken to a pre-determined one.

Stark, Stronach and Warne (2002) draw on empirical and clinically based MHN sources to suggest that joint or multidisciplinary team working characterised by collaboration and partnership is negated by power, politics and competition within

and among professions. Within the context of power, influence and politics as well as drawing from the policies and literature raised in Chapter 2, joint working for MHNs may well be considered a pseudonym for being at least partially subsumed within other disciplines in terms of both professional roles and identity. Certainly within this pottage of power, politics and competition the benefits or drawbacks for service users of MHNs being identified as different from other mental health professionals or other nursing groups remain unclear.

3.3.3 Personal identity journeys

The identity considerations examined so far offer only one level of understanding identity, mainly from the perspective of professional roles. Identity not only is temporally bound, but also exists within a multiplicity of discourses that utilise variant names or labels to denote a single phenomenon. As such, a single fixed point of MHN identity can be put forward as not ever having existed; rather it has evolved over history through being influenced by transformational discourses. Such a view is supported by the philosopher Foucault, who proposed that human beings offered such complexities that synthesising a fundamental identity was not possible, particularly owing to their constant state of becoming (Foucault, 1991a, p. 94). The perspective of professional identity being viewed in isolation also assumes that a personal identity is quarantined from MHN roles. Given the investigative topics of mental health nursing and psychological therapies, each grounded in a therapeutic use of self and therapeutic relating that requires an 'I' and 'thee' to relate, such a demarcation of 'selves' is questionable.

This interplay between multiple identities and awareness, identity and work roles was highlighted by Öhlén and Segesten (1998), who specifically researched nurse identity. Interviewed nurses reported an "experience" or a "feeling" on a continuum between weak and strong of being a nurse when describing their professional identity. Interestingly, the reported findings by Öhlén and Segesten (1998) were similar to the view of Gee (1999), who also proposes a wider view of identity that connects professional and personal, and as being both an objective and a subjective construct. As Öhlén and Segesten (1998) described in reinforcing the central nature of the social construction of identity: **"**The subjective part, the person's feeling and experience of her/himself, was considered as the base for the objective part, other people's image of the person as a nurse" (p. 722). Of additional significance to this study is that links between EI and professional nurse identity were also found. Self-knowledge, stress tolerance and professional knowledge as well as trust in one's own capacity and feelings were all raised by nurse participants as significant factors in their personal/professional identity (Öhlén & Segesten, 1998).

As personal identity partially constitutes professional identity, some attention to the understanding of personal identity is required. Mainstream psychology, experiential psychology and spirituality offer three paths through which to explore personal identity. Mainstream psychology places great emphasis upon cognition dictating behaviour, arguably leaving all other aspects of self occupying an underprivileged positioning in developing self-awareness and consequently self-identity (Ehrich, 2003). Currently occupying the evidence based high ground is the

cognitive behavioural view. This view proposes that each person has a schema or a map of herself or himself, the world and the future, which is formed from both real life experiences and attempts to impose meaning upon life events (Beech, 2000). Automatic thoughts and self statements generated by our personal schemata directly influence emotional responses, and consequently our behaviours. Values are placed upon thoughts by ourselves and those around us as being rational or irrational and emotions as either positive or negative. Self-knowledge and change focus upon knowing and subsequently altering our faulty life schemata. This predominantly positivist epistemological view of self-identity and of psychological therapies boldly proclaims accurate empirical measurement of human subjective experiences within a framework of humanistic principles (Beech, 2000).

In contrast to cognitive behavioural approaches, existential psychology places primacy upon an experiential self that precedes cognitive labelling or categorisation of experiences (Clarkson, 1989, p. 13). More congruent with phenomenological philosophy than with biological models, this approach sees the self as an integration of physical body, intellect and feelings, as well as perceptions, within a social environment. Perceiving, feeling and behaviour are phenomenologically undertaken, rather than the emphasis being upon re-inscribing existing schemata. This phenomenological approach allows a stepping aside from habitual thinking patterns, consequently allowing the potential for the enhanced existential perception of both self and the external environment (Idhe, 1977, as cited in Yontef, 1993). Consequently both subjective feelings and objective observations are considered to have real meaning. A connectedness is evident here between a

psychological approach directed at self-discovery and a research methodology directed at 'other' discovery (Hurley, 2008b).

Spiritual models of self-construct identify self-concept as the totality of the individual's thoughts and feelings, creating a subjective phenomenon originating from and continually influenced by social experience (Bhugra, 2007, p. 126). This self incorporates factors such as characteristics (gender), roles, abstract identification (ideology), interests (judgements), physical self, personality and external references (judgement input by others). These characteristics are bound by systemic senses of self moral worth, self-determination, unity and competence (Gordon, n.d., as cited in Bhugra, 2007, pp. 128-29). Spirituality may be seen as constituting a broad faith or the values and ethics by which we conduct ourselves. Within this view, spirituality offers enrichment of the mass driven formulations of self-identity which in turn give impetus to alternative views of engagement between self and the external environment, emphasising the emotional and contextualised self within character influenced decision making (Cox, Campbell & Fulford, 2007, pp. 20-21).

Held values do not occur in isolation but are formed or at least partially formed by societal and cultural influences heavily influenced by change. Arguably such societal change generates an increasing superficiality of self, dominated in our western society by presentation and style (Conway, 2007, p. 73). Our western society is also dominated by a break with extended family and clan, culminating in perceiving others and self as individual, separate from family influences and predominantly

empowered by economic affluence alone. In turn, these influences impact upon the values that we carry into relating as both citizen and professional with an increasingly complex world (Conway, 2007, p. 76).

3.3.4 Professional identities journeys

As with personal identity, professional identity can be viewed as a dynamic construct, evolving from a past and toward a future identity position. This journey toward professional identity has been associated with both educational and work based experiences (Reid, Dahlgren, Petocz, & Dahlgren, 2008). Within the context of professionals generally, and for this study the professional identity of MHNs in particular, influences shaping both the current and the future journeys of MHN identity are often external to the profession. As discussed in Chapter 2 when analysing key policy documents, these influences have a profound impact upon the professional roles of MHNs. One key influence permeating through such policies is moving professional culture toward delivering increasing efficiency, predictability and control, often through generating universal professional standards expressed as competencies or capabilities (Turner, 1993). While universal conformity to high standards of competencies may initially appear to hold no fears for any professional, this view assumes the rational application of approaches to achieve efficiency, predictability and control, approaches that sit in the lifeworld of work environments. However, as Ritzer (1983) evocatively proposes, such McDonaldisation of organisations can equally generate irrationality and inflexibility through over rationalisation.

Irrationality can also be generated through increasing points of tension existing between the idealised 'universally competent collective professional' MHN identity and the reality based 'individually competent professional' identity. Such tensions are exacerbated when not only the competencies but also the tools for and the approaches to achieving wellness for service users are made universal. Within this wider context, all service users requiring psychological therapies would for example be offered the "CBT wellness nutrition" from the tick box menu of "Improving access to psychological therapies implementation plan: National guidelines for regional delivery" (Department of Health, 2008) and evidence based practice of "Best practice competencies and capabilities for pre-registration mental health nurses in England" (Department of Health, 2006b) to the exclusion of any other possible intervention. It is this caveat that highlights the generation of irrationality and inflexibility through over rationalisation, the irrational aspect being that the service user's diverse individual needs must conform to the restricted outcomes of the policies that were initially designed to be service user focused.

Stronach, Corbin, McNamara, Stark and Warne (2002) identify further tension points for contemporary professionals. In the concept of the 'collective professional', the interplay between personal and professional identity comes into focus. MHNs, as are many other professional groups, are 'lumped' into named categories, names that, as earlier highlighted by Giddens (1997), have significant influence upon perceived identity. A well known example of this within nursing is the groupings ranging from novice to expert practitioner (Benner, 1982). The plethora of categories in which MHN identity performances occur offers at least

some insight into understanding the identity confusion of the profession. Somewhere in the midst of simultaneously being an “agenda for change level 5”, “in-patient staff nurse” or “level 6 professional skills for health framework”, the personal identity exists and attempts to be expressed. This same nurse may also have additional titles of acute care specialist, nurse specialist, nurse therapist or nurse prescriber or more generic titles such as mental health officer or therapist.

This breadth of collective professional titles in itself suggests an identity crisis for the mental health nursing profession. The resultant disjointed, reactionary and “jack of all trades” (Crawford, Brown, & Majomic, 2008) professional approach of MHNs may negate a deeper engagement with any single role or approach to level of identifiable expertise. Indeed, in their well supported study of MHNs Stronach *et al.* (2002) found nurses reporting conflictual, hollowed out and uncertain roles, seeking a professional identity that had not been found. Arguably, this can be seen as manifesting a lack of acceptance of the externally derived categories and roles that influence MHN professional identity, whilst simultaneously demonstrating the absence of a collective engagement in generative discourses that feed into forming a professional identity for themselves.

Organisational considerations also come to bear upon the direction taken by professional identity formation. Stronach *et al*. (2002) in their study of both teachers and MHNs dichotomised the broader organisational influences as being economies of performance and ecologies of practice. Performance economies are typically audit driven requirements of professional performance that may or may

not be in conflict with performance directing knowledge gleaned from ecological sources such as individual experiences. While neither constitutes an absolute 'truth' about how professional practice should be enacted, the influence of proliferating quality control measures is significant to professional behaviours and hence identity. Such quality control seeks standardisation above all else, best achieved through bureaucratic structures (Limerick et al., 2002, p. 84). This bureaucratic structuring of health care delivery arguably locks nursing care into inflexible patterns of behaviour, which are unproductive for change. Consequently, optimal participation, generation of the most workable alternatives and maximal use of all participants' talents in planning and responding to change are mitigated (Hurley & Linsley, 2007b). This stance reflects that of the mental health nursing profession itself, existing as it does within rationalistic economies of performance and more experiential ecologies of practice (Stronach et al., 2002).

While it is perhaps a provocative comparison, the control enacted to achieve the economies of performance can be argued as reflecting at least the concept of panopticism (Foucault, 1991a, p. 200). Derived from the design of a French prison where prisoners were partitioned so as to be observed without seeing the supervisors or making contact with other inmates, panopticism creates a distinctive power relationship. As prisoners knew that they were being observed, they engaged in self-regulated behaviour to avoid punishment. As Foucault explains, people are made subjects and then move toward subjecting themselves to control. In the case of economies of performance, as increasingly new ways of performance

economies are utilised through power, control and acceptable knowledge, identity is tied to that way of being a professional (Foucault, 1991a, pp. 200-202).

In recognising the need for responsive structures and staffs, health organisations have sought to meld neo-corporate organisational structures to existing bureaucratic ones. This melding of bureaucratic and neo-corporate structures encompasses core theoretical issues of organisational discontinuity, neo-corporate bureaucracy and ineffective leadership as well as disunity toward organisational values and consequently disempowered staff (Limerick et al., 2002). Additionally, organisations have expectations of staff productivity, initiative, accountability and creativity. This expectation, with an emphasis on the proactive individual, potentially offers incongruence between communicated organisational expectations and neo-corporate bureaucratic managerial behaviours. Such incongruence in turn fosters a sense within staff that the organisation and its leaders are not respecting of staff, with a resultant exacerbation of a victim rather than a participant identity (Hurley & Linsley, 2007b). Given such inner conflict, a beginning point for understanding many health organisations is theoretically akin to individuals embarking upon psychotherapy to find their true selves. The core individual question in those circumstances of “Who am I?” is altered for the organisation to “What am I?”, hence confusing all those in contact with it (Hurley & Linsley, 2007b). The NHS organisation in which MHNs dwell can therefore be seen as an important influence upon the professional identities of MHNs.

Another organisational influence upon the identity of MHNs is that multi-disciplinary teams are increasingly being developed. Historically in the UK each discipline operated separately, with teams of community mental health nurses working in relative isolation from social workers, psychologists or counsellors. However, this is being increasingly replaced, as is seen in the example of crisis resolution and home treatment teams. Hundreds of these services have been established across the UK over the past five years, nearly all being multi-disciplinary (Onyett, Linde, Glover, Floyd, Bradley & Middleton, 2006*).* Identity previously attributed to a profession such as mental health nursing can within the midst of radical organisational change be attributed instead to departments or teams (Callan, Gallois, Mayhew, Grice, Tluchowska & Boyce, 2007).

Indeed, Callan *et al*. (2007) strongly support an argument that identification with larger social categories such as professional groups offers less opportunity to achieve distinctiveness and inclusiveness when compared with a smaller multi-disciplinary team. As MHNs self-categorise membership and identify with organisational groups for self-enhancement, those in multi-disciplinary teams are theoretically more likely to exhibit behaviours consistent with their chosen groups' interests and objectives (Hogg & Terry, 2000). However, in a robust study of over 600 professional health staffs in multi-disciplinary teams experiencing organisational change, Callan *et al*. (2007) found that over 65% strongly identified with their professional department rather than the smaller work unit. This suggests that underpinning professional values remain highly relevant to the individual's identity, and can be made more relevant when perceived as being under threat.

3.4 Underpinning MHN epistemology

The issue of identity having been looked at from a theoretical perspective with MHNs in the background, it is a subtle yet important shift of perceptive to look now at what is mental health nursing with identity in the background. So what is a mental health nurse? Authors such as White and Roche (2006) offer a provocatively broad and highly inclusive definition that is also evidentially free of specialist axiomatic and epistemological underpinnings, education or registration:

> A mental health nurse is defined as a nurse of any category (registered, enrolled, assistant in nursing), working in a position that is primarily focused on the treatment and care of people with mental illness. The definition applies to nurses working in inpatient, ambulatory-care, or community-residential settings. (p. 209)

By contrast, Happell (2006) offers a more pragmatic view of holding distinctive professional registration achieved through undertaking specialised MHN training and clinical experience. Regardless of which polarised definition is used, it appears that mental health nursing is losing clarity as a distinct professional group, as exemplified by the loss of a separate professional identity (Holmes, 2006). Indeed, Holmes (2006) goes on to predict that, given the future trends of diminishing recruitment for all health disciplines, a 'post-professional' era will develop where the identity focus will not be on a particular professional group, but instead on matching the service users' needs to the capability profile of the care giver. This view of a radically different future MHN professional identity is not dissimilar to that of Barker (2006), who advocates less attention being paid to the role of MHNs

in favour of what people need from them. In further advocating for diverse types of MHNs, Barker (2006) highlights the imperative of being united by an ethical focus on non-maleficent interventions and fostering nurturing therapeutic milieux rather than being fixated on quantifying MHN roles and subsets. Whilst such challenges face the MHN profession, the majority of the MHN debate manifestly ignores the issue.

Contemporary professional debate about the nature of mental health nursing increasingly revolves around issues of emphasising realistic paradigm evidenced interventions and promoting nursing as humanistic caring (Ramsay, 2006). Such a polarised debate reflects the ongoing difficulty that mental health nursing has had in being able to define or to distinguish itself from other professional bodies in the mental health field (Clarke, 2006). At the most fundamental level a basic shared ontological and ethical stance is required for any relationship to occur. This shared stance needs to be underpinned by a common language that in turn supports a common reality and agreement on acceptable behaviours (Gergen, 1999, p. 81). Indeed, the identity of MHNs continues to be formed rather than 'informed' through a deconstructive lens, gradually reducing their professional identity into compartments of capabilities and tasks such as those identified by the Chief Nursing Officer reviews and Ten Shared Capabilities (Sainsbury Centre for Mental Health, 2004; Scottish Executive, 2006a). This reflects the wider concerns identified by Stronach *et al.* (2002), who highlight the imperative for professional 'self' identity to be reconstructed from within and against the increasingly economic and audit driven culture in which it dwells.

This requires MHNs to have both voice and agency. Agency, or the capacity for voluntary social action, is powerfully entwined with the social structures in which it is performed, each potentially influencing the other toward change (Giddens, 1984, p. 25). Given the longstanding disempowerment of staff through not only autocratic leadership but also mental health nursing culture, achieving effective voice and agency appears a challenge. Mental health nursing culture is historically grounded in dependent role delineated asylum attitudes (Nolan, 1993, as cited in Hurley & Linsley, 2007b). Continuity of roles combined with values such as loyalty and expectations of lifelong employment hold deep historical roots in mental health nursing, arguably more so than in other professional groups (Nolan, 1993, as cited in Hurley & Linsley, 2007b). These roots can be seen in asylum graveyards where patients and family generations of staff are buried side by side, a powerful symbol of the ingrained concept of being a corporate citizen. This professional cultural history is compounded through British cultural history, containing hierarchical values and a leadership social class (Grace, 1995).

This historical view of a disempowered mental health nursing profession initially appears to offer little hope of vibrant voice and agency being employed to construct an internally driven professional identity. However, turning to Foucault (1988) offers a potential for a less pessimistic view. Disempowerment, as described by Stronach *et al.* (2002) and within the context of this study, is connected to diminished influence on clinical decision making and to the potential 'ownership' by the psychology and medical disciplines of the delivery of psychological therapies. As highlighted by Clinton and Hazelton (2002), such a view of power assumes it as

being a finite resource, held by one group or position and hence denying other groups or positions access. Foucault (1988), however, eschews resistance toward power; as he states:

> Even though the relation of power may be completely unbalanced or when one can truly say that he [*sic*] has 'all power' over the other, a power can only be exercised over another to the extent that the latter still has the possibility of committing suicide, of jumping out of the window or of killing the other. (1988, p. 12)

While this is somewhat dramatically stated, the message of unseen possibilities, of solutions as yet unseen and ultimate self-determinism has relevance to MHNs. Foucault (1988) places the emphasis in resistance to dominance on self-mastery, which is central to not only identity but also EI and psychological therapies:

> [This i]s precisely the challenging of all phenomena of domination at whatever level or under whatever form they present themselves – political, economic, sexual, institutional, and so on. This critical function … emerges right from the Socratic imperative: "Be concerned with yourself, i.e. ground yourself in liberty, through the mastery of self". (Foucault, 1988, p. 20)

As is already suggested through discussions of social constructionism, the palpable nature of MHNs' disempowerment may be seen as the effect of resistant discourse on more dominant professions. MHNs have not only choice in how they react to role expansion and defining influences on how these roles are transfused into clinical practice, but also the incumbent responsibility toward action that rests with choice. If, as Foucault (1988) suggests, power is unlimited then it is the mental health nursing profession that must generate influence.

3.4.1 Splits and schisms

The diversity of the profession's epistemological stances toward mental health is possibly reflected in the range of roles that they have assumed and in the capacity of many to perform a multiplicity of roles, ranging from relationship formation to complex psychological or pharmacological interventions (Fitzpatrick, 2005; McCabe, 2006). Indeed, such reflexivity may in itself be the defining professional characteristic of MHNs. Less diverse, however, are the professional axioms which are predominantly client centred and interpersonally driven (Peplau, 1987). Rydon (2005) sought the views of service users to overcome the ambiguity of mental health nursing's poorly conveyed frameworks, philosophies and theories. The service user perspective about who is a MHN arising from the study conducted by Rydon (2005) targeted and prioritised personal qualities, relationship formation qualities and communication skills rather than specific interventionist skills.

As previously stated, the mental health nursing profession is arguably epistemologically polarised between medical model approaches and that of the

tidal model, which is outlined shortly. Intertwined with this polarisation is another polarisation – that of the strategy and person enabled MHN. What is argued is that, through making individual MHN enablement a primacy, nurses will be better equipped to meet the needs of their clients and organisations, as well as themselves. While unarguably requiring educational creativity to achieve this outcome, this focus upon person enablement places the emphasis of MHN upon human engagement and self-reflection, thereby echoing the established philosophical underpinning of Peplau (1987).

Such underpinnings offer professional stability within the context of rapidly evolving roles and organisational fluidity. Such an approach may also offer an identity marker to which the MHN profession can more homogeneously ascribe (Hurley & Rankin, 2008). The alternative emphasis on enabling MHNs in strategy based interventions such as prescribing and CBT would ideally 'sit behind' the person enabled MHN and be enhanced by it through being based upon interpersonal competence. By contrast, the amenability of measuring psychomotor and cognitive objectives for purposes of audit and governance has possibly resulted in workplace training and education placing more emphasis on strategy attainment.

3.4.2 The medical model

It is such amenability to empirical measurement that supports the first of the two epistemological models underpinning mental health nursing. Additionally, the certainty that the medical model communicates what mental illness is and how to respond to users' needs offers a concrete assurance to its advocates within a

professional field more accurately defined and characterised by uncertainty and consequent anxiety (Lakeman, 2006). Freund, McGuire and Podhurst (2003, pp. 6-7, 220-223) set out the major assumptions of the medical model, beginning with identifying the model as creating a mind–body dualism with a reductionist view of illness. The obvious outcome is that an individual experiencing mental illness requires the expertise of the medic, and is a passive recipient of treatment until the chemical or structural treatments initiated by the medic have their impact. Treatments can be expertly identified by the medic as the model assumes that each disease has a specific aetiology that disrupts the efficient functioning of the body, seen by the medic as existing within a machine metaphor that necessitates a regime of control to be placed upon it to resume full functioning. As a consequence of this approach, the illness, identified by labels created by medics, lies within the sphere of the individual separated from relationships and society.

Within the UK context of mental health, the medical model was effectively placed in the administrative, philosophical and financial control of mental health 200 years ago, through parliamentary laws excluding all other professions from running asylums. The most elementary feature of the medical model is that disease originates from organic tissue malfunction, logically requiring corrective interventions to focus upon rectifying the functioning of the tissue. Consequently, medical model explanations of depression and psychosis dwell in imbalances of neurotransmitters and acetylcholine addressed through medications designed to rebalance these chemicals. Diagnosis is achieved through identifying clinical signs and symptoms that in turn indicate which disease process is occurring and hence

which medications to utilise (American Psychiatric Association, 2000). The diagnostic labels are drawn from the Diagnostic and Statistical Manual IV-TR (American Psychiatric Association, 2000) that, despite the positivist evidence base that supports its use and the use of medically based treatments, has virtually no listed aetiology for any of the listed mental illnesses.

The importance of this construction of disease labels and treatments for MHNs is that the historical power of the medical model alongside the explanation for illness dictates their daily roles and hence identity (Coleman, 2000; Manning, 2007). If, as the medical model explains, mental illness is generated solely from physiological disorders then the medical profession is the most qualified to 'cure' it. They must therefore be clinically in control as well as ensuring that the organisational structures allow for effective medical care. MHNs therefore have the subservient role, responding to medical directives rather than initiating helping interventions and structuring the working environment for the medics. MHN tasks will be logically centred on medical treatments such as ensuring medication compliance and limited prescribing rights and monitoring the efficacy or side effects of medical treatments (Brooker & Butterworth, 1994).

3.4.3 The tidal and recovery models

The tidal model is a very recent model for MHNs that is derived from the work of Phillip Barker, who believed that mental health nursing lacked a congruent model of care that was inclusive of social and cultural dimensions of what is commonly referred to as mental illness. The model seeks to draw the MHN toward the human

needs of people from a strengths based perspective. Rather than focusing upon the illness, the tidal model seeks to emphasise comprehending the person's current situation within the context of that person's experiences of herself or himself, those around her or him and the wider world (Barker, 2000). These three contexts emphasise mental illness as a manifestation of a problem of living rather than a disease. Also in comparison to the previously outlined medical model, the client rather than the practitioner is seen as a resource for achieving wellness.

The tidal model draws from chaos theory, itself focusing upon unpredictable discontinuous change, and holds few assumptions about the correct process and end point course of a person's life, preferring instead to focus on the kind of support that people might need. In terms of the model's impact on MHNs, Barker (2000) differentiates between psychiatric nurse functions and MHN functions. The latter more direct interventions are utilised when the client is highly dependent and vulnerable, while MHN interventions involve an even more collaborative approach to the client's personal growth and self-discovery. Philosophically framed by phenomenology, the tidal model has a narrative structure reflective of social constructionism, in that the documentation of assessments and records is notated verbatim, consequently allowing the voice of the client to be heard rather than allocating primacy of interpretation to the mental health practitioner. Clients' narratives of themselves and of those around them hence retain individual meanings and address disempowerment through promoting marginalised voices. Table 3.3 shows the key assumptions and MHN capabilities within the tidal model.

Table 3.3: Tidal model competencies (adapted from Buchanan-Barker & Barker, 2008, pp. 95-97)

Underlying assumption	MHN tidal model competencies
Genuine curiosity opens understanding of the client's story	Capacity to listen actively to the person's story Capacity to help the person express herself or himself at all times in her/his own words Capacity to show interest in the person's story
Focus upon client resources, both personal and interpersonal, rather than deficits and weaknesses	Capacity to help the person develop self-belief Capacity to help the person develop awareness of how s/he, others or events have influenced changes
Respect for the client's wishes, not paternalism	Commitment to helping the person record her/his story in her/his own words Capacity to help the person express herself or himself at all times in her/his own words
Crisis is a growth opportunity	Capacity to help the person identify what needs to happen in the immediate future
All goals are owned by the client	Capacity to develop a care plan based, wherever possible, on the expressed needs of the person Capacity to help the person develop awareness of how s/he, others or events have influenced changes
Effective interventions are sought at the simplest level	Capacity to help the person identify specific problems of living and a solution plan Capacity to help the person identify what change would be a step toward a problem of living

Arguably the underpinning foundations of the tidal model are not unique. Rather the model appears to borrow from phenomenology, social constructionism and brief solution focused therapy, as well as incorporating basic nursing tasks such as assessment, planning and intervening. Certainly through merging these congruent constructs and then applying the merger to mental health nursing, a very different client and MHN process is undertaken. While the medical model focuses upon

illness and external chemical treatments, the tidal model embraces a holistic view of the person and her or his life voyage. Consequently, MHN roles expand beyond responding to medically initiated treatments to co-responding with the client to the client's needs for more successful engagement with life. The roles and required competencies for each model inform and reflect upon professional MHN identity.

The tidal and recovery models have been presented together as they are very similar, differing mainly in that the recovery model grew out of the service user movement (May, 2000). The recovery model consequently takes the stance that the service user owns their own recovery process, as distinct from practitioners or services. The recovery model also places an emphasis on the lived experience of the service user, rather than levels of symptomatic control to focus interventions and outcome expectations. Recovery hence differentiates itself from cure in that it seeks a recovery of the person with, or without a recovery of the illness (Davidson, 2005). Clearly power and re-distribution of power are central here with health and social practitioners needing to engage in discourses that promote such power rebalancing toward service users (Masterson & Owen, 2006). Collaborative approaches that encourage self management, and that view the service user as an expert on their own needs are the desired outcomes of such power focused discourses (Davidson, 2005).

3.5 Underpinning educational epistemology

Both current and future MHN identity, as well as MHN successful engagement with psychological therapies, are directly influenced by education and training. This

section of the chapter examines the teaching and learning models that have application to mental health nursing. Transformational learning is outlined and subsequently shown to be the foundational learning block to heutagogy, offered as being the approach to mental health nursing requirements that is most congruent with delivering talk based therapies. Work based learning is also given prominence in this section of the chapter as the work environment is the major learning environment for MHNs, as well as being potentially problematic.

Mental health nursing education is challenged to provide 'end product' practitioners in relation to knowledge and skills for practice, as well as developing related underlying values and attitudes. As this study seeks to commence informing a MHN driven curriculum for education and training to deliver psychological therapies, an educational model that is congruent with all the constructs needs to be identified. Within the context of this study the term "training" pertains to MHNs gaining competencies to undertake their professional roles successfully, while the term "education" is used to refer to the wider acquisition of knowledge and understanding beyond specific work based roles alone.

3.5.1 Transformational learning

Transformational learning, which is closely linked to the work of Mezirow (1994), is a form of learning that pertains to adult learners, and is hence relevant to nurse education. Transformational learning is centred on the way in which human beings communicate and, while it is not totally focused on self-transformation, it does have this as a significant aspect of its end product of learning. Arguably,

transformational learning holds a constructivist view of learning and knowledge, as well as a generative approach to knowledge and the self. These tenets are visible though seeing learning as the "process of using a prior interpretation to construe a new or revised interpretation of the meaning of one's experience as a guide to future action" (Mezirow, 2000, p. 5). Additionally, with transformational learning learners reflect upon past experiences from a new perspective, subsequently generating new present and future orientated meanings from past ones (Mezirow, 1994). These frameworks of reference are seen as unconscious assumptions that shape our experiences and direct our social actions, and as such challenge taken for granted mindsets to be more inclusive, discriminating and reflexive (Mezirow, 2000). The list below exhibits Mezirow's view of this process:

Mezirow's Phases of Meaning in Transformational Learning (1981)

1. Confrontation with disorientating dilemma.
2. Self-examination occurring with feelings of shame, fear, guilt or anger.
3. A critical assessment of assumptions occurs.
4. Recognition that one's discontent and the process of transformation are shared.
5. Exploration of options for new roles, relationships and actions.
6. Planning a course of action.
7. Acquiring knowledge and skills for implementing one's plans.
8. Provisional trying of new roles.
9. Building self-confidence and competence in new roles and relationships.
10. Reintegration into one's life on the basis of conditions dictated by one's new perspective.

Certain conditions are recognised as being vital within this process that facilitate rational discourse and that need to be in place for transformation of meaning perspectives to be achieved. These ideal conditions include having complete information, being free from self-deception and being able to evaluate arguments objectively, as well as having an opportunity to participate in the various discourse roles and being free to express views, a cluster of circumstances arguably not always in place within practice settings (Mezirow, 2000). As highlighted by Merriam (2004), what is also problematic within this model of learning is that a high level pre-existing learner cognitive functioning appears necessary to be able to engage with transformational learning. This highlights that being able to engage in reflective discourse requires the capability to explore alternative perspectives while withholding judgment. Critical reflection is also compared by Merriam (2004) to a range of developmental models, all indicating a high level of cognitive development. Within the context of this study, however, one would expect MHNs to have such levels, and so be generally receptive to transformational learning as a medium to engage with learning to uptake roles in delivering psychological therapies. Additionally, Merriam (2004) concentrates her case on a cognitive perspective alone, ignoring EI constructs such as empathy, self-awareness and adaptability (Goleman, 1995).

Authors such as Dirkx (1998) take an even wider view of transformational learning through incorporating a spiritual, or at least a cognitive, element of transformation. Dirkx (1998) studied students who engaged in meditation and established a link

with transformational learning in terms of altered meaning perspectives. Spirituality may be seen as constituting a broad faith or in adopting a wider view and may also be seen as the values and ethics by which we conduct ourselves. Faith traditions offer enrichment to narrow cognitive formulations of transformation, in turn giving impetus to alternative ethical views and emphasising the emotional and contextualised self within character influenced decision making (Cox, Campbell & Fulford, 2007, pp. 20-21). This latter wider view incorporates the work of MHNs and adds worth to viewing transformational learning as a pertinent educational framework.

McAllister, Tower and Walker (2007) offer an application of transformational teaching to nursing. Of relevance to this study McAllister et al., (2007) show how transformational learning can be applied to influence values and attitudes that in turn impact upon effective utilisation of evidenced based interventions, and consequently diminish the theory-knowledge gap in nursing. Additionally, McAllister et al., (2007) make links between transformational teaching and important EI constructs such as self awareness and other awareness, as well as mental health service user issues such as nurses gaining increased awareness of inequalities and social marginalisation. Indeed, transformational learning with its emphasis upon self awareness can be seen as a vital underpinning to pedagogies such as heutagogy in that it fosters the development of EI capabilities, and hence contributes to the development of MHN identity. Finally, McAllister et al., (2007) demonstrate the importance of enabling learners to have critical evaluation and self directive skills to effectively engage with the clinical environment to gain

important learning, and hence develop as clinicians. This is clearly of relevance to this study as MHNs engage with both academic and clinical learning environments to develop their roles in talk based therapies.

3.5.2 Work based learning

Work based learning also offers a potentially significant component of education and training for MHNs assuming new roles. Tacit knowledge, where individuals obtain intuitive knowledge through attaining experiential learning experiences, has historically been the bedrock upon which nursing knowledge was accumulated (Raelin, 2007). This style of learning has been acknowledged not only as being effective in unstructured environments, but also as having a social base through sharing of experiences within a collective work environment. Mental health nursing has a large work based learning component directed at pre-registration, postgraduate and continuing professional development education and training. Indeed, half of all pre-registration training is in clinical placements that require learners to complete successfully learning based outcomes to be able to progress toward full registration.

While integral to MHN education and training, tacit information is accessed through recognition of work based circumstance without individuals having the capacity to articulate what it is that they know or even how they know it. Formal clinical supervision and reflective practice systems are required to utilise, enhance and legitimise tacit learning. Additionally, within these work-based learning environments MHNs will be working at the edge of their existing knowledge, skills and coping capacities, as well as dealing with the widely recognised emotional

pressures of working within acute mental health care (Huxley, Evans, Webber, & Gately, 2005; Lakeman, 2006).

These demands and those arising from role expansion necessitate the uptake of clinical supervision and reflective practice by MHNs. However, Edwards, Cooper, Burnard, Hanningan, Adams, Fothergill and Coyle (2005) highlight in their study of MHNs that, while clinical supervision represents an excellent means of coping with work related stress, MHNs preferred less formal approaches to stress reduction. Additionally, reflective practice and clinical supervision are currently poorly integrated into mental health nursing practice (Hyrkäs, Appelqvist-Schmidlechner, & Haataja, 2006). Reluctance about greater MHN participation in reflective practice and clinical supervision is a complex issue. Cottrell (2002) offers an overview of such issues in his study that uncovers themes of organisational tensions and mistrust among MHNs, their superiors and their employers. MHNs are likely to perceive that supervisors are colluding with management and that the supervision process is one of attack upon them, that little trust exists with the authority figures or that supervision is undertaken with tokenism, resulting in the whole process failing. Lynch and Happell (2008) highlight the vital stage of priming the organisational environment to promote the chances of clinical supervision being an effective work based learning measure. Interventions such as clearly communicating the difference from managerial supervision, underpinning the clinical supervision process with solid leadership and initiating supervision through a structured process are all identified as means to address historical MHN barriers to implementation.

While the NMC maintains a non-compulsory stance toward clinical supervision, a nursing response to integrate clinical supervision into practice will remain challenged. Within the context of delivering psychological therapies such a voluntary approach to clinical supervision is in direct contrast to the requirements of the role. This increases the likelihood of MHNs who engage in talk based therapy roles seeking or being given clinical supervision from outside their own profession. This outcome can potentially both contribute to a widening of knowledge through drawing from other professions and distance the participant from the MHN profession.

3.5.3 Heutagogy

What emerges from the previous discussions of approaches to education and training, and the barriers to integrating effective work based learning approaches, is that a synthesis of theory and practice is required to enhance MHN capabilities. In turn, such a synthesis requires a framework upon which to sit, a framework which provides a unifying lens through which education and training can be viewed.

Central to educational and training considerations is whether knowledge and learning are sought or taught, with the latter assuming an objectivist paradigm of learning. Paradigmatic assumptions congruent with this stance stem from the central position that reality exists independently from beliefs and experiences (Searle, 1993). Consequently, knowledge is objective and taught through predominantly pedagogically driven theoretical and practical reasoning. It is a reasonable view of current nurse education and training that nurses accumulate

knowledge and then, directly or indirectly, apply this knowledge to their practice. Improved practice logically then is a process of more knowledge accumulation and better application of that knowledge, a process that has been the primary force behind nursing education, training and research, as well as the vehicle of evidence-based practice (Ceci, 2003).

Phelps and Hase (2002) contest this rationalistic view by identifying through complexity theory that phenomena are unpredictable and are influenced by agent interaction. Within complexity theory great importance is placed upon both the interconnectedness of variables and the emergent qualities from those interconnections, with outcomes arising as much from the relationship among variables as from their intrinsic characteristics (Radford, 2006). Also central to complexity theory is that change within any system is continually evolving, and can be argued as being at least partially self-organised. Within the highly managed and risk averse health environments in which nursing is conducted, the acceptance of change being self-organising is a remarkable point of tension. In conjunction with this, the effects of change lack predictability in terms of reactive behaviours toward either self-directed or managed alterations. Learning consequently requires opportunistic flexibility in terms of content, process and timing, a shift away from proactive preparation for learning and toward sequential reflexive reactions to capture transitory learning opportunities as they arise and temporarily stabilise within a chaotic environment.

Heutagogy, a learner or self-determined approach to learning, reflects such a stance through acknowledging that people learn through random response to unpredictable need, frequently when faced with the limits of their current knowledge or capabilities (Hase & Kenyon, 1999). Learning content and timing are consequently determined by the learner situated within this unpredictable and constantly changing environment. Learning is likely to occur away from structured formal learning environments, and can therefore be linked to the value of learning within practice based settings. What is also highlighted is that heutagogy influences holistic learner development, inclusive of capability and underpinning values. This wider view of learning therefore incorporates aspects of discourse based transformational learning (Mezirow 1994, 1996) and self-directed problem based andragogical learning. As a new and emerging educational construct heutagogy is certainly contestable and would require the learner to be highly self aware so as to identify their learning need. Indeed, rather than viewing heutagogy as another educational revolution, it can be seen as an evolutionary step toward melding education and training with the lifeworld determinants of adult learners. Heutagogy reflects the complexities and unpredictability inherent in nursing whilst simultaneously acknowledging the requirements for individual capability in terms of knowledge, skills and values, as well as learner holistic development (Phelps & Hase, 2002; Stephenson, 1994).

Uncertainty surrounding the learning environment can be viewed within the context that heutagogy is underpinned by Rogers' (2007) theory that learners are seen as only facilitated toward learning, rather than being directly taught. This

facilitation reduces the opportunity for the learner to experience being under threat, consequently allowing a relaxation of ego boundaries and hence being more open to learning. Effective heutagogic environments can consequently be seen as those that minimise threat to the self and that promote differentiated perception of experience (Ashton & Newman, 2006).

Within MHN learning environments, the presence of both personal safety and the acceptance of variable experiential perceptions could be argued as being, to revert back to complexity theory, unpredictable. Self can be argued as being threatened on a professional level through increasing managerial directives directing responses to environmental stimuli or through physical challenges of potential violence and aggression. Lakeman (2006) offers a thoughtful insight into the emotional cauldron in which MHNs operate. In uncertainty being identified as an occupational theme, the genesis of emotions such as fear and anxiety becomes apparent. Uncertainty is related to the diagnosis, treatment and origins of 'madness' but could have been extended to include the ethical and moral implications related to such uncertainties. Additionally, self-defeating coping strategies such as constructing facades of certainty to deal with permeating uncertainty are identified as typical occupational responses. Holmes (2006) in her paper exploring the recruitment and retention challenge facing nursing also uncovers vital learning environment challenges applicable to heutagogy. Given that the baby boomer generation is being replaced by generation X and generation Y as university students, a different set of values and expectations exists. The structured, unhealthy and emotionally

cold *milieux* of hospitals, combined with the stressful nature of nursing work, generate high attrition rates both during and after nurse training.

3.5.4 Educational splits and schisms

Given Radford's (2006) identification of the importance of the interconnectedness of factors, and the emergent qualities from those interconnections within complexity theory that support heutagogy, an examination of the key education and training stakeholder relationships highlights the challenges in preparing nurses for practice. As nurse training is shared, it is obvious that both academics and clinical staff have an equal responsibility for the quality of learners' educational and training experiences (Timmons, Randall & Park, 2005). Yet despite considerable attention the issue of structuring effective links between academic and practice based stakeholders in nurse education and training lacks a conclusive best practice model. There exists recognition within the literature that practice based learning is an essential component of education and training, and that melding practice based learning with academic components is a challenge for all stakeholders. Despite this high profile of practice based learning, Pollard, Ellis, Stringer and Cockayne (2006) identify that the majority of studies focusing on mentorship are small scale in nature with low level general application of findings.

Allen and Simpson (2000) offer a preceptorship focused evaluation of mental health stakeholders in pre-registration training for identifying common problem areas. What emerges is that the quality of communication among these stakeholders influences the efficacy of linking academic and practice based learning. Through

drawing on the experiences of tutors and preceptors, the study also highlights a disparity between the perceived focus and the priorities of each professional group. Tutors offering preceptor updates often cancelled sessions owing to low attendance, while preceptors experienced a lack of information regarding the academic curricula. Additionally, the link tutor role was identified by both students and preceptors as vital in terms of support and communication, yet a clarification of what this support should entail was absent. Tutor application to the link role was reported as highly variable owing to issues such as workloads and travel.

Management was also identified as playing a key role in terms of preceptor support and in maintaining communication with academic based stakeholders. The pivotal role of preceptors is further highlighted by Mullen and Murray (2002), who identify a causal relationship between the attitudes, skills and experience of precepting clinicians and students' experiences of their placements. Key issues included the level of organisational knowledge, the ability to manage workloads and the level of confidence of the preceptor in performing this aspect of her or his role.

Regardless of the linking model being utilised, tutor roles specifically resonate with themes of competing work commitments and role ambiguity. Brown, Herd, Humphries and Paton (2005) emphasise that students place high value upon lecturer placement visits despite being unable to identify what their expectations of the tutor are. It was also evident that tutor participation, interpretation and commitment to linking roles were highly variable, with communication and clinical

staff support two common functions. Owen, Ferguson and Baguley (2005) highlight additional issues of tutors being in clinical settings. These issues centre on the loss of tutor clinical competencies and clinical staff's perceptions of tutors as lacking clinical credibility, effectively undermining the role of the link tutor. It is also apparent that attempts to re-engage tutors in clinical roles and consequently regaining clinical credibility are fraught with either organisational or individual tutor based challenges, as well as tensions being generated when tutors challenge perceived poor practice.

It is apparent from this viewing of practice based learning that two significant factors, academically focused tutors and clinically focused practitioners, while sharing the irrefutably valuable vision of enhanced nurse learning, are fundamentally incongruently situated in relation to each other.

3.5.5 Social constructionism and education

Given that social constructionism is the overarching conceptual framework for this study, a brief exploration of education through its axiomatic lens is indicated. Whilst they are separate theoretical models, social constructionism and previously discussed complexity theories share important characteristics. Both place importance upon interconnectedness and the emergent qualities from those interconnections, with an emphasis on relationship, either among factors or among people (Gergen, 2001; Radford, 2006). Also central to both theories is that change is continually evolving.

Social constructionism explains pedagogical practices as stemming from either exogenic or endogenic origins (Gergen, 2001, p. 116). Both are viewed as co-existing between a material external world and an interpretive internal psychological world. Exogenically viewed, knowledge acquisition is obtained when the inner psychological processes accurately reflect the reality of the external world, typically achieved through detached observation. Whilst also based in a framework of mind/matter duality, endogenic knowledge attainment is achieved through accepting the material world as a given, focusing instead upon the internal interpretation of that given reality. Consequently exogenic curricula are subject orientated and transmitted through direct observation of reality or lectures to supplement what direct observation cannot provide. Conversely, endogenic educational approaches are learner centred, with orientations to critical reflection (Gergen, 2001, p. 117). Social constructionism, with its emphasis on reality and truth being generated within relationship, shifts the locus of knowledge away from being individually attained and contained and toward being an ongoing process of people coordinated toward learning (Gergen, 2001, p. 119).

3.6 Chapter summary

This chapter introduced social constructionism as the lens through which to view the underlying constructs of this study as well as its findings. I sought not only to examine social constructionism critically, but also to apply its view of the world to MHN identities. The emphasis on meaning generation at the point of human relating exhibits congruence with psychological therapies, as well as the value

placed by MHNs on the therapeutic relationships that they hold with their users. Additionally, the challenge for MHNs to have voice within the context of the traditional power of medicine, psychology and adult nursing is starkly exposed through the lens of social constructionism. While this view may offer the comfort of an explanatory model for MHNs, social constructionism also places responsibility for challenging traditions upon those same MHNs.

Arguably, the mental health nursing profession has been shown as being divided between different models of care whilst also being simultaneously unified through a patient centred approach to care delivery. Within the context of identity theory, such division can be argued as being 'normal', with homogeneous professional identity being offered as a flimsy facade utilised to present the neat packaging of simplistic identity understandings. The complexity of identity has been highlighted through exploring the interwoven underpinnings of shared personal and professional identity, temporal identity evolution, and the power of names and titles. Additionally, the complexity of identity has been emphasised through diverse mechanisms such as categorisation, self-identification and even spiritual/ethical approaches. Despite such complexity, there is abundant evidence that the power of traditional meaning generators can be challenged by the individual in terms of identity acceptance resistance. Also apparent, particularly through the examination of current policy in Chapter 2, is that education and training are a major vehicle in influencing MHN identity formation, particularly through competencies and capabilities. Heutagogy, which maximises individual learning potentials,

consequently offers not only a valid educational framework embedded in the MHN lifeworld, but also a partial self-determining approach to education and training.

This study poses three research questions, the first seeking unique MHN contributions to psychological therapies, the second exploring EI as a theme within mental health nursing and the third searching for experiences contributing to MHN identity formation. The purpose of these questions is to commence informing a curriculum that will prepare MHNs to assume new roles in psychotherapies. Contributions to this investigation discussed in this chapter begin with the premise of social constructionism that truths, as distinct from a singular and absolute truth, dwell within the complex rules of MHN social settings. However, these settings have been shown to be characterised by influential social discourses external to mental health nursing, consequently influencing understandings of mental illness, valued knowledge and mental health nursing roles, and therefore MHN identity. In turn, identity has been revealed as being a highly complex construct that simultaneously is both stable yet evolving, externally generated and self-constructed as well as being predominantly singular, yet partially multiple. MHN identity can also be viewed as being additionally complex through incorporating a mixture of personal and professional self, and through being experienced as both subjective and objective. This mix draws us toward seeing EI as being connected to MHN identity through self-knowledge, stress tolerance and trust in one's own capacity and feelings.

Chapter 4 introduces the research design utilised in this study, commencing with establishing a link between social constructionism and the utilised direct

phenomenological method. That chapter seeks to establish the study as being trustworthy, and as having worth through eliciting new understandings and promoting the often muted discourses of MHNs.

CHAPTER 4: METHODOLOGY

4.1 Chapter introduction

Previous chapters have focused upon exploring core constructs of this study such as identity, mental health nursing and EI, as well as education and training. This exploration has sought to offer not only an insight into the complexity of each individual construct, but also to highlight the interactive relationship among the constructs. Chapter 4 now introduces the research methods utilised to explore these constructs via responses to the questions of:

1. What, if any, are the perceived distinctive qualities, abilities and behaviours of MHNs engaged in the delivery of psychological therapies in the United Kingdom?

2. What, if any, are the thematic resonances of these MHN experiences with the construct of Emotional Intelligence and how have they been developed?

3. What journeys through structures of social rules and processes did MHNs undertake to reach their current identity, both personally and professionally?

In seeking to justify the adopted methods this chapter briefly revisits social constructionism as a research paradigm, placing particular emphasis on the congruent relationship that constructionism holds with both the topic under investigation and the qualitative research orientation adopted for this study. This research orientation is unfolded to allow an examination of qualitative approaches

generally and then increasingly focuses upon phenomenology, direct phenomenology and the research techniques employed to utilise direct phenomenology. Questions of research rigour and trustworthiness are also explored through examining underpinning issues of credibility, transferability and confirmability, as well as dependability. This chapter also explores the ethics and politics of the study, with a focus on power differentials existing within research contexts. Guba and Lincoln's (2005) ethical considerations of voice, reflexivity and representation are used to guide this focus, which culminates with a model (Figure 4.1) demonstrating how ethical research can empower research participants. Finally, as this study moves toward reporting the research findings, commencing in Chapter 5, considerations in reporting the data are offered along with introducing the research participants.

This study has sought to attain dependability and trustworthiness through establishing congruence among the adopted research paradigm, methods and techniques (Harreveld, 2002). As described in Chapter 3, this study assumes a position of social constructionism, and as such requires methods and means through which to obtain, explore and ultimately disseminate findings. Social constructionism as a research paradigm focuses upon the socially constructed nature of reality and an exploratory emphasis on perceived reality within social contexts (Miller, Kulkarni, & Kushner, 2006). Such an approach emphasises exploratory approaches from an insider perspective and is wholly congruent with qualitative methods.

Social constructionism places explicit emphasis on human interaction for generating meaning, and on the meaning making process in influencing our responses to life experiences (Gergen, 2006). Qualitative research is based upon the idea that reality is constructed, and seeks to uncover a greater understanding of the construction process (McLeod, 2001, p. 2). This congruent relationship between the qualitative approach in this study and the adopted paradigm is reinforced through understanding that, by studies being placed in natural settings, qualitative approaches make sense of phenomena through exploring the meanings that people attribute to them (Denzin & Lincoln, 2005, p. 3).

4.2 Contextualising the study

As applied to the context of this study, it is envisioned that components of EI are central to the successful delivery of psychological therapies as well as forming a distinctive MHN contribution to care delivery. The enhancement of EI through education and training is consequently seen as vital and reliant upon greater understanding of MHN meaning perspectives at the interface of psychological therapies. Through being informed by a social constructionist framework, the interplay among MHNs, EI and psychological therapies can be considered within the context of the complex work and professional arena in which they are enacted.

Table 4.1 below offers a comparison of the research questions stated overtly and then stated under the paradigm of social constructionism. Through this comparison, the powerful influence of texts and discourses enacted within social arenas upon MHN identity and psychological therapy roles becomes evident.

Table 4.1: Research questions as methodological questions (adapted from Harreveld, 2002, p. 166)

Research questions	***Methodological questions***
What, if any, are the perceived distinctive qualities, abilities and behaviours of MHNs engaged in the delivery of psychological therapies in the United Kingdom?	From the multiple available descriptions of your role in therapies, which offer/s a truth toward understanding MHNs' particular contributions to delivering therapies?
What, if any, are the thematic resonances of these MHN experiences with the construct of Emotional Intelligence and how have they been developed?	From the multiple available descriptions of your contributions to delivering therapies, which relate to EI and within what social relationships were they developed or negated?
What journeys through structures of social rules and processes did MHNs undertake to reach their current identity, both personally and professionally?	How has the process of your identity formation been affected by the texts and discourses of influential traditions?

Research question one has sought to establish what MHNs perceive as being distinctive in their approach to therapies. This is a pivotal issue in terms of identity in that the point of difference most clearly establishes an identity standard. Additionally, the question leads participants to draw upon their lifeworld experiences as MHNs to respond to the phenomenological query of "What is going on here?" By asking participants to reach into the foreground of their experiences, the correct focus for direct phenomenology is maintained. When stated methodologically, research question one reflects the premise of social constructionism that truths are multiple and non-hierarchical.

Likewise, research question two when stated methodologically reflects these same values toward truth and knowledge, while also incorporating the social relationship as the point of meaning generation. Given the resonance that EI capabilities have with social engagement and self-engagement, congruence with social constructionism is established. As such, research question two seeks participants' views of themselves in relation to established EI capabilities as well as the process by which they were developed.

Finally, research question three draws on the wider and influencing MHN identity considerations such as health policy, workforce dynamics and individual experiences. The latter holds importance given the significance of personal identity to professional identity. Methodologically stated, research question three highlights the power of static traditions in holding privileged influencing positions expressed through language and ultimately impacting upon roles and consequently identity.

The voices of participants are given the priority throughout these questions and are expressed from a phenomenological and experiential perspective. Additionally, the three research questions embrace the key concepts of direct phenomenology through tapping into the experiences of the participants, exploring their socially based actions and searching for subjective meaning (Titchen & Hobson, 2005, pp. 124-126).

4.3 Research paradigm

Research is supported by the pillars of epistemology and ontology, referring respectively to the nature of knowledge and truth and to questions surrounding the nature of being (Somekh & Lewin, 2005). It is these two pillars of research that inform research methodology that have traditionally been approached from two divergent paradigms, those of positivist and naturalistic approaches.

A positivist stance would describe research as involving a systemic approach to discovering or validating knowledge, differentiated from common knowledge, and then developing an application of that knowledge to educational advancement (Proctor, 1998; Walker & Evers, 1988). The ontological assumption here is that there is a naturally occurring external reality investigated from an epistemological stance of independence between researcher and researched. Assuming this paradigm will philosophically draw the research toward a deductive approach, seeking to identify causal relationships within a fixed design and tight controls over that being investigated – an approach traditionally informed by 19th century Newtonian science (Taylor, Kermode & Roberts, 2006, p. 4).

Comparatively, naturalistic social constructionism views reality, truth and hence research as being generated within relationships. Consequently, the locus of knowledge acquisition is shifted toward the emergent qualities of interconnected people and applied to generate transformational truths (Gergen, 2001, p. 119). This approach assumes that reality is individually constructed and hence is multiple and subjective, consequently requiring an interactive investigative approach between

researcher and researched. This approach assumes an inductive process seeking individuals' lived experiences within the context of the research environment and rejects positivist assumptions of the existence of an objective, singular reality characterised by natural, immutable laws. Consequently, qualitative research adopts a holistic view of the world where multiple realities exist because reality is based on perceptions and these perceptions are individual, and change over time and in different social settings.

4.3.1 Social constructionism in relation to qualitative research

As described in Chapter 3, social constructionism is the paradigm adopted for this study. Social constructionism seeks an emancipatory critical reflection that challenges taken for granted views of the world (Gergen, 1999, p. 101). Central to this critical reflection is that human activity is the focus of attention, with individuals being viewed through their participation with the environment (Stetsenko & Arievitch, 1997). Comparing this reflection to the list of characterising aspects of qualitative research presented in the qualitative research orientation section (section 4.4) of this chapter demonstrates congruence between the two. The focus upon not just human activity, but also the lifeworld context in which that activity occurs, reflects a shared philosophy as well as the 'gritty bits' of this study, MHNs' expanding roles within politically charged neo-bureaucratic and clinically challenging environments.

The search for emancipatory critical reflection that challenges taken for granted views of the world also closely connects to the challenges facing MHNs. Taken for granted views of medical and psychology disciplines influencing MHNs' education and clinical practice in relation to therapies, as well as the pre-determining of what constitutes acceptable evidence-based psychological interventions, are two such positions. Arguably, another taken for granted view within the context of this study is the inert positioning of MHNs in relation to pivotally defining events within their profession. Constructed by historically and perpetuating contemporary powerless social roles, MHNs are not only failing to verbalise their views, but also not assuming responsibility for the direction and identity formation of their own profession (Hurley & Ramsay, 2008). Consequently, emancipatory critical reflection, inherent in social constructionism and qualitative research, is another imperative within this study. Such emancipatory repercussions of research are a perceived present and future necessity for qualitative research generally, with an increasing recognition that researchers have a responsibility to engage in democratic research that benefits and improves the lives of participants (Denzin & Lincoln, 2005, pp. 34-35).

Social constructionism gives great consideration to the meanings of words, which as previously discussed in Chapter 3 are seen as performances or actions. Central within this emphasis is the question of how to capture the true meanings of another's words and actions. Whilst bracketing of prejudices and interpretive stances may be possible, to be truly without any level of prior reference would theoretically leave no possibility of mutual discourse or even understanding. Social

constructionism proposes that, rather than meaning being perceived as an individual search for understanding of otherness, meaning is "an emergent agent of coordinated action" (Gergen, 1999, p. 145). Hence meaning is a joint action venture, one immersed in historical and cultural contexts. Meaning and understanding are thus relational and, while at least partially framed by history, are also futures orientated.

It is apparent from not just qualitative approaches generally, but also the direct phenomenological approach adopted for this study, that reciprocal meaning making, central to social constructionism, lies at the heart of this study. The semi-structured interviews allow the participants to generate their personal meanings from their experiences whilst simultaneously allowing the investigator to challenge, clarify and explore the potential blind spots of the participants, as well as of the investigator. The study's data analysis technique of thematic analysis, while initially resting with the interpretivist approach of the investigator, requires an immersion in the participants' texts derived from relationship. Additionally, as social constructionism argues that the self and psychological phenomena such as cognition and memory are constructed within social action, an investigator/researcher positioning of distance as in quantitative approaches is incongruent. Rather, as postulated by Stetsenko and Arievitch (1997), a co-construction between researcher and participant is required. Within this study, the presented data themes are my constructions from the research participants' dialogue; however, the impact of shared meaning generation at the point of social contact within the interview processes cannot be entirely ignored.

4.4 The qualitative research orientation

For the purposes of this study, alternative quantitative research orientations were considered. A survey focusing on codified responses to specific questions about the new nursing roles would have been a quantitative avenue to pursue. Sub-groupings of MHNs could have been similarly surveyed, offering an advantage in identifying relationships among staff responses. However, it was felt that such an approach would have negated the participants' lived identity experiences (Marshall & Rossman, 1999, p. 61).

These lived experiences inform nursing knowledge, and identify sociological influences upon curriculum that consider future social needs through translating values and knowledge that in turn significantly influence curriculum content (Print, 1988). Additionally, a quantitative orientation to this study would have required adopting a distancing stance, effectively removing personalisation in favour of discourse based on a presumed external world, separate from the internal world of those experienced in the research topic. Such separation would have risked minimising the affective states of participants and engaging in objectively framed discourse that would have reflected only partially the depth of human experiences (Gergen, 1999, p. 76). Rather, qualitative research that offers a highly relevant and congruent method to the investigative topic is required. This research approach as described by Pring (2000, p. 44) is: " … that which is distinctive of the personal and social, namely, the 'meanings' through which personal and social reality is understood". Finally in supporting the rejection of a quantitative approach to this study, the nature of the research problem informs the approach to be adopted. In

this case, the nursing evidence base informing distinctive MHN contributions to psychological roles is limited, indicating an exploratory qualitative research approach.

Cutcliffe and Goward (2000) identify MHNs as a rich resource of unprocessed and informal micro phenomenological studies gleaned from practice, indicating the appropriate employment of qualitative approaches in exploring MHN identity issues. This approach to research acknowledges that the MHNs' experiences cannot be value free and that this study cannot be divorced from the cultural, social and political contexts of the topic. The strength of the qualitative orientation used for this study means that findings are contextualised, are situated within the practice setting and have relevance to those involved in the study. Consequently, the broad goals of qualitative research, to expand knowing toward the complex social systems in which we dwell and to promote a greater understanding of how reality is constructed, have been addressed.

Qualitative research can be broadly grouped into three main areas of knowing: the knowing of others; the knowing of phenomena; and reflexive knowing (McLeod, 2001, p. 3). This study, as with much qualitative research, is directed toward the knowing of others (the MHNs), as well as developing reflexive knowing through paying attention to construction processes impacting upon MHN identity. Implicit within all qualitative research is that, while a truth that offers enhanced clarity toward the research topic may be found, this is both temporally bound and incomplete. It is this search for meaning that also helps define qualitative research.

Qualitative approaches cut across a wide range of disciplines, research topics and fields. Qualitative approaches can also be seen as a grouping of beliefs, grounded in multiple theoretical paradigms and without a single defining methodology (Denzin & Lincoln, 2005, p. 7). Given such diversity of what constitutes qualitative research, a search for some generic characteristics helps at least to shape the framework under which qualitative research is conducted. Taylor, Kermode and Roberts (2006, pp. 7-10) offer the following as characteristics of qualitative research:

- The research takes account of the perspectives of those being studied.
- Emphasis is on detailed description.
- There is a focus on the context in which the research took place.
- There is interest in the individual's perspective.
- Concepts are not defined before the research begins.

Both the defining characteristics and the inherent divergences within qualitative research are evident when comparing the list of essential characteristics devised by Taylor, Kermode and Roberts (2006) with that of Neuman (2000, p. 16), who identifies eight key points:

1) The construction of social reality

2) Interactive processes and events

3) Genuineness

4) Explicit acknowledgement of the researcher's values

5) Context/lifeworld

6) Few participants

7) Thematic analysis

8) Researcher's involvement.

Most apparent from comparing the two lists is what the qualitative approach is not, rather than what is essential, defining or mandatory for a research study to be termed qualitative. Absent are the modernist/positivist approaches to enquiry of cause and effect, quantification and deductive methods, as well as an abstract contextualisation of the study (Denzin & Lincoln, 2005, pp. 11-12). Shared between each list are the perspective of the participant and the presence of the researcher. This study reflects significant elements of the lists of Taylor, Kermode and Roberts (2006) and Neuman (2000).

The lifeworld context of the study's focus is captured by highlighting a clinical MHN perspective toward the MHNs' professional identity and toward their positions on future training for psychological therapies. Additionally, through being a MHN, qualified counsellor and qualified psychotherapist, my own values and presence within the research are evident, as outlined under 'personal positioning' in Chapter 1. A close examination of the characteristics of qualitative research methods shows how the role of the researcher is heavily influenced by the selected paradigm and methods. Within qualitative approaches the values of both the participants and the researcher are central to the construction of a truth (Scott & Usher, 1999, as cited in Danaher, Danaher, & Moriarty, 2003). The researcher can become a "complicit component of the research project, rather than … a detached, objective observer" (Danaher, 2001, p. 69). Whilst required to be immersed within the qualitative process, simultaneously the qualitative researcher also needs to withdraw through

laying aside pre-existing beliefs. This duality and flexibility of being provide a significant test for the researcher and arguably this complex placement of the researcher in relation to the research represents qualitative research's greatest future challenge (Denzin & Lincoln, 2005, p. 21).

This study reflects aspects of both the above named lists of characteristics of qualitative research through being based upon a narrative description of the participants' experienced realities. What was sought was a rich text rather than attempting to narrow or define participants' responses through questionnaire styles of responses. This rich narrative text was generated through the interactive process of an in-depth interview that received thematic analysis verified by participants and that consequently sought a genuineness of representation.

A brief historical perspective of qualitative research approaches offers further justification for the use of phenomenological approaches to social science research generally, as well as to this study. This historical perspective highlights the evolutionary nature of qualitative research approaches, contextualising the modifications to Edmund Husserl's (1859-1938) philosophical beginnings. Qualitative approaches have been evolving, with prominent authors such as Denzin and Lincoln (2005, p. 3) identifying key eras of development. While there are significant remnants from each era contemporarily active, qualitative approaches have generally moved on from the initial traditional era characterised by researcher authority and anthropological approaches. Modernism of the 1970s and 1980s propelled qualitative approaches to compete – some would say battle – with

quantitative approaches to be seen as rigorous and valid through standardising the stages and techniques of qualitative research. Postmodernism, social constructionism and an increasing view that paradigms exist upon a unifying epistemological continuum all impacted upon qualitative research approaches (Walker & Evers, 1998). These impacts include the increasing voice of both researcher and participants within qualitative studies, as well as promoting acceptance of mixed methodologies. It is apparent from this historical review that, as culture, society and philosophy shift, so too do the means and methods by which we seek to understand the world in which we dwell. As such, qualitative research approaches shift, move and evolve or can be conversely argued as being unstable and without solid foundations. This instability could be seen as a flaw, particularly from a positivist understanding of reality. However, as Denzin and Lincoln (2005, p. 3) suggest, the researcher can be seen as a *bricoleur*, one who uses research tools to achieve the research task rather than being held to a formula or step by step research: "The *bricoleur* understands that research is an interactive process, shaped by his or her personal history, biography, gender, social class, race and ethnicity, and those of the people in the setting".

4.5 The phenomenological research method

Phenomenology is the investigation of everyday experience from the perspectives of those living the experience, as it is considered that meaning can be understood only by those who experience it (Titchen & Hobson, 2005). Phenomenology has been described as a method without technique (O'Donoghue & Punch, 2003, p. 62). Phenomenology has also attracted multiple definitions variously describing it as a

philosophy, as an overarching view of qualitative research and even as being loosely associated with the quantitative research paradigm (O'Donoghue & Punch, 2003, p. 42). Certainly both the philosophy and the application of phenomenology have specific and problematic values. Within the context of this study the philosophy of phenomenology fits well with the constructs of identity and with psychological therapies. All are underpinned by a fundamental starting point question of "What's going on here?", rather than presupposing reality. Additionally, the search for an essence that sits behind layers of persona or neurosis is fundamental to most psychologically based therapies. Identity, and specifically MHN identity, can also be seen through the same lens as identity markers, those which fundamentally link MHNs existing behind the layers of roles and functions that they perform. Additionally, many of the skills inherent in mental health nursing and psychological therapies have transferability to phenomenological research approaches. Engagement with others, interviewing skills and communication skills are such examples.

4.5.1 Direct phenomenology

The qualitative orientation used in this study is supported by direct phenomenological methods. The researcher's attention in direct phenomenology is focused upon participants' subjective perceptions and consciousness of their experiences with the aim of presenting these perceptions clearly, and understanding their basic structure and meaning through a process of interpretation. In common with contemporary phenomenological approaches, the ultimate goal is: "To elucidate the essence of the phenomenon being studied, as it

exists in the participants' concrete experience" (McLeod, 2001, p. 41). Direct phenomenology is centrally concerned with seeking shared meanings that can then be generalised into types of subjective experiences (Titchen & Hobson, 2005). By comparison, indirect phenomenology is more concerned with the analysis of everyday social actions embodied in intuitive non-verbal knowing. Strengths of this direct phenomenological approach are that it incorporates lifeworld determinants, rational understandings and subjective meanings as well as social action.

This direct approach to phenomenology has its roots in the work of Husserl, who as noted above placed an emphasis on separating the conscious person from the world of objects (Titchen & Hobson, 2005). It is necessary to highlight that when a phenomenon is explored the object of the study, in this case MHN identity, must also be explored rather than just the participant's perception and experience of that phenomenon. Husserl included both when attempting to understand the essence and meaning of phenomena as the essence lies within that relationship, as well as within its own existence. Husserl sought certainty through examining emotions, action and perceptions as well as relationships, a search for a level of understanding that can be argued as impossible. Table 4.2 below offers an overview of the fundamental constructs of direct phenomenology as applied to this study.

Table 4.2: Key underpinnings of direct phenomenology (adapted from Titchen & Hobson, 2005, pp. 124-126)

Focus	Shared intersubjective meanings among participants.
Concepts	Experience, rational social action, subjective meanings.
Description	Interpretation of social action through typification arising from empirical questions directed toward knowledge and meaning of participants' inner worlds.
Questioning	Open questions encouraging reflection. Challenging taken for granted positions toward 'what is going on'. Specific questioning used that encourages participant self-evaluation of own decision making and action taking.
Interpreting	Re-presenting the participants' subjective meaning context with the researcher's second order objective meaning context. Typification describing how participants made sense of a situation, with commonalities across participants sought.
Skills	Attitude of openness and curiosity. Suspending values. Lingering/immersion in the described situation. Attention to detail. Communication. Empathy.

4.6 Research techniques

4.6.1 Data collection through interviews

As an exploratory qualitative method has been used, semi-structured interviews that seek rich and in-depth accounts of lived experiences from those existing at the interface of psychological therapies are an appropriate approach to data collection (Titchen & Hobson, 2005). As MHN identity, connectedness of MHN identity to EI

and possible future directions for MHN training are little known, semi-structured interviews allow consideration of most if not all available options and the opportunity to amend the guiding research questions as data emerge from the interviews, and to seek knowledge through interaction and interpretation with the research participants toward the investigative topic (Marshall & Rossman, 1999, p. 152).

Interviews allow for an expansion of the individual experiences and meaning contexts of the participants and a greater understanding of the phenomena under investigation (Titchen & Hobson, 2005). Interviews, especially ones conducted under the lens of social constructionism and a qualitative approach, cannot be seen as a neutral search for data. Rather, interviews are a collaborative endeavour, an active process between two people with the interviewer as well as the interviewee owning her or his own context and history (Fontana & Frey, 2005). Through owning my own positioning in relation to MHN identity, EI and education and training, a platform of genuineness is established rather than a false one of assuming a position of neutrality. From this platform a greater ease of relating, engaging in narratives and partnership within data collection is created. Given the primary task of the interview, to gain an understanding from another of her or his truth, such empathic underpinnings appear essential to generate rich text. Additionally, with psychological therapies being central to this study, an imperative exists to enact the underpinnings of health communication (therapy micro-skills) to achieve congruence between research topic and research technique. Table 4.3 below lists what are considered to be the core conditions for a helping relationship within

counselling and the underpinning skills thought to enhance communication in and through research.

Table 4.3: Shared skills between research and the investigative topic (adapted from Eagan, 1998, p. 89)

Communication skills	**Core conditions**
• Non-verbal attending	• Empathic understanding
• Paraphrasing	• Genuineness
• Reflecting	• Non-judgemental approach
• Open ended questions	• Unconditional positive regard
• Summarising	• Confidentiality
• Clarifying	• Warmth and respect

It is apparent that a sharing of skills between therapies and data collection exists, as well as the ethical underpinnings that reflect a contemporary and naturalistic stance in relation to conducting research interviews. From such underpinnings the interviewer–interviewee relationship has much greater potential to be transformed into one of listener and narrator. Such a stance toward research interviews is well described by Fontana and Frey (2005, p. 696):

> New empathic approaches in interviewing deviate from the conventional approach; they see that it is time to stop treating the interviewee as a "clockwork orange", that is, looking for a better juicer (techniques) to

> squeeze the juice (answers) out of the orange (living person/interviewee).

The new empathic approaches take an ethical stance in favour of the individual being studied. The interviewer becomes a supporter and partner in the study, hoping to be able to use the results to advocate social policies and seek to ameliorate the conditions of the interviewee.

A direct phenomenological approach was used for collecting interview data from MHNs. This phenomenological approach focuses upon human conscious knowing and shared meanings among participants with the aim of developing abstract conceptual frameworks. Unlike existential phenomenological and ethnographic approaches, observation is not utilised. Instead open questioning that seeks participant understandings, social constructs and challenging beliefs, as well as understanding social actions, is employed. Specific questioning is also utilised within this phenomenological approach (Titchen & Hobson, 2005). This approach of utilising exploratory questioning and clarifying communication techniques allows the identification of specific issues arising from the research questions such as perceived abilities and the integration of tools with the use of a therapeutic self. Additionally, such an approach allows for expansive exploration around research questions addressing identity journeys, inter- and intra–personal experiences and resonances with EI.

MHNs in the local health trusts were disseminated a written invitation through their professional lead officers to participate in the interviews. Qualitative research focuses on including participants who can offer a rich perspective related to the research question rather than seeking representative samples. As such, the term "purposive" for the sample in this study appears most accurate with convenience sampling referring more to the availability of participants (Polit & Hungler, 1999, p. 300). Both in-patient and community based staffs were sought to allow comparing and contrasting of experiences and to offer a broader MHN perspective of delivering psychological therapies. 25 participants were sought, with total participant numbers being finally determined by the depth of the emerging data. Participant responses to participating in the interviews varied widely. Two participants wished to have an idea of what questions would be asked prior to the interview. Although this may be considered as potentially increasing the risk of reinforcing researcher views and eliding other potential points of view, the ethical balance of achieving participant benefice was preferred. Conversely, five participants initially agreed to participation without even reading the provided information sheet, in essence agreeing to be interviewed with no meaningful understanding of the study. These participants were subsequently encouraged to read the sheet to ensure informed consent was being enacted.

Research dependability and confirmability have been enhanced through clear audit trails and memo entries (Harreveld, 2002). Memo entries made by the investigator during or immediately following interviews included data from interviews, and were supplemented with contextual information on how data were collected. Memo

entries also included researcher understandings and emerging insights that spontaneously arose following interviews. These reflections included possible future directions for research and methodological reflective entries (Roberts, Priest, & Traynor, 2006).

4.6.2 Data analysis

Qualitative analysis is centrally concerned with the interpretation of text or hermeneutics, a term that has attracted varied understandings. It can be defined as: “The act of interpretation which brings to light an underlying coherence or sense within the actions, behaviour or utterances of a person or group” (McLeod, 2001, p. 22). The emphasis within this definition is one of interpretation, with the underlying goal of enhancing knowing or understanding toward a particular phenomenon. However, hermeneutics is both historically and culturally grounded, culminating in learning by the interpreter. In returning to the social constructionism of Gergen (1999), a shared valuing of understanding that arises from cultural constructs is evident within hermeneutics. While hermeneutic approaches can be argued as existing separately from those of phenomenology or grounded theory through the investigator being immersed in rather than bracketing from pre-understandings, a partial fusion or sharing of ideology also exists.

A clearer separation between interpretivist and hermeneutic approaches lies in the type of data used, in that hermeneutics explores texts that exist within the public domain. Considering both the source of texts and the use of bracketing in this study, a clear interpretivist stance toward the data is evident. Within this stance,

the narratives represent social action and ways of making sense of the world (Denzin & Lincoln, 2005, p. 641). This sense making is retrospective, drawing on past experiences, actions and events to create meaning. The viewing of narratives as social action highlights the history, present moment and future possibilities of the narrative. The words spoken in the interviews could be seen simply as recorded data or text. However, the MHNs participating provided narratives that were constrained by and/or liberated from their social, organisational and professional contexts. Their words, as viewed through the social constructionist lens of this study, are actions that can be seen as defending past actions and/or explaining or challenging traditions. This viewing of the data analysis firmly places it into the genre of identity work, which is the process whereby MHNs construct themselves through narrative within the context of their roles, organisations and culture (Chase, 2005).

Qualitative data analysis commences upon data collection and can continue throughout the research process, allowing for understandings not predicted at the beginning of the study to be explored. Phenomenology includes the qualities of description, reduction, essences and intentionality (Merleau-Ponty, as cited in O'Donoghue & Punch, 2003, p. 45). Description refers to the lived experience of any phenomenon that is reduced through a suspension of all pre-existing assumptions to ensure an untainted description of experience. Core meanings are sought through an exploration of both objective experiences and subjective reflections upon those lived experiences. In this sense, the listener–narrator roles established within the previously described interview relationship are extended through the

search for core meaning within the narrative text. Exploring lived experiences within the everyday world remains the core concern for all phenomenological approaches. The direct phenomenology adopted in this study reflects this focus of investigation in striving toward developing decontexualised ideals through both subjective and objective detached contemplation.

Thematic analysis examining the experience structures of participants is widely used with variation across phenomenological studies, and has been utilised to analyse the interview data in this study. Texts of recorded transcripts were repeatedly read in a search for distinctive meaning units relating to the study's aims. This requires both manifest and latent analysis to ensure an understanding beyond the surface level alone. Everyday language is transformed and synthesised, reflecting the essence of each meaning unit into the most general meaning of the phenomenon. This phenomenological reduction seeks to lead back to the core of the phenomenon by peeling back layers of taken for granted assumptions (McLeod, 2001, p. 39). This requires paying attention to the interpretive practices and self and reality constructions within each individual narrative and then across the separate narratives. Data are constantly compared and tested for negative case examples and consistency of information with plausible alternative explanations sought and justified. Consequently all emerging themes and patterns are challenged. Commonalities across participants' experiences of the phenomena are then sought and are justified as to why they fit with the topic under investigation (Giorgi, 1985, p. 47). These objective reconstructions enhance the transferability of

findings compared with taking an existential phenomenological approach (Titchen & Hobson, 2005).

This process which was undertaken in the study was enhanced by the use of NVivo qualitative software that is briefly discussed here to offer an explanation of how the analysis process was enacted. Chapter 9 offers a more in-depth reflection on the use of qualitative software that incorporated the quantification of findings. Whilst MP3 audio files were being listened to, the transcribed interviews were simultaneously being read and coded using the NVivo 7 software. Sections of text were highlighted and assigned a free node with a unique descriptor. After the coding of six scripts was completed, the free nodes were critically re-examined to ensure fit with the aims of the study, compatibility with the unique descriptor and the consideration of alternate explanations. These free or floating nodes were then placed under tree nodes denoting a major theme that reflected the commonality of participants' experiences. Many initial free nodes were not included as informing tree nodes, and new nodes were added throughout the analysis process. Links to memos were attached to the coded transcript of the relevant participant where researcher reflections and/or insights arose in relation to that specific piece of text. NVivo also clearly shows which specific pieces of text fed into the creation of both the initial free nodes and the latter tree nodes, as well as quantifying the number of textual pieces that culminated in a theme. Hence the identification of developing themes can be justified, consequently improving the trustworthiness of the data analysis through minimising variances.

Such potential variances are further minimised through the investigator bracketing or suspending her or his own beliefs and values throughout the data collection and analysis stages. Bracketing requires self-awareness of existing investigator views toward the topic under investigation, and ongoing self-monitoring to ensure that the social constructions of MHNs are accurately obtained and explored. Based on the phenomenological approach of Husserl, bracketing suggests that only through moving away from any pre-determined position of understanding can the researcher represent the participants' experiences and hence uncover new illuminations (McLeod, 2001). Beech (1999) offers bracketing as a fundamental methodological principle whereby preconceptions are placed in abeyance so that experiences are ordered and made sense of in relation to previous knowledge and experiences.

Husserl described this process as eidetic seeing, or seeing essence achieved through being able to dispense with a taken for granted position and adopting a transcendental position toward that which is being explored (McLeod, 2001, p. 38). Clearly of most importance is to be aware of what pre-existing attitudes were being held toward the issues of MHN identity and the role of EI and educational interventions to enhance psychological therapy delivery by MHNs. Credibility, which establishes the trustworthiness of the research, is consequently enhanced (Harreveld, 2002).

4.7 Reliability and validity

Key criteria for evaluating the quality of qualitative research conducted within the framework of social constructionism are those of trustworthiness and authenticity (Guba & Lincoln, 2005). Underneath these dual criteria is the fundamental question, particularly for constructing transformational discourses: "(How) Can I use these findings to generate change?". For findings to be acted upon in terms of informing action and policy in the fields of health, education and therapy, community members must have confidence that findings have validity. Consequently, validity can be seen as pertaining to two areas: firstly the rigour required from the researcher to establish validity; and secondly from the reader of the research when reading and applying outcomes. Onwuegbuzie and Daniel (2003) highlight common issues with qualitative research that fail to establish rigour and thereby foster confidence within the consumers of such research.

Failure to legitimise research findings is one such key issue. This primarily arises from a philosophical stance that validity is irrelevant to qualitative research. Indeed, wide variances exist in qualitative approaches on the very definition and utility of validity. To have findings accepted, particularly within the positivist dominant arena of mental health, rigour is essential and has been sought in this study by viewing validity as being multi-dimensional through the constructs of credibility, transferability, dependability and confirmability (Harreveld, 2002), which are expanded on shortly. Through using overt audit trails, making constant comparisons/contrasts and searching for alternative explanations in data analysis,

as well as obtaining participant feedback, this study offers rigorous validity for the consumer (Onwuegbuzie & Daniel, 2003).

Harreveld (2002, p. 194) offers a comprehensive overview of key considerations of qualitative constructs pertaining to validity and reliability. These constructs were drawn from the work of Lincoln and Guba and were presented by Harreveld (2002) as qualitative components of rigour and trustworthiness, terms to replace the equivalent quantitative terms of reliability and validity. They are credibility, dependability, confirmability and transferability.

Credibility: The process of generating the truthfulness and trustworthiness of reconstructions and interpretations within the study.

Included in establishing credibility is that the study's theoretical framework, data collection and analysis processes are congruent. Through ensuring that the research questions are pertinent to MHN identity, that MHNs are engaged with psychological therapies and that the framework of social constructionism permeates the study, credibility is enhanced (Guba & Lincoln, 2005). Additionally, through the use of multiple data sources of evidence, interviews and documents, triangulation (a process of using multiple perceptions to clarify meaning) has been addressed (Denzin & Lincoln, 2005, pp. 5-6). The credibility of the design has also been strengthened by explaining my system of data collection methods and analysis strategies in detail. Additionally, data have been quantified rather than being expressed in more general terms such as "many" or "most".

Dependability: Within the context of qualitative research, dependability can be understood as the extent to which findings can be depended upon to provide consistency and credibility of findings.

Central to promoting a sense of dependability is that the actual design and enactment of the research have a high level of coherence. This coherence is evident through the choice of paradigm (social constructionism), orientation (qualitative), method (phenomenology) and techniques (interviews and thematic analysis). All these aspects of the study are congruent with the others as well as with the investigative topic. As with the issue of credibility, clear audit trails leading back to the raw data are vital (Harreveld, 2002, p. 198). This allows for the research data, gleaned from interviews and texts, to be seen as trustworthy. An important component of trustworthiness is dependability, analogous to reliability (Onwuegbuzie & Daniel, 2003).

Confirmability: Closely related to the construct of dependability is that of confirmability. This raises a central question of whether the findings can be validated (Denzin & Lincoln, 2005, p. 24).

As with dependability, this relies heavily upon clear audit trails and the coherence of the study's design. Also inherent within this construct is that of credibility, the truthfulness and trustworthiness of reconstructions and interpretation of the data. Given that this study assumes a qualitative approach which by definition requires a subjective immersing in the data for the purpose of analysis, results must be confirmable. Confirmability can also be seen as being enhanced through the employment of analytical software such as the NVivo software used in this study.

The use of themes being presented in terms of the frequency with which they occurred also promotes confirmability through highlighting analytical honesty and demonstrates a level of extensive documentation of the presented data (Onwuegbuzie & Daniel, 2003).

Transferability: Is determined by the person who seeks to make the transfer, not the investigator as researcher. It is the job of the original investigator or researcher to provide enough descriptive data, while it is up to other researchers, if they wish, to bring to bear their own contextual evidence (Harreveld, 2002, p. 186).

Being qualitative, this study seeks to offer insights into the particular MHN professional, educational and social processes and practices in the UK. Arguably even this limitation upon transferability is optimistic; it can be asserted that these findings are representative only of the participants, as it is their unique and individual views, perceptions and experiences that have generated and then confirmed the data. Additionally, the health environment context in which this study is situated prioritises RCTs as being genuinely transferable. As stated under the sub-heading of credibility, data in this study have been quantified through the use of counts, consequently allowing the reader of the study to determine if descriptive terms such as “many participants” or “most participants” are trustworthy and hence potentially transferable (Onwuegbuzie & Daniel, 2003).

It is evident throughout these varied qualitative terms addressing validity and reliability that sound research construction, implementation and verification are required. Guba and Lincoln (2005, p. 207) offer further insights into how validity can

be fostered within social constructionist enquiry. The theme of these insights is that of authenticity, closely associated with the concept of trustworthiness. Fairness, the first of Guba and Lincoln's criteria, refers to balance in representing the scope of stakeholders' voices within the text of a study. Ontological and educational authenticity refers to a validity whereby the conducted research creates a moral and ethical critique of the topic under investigation. Catalytic and tactical authenticities relate to validity criteria whereby participants in the study are roused toward challenging the traditions that they find themselves constrained by.

This examination of the qualitative research orientation has sought to offer clarity toward the investigative approach being a highly credible strategy by which to explore MHN identity. Dependability and trustworthiness have been highlighted through establishing congruence among the adopted research paradigm, orientation, method and techniques. Additionally, rigour has been sought through adopting a multi-dimensional view of validity underpinned by the constructs of credibility, transferability, dependability and confirmability. This research strategy consequently offers the reader grounds for confidence in the study findings and recommendations.

4.8 The ethics and politics of the study

Qualitative approaches generally, and certainly in this study, are increasingly concerned with the ethics, politics and power differentials existing within research contexts. While issues of ethics, representation and dissemination are elaborated later in this chapter, it is fitting to highlight related issues specific to the study at the

front, rather than at the end, of the chapter as if an afterthought. As discussed in Chapter 2, MHNs operate in hegemonic relationships with both medicine and psychology. Additionally, while the focus of this study is on MHN identity as related to psychological therapies, the ultimate recipient of psychological therapies will be the highly marginalised service user of mental health services. Arguably both groups, MHNs and service users, experience domination and a degree of powerlessness. Equally, while MHNs are relatively dominated by more powerful professions, the social position and comfort of MHNs are immeasurably better than those of many service users. Consequently, this research has significant themes of power, politics and ethics that require addressing. Power and politics, as viewed through the lens of social constructionism, require transformation to be enacted. While small in nature, this study, through seeking, verifying and disseminating the views of MHNs toward their profession, reflects the principles of self-determination, participant benefice and representation.

Guba and Lincoln (2005, pp. 209-210) offer a compelling view of the way in which knowledge and truth are generated (methodology) via research findings and the relationship between research investigator and participant in relation to research ethics. Key constructs underpinning these interrelated constructs are those of voice, reflexivity and representation.

Ethical considerations of voice pertain to the multi-layers of voices present in a study, and the challenge of presenting the author's voice as well as the voices of the participants. A broad example of such considerations for the nursing profession

has been the interpersonal nature of a qualitative approach which raises the potential for role confusion between researcher and clinician responsibilities. In terms of this study, ethical considerations have sought to mirror the ethical platform of Anteliz, Danaher and Danaher (2001) in identifying the interview as the democratic conduit for increasing understanding. Additionally, such an approach reflects the person centred approach congruent with that of virtue ethics that is in turn reflective of the characteristics sought from MHNs through academic and professional standards (Begley, 2005). While the focus is upon MHN identity and EI related to delivering psychological therapies, it is crucial to highlight that all such considerations ultimately impact upon the service user, who consequently has a vicarious positioning within this study. Within this sense Champ (2002) takes a wider view of democratic participation in research through asking why users of service are not participants in the design and methodological choices for research undertakings. This study is unapologetic about maintaining only a MHN perspective in preparing and undertaking the research. Whilst having unambiguous support for service user empowerment and prioritised positioning, there also remains a need for the MHN profession to be autonomous at some stage of its historical development. This is especially pertinent when investigating a core MHN issue such as professional identity.

The second of Guba and Lincoln's (2005, pp. 209-210) ethical concerns is that of reflexivity, or the process of engaging in critical reflection on self as researcher. Such a reflective undertaking highlights the relationship between qualitative research methodology and ethics. Not only do we bring ourselves to the research

but also the ‘me’ that I bring is fluid and multi-dimensional. Each self requires individual critical interrogation as well as reflection upon its relationship within the complexities of the research process. These multiplicities of ‘me’ within this study include myself as a MHN, researcher and student, as well as counsellor/therapist, educator and social self. Each of these pertains to the very heart of the study and required reflexiveness to bracket and suspend beliefs at some research stages, while utilising an intimate experience of the constructs within the study at other stages, such as in the data collection.

The complexity and value of undertaking such reflexive exercises cannot be overstated. Learning about our values, attitudes and engagement with an external research topic demands an internal engagement with the totality of self. Such engagement is itself potentially bound by cultural and societal influences (Hurley, 2008b). Within a contemporary western context, self-engagement is most frequently dominated by cognitive reflection, with the emotional and spiritual self being quarantined (Pfeifer & Cox, 2007). Such a narrowing of self-reflexivity struggles to respond to our engagement with the problem of how to live (Szasz, 1983, p. 21). Such living is often characterised by stressful and disharmonious human relations resulting in conflicting needs and values (Szasz, 1983, pp. 20, 23). Contributing to more harmonious human relations within the research process accordingly requires movement of self from a current position of ‘now’ to that of the research. Hence our personas, cognitions, emotions, perceptions and consequently behaviours are moved toward that research, where we choose which parts of self to adopt and which parts to repress.

This dichotomy of adoption and repression requires first self-awareness to make that choice, and then the authenticity to avoid self-deception (Hurley, 2008b). A specific example of this process in this study was in the context of the data collection interviews. Frequently, MHN participants struggled to articulate an emerging personal awareness or expressed emotions related to difficult past experiences. This required stringent repression of my helping 'counsellor/psychotherapist self' while maintaining the necessary researcher curiosity underpinned by communication micro skills to explore the topic of investigation.

Representation, the third of Guba and Lincoln's (2005, pp. 209-210) ethical concerns, offers a challenge to researcher positioning through research findings being viewed as either representative of the world 'as is' or as negating and constricting other equally legitimate ways of being. Paternalism certainly exists within considerations of representation and dissemination of findings arising from research participants. Negation of any paternalism is quickly achieved through applying the lens of social constructionism to ethical representation. As outlined in Chapter 3, social constructionism does not seek an absolute truth but rather places 'a truth' within the context of the rules of specific social encounters.

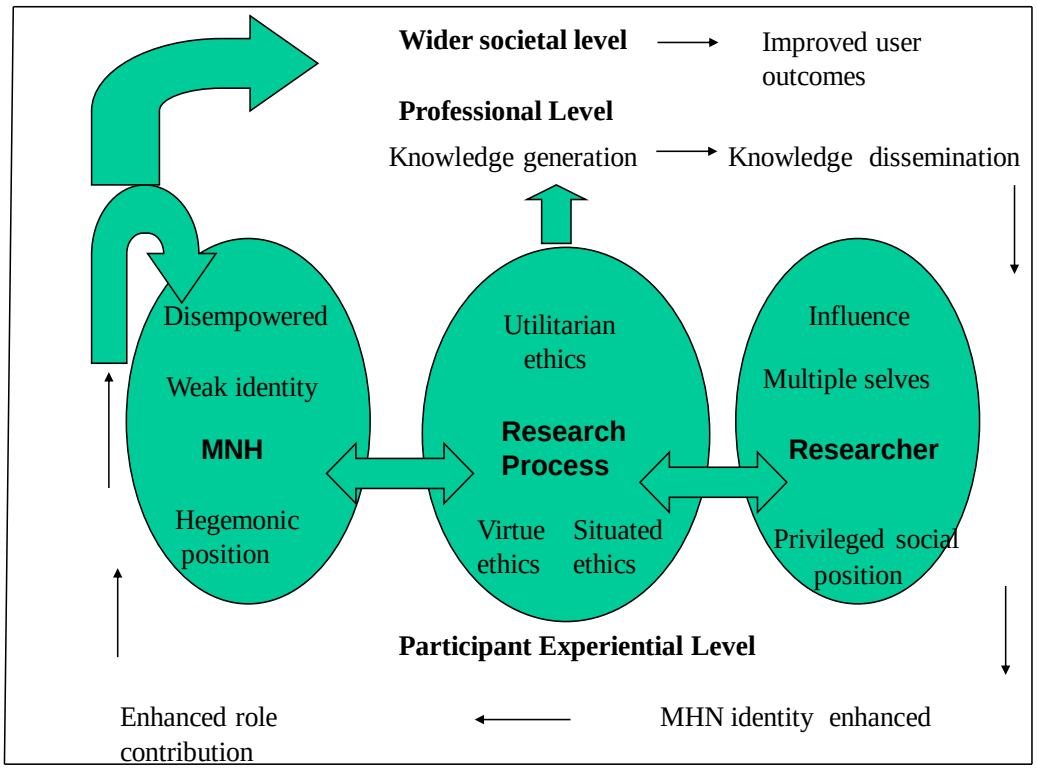
Consequently, careful ethical consideration of both the dissemination of research findings and the methodology utilised to collect data is required. Dissemination immediately denotes representation, and as such generation of meaning perspectives that can influence cultural attitudes. Rowan (2004) emphasises the

ethical considerations of representing participant texts through a melded sociological and discourse model. What is evident is the relationship between research linguistic utilisation and varied social positions of participants and researchers in relation to the formation of social attitudes, knowledge and ultimately societal responses experienced by research participants. Minimisation of risks associated with unintended linguistic misrepresentation within this study includes the use of quotations to evidence thematic findings; preambles highlighting such risks and having participants verify the interview transcripts prior to analysis.

Also pertinent is the need for respectful mindfulness that researchers and participants can often dwell in different social contexts, hence creating a relationship of partial mutual outsidedness. Anteliz, Danaher, and Danaher (2001) offer a critical perspective of Bakhtin's (1986) work on the concepts of outsidedness and creative understanding to move toward improved representations. Constructs of separateness co-existing with genuine interest apply well to this study. The confluence of a non-hierarchical outsider perception with that of MHNs' lived experience offers potential mutual creative understandings. Kenny (2001) puts forward a strong argument for the broad dissemination of research findings and hence creative understandings. Kenny graphically illustrates the ethical imperative for research outcomes to make a difference in participants' lives through underscoring research participation as a personal investment to generate betterment.

Figure 4.1 seeks to demonstrate at least partially how this process operates within the context of this study. From a participant perspective, the dissemination of research findings represents a stage of vulnerability and powerlessness that commenced with the researcher leaving the research field to commence data interpretation (Cotterill, 1992). Consequently, the question of what researchers hope to achieve as posed by Danaher (2001) has been addressed. The academically confined response of informing curricula of evidenced interventions at the interface of psychological therapies may well expand to be inclusive of being an accountable 'Hermes' for the voices of the often unheard MHNs and raising the importance of EI as influencing MHN identity.

Figure 4.1 An ethical model for the study (adapted from Brofenbrenner, 1989, as cited in Rowan, 2004, p. 14)



The necessity for having a framework of dynamic research relationships is promoted by Coombes and Danaher (2001) through seeking congruence between the matrix of educational research ethics and the models that guide it. Figure 4.1 diagrammatically outlines the application of such a framework to this study. This framework offers a melding of ethical models as it seeks to reflect the complex lifeworlds of not only the research study but also the MHNs in their clinical practice.

Within the above model the MHNs, the researcher and hence the research processes occur in a macro-system bound by knowledge availability and utilisation toward MHN identity. The MHNs' individual experiential level is bound by disempowerment and hegemonic relating influenced by a perceived weak professional identity. These micro and macro constructs act as potential barriers to the enactment of empowerment and self-determination. By contrast, the researcher's experiential level is bound by liberating elements and the complexity of bringing multiple selves into the research arena. Through the researcher and the MHNs interacting within a research process bound by situated, virtue and utilitarian ethics (McKie & Swinton, 2000; Pring, 2002; Roberts, 2004), benefit and empowerment directly flow back to each participant's experiential level. Benefit also flows into the macro-system by adding to knowledge availability, thereby vicariously influencing the other features in the macro-system.

Situated ethics, with an emphasis on the ongoing interrelatedness between researcher and the entirety of the research process, and virtue ethics, emphasising the ethical character of the researcher and research participants, add a reflexivity

and an existential responsiveness within a humanistic framework (McKie & Swinton, 2000; Pring, 2002; Roberts, 2004). However, virtue ethics have been criticised for lacking action guidance and practical application (Begley, 2005). Morrison (2002) strongly supports situated ethics in reviewing the work of Simons and Usher (2000), particularly highlighting its congruence with unique existential dilemmas arising from educational research, and consequently having a reflexive congruence that universal ethics codes lack.

While being logically coherent, this argument is proposed with a lack of underpinning support for situated ethics and is also offered as a replacement for, rather than an expansive theory of, applied ethics. Such confluence of theory appears indicated given the practical, ideological and contextual challenges arising from the research arena. Danaher, Danaher and Moriarty (2003) offer a critical review of Scott and Usher's (1999) ethical model that promotes open autocratic research as the most appropriate research model. In challenging the idea of altruistic researchers, Danaher *et al*. (2003) suggest that a sharing of interests between researchers and researched groups risks misrepresentation.

Narrowing the focus to MHNs, debate on applicable ethical models has incorporated the ethics of care, often contrasted with Kantian models of ethics. The ethics of care originated from feminist views that women incorporate ethical considerations within a meaningful relationship context. Resonating strongly with situated ethics, the ethics of care incorporate emotional as well as rationalist considerations into ethical decision making, hence more closely reflecting the

realities of human psychological functioning. The work of Pring (2002) resonates directly with this core debate within nursing about the ethics of justice in relation to the ethics of care, which itself raises paternalistic issues within considerations such as researchers acting as gatekeepers or guardians for disempowered populations.

4.9 Considerations of reporting the data

Deciding how to report these findings commenced with reflecting upon the core question of when a theme is not a theme. If a theme was to be reported in this study, how many participant voices would be required to make this happen? If only majority expressions were to be accepted as creating truth about MHN identity, or indeed any topic of qualitative investigation, then the generation of novel or unique knowledge would cease. Given the social constructionist framework adopted for this study, minority voices can be argued as demanding articulation, or else the dominance of power as a generator of truth could be repeated in this study. However, the democratic underpinnings of qualitative research also necessitate that themes arise from a significant number of participants. Additionally, Guba and Lincoln (2005, p. 207) suggest that validity is fostered through demonstrating fairness, as related to representing the scope of stakeholders' voices in the study. Finally, as the topic of investigation is directed toward gaining a clearer understanding of MHN identity that has been shown to be opaque and internally contested within the profession, highlighting areas of majority agreement can be argued as being a priority within the context of this particular study. Consequently, all the themes identified in this study have a minimum of 12 contributing participants. Where minority views of participants are expressed in the text of this

study, they are labelled as being such and are seen as having worth in contributing to greater understanding of the topic under investigation.

Given considerations of reporting the data focused upon the number of participants as making a theme or not, it remained to decide if these should be expressed as counts or, as with many qualitative accounts, by means of terms such as “many”, “most” or “some”. Arguably, by being provided with counts the consumer of the research can make unambiguous decisions as to the credibility of the phenomenon being grouped as a theme. Additionally, through the use of counts and percentages it is argued that a clearer picture of the phenomena under investigation can emerge when contrasting data findings between categories of participants. Certainly the quantification of qualitative data is not without advantage. Onwuegbuzie and Daniel (2003) offer the view that the use of quantitative expression is not incompatible with deriving meaning from texts, while Sandelowski (2001) highlights that counts of presented themes prevents over or under weighting of those themes, hence enhancing the overall trustworthiness of findings. Sandelowski (2001, p. 231) goes further in support of such quantification by offering that patterns are more discernable, analytic integrity is enhanced and accuracy of descriptive events is increased.

Argument can be mounted for including the use of counts in qualitative research. Key considerations in deciding to use counts for reporting the qualitative data in this study were to:

1. Enhance the credibility of the findings through the unambiguous presentation of the intensity of the phenomena being presented
2. Offer an opportunity for a clear contrast to be made among different work categories of MHNS which are outlined shortly
3. Reflect the reality of the value placed on such reporting within the world of health service delivery
4. Demonstrate the inclusion of minority voices within the study without distorting the truth constructions of the majority.

Despite the decision to quantify the data, partially in search of clarity and transparency, it is vital for the reader to be aware that many sections of text have been coded under multiple themes. These pieces of rich and dense text represent succinct expressions of experienced multiple truths. Additionally, when reviewing the findings and subsequent discussion the reader needs to recall the overarching tenets of social constructionism that have guided this entire project. While these were expanded on in depth in Chapter 3, it is worthwhile offering a brief outline of the four pillars of social constructionism, as it is through the lens of those four pillars that the findings have been obtained, analysed and discussed.

1. The key principle underlying this assumption is that language fails to represent an independent world. Inclusive of all forms of representation, this postulates that for any phenomenon there are an infinite number of possible descriptions, none of which holds privilege over any other.

2. It is only through relating that meanings are generated by the way in which language and other representations are used. In this manner, meaning generated through language/text is embedded within human communities and thus negates meaning being reduced to nothing more than syllables and markings.
3. Shared language and description are the major constituents of social life and these shared descriptions represent traditions which bind cultural life. Only through relationship formation and the creation of rationality within those relationships can these traditions thrive. Engaging in such meaning generation can not only sustain traditions but indeed also offer the platform from which to challenge them, enabling progressive change through new ways of relating, new language forms and new world interpretations.
4. Challenging existing traditions to enable new futures also creates tensions and resistance from within those traditions. In the absence of a universally accepted 'good' construction the 'best' one is sought. However, this 'best' construction usually arises from those within the tradition most likely to resist change.

These underpinnings have guided the data interpretation and have helped to 'make sense' of discussions arising from the findings. Were an alternative framework applied to these findings, the interpretation and arising discussions would naturally be very different.

It is also important to determine the extent and purpose of utilising quotations from the participants to demonstrate the themes arising from the data analysis. Using the textual quotations of the MHNs to introduce and underpin the key themes places their voices at the centre of the constructions of their identity. Selection of texts to use arose from frequent readings of the transcript texts and identifying passages that were most representative of the themes' essence.

Finally, findings arising from the constructions of participant MHNs are reported as an 'all inclusive' grouping of participants as well as then being broken down into smaller groupings under the headings of:

- Core roles
- Location
- Gender
- Experience
- Education.

This allows comparisons to be made among groupings, as well as allowing greater voice for each grouping of participants. Additionally, findings from the interviews are compared with the themes arising from the analysis of policy and statutory documents outlined in Chapter 2, as well as with key issues from the literature review. These comparisons seek to highlight areas of both confluence and conflict in the construction of MHN identity.

4.9.1 Meet the participants

A careful balance must be maintained between offering the reader a sense of the participants as people and maintaining their confidentiality. Naturally, all participants are MHNs who are currently working in that role in either England or Scotland. Two sites were used in Scotland, necessitating their being described as sites A and B. Convenience sampling was used in that the requests for recruitment were directed at health trusts that were accessible. Selection for the study was that the participant had to be a qualified MHN. Through circulating the request to take part in the study through managerial, educational and clinical departments in each trust, a cross section of MHNs was sought. When the desired number of 25 participants coming from a cross section of departments and geographical sites had been met, recruitment was ceased. During the course of the data collection process one participant's (research participant 11) text was unable to be used, reducing the number of participants to 24. Relevant demographic breakdowns include:

MHN Experience	0-10 years	5
	10-20 years	10
	20+ years	9
Gender	Female	13
	Male	11
Research site	England based	7
	Scotland based A	9
	Scotland based B	8

Academic level	Diploma	4
	Degree	10
	Masters	10
Therapy qualification	None	4
	Short course	11
	Formal qualification	9
Core role	Academic	4
	Managerial	3
	Clinical	17

It is evident from the above breakdown of the participants that the presented data are taken from a diversity of MHN voices. A research participant (RP) voice introduces each remaining chapter and participants' voices are also deployed to highlight the themed data within those chapters.

4.10 Chapter summary

This chapter has sought to establish the worth of the study through critically examining not only issues of research design, but also the ethics and politics involved. This study's worth can be argued as being established through the congruent relationship between the research framework of social constructionism and the direct phenomenological method employed. This relationship is embedded within the research participants' voices and social actions from where greater understanding of MHN identity is sought. Credibility, dependability and confirmability have been highlighted as being integral to this study through

establishing the coherence of the research design and the transparency of the research process. While transferability of qualitative research remains a contested issue, this debate has been shown as now focusing on the degree of transferability rather than whether it is possible. The ethical complexities evident in all research have been shown within the context of this study to be predominantly directed toward issues surrounding representations of marginalised voices. The mechanisms and processes through which the views and experiences of MHNs introduced above have been represented in the study, offering the reader confidence that the truths of MHNs toward their professional identity lie at the heart of the data findings detailed in Chapter 5.

CHAPTER 5: THE MHN LIFEWORLD

> (RP2) Throughout the whole of the NHS service your skills and value [are] minimised; you know what I mean? It's like, you're a nurse and that's very lovely but it's not really that valuable, you know.

5.1 Chapter introduction

This chapter commences reporting the research outcomes arising from the data analysis of the 24 conducted interviews. As stated in Chapter 1, the construction of a MHN lifeworld contextually places findings for each of the research questions, and was emergent throughout the data analysis. Initially in this chapter the key themes representing the MHN lifeworld are identified, and then briefly described. These themes are those of:

- Low power and worth
- Obstacles to success
- Uncertainty.

The themes are then presented as numerical data across the subcategories of MHN participants outlined in Chapter 4, with subsequent discussion and critical analysis of evident trends. Each of the themes that characterise the MHN lifeworld is then individually explored in depth with participant quotations, reference to findings from similar studies and relevant theory.

Through the process of the data analysis of the participant interviews, an emerging construction became apparent. This construction of the MHN lifeworld

encompasses all three research questions and as such is explored here as an overarching influence upon all aspects of this study. This lifeworld provides the context in which MHN identity is formed and is pivotal in considering the internal and external resources for and impediments to MHNs undertaking roles in talk based therapies.

While also mentioned in Chapter 6, Howard's (2006) concept of narrative filters supports the necessity for presenting the MHN lifeworld characteristics prior to the other findings. In acknowledging that filters to narratives exist, it is essential to identify and then explore if and how these may restrain the participants' stories. Identifying that MHNs constructed a working world characterised by low perceived power and worth, barriers to success and uncertainty reinforces the imperative to understand the environment from which the research data emerged. Without this context, the verbal constructions that created the themes for the three research questions are rendered mono-dimensional, lacking the depth of the social environment from which they arose. Additionally, this context of the MHN lifeworld accurately reflects the characteristics of social constructionism that frames this study and reinforces the advantages of adopting a flexible research design that allows constructions from participants' voices to inform the reader of their full experiences of the topic under investigation.

5.2 MHN lifeworld themes: An overview

Collectively participants spoke of the world in which they perform their mental health nursing roles as being characterised by:

1. Low power and worth (87% of participants with 83 references). Perceived MHN low power and worth directly impact upon the therapeutic relationship, the quality of care and the capacity of MHNs to define their own identities. While management, policy and other disciplines were identified as creating this low worth and power, MHNs also self-generate such powerlessness. Talk based therapy qualifications were identified as a means of escaping from this positioning.
2. Obstacles to success (83% of participants with 86 references). This characteristic of the MHN lifeworld highlighted both current and potential barriers for MHNs as they interfaced with psychological therapies. These barriers were identified as being generated from inside the MHN profession, as well as from other disciplines and management approaches.
3. Uncertainty (79% of participants with 64 references). Uncertainty reflected the complexity and unpredictability that characterise the work of MHNs. This theme also reflected the stance of MHNs toward their own professional identity.

5.2.1 Themes as numerical data

Table 5.1 below illustrates the breakdown of constructions arising from each MHN category toward the MHN lifeworld. These are expressed as a percentage of participants within each category and the number of references made to construct the theme. The participant demographic breakdown, as initially outlined in Chapter 4 has been repeated immediately below to assist in interpreting the results.

MHN Experience	0-10 years	5
	10-20 years	10
	20+ years	9
Gender	Female	13
	Male	11
Research site	England based	7
	Scotland based A	9
	Scotland based B	8
Academic level	Diploma	4
	Degree	10
	Masters	10
Therapy qualification	None	4
	Short course	11
	Formal qualification	9
Core role	Academic	4
	Managerial	3
	Clinical	17

Table 5.1 Participant constructions of the MHN lifeworld

Categories	Low power and worth	Obstacles to success	Uncertainty
Academic	100% (18)	100% (12)	100% (13)
Clinical	76% (38)	76% (63)	64% (35)
Manager	100% (17)	66% (10)	100% (10)
England	100% (16)	71% (30)	85% (23)
Scotland site A	66% (27)	77% (24)	66% (18)
Scotland site B	87% (30)	87% (31)	75% (17)
Early career	60% (8)	40% (9)	80% (14)
Mid career	90% (28)	80% (42)	60% (16)
Late career	88% (37)	100% (34)	88% (28)
Diploma	75% (8)	75% (15)	75% (11)
Degree	80% (27)	70% (33)	80% (20)
Masters	90% (38)	90% (37)	70% (27)
Not therapy qualified	50% (6)	25% (5)	25% (3)
Short course qualified	90% (35)	90% (43)	90% (37)
Formal therapy qualification	77% (29)	88% (37)	77% (15)
Male	81% (34)	63% (28)	63% (22)
Female	84% (39)	92% (57)	84% (36)

Given the small numbers within each category and the qualitative approach to this study, there is little value in engaging in detailed statistical analysis of the above figures. Rather, value lies in identifying any general trends within each category, as well as between categories. It is evident from viewing Table 5.1 that there is an internal consistency within each category in relation to each of the three major themes in terms of the percentage of participants or responses made. This can be argued as adding to the trustworthiness of the constructed characteristics of the MHN lifeworld in that participants consistently constructed the three themes as being present.

When the data between categories are examined, other general trends appear. The most evident is that the obstacles to success theme attracted the highest four number of responses, suggesting that this was perceived as a dominant aspect of the MHN lifeworld, with all three themes receiving two 100% responses. It is noteworthy that participants with managerial roles least identified this characteristic of the MHN lifeworld within the work role category of participants, potentially owing to being in the most empowered position to respond to obstacles. It is also noteworthy that the percentage of participants talking of obstacles increased with years of service. It is possible that more junior staff members have less demanding roles, and hence are less likely to experience obstacles. Additionally, senior staff members are more likely to experience career plateauing and increasing limitations to career progression, possibly contributing to experiencing less uncertainty (Hazelton & Clinton, 2000).

Interestingly MHN participants with no training in talk based therapies expressed the lowest levels of perceived obstacles and uncertainty, possibly suggesting that traditional nursing roles that exclude talk based therapies are less problematic for these MHNs. Conversely, the comparatively high number of statements made by participants with short term therapy training identifying obstacles and uncertainty suggests tension between MHNs and the new roles in talk based therapies. While again acknowledging the small numbers within this study, the provision of formal education in talk based therapy would appear to have had little impact in reducing these perceived tensions. The findings of Cameron and Kapur (2005), who reported

MHNs who had received training in psychological therapies being less prone to report stress or low morale, suggest that the MHNs are at least being enabled to cope with these tensions, if not eradicate them. Additionally, they appear to experience less uncertainty and powerlessness than those who have undertaken short courses in psychological therapies.

A gender difference in relation to obstacles to success appears evident, with female MHNs having expressed substantially more experiences of this. This gender difference was also evident in relation to the theme of uncertainty, with female MHNs again having expressed more experiences of this than the male participants, despite also expressing marginally higher levels of perceived power and worth. As a separate theme constructed by only 8% of participants, gender is not represented in this analysis in depth. However, given the numerical comparisons evident in Table 5.1, gender certainly needs acknowledgement.

Research Participant 2 (RP2), a female MHN, offered some insight into gender differences within mental health nursing:

> (RP2) We have [male] nurses who establish a relationship with their patients but are sometimes not as good as women, I think, but they are better at the problem solving or moving people on, and I think sometimes – sometimes, women nurses are better at the intimacy and not so good at the problem solving.

This speaker contended that the focus on forming intimate therapeutic relationships undertaken by female MHNs distracts those same nurses from problem solving in relation to obstacles and uncertainties as effectively as their male counterparts, who in turn are less focused on intimacy. These gendered tensions in mental health nursing have also been identified as feminine caring verses male treatment (Chan, 1998), and as female MHNs having higher awareness of the emotions of themselves and others (Humple, Caputi & Martin, 2001). Additionally, the capacity for female MHNs to negotiate successfully their professional identities amidst limited power has also been previously identified (Oschma, Yonge & Mychajlunow, 2005). The work by Oschma *et al*. (2005) also highlights that MHNs regardless of gender have historically embraced new roles and opportunities to build their professional identities, a finding that has wider relevance to this study than gender alone.

Each of the three major themes that constitute the described MHN lifeworld is presented and explored in separate sections below. These are the themes of low power and worth, obstacles to success and uncertainty. As noted above, the themes are presented through participant quotations and are critically discussed in relation to existing theory and evidence. Where participants are being quoted and " ... " appears, this represents deleted text.

5.3 Lifeworld theme: Low power and worth

> (RP1) I think it's about the dominance of medicine and psychology – definitely it is. It's about them being seen as better paid; they are respected …. They have authority and are perceived to be in charge.

> (RP13) It's not a glamorous profession and like when you look at the stigma surrounding mental health then it does beg the question why would you want to engage with that. Why would you want to become a mental health nurse?

Power can be viewed as both the capacity and the right to act, with the latter requiring consent from the recipient of power (Hindess, 1996, as cited in Harreveld, 2002, p. 114). This concept of sources and recipients of power alerts us to power having a direction of hierarchical travel, although an individual may in fact be both exercising and receiving power. Discussions of power within the context of mental health nursing must first acknowledge the power position of the service user, given her or his highly stigmatised social position. It is widely recognised that service users and their carers have been in a profound position of disempowerment for many years, necessitating widespread changes to health care delivery to promote their empowerment (Scottish Executive, 2006a). Additionally, power cannot be viewed in isolation from other aspects of this study. Indeed, power and its application and non-application are central to the study, with MHNs being the recipients of policy informing their very identity, arguably with minimal consent. This relationship among power, politics and identity has been well mapped,

including within the thinking of the philosopher Foucault. Foucault highlighted the interplay between identity as a collective and historical effect of power laden discourses and identity being the essence of the individual (Bernauer & Rasmussen, 1987, pp. 22-24).

The presence – and also the absence – of power and worth within the MHN lifeworld have been widely acknowledged over many years. Authors such as Holmes (2001), Holmes and Gastaldo (2002), Ceci (2003) and Roberts (2005) have all examined the influence and power that MHNs both wield and receive. Lewis and Urmston (2000) also make connections between the power of the NHS organisation and the comparative powerlessness of nurses, often exacerbated by managerial behaviours and resistance to alternative views.

Barker (2001) has documented the power of medical discourses and influence over those of mental health nursing. However, Barker (2001) also assigns choice to MHNs, in that many subscribe to the medical model and to the very organisations that are disempowering. Barker and Buchannan-Barker (2005) also identify the invisibility of mental health nursing. In an echo of the minority inclusion of MHNs in executive level steering groups of their own professional reviews discussed in Chapter 2, Barker and Buchannan-Barker (2005) outline the broad policy exclusion of the profession, despite its increasing levels of expertise. Comparatively medicine and psychology are seen as preferred sources to inform mental health policy. The source of perceived low power and worth of MHN participants in this study has both an historical and a contemporary basis. Indeed, Brimblecombe (2005) carefully

charts over a century of medicine influencing mental health nursing to maintain their power and influence over it.

Peeling back the broad thematic label of low power and worth reveals a connection among power, care delivery and emotional intelligence. RP12 succinctly encapsulated this interconnectivity of power, care delivery and EI:

> (RP12) I think that's what good people bring; they don't need anything from the relationship particularly; it's a giving and supporting relationship and their ego and self-worth [are] good enough. If you went to a relationship with unwell people and your needs were met like that, that's a bit scary and it's bound to lead to some kind of misuse of the relationship and yeah, I think that not abusing the power comes from self-awareness.

It is evident from the statement above that MHNs require advanced levels of personal competencies to negate the abuse of power while simultaneously generating and maintaining self-worth. Arguably, one potential driver for abuses of the therapeutic relationship is that service users are the only group whom MHNs are able to exercise any significant power over. For those MHNs with low EI and/or unable to accept the Foucauldian (Foucault, 1988, p. 20) concept of power being unlimited, such abuses are potentially undertaken as a means to express influence.

The MHN participants in the study articulated behaviours that consciously abdicated power to service users, suggesting advanced personal competencies and

a willingness to self-sacrifice for the development of others. RP14 encapsulated this willingness, as well as the challenges faced by MHNs in developing others whilst dwelling within positions of perceived low worth:

> (RP14) I like to work with acutely ill patients but you can't continue to do that in an environment like an acute ward when you are not valued, and you are always going to be at the bottom of the pile when it comes to nurses, but these are the patients that need the most skills.

While articulating a problematic outcome of low power and worth, the above statement also expresses an attachment to and concern for the service user. Although previously discussed as a possible contributor to abuse within relationships, low power and worth can also act to generate a therapeutic relationship. By virtue of MHNs not being distanced through holding prestigious positions, service users potentially have greater access to the MHNs as people than as authorative professionals, a theme that is discussed further in reporting the findings associated with MHN identity in Chapter 6. This also demonstrates the employment of a MHN lifeworld survival strategy that effectively turns a professional weakness into a defining strength. There was little expressed passive hopelessness by the participants when discussing their low power and worth. Rather, participant MHNs articulated more active responses to such positioning through seeking more powerful positions within mental health nursing, leaving the profession or, as previously indicated and expanded upon in Chapter 6, using their comparative powerlessness compared with other professions to create therapeutic alliances with users.

The participants below reflect these responses. First RP17 describes the change from being a MHN to that of therapist. RP21 then conveys a sense of internal mental health nursing power when describing relationships with those who attained more powerful MHN positions:

> (Researcher) From your experience, do you have more power and more influence in your current role as a therapist?
>
> (RP17) Yes, without a doubt, but first of all that's what I'm here to do; I'm not here to fight for my role or fight for my identity.

> (RP21) I don't know – how do you make yourself heard …. I don't know how to put yourself forward to change things. I think very often there are nurses who are like at a different level or are planning in organisations but they were nurses such a long time ago; they don't work in the wards now. Perhaps they are the ones that need to be listening to the ones who are actually in front.

Chapter 3 highlighted that mental health nursing experiences internal divisions, particularly in relation to models of and approaches to care delivery. Such divisions can be interpreted as being at least exacerbated by the inability to exert influence upon most other aspects of their professional lifeworld. Enacting expressions of power within the MHN profession can also be seen through an internal mental health nursing 'hierarchy of worth' spoken of by some participants, including RP14's reference quoted above to "the bottom of the pile". Within this hierarchy,

community based nurses were perceived as having higher autonomy and worth than those working in in-patient settings. Additionally, those with specialist titles such as 'therapist' were perceived as holding greater status and autonomy.

Some participants with formal qualifications in talk based therapies in this study reported improved worth, having their MHN practice validated and that they felt more enabled to contribute to helping the service users with whom they worked. However, as indicated in Table 5.1 overall these participants reported lower levels of perceived worth and power than those without formal training in talk based therapies. This disparity suggests that influences beyond possessing formal qualifications alone are present. As identified in Chapter 2, limited therapist numbers, multiple role demands and the negative attitudes of either patients or staff have plagued mental health nursing efforts to integrate talk based therapies into the profession (Landeen, Kirkpatrick, & Woodside, 1996; Van Den Berg, Shapiro, Bickerstaffe, & Cavanagh, 2004).

Constructions of power and worth at the social interface of the MHNs and their employers in this study offered limited hope of successfully generating such an empowered future for all MHNs. RP2 below expresses not only low worth, but also the sense of betrayal that is indicative of the emotional responses that MHNs can experience within their work environments:

> (RP2) We still believe hugely in the NHS but the NHS however doesn't really believe in us. I think … as far as the NHS is concerned … that nurses are disposable in the way that hankies are disposable.

Echoing this sense of betrayal, RP8 highlights the lack of legislative support for nurse education and training as communicating low regard to MHNs, as well as those under their care, despite attempts being undertaken to achieve this over many years:

> (RP8) The one thing that psychiatric nurses have never had is statute to support development, which general nurses have; health visiting was in statute, and district nursing was in statute. But Tony Butterworth and his colleagues fought for statute around community psychiatric nurse training and never achieved it and we are taking forward the same argument and we are saying, "Why are psychiatric nurses so undervalued that you are unwilling to think about statute for them and yet here we are into the new training and a new model for a community nurse in general and that's going to be in statute yet again?" …. Yeah, but it also devalues our clients.

For the MHNs in this study a truth was that management behaviours often fail to construct any meaningful worth toward those they manage. The impact of the increasing control of professional behaviours by management discussed in Chapter 3, and the policy directives to accept prescribed values and behaviours discussed in Chapter 2, can be argued as generators of both the powerlessness and the diminished worth of the participants. The paradox of these policy documents is that, while they are overwhelmingly prescriptive and controlling of mental health nursing, they also offer potentially improved power and worth through new roles,

especially those in talk based therapies. Consequently, the manner in which they are communicated and implemented can be argued as being pivotal to the future well-being of the profession. Where generative futures can be constructed without debasing MHNs, the full benefit of assuming roles in talk based therapies for the profession and service users is more likely to emerge.

The positive impact on self-worth following training for talk based therapies is articulated below by RP6, who undertook such training:

> (RP6) I went in there thinking I was useless, rubbish, academically horrendous – all those things ….. It's got an assignment base to it, and it's full of all these highly academic people and that I'm going to be crap. And I came out thinking just because, you know, I'm not academically as polished as they are I can actually be equal.

Whilst the following perspective was a minority voice in the study, where empowerment of MHNs had been enacted within the workplace or health trust as described by RP7 below, it was reported as not only having a positive impact upon the MHNs but also as consequently improving service user care:

> (RP7) I think very strong management gives you a voice and I know acute care has had a greater voice in the trust and we have been able to produce some quite significant changes.

This relationship between empowered MHNs and quality care signals an imperative to attain such an outcome. Whilst predominantly identifying management and the

influence of medical and psychology disciplines as sources of their disempowerment and low comparative worth, participant MHNs also expressed self-responsibility for this disempowerment. Through not acting as a profession, not communicating their skills and not projecting the worth of mental health nursing outwards, MHNs can be argued as partially self-constructing their own position of low worth. RP17 quoted below highlights that where power and worth can be internally derived and then expressed patient care can be positively affected:

> (RP17) … getting a different perspective on things that it wasn't just as black and white as all of that and having the confidence to just actually say, "Well, actually you know I think there could be a different way to look at this patient's problems".

While low power and worth stemming from MHN constructions may initially appear problematic, they also represent an area where MHNs can actively assume responsibility for initiating positive change toward their position, rather than waiting for worth to be bestowed upon them. Care delivery and MHN worth and power are also connected to the theme of uncertainty, which is discussed shortly. Here MHNs are uncertain as to whether their interventions have any positive impact upon the service user. Reinforced through increasing managerial demands for empirical measures of efficacy, this lack of clarity was reported as generating a feeling of ineffectiveness, with resultant low MHN worth and low regard from others.

5.4 Lifeworld theme: Obstacles to success

> (RP23) I think if you lack the skills, lack the self-confidence, you know, it's difficult to know exactly what your role is; it's quite comforting to stay in a *status quo* …. But people could get trapped in it. I'm sure you've worked with people over the years – I know I certainly have – who … are burnt out with it.

Barriers to the successful implementation of talk based therapy roles into the MHN lifeworld were described and thematically interpreted. Re-examining MHN power and influence within the context of assuming these roles reveals some of these challenges, particularly within the context of in-patient settings. This closely reflects the findings of Levenson (2000), who found hospital work environments to be characterised by stress, uncertainty and increasing responsibility. RP13 below encapsulates many of the challenges facing MHNs within these settings:

> (RP13) That asylum based care, we still see it on acute wards …. I actually think that's where the biggest challenge will be. Introducing talk therapies into a very controlled, very focused, very short based environment.

Participants identified that in–patient settings are characterised by medical model psychiatric control and authority, and that their roles in delivering talk based therapies will be highly complex. Barker (2000) is perhaps the most prominent nurse leader to identify the dominance of the medical model, and to articulate the consequences of such dominance. One such consequence is the creation of

paternalistic relationships from medical model approaches that offer an immediate contrast to talk based therapy relationships that encourage self-responsibility. Power relationships will be further complicated through the application of mental health law. Service users under such restrictions have been deemed as lacking the capacity for sound judgment, and as such have had basic rights such as their liberty suspended.

The inherent challenge in delivering talk based therapies will move between these starkly different power relationships, possibly with the same service user. Equally, service users' expectations of their MHN may well be confused owing to the multiplicity of roles, and hence identities, that the nurse is assuming. This theme of obstacles to success has also been identified by other authors such as Stronach *et al*. (2002), who highlight MHNs as being confused about their core roles as well as being highly managed. In their study Clinton and Hazelton (2002) showed MHNs as often lacking the necessary power to advance themselves. Additionally, Crawford *et al*. (2008) identify MHNs as encountering barriers as well as recognition.

Some participants identified the role of medical staffs as being fundamental to the levels of success in MHNs delivering therapies:

> (RP17) I think often the patients were in and out so quickly that you often thought, "Well, can you actually follow through anyway with some of the work you were [doing]? … but at the end of the day it was consultants that dictated what happened to the patients anyway.

> (RP23) ... moving back up here [Scotland] I had to go back and work in the wards. You know, it was horrendous and I did it but it was awful how easily you slip back into that role and knowing, feeling frustrated, but knowing you weren't working how you should be working with people but also you just lost all that autonomy.

Conversely RP15 described how the support of medical staffs was instrumental in successfully incorporating psycho-social interventions onto an acute ward. Yet, even in this narration of successful implementation, power negotiations had been undertaken. Medical officers nominated and referred service users whom they assessed as being appropriate for talk based therapy, as well as identifying the required goals to be achieved. Self-referral by the service user or MHN identification of the need for talk based therapies was not evident.

It is apparent from the above that the incorporation of MHNs in the delivery of talk based therapies can be achieved without tensions only where the current hierarchy of power is maintained. This echoes the Department of Health (2006a) emphasis on MHNs delivering but not deciding care, and for MHNs not to engage in inter-disciplinary conflicts. Such implementation generates less resistance from the tradition of medical model control whilst simultaneously achieving the policy aim of improving access to talk based therapies, with resultant benefit to the service user. Additionally, MHNs can undertake specialised interventions that hold greater worth than current generic roles. This cozy picture of endemic benefit is at least partially spoiled through MHNs assuming additional roles and responsibilities with no

meaningful alterations to the existing power differentials between them and other mental health professions.

Continuing the focus upon power and influence as a barrier to success, constructions from participants' dialogues also identified management as a pivotal factor in the implementation of new roles. As discussed in both Chapter 2 and the paragraph above, existing evidence suggests increasing managerial control of professional behaviours and consequently of clinical practices. This exacerbates the pre-existing tendency toward MHN subservience that was identified by Lewis and Urmston (2000). This managerial influence was echoed within this study, with managers being identified as controlling the number and length of therapy sessions that service users could receive, as well as keeping minimum numbers of qualified staffs for each shift, consequently limiting the opportunities to engage in therapeutic interaction. Additionally, participants identified a policy driven target culture as diverting time and resources away from MHN clinical priorities and that there was a low priority attached to funding non-mandatory MHN education and training.

Participants also spoke of old fashioned hierarchical management systems that lacked the flexibility to incorporate new therapy roles within in-patient settings. This particularly applied to influencing acute ward environments to make them more conducive to delivering talk based interventions. Findings by Shatell, Andes and Thomas (2008) highlight the inhibiting impact that ward environments have

upon therapeutic relating, with both users and nurses reporting experiencing the in-patient environment as imprisonment.

As with the first lifeworld theme of low power and worth, MHNs are partially responsible for generating obstacles to their own success. Not least among these is the conflict between these new roles in delivering therapy and those MHNs wishing to maintain a traditional MHN identity. RP2 below gives a flavour of such identity tensions:

> (RP2) I think nursing and therapy are two separate things, and ought to be.
>
> (Researcher) Can nurses be Therapists?
>
> (RP2) I think if you give up your title of nurse you can be a therapist.

This fundamental question of when a MHN starts and stops being a MHN lies at the very heart of this study. The nine participants holding formal qualifications in talk based therapies diversely described their identities as being a MHN, a therapist and even as shifting between the two depending upon how their work duty allocation was posted for each month. Academic participants equally identified difference and potential tension between providing preparatory education and training for MHNs and for therapists. What is suggested here is that there is a partial incompatibility between mental health nursing and talk based therapies. While concerns regarding fitting in time to prepare MHNs for therapy or actually to deliver the therapy while maintaining existing MHN roles are potentially easily responded to through additional resourcing, perceptions of incompatibility are not. Discourse from within

mental health nursing that challenges its own traditional description appears necessary to integrate talk based therapies into MHN identity.

Such challenging discourse was offered by RP17 by identifying that the MHN culture of the low uptake of clinical supervision is one area that must alter for the uptake of talk based therapies:

> (Researcher) So this would be a fairly big cultural shift in your experience that nursing would have to undertake the shift to have been more engaged in talk based therapies?
>
> (RP17) Yeah, I would say so and not just lip service. I think you know a commitment on behalf of senior staff to supervise and commitment on behalf of the trainee and the nurses that need to be trained up to do that too. And I think it's new territory for a lot of people.

This low uptake of clinical supervision connects with the underlying theme being explored here of barriers to success. MHNs in both in-patient and community services described a solitary delivery of clinical interventions to service users. RP14 quoted below not only reinforces this view but also highlights that valuable knowledge is effectively held in silos, and hence lost to the wider profession:

> (RP14) … but it's sharing as well. You've got lots and lots of nurses about that have got lots of experience and we don't know what the other nurses are doing half the time. And if, like I say, if you've got a good mentor you will gain all the knowledge from them, but we don't share as a team or within the unit.

In community settings this lack of inter-professional contact was due to historical practice and solitary working, and within in-patient settings it was due to restraints on staff time, staffing levels and, as with community settings, historical practice. While generally talk based therapy is delivered in a solitary manner, clinical supervision is integrated into its delivery to ensure learning, safe practice and support for the therapist. However, MHNs' ongoing isolated practice may have bred a culture of not seeking critical responses to their practice from other MHNs, consequently negating progressive learning, and leaving many participant MHNs reporting a paucity of support.

Certainly this ongoing struggle to integrate clinical supervision into clinical MHN culture has been well documented. Coyle, Edwards, Hannigan, Burnard and Fothergill (2000) found that nurses prefer less formal mechanisms to structured supervision, while Cottrell (2002) highlights mistrust between clinical staffs and management as a source of low uptake of clinical supervision. More recently, Lynch and Happell (2008) highlight the efficacy of clinical supervision for reducing stress and improving clinical practice. However, the successful integration of clinical supervision as outlined by Lynch and Happell (2008) is also shown to be a delicate and complex process demanding staff time, organisational resource and commitment by all stakeholders.

Individually, participants identified other barriers to success within the profession, such as overcoming low confidence in offering therapies (RP20); philosophical

conflict between diagnostic driven CBT and non-labelling MHN approaches (RP18); longer training resulting in increasing academia at the expense of inter-personal skills (RP19); widening gaps in professional worth, regard and power between therapy trained MHNs and non- therapy trained MHNs (RP1); and the point that MHNs will need to instil confidence in their capability in other disciplines, users and accrediting bodies (RP3).

5.5 Lifeworld theme: Uncertainty

> (RP5) So what are you left with there if you get rid of the medical model? There is this uncertainty of where we stand …. We are touched by the medical model, we are touched by the psychological approaches and we are touched by all the social issues, all of which have a degree of uncertainty and we are mishmashing through it.

A specific feature of the MHN lifeworld as constructed by the research participants was that of uncertainty. This theme of uncertainty is relevant to many aspects of care delivery and appears strongly connected to MHN identity. Uncertainty has been identified in previous studies such as that by Barker (1996) as being central to mental health nursing. This connection between uncertainty and MHN identity refers to MHN identity being described as at best opaque, and also to the point that the manner in which MHNs respond to uncertainty in some ways helps explain their professional identity.

RP19 below articulates the complexity of trying to help other people effectively. Closely reflecting complexity theory as outlined by Radford (2006), the interconnectivity of the multiple variables and hence the multiple outcomes possible in mental health nursing are made evident. Uncertainty was described as involving complexity:

> (Researcher) What is it that makes you a mental health nurse?
>
> (RP19) I think it's the people thing. You are interested in people, you want to do it for people and you want to be there and I think the complicated nature of how people work. Because you can see lots of people have a psychotic illness but it's not the same. You can see lots of people are manic and their presentation is different. You can see lots of depressed people with similarities in all of them but it's the individual bits that make the difference.

Uncertainty was described as involving ambiguity:

> (RP19) Yeah, we've to be everything for everybody else but we've not to be ourselves. And the other thing about that is I don't know if we still have a handle on what being a nurse absolutely is because I think we do that much and we just flit round things and I think we have lost a bit of our identity. And I don't know – I don't know where or why it went and I don't know how to get it back.

Mitchell and Pilkington (2000) identified ambiguity as being part of nursing and that nurses should respond to it through seeking better understandings and new

knowledge. Mitchell and Cody (2002) identified that, through experiencing and exploring ambiguity, new and meaningful ways to help people can emerge for nurses. In many ways the words quoted above and below capture the essence of ambiguity for MHNs in that the lack of a guiding theoretical model generates multiple interpretations of mental illness, and consequently of mental health nursing. Barker, Jackson and Stevenson (1999) and Barker (2000) are previous authors who have identified similar findings.

This lack of knowing arising from the lack of a defining mental health nursing model that in turn can lead to ambiguity and resultant feelings of anxiety and uncertainty on how best to help users is well articulated below:

> (RP1) What the hell are nurses doing; what is your specific body of knowledge and expertise and professionalism? And that kind of vague "care" just doesn't cut it; it just doesn't do it. So you have to hang onto the other professions' body of knowledge and claim their authority for yourself.

> (RP14) And you draw on everything that you have learnt and everything you have gathered to help them improve and get better – you know, whether it's a social problem, physical health problem, you know. You are drawing on everything but you don't know whether it's the right thing because you haven't had that recognised training. You really don't know; you are just doing what you think as a practitioner.

Uncertainty was described as involving unpredictability:

> (RP5) I think perhaps another thing is, maybe we are more comfortable tolerating uncertainty than other professions. Because much of what we do, whether it's in the wards or whether there's a lot of chaos going on. And you can't predict what is going to happen. You are always going to work with this uncertainty and perhaps being able to kind of work through that with the person gives something special to the relationship.

The above participants encapsulated a vital characteristic of the MHN lifeworld. The characteristics of complexity, ambiguity and unpredictability are drawn from the work of Sorrentino, Nezlek, Yasunaga, Kouhara, Otsubo and Shuper (2008), who identify these are being the defining features of uncertainty. The impact of complexity, ambiguity and unpredictability, combined with knowledge deficits, barriers and low power, suggests an at times chaotic MHN lifeworld. Some participants articulated responses to this uncertainty and chaos that indicated attempts to increase understanding and predictability and hence reduce uncertainty, while accepting that this could be only a temporary adjustment. Alternatively, others sought more long term control, whether actual or perceived, through adopting the framework of talk based therapies or other models of working.

Applying the findings of Sorrentino *et al*. (2008) to these behaviours would suggest that the former have an orientation to uncertainty while the latter group have an orientation to certainty. Responsive choices in relation to uncertainty would

logically be influenced not only by low power and obstacles to success, but also by the limitations of mental health nursing itself. The absence of a guiding model or uncontested agreement as to core MHN roles, care approaches and professional identity limits responses to uncertainty to (a) remaining in the MHN profession and adjusting to uncertainty and chaos or (b) shifting to less uncertain work roles.

Consider possible humans' reactions when confronted with uncertainty and chaos. Affective responses will be associated with those of fear, anxiety and vulnerability, with behavioural responses being directed toward maximising safety, as outlined by Pollard (2001) in a study on workplace reorganisation. Additionally, uncertainty could also generate passivity through the lack of a clear direction or purpose for action. Cognitively, it is likely that attempts to make sense of the chaos will be undertaken. The employment of internal defence mechanisms is also likely as a means to reduce the levels of neurosis. MHNs who have an orientation to needing certainty may be highly motivated to form attachments to anything in their immediate environment that offers increased certainty, predictability and hence safety. The medical model and CBT present themselves as the bastions of such certainty, consequently offering MHNs a ready made and accessible refuge. Other therapy approaches direct therapist behaviours from models and guiding principles with greater clarity than that of mental health nursing.

RP15 articulated relief to be working from a guiding model when remarking on the impact of having completed a qualification in Psycho-Social Interventions:

(RP15) I think I'm a good nurse and I'm good at my job. But it was just – it just felt good to do something a bit more structured and give patients a slightly different role.

However, by effectively becoming a junior member of a model or approach external to mental health nursing, a MHN's roles, identity and status will be influenced by constructions from the pre-existing dominant voices.

Increased lifeworld certainty is also offered by management and policy sources. As discussed in both Chapter 2 and Chapter 3, the increasing environment of regulation is well documented. The policy documents analysed in Chapter 2, interpreted as a monologue of control toward MHN behaviours and values, promote predictability, increase role clarity and seek to expand knowledge. While these policy documents construct a picture of the MHN lifeworld as being historically unstructured and uncoordinated, there is no acknowledgement that this is at least partially inevitable. Nor do these documents offer any significant acknowledgement of the challenges for MHNs operating within an environment of chaos. The absence of acknowledging that much in the MHN lifeworld remains uncontrollable, unpredictable and individual suggests a desire to create control, or at least the illusion of control through policy and frameworks.

The discourse of managerialism/policy is dominant and through drawing from itself created a body of 'best evidence' that is able to sustain and expand its future constructions of mental health nursing. As each managerial/policy construction of mental health nursing is uncritically evaluated and embedded in the lifeworld of

MHNs, the illusion of certainty and control is reinforced. As with attachment to external models related to mental health nursing, there is little room apparent in this escape route from uncertainty to self-construct professional identity, exercise influence or initiate professional responses autonomously to care delivery. Indeed, choice is partially sacrificed for apparent certainty.

Constructions by the participant MHNs showed that many were very comfortable with, if not enlivened by, uncertainty. Rather than describing behaviours designed to control or minimise uncertainty, these constructions reflect an acceptance of 'what is' and behaviours designed to 'respond with'. While it is acknowledged that most participant MHNs were uncertain as to their professional identity, it is worth at this point mentioning the irony that many MHNs also identified mental health nursing as being effective amidst uncertainty:

> (RP3) Be more open minded and more objective about things. You start not to judge people too quickly and make assumptions about certain types of behaviour and I think you become a wee bit more comfortable with uncertainty and you don't think you necessarily have to have an answer to everything. It's not always logical and you are starting to understand these things and that makes you more comfortable with some things than other people might find.

> (RP7) I've done this job for 14 years and I think I'm still as enthusiastic as the day I started, probably more so because of my knowledge and understanding because I do feel this is the best job in the world for me.

> Because I do feel, you know, I come to work and I don't know what I'm going to be dealing with every day. Because of human nature, like, you know, you can talk to two people with the same illness who have different experiences who need different responses.

It is apparent in both these constructions of being comfortable with uncertainty that the 'not knowing' aspect of uncertainty has been embraced, allowing the individual to feel confident about coping with future uncertainty. This accommodation – even celebration – of uncertainty can be facilitated through both acquisitions of knowledge and acceptance of knowledge gaps. It is also apparent that both the above participants not only accepted uncertainty as being intrinsic to mental health nursing, but also believed that there is an attraction to working with uncertainty.

Points of tension are quickly evident where MHNs comfortable with uncertainty or provisional certainty collide with approaches and structures that communicate certainty and control. While this certainty and control represent 'a truth' when describing the MHN lifeworld, it was a minority truth in the experiences of the MHN participants in this study. Many MHNs experience incongruence between their own experiences of 'certain uncertainty' and what might be termed the 'uncertain certainty' promised by policy and management.

The statement below highlights this clash between a MHN comfortable with the 'certain uncertainty' of clinical practice and the expectations of quantifying the efficacy of interventions:

> (RP7) And I think they are going through the same problem: how do you quantify and how do you measure what you do? How do you prove to somebody else the success of your own interventions? Because we all know that people recover spontaneously without us.

The theme of uncertainty also directly pertained to MHNs' views about their own professional identity. Almost all participants expressed this, with many acknowledging that they had never contemplated what constituted MHN identity. Ambiguous understandings appeared to have stemmed from MHNs assuming a multiplicity of roles:

> (RP13) But you know, when's a nurse not a nurse, where's the cutoff point and I think we are very much seeing mental health nurses are taking on doctors' roles, psychologists' roles and what have you. But we are not actually saying, "Well, yeah, we are taking on these roles but what does this role encompass?" What we are actually talking about is not development of the role but development of the person's skills.

This overt lack of anything concrete that unambiguously identifies mental health nursing is remarkable given its long history of existence. Also remarkable is that the participant MHNs overwhelmingly accepted the lack of clear identity markers with little question or discomfort, while still identifying themselves as being MHNs. The

absence of external identity markers such as a unifying model, a specialised body of knowledge or specialised roles suggests that internal identity markers may be important. The research participants communicated highly personal and individual attachments to mental health nursing, while rallying around service user needs as a point of shared external unity. However, individual participants communicated a shared emphasis on the personal parts of self as being central to their MHN identity. These issues are discussed at much greater length when presented as key themes in the next chapter.

> (Researcher) Did being a mental health nurse prepare you for this?
>
> (RP6) I think it possibly did because – but then is that because I'm a MHN or is it because I'm me? You don't know if it's because of your personality and what's – they blur into one, don't they?

5.6 Encapsulating the MHN lifeworld

Despite the seemingly overwhelming challenges existing within the lifeworlds of participant MHNs, there was very little expressed despair or self-defeating emotions. Indeed, the personal capabilities of participant MHNs shone amidst an otherwise gloomy construction. The MHN drive toward developing others despite perceiving little worth or power speaks of a self-sacrificing that manifests through significant social competencies that in turn require advanced levels of self-awareness. Consequently, participant MHNs can be described as demonstrating advanced EI through the ways in which they use this powerlessness to improve accessibility for the service user.

The ethical requirement of empowering the service user and the overt strength of other disciplines and managerialism appear to have influenced MHN power negotiations being internally focused with the MHN profession's hierarchies of worth. This internal fragmentation of the MHN profession can be argued as being exacerbated by the expressed paucity of internal leadership and endemic uncertainty about what constitutes MHN professional identity. Potentially offsetting this fragmentation appears to be a focus on the service user (which is expanded upon as a theme in Chapter 6) and the EI capabilities employed by MHNs to negotiate their lifeworlds (which is expanded upon as a theme in Chapter 7). The policies discussed in Chapter 2 also offer a binding gel in relation to MHNs' identities and their roles within talk based therapies. They offer clarity of direction and also contain confluence with EI capabilities, particularly those of social competencies. However, this valuable contribution of policy is counteracted by being applied to MHNs rather than co-constructed with MHNs.

The constructions from the participants' dialogues showed an interface with talk based therapies that require precisely such binding gels as EI and service user focus. Professional identity was communicated as being further diluted and confused through MHNs assuming therapy roles, with some participants utilising these roles as a means to move toward positions of greater perceived worth and certainty. Perhaps the most evident barrier to MHNs assuming talk based therapy roles was that mental health nursing and therapy roles were positioned by some as being mutually exclusive. This minority view highlights that, despite attempts to assimilate therapy roles into nursing, the barrier of existing MHN identity needs to

be reconstructed to allow a new identity inclusive of talk based therapies to be formed.

5.7 Chapter summary

Chapter 5 has commenced the reporting of findings through introducing characteristics of the MHN lifeworld that are relevant to all three research questions, and hence the ultimate aim of the study. Consequently, education and training for MHNs preparing for roles in talk based therapies must consider and respond to the MHN lifeworld characteristics. This lifeworld as described by participants has been shown to be a challenging environment characterised by perceived low MHN worth and power and high uncertainty, and as a range of barriers needing to be overcome if talk based therapies are to be integrated into mental health nursing.

These challenges and barriers were also identified as being generated at tension points among the full range of stakeholders engaged in expanding talk based therapies, and MHNs. It was also made apparent that these challenges and barriers were constructed from within the MHN profession. These internal constructions highlight that variances on and confusions toward MHN identity are a pivotal factor in generating tensions toward new MHN roles. While the identity theory discussed in Chapter 3 supports the reality and even the necessity for multiple MHN identity performances, findings here also alert us that improved clarity toward shared MHN identity markers are required. Arguably without greater shared understandings

toward what mental health nursing can be and currently is, the successful implementation of new roles is challenged.

Chapter 6 presents findings from the data that help to answer research question one, which seeks to determine if MHNs bring anything that is unique to talk based therapies. Through this point of uniqueness being sought, the journey toward clarification of MHN identity is continued.

CHAPTER 6 WHAT IS A MHN?

> (RP13) But you know, when's a nurse not a nurse; where's the cut off point? I think we are very much seeing MHNs are taking on doctors' roles and psychologists' roles, but we are not actually asking, "What does this role encompass?" It has been said in literature if you want to get on then you have to step outside the profession, and nurses welcome that.

6.1 Chapter introduction

Chapter 5 commenced reporting the data emergent from the 24 conducted interviews for this study through describing and then critically examining the context in which the three research questions are immersed. This chapter responds to the first of those research questions, which asks:

- What, if any, are the perceived unique qualities, abilities and behaviours of MHNs engaged in the delivery of talk based therapies in the UK?

The wording of this question potentially shifts MHNs toward being contributors to knowledge about talk based therapies rather than being seen solely as recipients in need of education and training. The value and worth of mental health nursing are consequently highlighted. As discussed in Chapter 2 and Chapter 3, the issue of MHN identities is also central to this study, and responses to this question directly contribute to the ongoing construction of professional identities for MHNs. Arguably, without such clarifications of MHN identities the increased uptake of talk based therapies by nurses will fail to benefit fully both the profession and service users.

A brief discussion of narrative restraints commences this chapter, which then moves on to reporting the seven themes constructed from the analysis of the participants' responses to the first research question. These themes are briefly described and then presented as numerical data. The constructions of MHN identity that arise from analysing the numerical aspects of the data are then presented. Each theme is subsequently discussed and critically analysed with reference to findings from comparative studies and relevant literature. Following this in-depth examination of the data, the identity constructions arising from participant MHNs are contrasted with those of the policy review outlined in Chapter 2 to highlight the co-constructions of MHN identity, as well as areas of tension. The chapter concludes by contrasting these constructions with the core theoretical underpinnings of social constructionism.

6.1.1 Narrative filters

This ongoing identity work offers participant MHNs the opportunity to provide an autobiographical account of their own identities. As recognised by Howard (2006), this autobiographical account is influenced not only by interpretations of past events and anticipations for the future, but also by cultural narrative restraints within the present moment. The narrative constructions by the participants can therefore be seen as arising from the MHN lifeworld described in Chapter 5 and as being influenced by MHN culture. This narrative culture has been variously described as being at least partially characterised by self-effacement (Crawford et al., 2008), frequently conducted as background narratives to those of the client

(Brown, Crawford & Darongkamas, 2000) and increasingly censored by management (Stronach et al., 2002). Krejsler (2005) offers further narrative constraints to be considered within the context of professional identity constructions. Differing levels of power and competing epistemological perspectives held by professionals interact with one another within the organisational environment in which identity is at least partially formed, consequently influencing the generation and dissemination of identities.

When considered in conjunction with the MHN lifeworld themes of uncertainty, low power and obstacles, Howard's (2006) concept of narrative restraints appears relevant. Some participants exemplified such restraints through feeling that they had little to offer (self-effacement) and that they should best 'watch what they say' for fear of repercussion, or they told their story through the lives and actions of their clients. Additionally, the MHN lifeworld themes identified in Chapter 5 were peppered throughout the autobiographical accounts of the MHNs presented here in Chapter 6. However, resilience, clarity of expression and humour were also evident throughout these constructions of MHN identity. While the participants' individual identity journeys were possibly restrained, they were far from constrained. This positive outlook was continued in relation to the first research question, with an overwhelming acceptance by participant MHNs toward assuming the talk based therapy roles.

6.2 MHN identity themes: An overview

> (RP25) MHNs are looking at people as a whole person … and they are – I know it's perhaps a corny word to be using in 2008, but they are sort of bringing that more sort of holistic approach, seeing the person in terms of their socio cultural context. They [MHNs] are not just seeing it [psychological interventions] as a mind to be worked on.

In response to the first research question that sought perceived unique contributions that MHNs would bring into delivering talk based therapies, analysis of participants' discourses offered the following:

1. The MHN as generic specialist (100% of respondents with 103 references) – Participants identified mental health nursing as responding to the full range of service users' needs, consequently necessitating preparedness and capability to intervene across psychological, social and physiological domains.
2. The MHN as having a service user focus (91% of participants with 61 references) – Participants constructed this aspect of MHN identity as being embedded in attention to the service user. When challenged that other disciplines may equally make such claims, the majority of participants spoke of MHNs being comparatively more focused on the user than other disciplines.
3. The MHN as positioning and utilising the personal self (87% of participants with 81 references) – Participants spoke of mental health nursing as the therapeutic application of their personal selves that

operates in conjunction with their professional selves. As with the service user focus theme, participants constructed MHN identity as being associated with a greater use of the personal self than other disciplines.

4. The MHN as spending time with the service user (79% of participants with 48 references) – The theme of time was evident with participants identifying that MHNs spend extended periods of time with service users, unlike all other disciplines. Time as a theme was also described as being essential to responding to service users' needs and to constructing meaningful therapeutic relationships.
5. The MHN as delivering talk based therapies in versatile ways (75% of participants with 49 references) – MHNs deliver talk based therapies in innovative ways, not only to a more seriously ill user group than has traditionally occurred, but also through the mechanisms of delivery. In a way that is connected to the themes of both time and generic specialism, MHNs have taken therapy out of the therapy room with pre-set appointments and into a range of social settings and opportunistic timings.
6. The MHN as having an everyday attitude (58% of participants with 38 references) – Participants included practicality, common sense and a user lifeworld perspective as being part of MHN identity, particularly in comparison to other disciplines.
7. The MHN as having transferable skills (50% of participants with 22 references) – In this theme participants associated existing MHN skills,

capabilities and roles with being congruent with and transferable to offering talk based therapies.

6.3 Themes as numerical data

Table 6.1 below reports the extent to which each category of MHN participant constructed the MHN identity themes. These are expressed as the percentage of participants within each category and the number of references made to construct the theme. The participant demographic breakdown, as initially outlined in Chapter 4 has been repeated immediately below to assist in interpreting the results.

MHN Experience	0-10 years	5
	10-20 years	10
	20+ years	9
Gender	Female	13
	Male	11
Research site	England based	7
	Scotland based A	9
	Scotland based B	8
Academic level	Diploma	4
	Degree	10
	Masters	10
Therapy qualification	None	4
	Short course	11
	Formal qualification	9

Core role	Academic	4
	Managerial	3
	Clinical	17

Table 6.1 MHN identity themes

Category	Generic specialist	User focus	Positioning of self	Time	Versatile delivery	Everyday attitude	Transferable skills
Academic	100% (23)	100% (14)	50%(15)	100% (8)	25% (3)	75% (9)	25% (4)
Clinical	94% (62)	88% (42)	88% (47)	82% (39)	82% (38)	47% (18)	52% (15)
Manager	100% (15)	66% (4)	100% (8)	33% (1)	100% (8)	66% (7)	66% (3)
England	100% (36)	85% (14)	100% (25)	71% (12)	100% (20)	42% (14)	42% (6)
Scotland site A	88% (30)	88% (26)	77% (26)	77% (19)	55% (9)	66% (12)	33% (4)
Scotland site B	100% (34)	87% (20)	75% (19)	87% (17)	75% (20)	50% (8)	75% (12)
Early career	100% (18)	80% (18)	80% (21)	80% (18)	80% (15)	40% (3)	40% (2)
Mid career voices	90% (49)	90% (15)	70% (14)	80% (12)	70% (17)	40% (18)	60% (11)
Late career	100% (33)	89% (27)	89% (35)	77% (18)	77% (17)	77% (13)	44% (9)
Diploma	100% (9)	75% (11)	100% (16)	75% (11)	100% (9)	75% (4)	25% (2)
Degree	100% (41)	100% (28)	90% (28)	90% (26)	80% (29)	50% (14)	70% (13)
Masters	90% (50)	80% (21)	70% (26)	70% (11)	60% (11)	50% (16)	40% (7)
Not therapy qualified	75% (6)	50% (9)	75% (17)	50% (6)	75% (9)	50% (2)	25% (1)
Short course qualified	100% (52)	100% (33)	90% (40)	81% (25)	72% (23)	72% (20)	45% (10)
Formal therapy qualification	88% (37)	77% (16)	66% (11)	66% (16)	66% (14)	22% (6)	66% (11)
Male	90% (45)	90% (27)	72% (31)	81% (18)	63% (21)	72% (21)	45% (9)
Female	100% (55)	84% (33)	92% (39)	76% (30)	84% (28)	38% (13)	53% (13)

6.3.1 Discussion and analysis of numerical data

As in Chapter 5, given the small numbers within each category and the qualitative approach to this study, there is little value in engaging in any detailed statistical analysis of the above figures. Rather, value lies in identifying any general trends within each category, as well as between categories.

It is evident that there was agreement across participants that mental health nursing's unique contribution to delivering talk based therapies is the capability to be multi skilled. That this contribution is a response to user need was widely agreed, with only participants without therapy qualifications appearing to focus upon this less. The utilisation of a personal professional self over time to meet these users' needs is also evident across most participant categories, with managers appearing least focused upon the time that MHNs spend with users. The inclusion of practicality and common sense in this MHN identity appears least valued by MHNs with therapy qualifications, suggesting that they have less use for practicality when armed with specialist knowledge. Male participants also appear to value this practical aspect of mental health nursing more highly than female participants, who place more priority on the use of personal self than their male counterparts. Academic participants placed little priority on both versatile delivery of therapies and transferable skills between nursing and therapies.

Constructions of MHN uniqueness (and therefore identity) within each participant category offers the following descriptions of MHN identity. These are expressed in order of highest number of contributing participants. Where the percentage of participants is equal, priority is given to the theme with the higher number of references:

- Academics: Applying generic specialist skills over extended time periods to meet users' needs through practicality and some utilisation of the personal professional self.

- Clinicians: Applying generic specialist skills and the personal professional self to meet users' needs over time with innovative approaches and skills applicable to talk based therapies.
- Managers: Applying generic specialist skills and the innovative personal professional self to meet users' needs with additional practical approaches and skills applicable to talk based therapies.
- Early career: Applying generic specialist skills and the innovative personal professional self over elongated time periods to meet users' needs with some use of common sense and skills applicable to talk based therapies.
- Late career: Applying generic specialist skills through the utilisation of the personal professional self to meet users' needs over elongated time periods and requiring innovative interventions.
- Not therapy trained: The utilisation of the personal professional self and generic specialist skills in innovative and practical ways to meet users' needs over elongated time periods.
- Formally trained in therapy: Applying generic specialist skills to meet users' needs over elongated time periods with the innovative application of the personal professional self and skills applicable to talk based therapies.
- Diploma level: The utilisation of the personal professional self and generic specialist skills in innovative ways to meet users' needs with practicality over elongated time periods.
- Masters level: Applying generic specialist skills to meet users' needs with the utilisation of the personal professional self over elongated time periods with the additional need to be innovative.

- Male: Applying generic specialist skills to meet users' needs over elongated time periods through the utilisation of the personal professional self, practicality and innovation.
- Female: Applying generic specialist skills and the personal professional self to meet users' needs in innovative ways over elongated time periods and skills applicable to talk based therapies.
- English: Applying generic specialist skills and the personal professional self to meet users' needs in innovative ways over elongated time periods.
- Scottish: Applying generic specialist skills over elongated time periods to meet users' needs through the use of the personal professional self, innovation and practicality as well as skills applicable to talk based therapies.

While the above constructions have commonalities, the most apparent variance is with the participants with either no therapy training or diploma level training. Unlike the constructions by other MHN categories, those with either no therapy training or diploma level training placed greatest emphasis on the use of the personal professional self, as encapsulated by RP10:

> (RP10) … in this job you work with people that are quite high up in position … and people from the opposite end of the scale. If you can't go into these people's homes … and try and talk at some kind of their level then it doesn't matter what kind of mode you are working under. You have to kind of pitch yourself at different people's levels and get them on board and get them to feel like talking to you and get them to think

that you're not just another kind of suit that comes round and carts them away.

Conversely, the academic category placed least emphasis on the use of the personal professional self. Reminiscent of the “too posh to wash” nursing debate that suggested that nurses may consider themselves to be above basic care tasks such as bathing patients (Hooper, 2004), any relationship between increasing education and training and diminishing MHN utilisation of the self within therapeutic relationships deserves focused attention. Given the magnitude of such deliberations it is essential to stress once more that the small numbers and qualitative approach adopted in this study restrict generalisation of numerical findings. However, given qualitative methodologies’ roles in theory generation, value lies in tentatively offering some limited yet exploratory critical analysis.

The absence of guiding theoretical models in conjunction with generalist roles that exclude specialist training may guide MHNs to use the single intervention in which they are expert, their personality. Potentially reinforced through diminished uncertainty and a heightened sense of intervening effectively, this emphasis on the use of a personal professional self is well established in the nursing literature (Forchuk, Westwell, Martin, Bamber-Azzapardi, Kosterewa-Tolman, & Hux, 2000; Koehn & Cutcliffe, 2007; Peplau, 1987). Increased training and specialisation offer alternatives to this strategy that can be both rewarding and taxing. Increasing knowledge and skills whilst maintaining the use of a personal professional self

appears an ideal meld; however, the means to achieve this are not well established. This finding is highlighted as being a topic for future possible research in Chapter 9.

6.4 Identity theme: Specialising in everything

1. The MHN as generic specialist

> (RP23) This is who we are and I don't think nurses know the influence over the years that we're kind of pseudo doctors or now we've got to be pseudo psychologists and you know we are just the same as a social worker – no, we're not! We have unique skills that social workers don't have, that medicine doesn't have, you know, that all of other disciplines don't have.

While only one participant specifically used the term "generic specialist", the MHN capacity and willingness to respond dexterously to multi-faceted needs were expressed with pride and deep attachment, and as such are key identifiers of the MHN. This finding echoes those of Edwards, Burnard, Coyle, Fothergill and Hannigan (2001) as well as Crawford *et al*. (2008), who all noted this wide capability as being closely associated with MHN identity. Fitzpatrick (2005) and McCabe (2006) also highlight the range of roles assumed by MHNs.

While the finding in this thesis is similar to these other studies, the utilisation of the term "generic specialist" marks a point of difference. Ryan, Garlick and Happell (2006) report participants from their study using terms such as "jack of all trades" or "all rounder" to reflect the comparatively low professional status of MHNs, as

well as the diversity of roles that they assume, findings echoed by authors such as Cleary (2004), Nolan, Haque, Bourke and Dyke (2004). However, given the powerful yet inaccurate generative nature of words, and social constructionism's emphasis on meaning generation within relationships, these terms need revisiting to reflect rather than minimise the possession of widely ranging capabilities. The terms "jack of all trades" and "all rounder" are more reflective of a 'handy man' or a cricketer whose value and worth respectively rest with fixing the uncomplicated and versatility in a sporting crisis. By contrast, the term "specialist" attracts high value and worth with expectations of highly developed knowledge, skills and competencies toward complex and challenging phenomena (Hurley, 2009).

Additionally, the term "specialist" can be constructed as being focused on one contained area of knowledge, as being prepared for a particular role or as being highly differentiated. Arguably, within the context of health services the term "specialist" has been constructed to pertain to the former, and contains shared understandings of being predominantly medical, and of holding rank, privilege and competence over those lacking this narrow understanding of "speciality". However, in returning to social constructionism this narrow understanding of "specialism" is not the only truth. If greater understandings of MHN identities are to be generated, then new conversations, transformational discourses and actions must be undertaken to attain new possibilities (Gergen, 1999, p 116). Suspending the taken for granted position of "specialism" as being predominantly (though not exclusively) medical, as pertaining to one small in depth knowledge area and as being privileged allows evaluation from another position. Where this generative

discourse focuses upon understanding “specialist” as being differentiated from others, new understandings of MHNs are potentially released.

The analysis of the participants’ discourses in this study has constructed this identity marker with the perception that no other discipline can do what MHNs can do, grounds for attracting the label of “specialist” through being, as argued above, both differentiated from others and prepared for that particular role. RP25 constructs the MHN as generic specialist in outlining what was described as MHN “shape shifting”:

> (RP25) One of the things that often comes across I think from talking to service users in varying contexts – one of the things they most value about nurses is that sort of intimacy. That … the nurse who is perhaps doing some sort of loose psychological supportive therapy one moment might the next moment be sort of just taking their pulse, or dressing a wound, and the next moment might actually be helping them to sort their housing, and the next moment possibly having a game of scrabble with that same person. Now I've never yet seen a psychotherapist, or, you know, a clinical psychologist in a number of different settings – I’ve never actually seen them playing scrabble or filling in a housing form or doing a dressing or giving an injection or giving medication.

Here the value and worth of not only the ability to move quickly between tasks in response to user need but also the preparedness and willingness to do so are

communicated. Many other participants, such as RP3 quoted below, spoke of their ability to attend to physical healthcare needs, as well as social and psychological needs, as a key unique contribution. These healthcare needs included issues such as medications, hygiene and management of aggression, as well as wound care:

> (RP3) I think we have a more, if the term is right, a more psychosocial, bio-psychosocial interest in the patient. Because I think we do, we take on board physical issues, medical issues; we recognise that because we have grounding in that and we recognise the psychological processes that are happening and you know some more than others and we are very conscious of the social context that the patient finds themselves in and the influence of the environment. I have this feeling that maybe other health professionals will probably focus more on one of these three aspects.

RP17, who is both a MHN and a therapist, spoke of how having biological knowledge of mental illness offered a broader range of understandings of both users' behaviours and their therapy needs. What is apparent from all this construction is that it is the MHN who is the only professional performing the range of identities reflective of the service users' needs.

As identified by Hurley, Barrett and Reet (2006), the MHN has long been recognised as someone who will dip into a therapeutic 'toolkit' (arguably another reference to

being a less than professional “jack of all trades”). This toolkit not only refers to a range of knowledge, skills and capabilities, but also was communicated by many MHN participants as referring to a depth of knowledge. This depth of knowledge appears influenced by user need, and as such is at a sufficient level to help users, but may be below what MHNs and accrediting bodies see as being required of a specialist:

> (RP9) As mental health nurses we see our skills as a toolkit. You kind of look at a client and you open your box and you think, “Okay, solution social therapies will work with you because you’ve got all these issues in the past, and we’re not going to be able to affect those but we can work on the crisis”. And then you may meet somebody with very negative dysfunctional thinking and use CBT. You might meet somebody who’s having auditory activity who wants to be able to control the voices in his head and you use that skill. I kind of use that very broad spectrum of skills but tailor them to the individual, and I would say I'm not particularly skilled within any of them to be called – you know, I'm not a CBT specialist, I'm not a solution therapist, but have enough knowledge and understanding to use them within my clinical work.

Given the diversity of service users’ individual needs and the range of service users whom MHNs will have under their care, the development of generic specialist capabilities is unsurprising. However, the application of the multi capable MHN is not restricted to the direct delivery of user care. As established in Chapters 2 and 3,

MHNs occupy a comparatively powerless position in relation to other professions, and as such also respond to their needs as well as those of the service user:

> (RP6) Nurses, on a ward even, are, you know, social workers, housing officers, nurses, advocates … wearing 20 different hats and adopting things and responding to the doctors' needs immediately …. You are pulled in all directions, your time is pulled in all directions and you know, I've not mentioned the patients in all of that!

6.5 Identity theme: Responding to the service user

2. User focus

Participant MHNs articulated their roles and work related behaviours as being primarily a response to service user need. While some participants articulated tension between managerial and user expectations of them, for the majority of participant MHNs the moral imperative lay with meeting users' needs. This imperative echoes that of Crawford *et al*. (2008) as well as Barker (2006), who highlights the importance of being united toward fostering a nurturing therapeutic *milieu*. A connection can be made between the MHN as generic specialist and the MHN being user focused. Through the process of seeking to respond to divergent user needs, the identity performances of a MHN have become wide reaching. Indeed, the service user can be seen as a major catalyst for MHN work roles, as well as the education and training that they undertake. Many MHNs articulated that meeting the needs of their service users was the main reason for undertaking education and training as distinct from other reasons such as career progression.

While the absence of a guiding and unifying theoretical nursing model was discussed in Chapter 5 as contributing to MHN uncertainty, in this context participants are unencumbered by rigid models or single focus interventions and are consequently freer to respond to the user:

> (RP20) I would say I work with people to support and promote their recovery in their self and well-being, whatever that may be to them and it's individual – everybody is on an individual journey.

However, as with the preparedness of MHNs to assume multiple roles, the same commitment must be present for MHNs to adopt a user focus. Where this is present, MHN identity becomes a co-construction at the interface with the service user:

> (RP13) I don't think we are dissimilar in many aspects to other health care professionals but I think it's more of a personal philosophy …. What marks us out, I believe, is this personal commitment to mental health which is a difficult client group.

> (RP23) I've always felt really strongly about engagement and I felt that was something that wasn't really acknowledged, that how really important that is and that's really the absolutely defining ability of your role. If you can't engage with people, you can't do the job.

As with this study, such defining commitment to the service user has also been identified by O'Brien (2001) and Cleary (2003), with the latter study being undertaken in the context of significant policy changes in Australia. These findings showed MHNs as being highly responsive to policy change where user need was being addressed. The view that MHNs have a strong service user focus expressed through the therapeutic relationship is also well established in the nursing literature (Beeber, 1998; Morse, Miles, Clark & Doberneck, 1994). However, studies by Scanlon (2006) and Moyle (2003) highlight that this user focus as expressed through the therapeutic relationship is not necessarily a natural or easy task for many MHNs. Both these studies highlight the necessity for the co-existence of the MHN willingness to engage and the possession of significant interpersonal skills by the MHN. What is indicated here is that the successful adoption of a user focus on care requires EI capabilities.

6.6 Identity theme: Personalising the roles

3. Positioning of self

> (RP10) I always feel more uncomfortable personally if I feel as though I'm working with somebody and I'm working exactly to a tool – that kind of thing doesn't suit me. Where I feel like you are just being yourself with somebody but you know you are using a tool that suits me better.

Participant MHNs collectively constructed a palpable identity marker – that is, the significant utilisation of the personal self to fulfil their professional roles. MHN identity can therefore be viewed as existing in a blending of the personal and the

professional selves. When considered in conjunction with the theme of the user focus, it appears that this mixture of personal and professional selves will alter depending upon the service user's needs, as well as the interpersonal capabilities of the MHN. This theme establishes a link between the MHN identity as constructed from the participants' discourses and EI.

The use of self within therapeutic relationships closely mirrors the well established view of mental health nursing being an interpersonal endeavour with the user, as noted by the seminal nurse theorist Peplau (1989, p. 28). It is this focus that makes nursing distinctive. A strong case can be made for Peplau's theory of interpersonal relating as being the historical basis for the professionalisation of nursing, again suggestive of a link between the personal and the professional selves (Gastmans, 1998). In their large study of MHNs, Jackson and Stevenson (2000) also found that the MHN uses a mixture of personal and professional selves in responding to users' needs. Other studies such as those by Öhlén and Segesten (1998) and Edwards, Burnard, Coyle, Fothergill and Hannigan (2000), and the landmark research by Barker (2000) also mark mental health nursing as an integration of the personal self into a nursing identity.

As discussed in Chapter 3, identity is a construct that is understood as being multiple (Gee, 1999, p. 39), as well as being at least partially self-generative through social action (Gergen, 1999, p. 133). Both of these identity concepts are apparent in the data findings from this theme of positioning self. Consequently, this theme of the positioned personal self can be proposed as resonating not only with landmark

nursing and mental health nursing theory and studies, but also with wider identity theory.

The uniqueness and professionalisation of nursing can be traced back to the emphasis upon inter-personal relating that in itself demands the use of self within professional relationships. It is remarkable that this very point of professional distinctiveness can also be constructed as the reason why nursing is not a profession, being more a sympathetic personal chat than a professional engagement. The increasing power and influence of the rationalisation, positivist outcome orientation and managerial regulation of care delivery certainly represent a counter construction to the personal self being 'professional'.

This use of the personal self is also associated with the delivery of talk based therapies (Peplau, 1986). RP10 quoted above is aligned to the approach of being her or his genuine self while simultaneously employing an evidence based therapeutic tool. The option of adopting a pre-determined way of being is communicated as a barrier to personal and hence professional effectiveness.

The participant MHNs constructed the 'good' MHN as one who utilises the personal self to help the service user. It was arguably apparent that this is a highly valued aspect of MHN identity, and that therefore prioritising specific therapeutic tools over the use of the personal self is by logical extension being a 'bad ' or 'non- MHN':

> (RP12) I think there are dangers, and there are huge benefits for nurses who are good at what they do will get better at it with better skills and

> better competencies, and having more tools at their disposal, they will do much better. There has, I think, always been staffs who have been less comfortable with using themselves and their own personality and attributes in their work, and they probably welcome the chance to have a toolkit to use and stand behind … applying that toolkit to people. So there's a danger that people that need props and crutches will use them and still won't bring anything themselves.

Participants also communicated the complexities that lie within the utilisation of the personal self within their professional practice. These complexities commence with the capability to access and then to use different parts of the self with a range of service users, key EI capabilities. As viewed through the lens of social constructionism, the identity of the MHN is consequently being constructed, dismantled and reconstructed within those social contacts (Eisenberg, 2001). Rather than presenting an 'absolute single true self', MHNs construct 'a true self' within the context of the rules within specific social settings, conventions and groups. Their identity is described and explained at this conjunction with the service users, accurately reflecting the meaning generation theory of social constructionism (Gergen, 1999, pp. 47-49).

As stated by RP13, this makes mental health nursing a highly personal experience:

> (RP13) Mental health allows you to develop that sense of personhood and I think it's more of a journey, a personal journey than being say the general nurse.

However warm and possibly even reassuring such constructions of MHN identity are, this personalisation may have consequences. If mental health nursing and MHN identity are indeed highly personal then they are also individual, potentially negating constructions of a collective professional identity recognisable to those external to mental health nursing. Such individual positioning will also be at odds with the regulating of MHN roles and behaviours made evident in the review of policy documents in Chapter 2. Additionally, through assuming a personal positioning toward professional identity all criticisms of performance and recommendations for changing performance may also be experienced as personal, potentially setting up resistant defence mechanisms and generating emotional distress.

Some participants described their professional roles as being touched by an intimacy whereby they left themselves open to experiencing not only the joys and successes of their service users, but also the pain, suffering and even aggression of those users. Reflective of Barker's (2000) tidal model, the MHN undertakes a journey with the user that, while challenging, also offers opportunities for personal growth for the MHN. The emotional courage and commitment required to adopt such professional positioning were left totally unstated by any participant, echoing the finding by Crawford *et al*. (2008) of MHNs having self-effacement toward their work roles.

The prominent position of the personal self within professional identity is certainly suggestive of MHNs emphasising being "person enabled" over being "strategy enabled" (Hurley & Rankin, 2008). Participants placed a high value on communicating an authentic self toward service users as a means of generating a sense of trust and safety. In turn, the MHN gains greater access to the user than other disciplines, and through possessing less power than other disciplines is more able to form a genuine partnership. While emphasising the personal self allows such access and potentially narrows the gaps in power and status with users, participants also identified over simplification as a danger. If nursing is a solely personal endeavour, the need to undertake education and training and to generate theory and models to reduce the uncertainty of the MHN lifeworld may be argued as unnecessary. Participants placed highest value on those who maintained a personal use of self while keeping informed of relevant theory.

6.7 Identity theme: The influence of exposure

4. Time: Sharing the user's world

> (RP17) You are there you know all week with patients, all day and all night …. You get to know them very well in time.

> (RP15) The ward that I came from, in the IPCU there was 10 and then it went down to 6 patients so you had the quality time to deal with people … but down here, you know, there's 22 patients and it's a luxury that you have the time to spend a lot of time with them.

In addition to the unique contributions that MHNs offer talk based therapies that have already been discussed, analysis of participants' discourses identified the time spent with the service user as being distinctive in relation to other disciplines. The time spent with users offers much greater opportunity to foster meaningful relationships, with the MHN and the service user being in effect left exclusively in each other's company for the majority of the time. Other studies have also identified relationships between time and the quality of care. In their large study, Jackson and Stevenson (2000) connect the time spent with users as contributing to the MHN having a greater depth of knowledge about the user than other disciplines. Rogers, Pilgrim and Lacy (1993, as cited in Jackson & Stevenson, 2000) identity the length of time that MHNs spend with users as the sole unique characteristic of the profession. Castledine (2008) also links time with the quality of nursing care, inclusive of psychosocial interventions.

RP5 quoted below highlights the value to users when MHNs utilise the time that they have effectively:

> (RP5) From feedback from people who have helped over the last few years, from talking to them about what's made a difference in their lives …., it's the time that nurses have spent with them that has made significant differences. So time has been a big factor.

However, other studies show that this theme of time is not always effectively utilised. West, Barron and Reeves's (2005) study showed nurses perceiving a lack of time as being a barrier to delivering holistic high quality care. In their study of an

acute in-patient ward Whittington and McLaughlin (2000) found that, despite MHNs being around users for long periods, less than half of that time was actually spent with them. Additionally, less than 10% of this time was spent on psychotherapeutic activities, a finding that echoed earlier studies such as those by Martin (1992), Ricketts (1996) and Robertson (1995). While this paucity of therapeutic time is partially attributed to pressures of administrative and task orientated duties, poor training for therapeutic intervening is also identified. Bowles and Jones (2005) also offer insight into rationales why MHNs may spend a third of a shift speaking to one another rather than with users or carers (see also Whittington & McLaughlin, 2000). Staffs experience genuine fear and anxiety when confronted with highly challenging users, and unless this burden can be spread across the system of care delivery the option of withdrawal may be considered.

RP14 quoted below encapsulates both the advantages and the challenges of prolonged time with users in acute environments:

> (RP14) I think they [other disciplines] have got a lot to learn from us in respect that they only come on the ward for brief periods of time. They don't spend any time, especially on the in-patient side where people are acutely or psychotically ill and they would have no idea; they spend five minutes talking to that person, and make an informed decision of that person, and they don't see – they don't spend that time with that patient and they haven't got the skills that nurses have in dealing with people in violence, aggression, you know. It can be quite – if you see

> their faces if they come onto an incident on the ward you know they run the opposite way.

RP14 also makes a link between spending time with the service user in challenging environments and the development of skills. While this refers specifically to skills associated with responding to violence and aggression and coping with prolonged exposure to acute illness, this consequence of exposure to clinical challenges has wider application. Another theme from this study, which is expanded upon in Chapter 8, is that MHNs have a bias toward work based learning that, when considered with the heutagogic framework outlined in Chapter 3, suggests that important learning opportunities exist owing to the length of time spent in challenging environments.

While the capabilities and attitudes of MHNs influence the effective utilisation of time, the impact of managerial and governance structures is also evident:

> (RP6) If I know somebody is being human and listening to me and actually being interested in me, that's a big part of what would then give me some comfort and satisfaction, and if they are not allowing staff the time to do that then that's a big part of human intervention that you are losing.

This specific subsection of the theme of time was very prominent in the large study by Stronach *et al*. (2002), as well as studies by Walter, Cleary and Rey (1998) and Garland, Kruse, and Aarons (2003), which all show a tension between either

managerial or policy objectives and clinical perceptions of where time should be prioritised. Additionally, Michie, Hendy, Smith and Adshead (2004) found in their study than many clinicians felt that health targets and measures requiring completion by clinical staffs were hindering rather than assisting health care delivery. However, as stated by RP24, MHNs often fail to take the time to record their actions and consequently lack evidence of their value and effectiveness:

> (RP24) I think we let ourselves down as mental health nurses. We are not taking the time to write about these findings. I keep coming back to this – doing, doing, doing, we're doing the work but we are not always writing it down …. To say, "Well, this project, this is what we have been doing here and actually properly evaluating that".

6.8 Identity theme: Novel approaches

5. Versatile delivery

The theme of versatile delivery in essence responds to the question of what MHNs bring to psychological therapies. Analysis of participant MHNs constructed their engagement with talk based therapies as bringing therapies to a more seriously ill client group than has previously happened. Additionally, MHNs took therapies out of the office and into coffee shops, service users' homes and more flexible delivery approaches.

> (RP12) Mental health nurses have that extra willingness to engage with difficult … people who are difficult to engage with and you know what you see isn't what you get, there [are] more and more layers to them,

> and with people who have been in services for a long time there may well be a lot of damage to undo.

> (RP13) It's like CBT's being used with schizophrenia, coping with hearing voices and things like that. That's come from knowing the client and the client group and the real trick is taking the therapy and saying, "How can I make it work for that type of client?"

> (RP16) A lot of my clients are young guys so for them to come to the clinic is, I mean, I think they have this problem with the whole authority thing …. To meet somebody in a pub or a coffee shop or even walk around a park it takes a lot of the – what's the word here – it's less formal, I suppose, but you can maintain your professionalism while doing it.

This finding reflects that of Munro, Baker and Payle (2005), who note increasing utilisation of CBT on acute in-patient units, as well as findings by Voyer and Martin (2003), who identify MHNs as providing innovative interventions. Additionally, Fisher (2005) highlights MHNs as having core roles in improving access to counselling. Recent mental health nursing literature shows that MHNs are taking therapies to those experiencing serious mentally health problems across both community and in-patient settings (Brooker, 2001; Griffiths & Harris, 2008; Jones, Tyrer, Kalekzi & Lancashire, 2008; O'Neill, Moore & Ryan, 2008; Tarrier, Barrowclough & McGovern, 1999).

The participants quoted below articulate how the profession's ability to consume and then transform knowledge is applied to therapies. MHNs' capacity for being generic specialists appears to thread through this theme of versatile delivery in that it is this capability that allows the MHN to collect broad experiences, and then to apply those experiences across a spectrum of settings that would exceed the range of a specialist mental health discipline:

> (RP8) We have garnered many things from other professions to make up what we are and I was a bit uncomfortable with that because I thought, "What are we then?", but as I went further on and looked, it's that bit about bringing many things together and it's how we put them together. There's no other profession that combines all these different things in the way psychiatric nursing does and then delivers it back.

RP17, who moved from acute in–patient nursing to delivering therapies, spoke of her or his capacity to cope with users exhibiting acute symptoms of mental and emotional distress, as well as higher levels of risk compared with fellow therapists without a MHN background:

> (RP17) You know, I think I've seen the more bizarre things, and I've had to restrain patients, and I've had to give people injections when they have been very unwell, and I've had to run for patients that have absconded from the wards, you know, and I've just seen and done different things over the years. I think nothing really fazes me that much

now. Yeah and I think therefore that gives you a bit of confidence that you know you can handle anything.

While this link between mental health nursing and delivering therapies can successfully enhance MHNs and enable them to assume this role, participants also highlighted areas of tension. That challenges exist for MHNs undertaking these roles was also established by Grant and Mills (2000), Brooker (2001) and Paley, Myers, Patrick, Reid and Shapiro (2003), who highlighted the need for MHN commitment, as well as significant organisational and financial support. RP15, trained in talk based therapies, emphasised that staff shortages and unexpected events within in-patient settings can be a barrier to being able to deliver therapies. Supportive management and support from other disciplines were identified by this participant as essential for MHNs to assume therapy roles in addition to their current responsibilities. Other participants commented that MHNS will need to adopt less custodial and more therapeutic approaches within in-patient settings to implement successfully the integration of talk based therapies.

6.9 Identity theme: Being ordinary

6. Everyday attitude

(RP1) I do believe that psychiatric nurses do this; they play up their common sense. You know, all those darn psychologists and their high faluting ideas. What we've got – yes, we have got ideas but we can translate it into everyday, normal relationships where people like our

patients are, and we're the ones that can use these approaches in everyday language.

Analysis of participant MHNs' discourses also constructed them as being "ever practical" and grounded in "everyday attitudes". Potentially arising from the theme of utilising the personal self, these everyday attitudes are seen as being more closely aligned to the service user's lifeworld, with participants often acting as translators for users after they have had exchanges with medical or psychology staffs. Barker, Jackson and Stevenson (1999) showed in their study exploring the need for MHNs that the ordinary self was both used by nurses and required by service users. It was apparent that the ordinary self is a key MHN tool for relating with service users, and was connected by Barker *et al*. (1999) to the theme of time. Time spent with users was associated with the increasing use of the personal or everyday self (as distinct from the professional self) and was presented as a distinctive MHN identity marker that weakened with decreased time with service users.

In a development that is also closely aligned with the theme of versatile delivery, MHNs are making therapies more understandable through using the language of the service users. This everyday attitude is illustrated by RP25 below, who identifies an intersection between the lifeworlds of users and MHNs that the medical profession generally lacks:

(RP25) You are more likely to have nurses living amongst patients, and where I work I often hear people say, "Oh, she just lives down the road

> from me" or "She's just round the corner", but also in a sense of proximity in terms of class. Most nurses have probably had the same educative experiences, not in every case, but quite often than perhaps other professions have had, because, you know, for instance I'm thinking about some of the psychiatrists I've worked with who have been educated privately. There aren't many service users that I see have had a private education.

Associated with the generic specialist and user focus themes, participant MHNs spoke of the application of this everyday attitude as being directed toward helping service users:

> (RP23) I think on a very practical level, if you can do things for people on a practical level, like sort out benefits and organise housing, make their lives easier, then initially if they can't really see what the value of the CPN is, and they haven't got a mental health problem, and they don't want to talk to anybody, then "Who are you, you know, coming along and talking to me?". If you can actually make their life easier in a practical sense then that can be a great way in.

What is articulated above is how this everyday approach and this willingness to adopt flexible work roles for the user are employed as tools to foster engagement. This theme of everydayness or being ordinary reflects findings from Hill and Michael (1996) showing MHNs perceiving their roles to be ordinary and Takase, Maude and Manias (2006), whose study of Australian nurses highlighted that this is

the public's perception of nurse identity. Crawford *et al*. (2008) also identified that MHNs felt that their roles are undervalued owing to be seen as being ordinary. This focus upon being 'everyday' resonates with the reported theme of MHNs' perceived low worth and their powerlessness reported and discussed in Chapter 5.

Indeed, despite the impact of interventions such as those described by RP23 above, there is a sense that the external perception of MHNs is that they do, and as such are, "nothing special". Reinforced by being generic rather than focused specialists, this 'ordinary' aspect of MHN identity appears well entrenched. However, in returning to Table 6.1 where the data were broken down into participant categories, MHNS with therapy qualifications spoke least of being ordinary or every day. This suggests that attaining therapy qualifications moves the MHN toward being something 'special', at least from the perspective of the MHN.

6.10 Identity theme: Cross over

7. Transferable skills

The final theme of constructing MHN identity was that of MHNs possessing a set of capabilities that is compatible with delivering talk based therapies. When considered with the willingness of MHNs to engage in this role, this theme suggests that education and training aimed at developing psychological therapies capabilities in MHNs will, in part at least, commence from pre-existing capabilities:

> (RP13) Well, I actually think it builds on the core skills of what is a mental health nurse, and that's a lot … about engagement with another person. And part of that is about being aware of one's emotions, and being

> aware of another's emotions, and being able to utilise that, that exchange of being and feeling in a very motivated and productive way.

Participants generally identified that process of engaging with users, and helping users move more closely toward where they would like to be in terms of coping with their problems, as being central to both mental health nursing and psychological therapies:

> (RP20) I think half will probably realise that they are actually doing it all the time anyway. We are engaging with people, we are speaking to people, we are talking about – you know, they are stressed and we are trying to help them towards their goal, you know. I don't think it's hugely alien.

This connection between MHN capabilities and those required for offering therapies reflects key findings by Burnard (2003), as well as Koehn and Cutcliffe (2007), who note interpersonal relating as being a pivotal transferable ability. Additionally, the study by Griffiths and Harris (2008) showed high levels of perceived compatibility between talk based approaches and assertive outreach work. However, this also potentially highlights an area for future education and training concern where some MHNs may feel they are already capable of delivering more formal talk based interventions and are not therefore primed for learning.

6.11 MHN identity constructions: Participants and policy

The identity constructions of mental health policy discussed in Chapter 2 and those of participant MHNs elaborated in this chapter require contrasting in order to identify co-constructions, as well as areas of possible tension. The point where the themes of policy meet those of the individual MHN represents a potentially powerful construction point of MHN identity. This point of relationship will be likely to generate new conversations, words and actions, and hence new possibilities (Gergen, 1999, p. 116).

In Chapter 2 I offered a definition of mental health nursing derived from the examined policies and documents as being the:

> Therapeutically targeted ethical use of a critically reflective professional yet regulated self, for the empowerment of diverse and disempowered others.

Capturing the core constructions of the analysis of participant MHNs' responses to this first research question suggests the following definition of mental health nursing:

> Widely competent flexible application of personal professionalism guided by user need and enacted within often unpredictable and disempowering work based contexts.

Contrasting these two definitions shows that, while differences are evident, there is also commonality toward the core reasons for being MHNs. These co-constructions toward MHN identity appear to include:

- Responding to the needs of others
- High values toward therapeutic relating
- High values toward EI capabilities that allow relating to and developing others
- Flexible working
- The need and willingness for MHNs to engage in talk based therapies
- Little attention to the empowerment of MHNs.

This cluster of co-constructions offers a solid basis for MHNs to assume roles in talk based therapies. That both the need and the willingness co-exist reduces the potential for resistance from either group, as well as building credibility for the requirement for this role expansion. The acceptance of the need for MHNs to assume these roles may well be embedded in the core shared identity construction of responding to the needs of others. Examined policy and documents, as well as participant MHNs, identify that the service users' needs for such interventions require a response by mental health nursing. It is also evident that therapeutic relating is an important vehicle by which MHNs will deliver talk based therapies, and that values and attitudes congruent with the construct of EI underpin such relating. It is noteworthy that the participants' focus on the service user and the policies' emphasis on establishing user focused systems result in MHN disempowerment being sustained.

While co-constructions between the examined policies and the participants are evident, there are also areas where tensions toward the roles and identities of MHNs arguably exist. Table 6.2 and Table 6.3 below outline these tensions:

Table 6.2: Points of tension for MHN identity construction

Participants	**Policy**
Generic approach to therapies	Restrictions on therapy modalities
Acknowledge global MHN lifeworld features	Non-recognition of MHN lifeworld features
MHN identity co-constructed with the user	MHN identity co-constructed with minimal MHN control
Multiple roles as a core identity marker	Specialism inherent within therapy roles
Innovation	Regulation of professional roles
Personal relating and being	Professional relating and being

In Chapter 3 Table 3.2 “Social constructionism and MHN identity” (adapted from Gergen, 1999, pp. 47-49) I responded to the identity constructions of policy from the perspective of the key pillars of social constructionism. Table 6.3 below responds to the identity constructions of participant MHNs, also from the perspective of key pillars of social constructionism.

Table 6.3 Social constructionism and MHN identity 2 (adapted from Gergen, 1999, pp. 47-49)

Social constructionist principle	Application to MHN identity
The terms by which we understand our world and ourselves are neither required nor demanded by "what there is".	MHN identity that has been created from a platform of perceived low power and worth is highly inclusive and multiple.
Our modes of descriptions, explanations and/or representations are derived from relationships.	The meaning of MHN identity is generated from an 'other' (user) perspective at the social interface with the service user.
As we describe, explain or otherwise represent, so do we fashion our future.	Future MHN identity is at a crossroads with barriers to adding therapy roles to existing generic specialist roles. MHNs specialising in therapies will in all likelihood cease to be considered nurses.
Reflections on our forms of understandings are vital to our future well-being.	Performative discourse is limited to internal MHN arenas with identity shaping perceived as being externally influenced by more powerful others.

The contrasting of identity constructions in the above tables illustrates the points of tensions that occur where identity formation moves away from a locus of self-generation toward that of external influence and external perception (Berger & Luckmann, 1966, p. 194). This external influence appears clear, with MHN Identity formation from both participant and policy perspectives being largely either a reaction to service users or a production of policy, rather than identity construction being generated from within the profession.

Participants constructed an identity that is characterised by flexibility, fluidity and expansiveness toward the MHN roles undertaken. By contrast, the constructions of policy can be characterised as being themed by control, regulation and speciality. Given that the theme of generic specialist was prominent in the identity constructions of the participants, this is a potentially important point of difference. The extent of this difference is made more pronounced when considering that

fluidity and responsiveness by MHNs toward the users' needs underpin this theme. Additionally, the construction of policy toward MHN identity and their new roles ignored the impact of the environment in which MHNs will be engaged in talk based therapies.

While the examined policies appear to seek predictability and conformity for MHN roles and identities, it is worth recalling from Chapter 5 that uncertainty and unpredictability were MHN lifeworld themes, themes that many participants were comfortable responding to. Arguably, the constructions of the participants more accurately reflect identity theory through constructing their identities as being both multiple and flexible (Foucault, 1991b, p. 94; Gee, 1999, p. 39) as well as being grounded within the personal experiences of practice.

If one were to put aside momentarily the issue of power and influence, the tension points listed in Tables 6.2 and 6.3 and discussed above do not appear insurmountable, particularly given the foundational co-constructions toward MHNs assuming talk based therapy roles, also recently discussed. By accepting the multiplicity of truths and the absence of binary value judgments, either column of identity constructions could be a readily acceptable MHN identity that interfaces with talk based therapies. However, power is central to identity construction through the use of language and text within social relationships (Gergen, 1999, p. 40). Additionally, truth is seen through the eye of the paradigm in which it dwells (Latour, as cited in Gergen, 1999, p. 55), and is also susceptible to self-deceit.

Engagement to resolve these tension points appears to rely upon a shared desire for, and vision of, an agreed need and general direction for change. Such a position appears at odds with the view of identity generation being inexorably intertwined with power generation (Cheek & Rudge, 1994) and that identity discourses seek to entrench power rather than genuinely to co-construct (Kermode & Brown, 1996). The interpretation of 'best' MHN identities and roles arises from those within the tradition who are the focus of the generative discourse, in this case the makers of health policy. Through largely excluding MHN participation from meaningful or powerful roles in formulating and applying policy relevant to MHN identities and roles, policy makers can be argued as maintaining pre-existing constructions and consequently rejecting alternatives to their own views.

Given such understandings of power and identity generation, the emergent MHN identity may drift temporally toward increasing specialisation, increasing external regulation of behaviours and decreasing use of a personal and hence an individualised self. Increasing numbers of MHNs undertaking specialist roles may in turn create silos of specialism lacking even a cohesive nursing identity title, effectively removing them from the MHN profession (Giddens, 1997, pp. 582-583). This view of MHN identity has resonances with the findings by Stronach *et al*. (2002), as well as those of Crawford *et al*. (2008). Additionally, Appendix A demonstrates that generic nursing leaders are engaging in exactly these types of identity labelling discussions. Challenging such an outcome to enable progressive change through new ways of relating and new interpretations of mental health nursing appears to rely upon working from the areas of commonality of identity

constructions, and upon the willingness by those in influential positions to accept the views of MHNs toward their own identity and roles.

6.12 Chapter summary

The participants' voices have been prominent throughout this chapter as they offer their discourses on MHN identity. Co-existing with these individualised identities are the identities described by each sub-section of participant that showed variations on emphasis toward the MHN identity themes that collectively construct yet more identities of MHNs. That professional identity is a simple or a singular construct has effectively been dismissed by the participants in this study. Rather they have communicated their identity as being simultaneously individual yet partially shared, and personal yet responsive to others' needs and, arguably most importantly, that MHN identity must be understood as a 'package' of identity markers rather than seeking singular distinguishing differences.

Giddens (1997, pp. 582-583) describes identity as a plurality of distinctive characteristics rather than a search for a singular defining feature, highlighting that identity constructions are complex and fluid. A primary importance for this study is that the analysis of the complex self-representations of professional identity by the participants has provided a response to the first of the research questions:

- What, if any, are the perceived unique qualities, abilities and behaviours of MHNs engaged in the delivery of talk based therapies in the UK?

Analysis of the participants' discourses have offered the uniqueness of MHNs' contributions to talk based therapies as being this complex identity package of seven characteristics that no other discipline can offer. MHNs respond holistically within the delivery of talk based therapies, moving with fluidity in response to users' needs, unencumbered by prescriptive, historical or dogmatic theoretical models. Through heavily investing a personal self within this professional responsiveness, the uniqueness of MHNs' contributions to talk based therapies is enhanced. This personal investment appears to be enabled through having greater access to service users not only through a sharing of powerlessness as outlined in Chapter 5, but also through the time that MHNs and users share, particularly within in-patient settings.

With 75% of respondents constructing a MHN identity of versatility at the interface with talk based therapies, the unique offerings of the profession to these roles are made even more explicit. This versatility has blended talk based therapies with simultaneously responding to other user needs, radically shifted the delivery sites of talk based therapies and taken these therapies to new and more seriously ill groups of users.

Findings from this study help support those of previous studies directed toward MHN identity, particularly those reporting the breadth of MHN roles, MHNs adopting a user focused approach and the time that MHNs spend with service users. However, this study contributes to new knowledge through first focusing on what MHNs bring to talk based therapies, rather than focusing on what education

and training they need. Consequently, findings that highlight the innovative engagement by MHNs in delivering talk based therapies, their transferable capabilities to these roles and their applications of everyday attitudes constitute fresh additions to current constructions of MHN identities. Additionally, while the breadth of MHN roles has been previously reported, the stance of MHNs occupying specialist status owing to their generic capabilities is a potentially important contribution, attracting professional worth to MHNs' versatility rather than merely a 'tradesman's like' recognition.

Findings in response to Research Question 2, which explores the relevance of EI to MHN identity, are presented in Chapter 7. Linkages between findings reported and discussed in this chapter, as well as those in Chapter 5, are also identified and critically examined in the next chapter.

CHAPTER 7 EMOTIONAL INTELLIGENCE AND THE MHN

(RP18) I think you need to have awareness of yourself, you need to be aware of yourself; with therapy it's very, very important …, as well as developing others.

7.1 Chapter introduction

This chapter responds to the second research question in this study:

- What, if any, are the thematic resonances of MHN experiences with the construct of Emotional Intelligence?

The presentation of the findings in this chapter varies slightly from that presented in the other data reporting chapters in the study in that word count data are included. In this chapter the findings which arise from the 24 conducted interviews are first expressed as numerical data, with trends being highlighted and discussed. The data are then presented as themes under the four groupings of EI outlined in Chapter 2, namely those of personal recognition, personal regulation, social recognition and social regulation (Consortium for Research on Emotional Intelligence in Organisations, 1998). Each theme is discussed critically and in depth with reference to findings from other relevant studies and theories. Finally, the relevance of EI to findings arising from both Chapter 5 and Chapter 6 is shown as a means to highlight the inter-connectivity of the construct of EI with MHNs.

The high value that MHNs place upon EI is shown throughout this chapter, a view that is succinctly expressed here:

> (RP22) I think that it [caring and helping others] is about the individual and the world around them, and if the MHN doesn't know that then they should go and serve in a shop.

As discussed in Chapter 2, EI is a grouping of personality traits that focuses upon an individual's ability to recognise and regulate cognition and emotion in relation to self and others (Mayer & Salovey, 1997). As also shown in Tables 2.2, 2.3 and 2.5, EI covers a range of intra- and inter-personal capabilities that are identified by mental health related UK policy as being essential. The clarity of this relationship between EI and mental health nursing has been reinforced through the findings described in Chapter 6. These findings demonstrated that MHNs employ personal parts of their selves within a therapeutic relationship aimed at developing others, a powerful reflection of deploying EI capabilities.

Findings reported here in Chapter 7 reinforce this relationship between EI, MHN identity and the application of EI to delivering talk based therapies. Constructions from the participants' voices suggest that EI capabilities are essential for effective mental health nursing, particularly those capabilities focused on self-awareness and developing others. Arguably an imbalance exists between this central role of EI within mental health nursing and delivering talk based therapies and the focus by policies on preparing nurses for these roles.

Policy documents such as "Improving access to psychological therapies implementation plan: National guidelines for regional delivery" (Department of

Health, 2008) and "Consultation on the development of national occupational standards for psychological therapies" (Skills for Health, 2007) overwhelmingly focus upon training for specific approaches to therapies, particularly those of CBT. Additionally, these policies explore designing organisational structures in which to accommodate the MHNs who complete such education and training packages. Consequently, the vitality of developing education and training that enhances EI capabilities is placed into the background with therapy approaches and organisational structures being given priority. Through highlighting the voices of the MHNs who participated in this study the schism between their constructions and those of policy are made apparent.

7.2 Themes as numerical data

As identified in Chapter 2, Goleman's model of EI (Consortium for Research on Emotional Intelligence in Organisations, 1998) has been used throughout this study as it captures the complexities inherent in the working lives of MHNs, inclusive of clinical and managerial considerations. Additionally, Goleman's model highlights the relational aspect between the self and others that has been shown as central to mental health nursing and to psychological therapies (Freshwater, 2004; Freshwater & Stickley, 2004; Hurley & Rankin, 2008). Consequently, the themes expressed by participants are organised in relation to and distilled as the four broad areas of EI outlined above in Chapter 2 (Consortium for Research on Emotional Intelligence in Organisations, 1998).

In addition to the table format of numerical data that have been used in both Chapter 5 and Chapter 6, a word count of key EI capabilities in the participants' transcripts was performed using NVivo. These word count data are presented below within the EI quadrants, in order from the most to the least frequent occurrence.

1. Personal recognition

- Awareness – 56 counts

2. Social regulation

- Relationship – 48 counts
- Change – 21 counts
- Communication– 16 counts
- Engagement – 13 counts

3. Social recognition

- Empathy – 28 counts

4. Personal regulation

- Confidence – 27 counts
- Trustworthiness – 10 counts
- Adaptability – 7 counts

The participant demographic breakdown, as initially outlined in Chapter 4 has been repeated immediately below to assist in interpreting the results.

MHN Experience 0-10 years 5

	10-20 years	10
	20+ years	9
Gender	Female	13
	Male	11
Research site	England based	7
	Scotland based A	9
	Scotland based B	8
Academic level	Diploma	4
	Degree	10
	Masters	10
Therapy qualification	None	4
	Short course	11
	Formal qualification	9
Core role	Academic	4
	Managerial	3
	Clinical	17

Table 7.1 Themes of EI by participant category

Categories	Personal recognition	Personal regulation	Social recognition	Social regulation
Academic	100% (12)	50% (4)	50% (7)	100% (9)
Clinical	88% (37)	65% (33)	76% (25)	82% (37)
Manager	67% (6)	100% (6)	33% (3)	67% (7)
England	71% (14)	86% (14)	43% (10)	86% (18)
Scotland site A	89% (24)	44% (12)	78% (18)	89% (20)
Scotland site B	100% (17)	75% (17)	75% (7)	75% (15)
Early career	100% (16)	80% (9)	75% (4)	80% (9)
Mid career	80% (19)	70% (20)	60% (12)	80% (20)
Late career	89% (20)	55% (14)	78% (19)	89% (24)
Diploma	75% (8)	75% (11)	75% (8)	100% (17)
Degree	90% (26)	80% (20)	80% (15)	90% (22)
Masters	90% (21)	50% (12)	50% (12)	70% (14)
Not therapy qualified	75% (9)	75% (9)	50% (4)	50% (8)
Short course qualified	91% (28)	64% (20)	73% (21)	91% (23)
Formal therapy qualification	89% (18)	56% (12)	78% (10)	89% (16)
Male	82% (28)	64% (18)	64% (14)	73% (18)
Female	93% (27)	69% (25)	69% (21)	93% (35)

7.2.1 Discussion and analysis of numerical data

The general trend of the data showed a focus by participants on the personal recognition and social regulation quadrants. This possibly suggests that the participants constructed their current or future roles in delivering talk based therapies as involving utilising their personal selves to develop others. As discussed in Chapter 6, this deployment of the personal self within professional helping roles is a core theme of MHN identity within this study. This theme has also been widely acknowledged previously by authors such as Peplau (1989, p. 28), Gastmans (1998) and Öhlén and Segesten (1998), as well as Edwards *et al.* (2000) and Barker (2000).

From the data displayed in Table 7.1 the preference by management participants, unlike other work role categories, appeared to focus upon the personal regulation and social regulation quadrants. This focus reflects that of the policies and documents examined and critically analysed in Chapter 2, which also focused less upon personal recognition. All three work role categories emphasised social regulation over social recognition. Little variation was apparent among the research sites, with only the low focus on social recognition in favour of social regulation by English participants compared to those from Scotland being of some note. However, the social recognition quadrant of EI capabilities was generally least focused upon across all categories.

Little variation was also evident when examining the data from the perspective of career stage. Those in their early career stage appear to have constructed a very balanced view of all four EI capability quadrants. It is noteworthy that as career progresses there was a decline in the number of participants focusing upon the personal regulation capabilities. This decline also reflects the data examined from the perspective of educational level. While the focus on capabilities such as self-awareness, self-assessment and self-confidence appeared to increase in line with qualification level, those of initiative, trustworthiness and conscientiousness were less reported as qualification level increased. Indeed, those at masters level qualifications reported a reduced focus upon social regulation.

This pattern was repeated when examining the category of qualification in talk based therapies. Those with no qualifications placed lowest emphasis on personal recognition. This group also had a comparatively low focus on social regulation capabilities, possibly suggesting that they feel the least skilled to develop others through talk based therapies. As with previous categories related to qualifications, the emphasis on personal recognition rose in line with qualification, while the emphasis on personal regulation EI capabilities declined. Overall social recognition and in particular social regulation rose in line with increasing specialised qualifications.

Finally, the data showed a greater focus by the female participants on all aspects of EI, with the greatest difference between the two gender groupings being evident in the social regulation quadrant. As indicated in Chapter 5, female MHNs have previously been noted as having a higher awareness than male MHNs of the emotions of themselves and others (Humple, Caputi & Martin, 2001). Both genders favoured social regulation over social recognition and personal recognition over personal regulation, a finding that is reflective of the word count data and that suggests that these participants favoured the utilisation of the self for the benefit of developing others.

7.3 Thematic constructions of emotional intelligence

This second research question has sought to establish if there is any resonance between EI and mental health nursing engagement with delivering talk based therapies. For the participants in this study there was an unambiguous connection

among EI capabilities, mental health nursing and the delivery of talk based therapies. Responses to the four EI capability areas are ranked below in order of the number of participants identifying each area. Where these are equal, priority is given to the number of references made by participants.

7.3.1 Knowing yourself

1. Personal recognition (92% of participants with 57 references) – Participants identified the following capabilities as being central to MHNs engaging with talk based therapies:

- Emotional self-awareness
- Accurate self-assessment
- Self-confidence.

Emotional self-awareness was the most commonly identified capability under this grouping:

> (RP3) Self-awareness is massive; it's a massive area and it's impossible to see how someone could be a good mental health nurse without an essential grasp of themselves … how they feel about people. I think learning values are embedded in self-awareness as well, understanding how you feel, how you come across, how other people might judge you, so yes I see there is a very strong link between being person centred, recognising people, recognising yourself, managing interactions well

through social skills and emotional regulation. I see there is an intrinsic link between all of these things.

(RP10) Out of the list what do I class to be more important? Emotional awareness – it's sometimes easier to recognise in others than it is to recognise it in yourself, isn't it? I think it takes time to recognise it in yourself but I think if you can do that then it's quite essential.

As articulated above, the majority of participant MHNs saw self-awareness as being an essential skill to be able to enact the other EI capabilities. The significance of self-awareness in underpinning capabilities that enable the helping of others has been well established. The importance of self-awareness to therapeutic relationships has been outlined by Peplau (1987) and comprehensively explored by Cherniss *et al.* (1998). Jordan and Troth (2002) and Rydon (2005) also found in separate studies that self-knowledge is an essential capability for engaging effectively with talk based therapies and therapeutic relating. Additionally, Akerjordet and Severinsson (2004) in their study establish links between EI and the therapeutic use of self, as well as nurses with higher EI being more likely to be searching for greater understanding of personal and professional identity. The study by Akerjordet and Severinsson (2004) also found that MHNs employ their genuine selves within therapeutic encounters. Participants within this study made similar connections among self-awareness, genuineness and, as outlined in Chapter 6, the use of self within therapeutic engagement.

As established in Chapter 2, self-awareness is common across all variant models of EI, reinforcing its importance to inter- and intra-human relating (Bar-On, 2000; Goleman, 1995; Mayer & Salovey, 1997). Additionally, UK policy for MHNs acknowledges the importance of self-awareness in undertaking both current and new mental health nursing roles (Department of Health, 2006b; Scottish Executive, 2006a). However, as articulated by RP8, policy has also promoted psychological therapy approaches that emphasise techniques over the personal qualities of the therapist (Hurley, Barrett & Reet, 2006):

> (RP8) In some sense, I suppose I'm going into that because I wouldn't like us to go back to – yes, in order for you to be effective you need to get it [self-awareness] into therapy …. I do think we have maybe gone so far the other way. We're not even looking at self-awareness in terms of its contribution to the relationship, the therapeutic relationship. So we do I think need to bring some of that back.

RP24, an experienced MHN quoted here, offered some possible insight into why the numerically expressed data showed decreased emphasis on self-awareness with increased years of experience. In offering self-confidence as being important for engaging in talk based therapies, RP24 also highlighted the challenges facing less experienced MHNs, challenges that are possibly partially forgotten as experience is accumulated:

> (RP24) Self-assessment, self-confidence – again, when I first came into nursing I didn't have as much self-confidence as I would have liked and

that – you feel fearful; I felt a bit fearful initially about actually sitting with another person.

The majority of participants identified that the capability of looking within themselves toward their thoughts and emotions was an essential one for undertaking mental health nursing. This emphasis on and valuing of self-awareness was constructed as being equally applicable to successfully offering talk based therapies. For most, this capability of self-awareness was the very building block that all other MHN capabilities and interventions were built upon; as such self-awareness is central to MHN identity.

7.3.2 Developing others

2. Social regulation (87% of participants with 54 references) – Participants identified the following relationship management capabilities as being pivotal to MHNs engaging with talk based therapies:

- Developing others
- Influence
- Communication
- Conflict management
- Leadership
- Change catalyst
- Building bonds
- Teamwork
- Collaboration.

(RP15) Giving people back their responsibility – I think that's really important. You can provide them with the right tools, and I know it doesn't always work and people don't always want to take that responsibility, but I think you've got to. I think if they want to you've got to try and keep them motivated and support them to make the right choices.

(RP14) And you see them getting well, you know the depressed person who is psychotically depressed …. When they starting to get better they can remember you sat at their bed for 10 to 15 minutes every day … saying, "Come on, come to the dining room, come to the lounge". They remember the nurses who spend that time.

(RP4) Developing others, absolutely. You can say it two ways; it would be developing others by role modelling skills effectively so that others may learn from you. But there is also some kind of developing others in terms of developing the other in terms of the relationship, helping them to develop themselves.

That mental health nursing and talk based therapies are, and should be, focused on developing others is stating the obvious (Barker, 2000, 2006; Department of Health, 2006b; Peplau, 1987; Scottish Executive, 2006a; White & Roche, 2006). As articulated by the three participants above, the development of others is absolutely

central to the purpose of mental health nursing and is undertaken with a passion, commitment and focus on the user, a focus recognised in similar studies (Crawford et al., 2008). Akerjordet and Severinsson (2004) found that all participant MHNs in their study stressed the importance of possessing social skills to develop others, while McCallin and Bamford (2007) identified links between EI and effective team working in their nursing study. Wilson and Carryer (2008) in their investigation of EI and nursing linked fitness to practice as a nurse to the possession of these EI capabilities, while Weng (2008) associated EI with therapeutic relating, both studies reflecting the values placed upon social regulation EI capabilities by participants in this study.

Arguably, the EI capability of developing others can be viewed as the outcome or end product of the other capabilities in this social regulation quadrant being successfully enacted. In terms of the capability of communication, it can be both the largest source of patient dissatisfaction (Caris-Verhallen et al., 1997) and the very foundation upon which the therapeutic relationship is built (Riley, 2008, p. 18). Jordan and Troth (2002) also found that the EI capability of nurses to manage conflict is another important communication skill. RP3 reflects the importance of communication in developing others:

> (RP3) It's no coincidence that the new pre-registration curriculum document for Scotland focuses very much upon communication, values, interactions; it's completely underpinned by all of these. If the values are right and we get to know our patients and communicate correctly, the physical needs will be taken care of …. The focus has changed and any

> curriculum in Scotland that is written from now on is based on human rights principles, values and interaction and communication.

The application of communication was taken further by RP12, who identified that communication and leadership are intrinsically connected. This organisational view of communication and leadership applies as much to the effective development of others as does that outlined by RP3 above. Coordinated user care and effective leadership are essential for MHNs effectively engaging in talk based therapies (Department of Health, 2006b; Scottish Executive, 2006a):

> (RP12) There is a lot of work just now on helping people become leaders, and whilst [a] kind of natural leaders just float to the surface and people follow or people are encouraged by them we've never been very good at developing them as leaders and we've never been very good at communicating with other services and other departments and wards, and we're getting better at it and the need to get better at it is there. I think there are still a lot of barriers [to] open, free communication.

Given that many users of mental health services are experiencing difficulties in the way in which their lives are being experienced, it is also unsurprising that MHN participants identified strongly with being catalysts of change. The participants quoted below communicated the inter-connectedness of EI capabilities such as collaboration, communication and change:

> (RP18) Change catalyst … it's all about communication and how you communicate that change to them, … and collaboration; you can't do it without collaboration. It has to be done together with the person's consent, what they want to work on.

> (RP5) I would like to think there is an element of change catalyst …. The differences you can make by adopting that approach offer the opportunity perhaps for other people to change their behaviour to make a difference with that person.

It is worth noting that the quadrant of social regulation is the primary focus of both the policy documents examined in Chapter 2 and the tidal model of mental health nursing (Buchanan-Barker & Barker, 2008). Also as noted earlier in this chapter, participants in the category of managers focused most frequently upon this aspect of EI. This reflects findings from multiple studies that have shown a correlation between EI and leadership (Ashkanasy & Tse, 2000; Sosik & Megerian, 1999; Wolff, Pescosolido & Druskat, 2002; Wong & Law, 2002).

A resonance exists between the EI capabilities of social regulation and the core roles and values of the participant MHNs. Indeed, while self-awareness was identified earlier as being central to how MHNs enact their roles, the social regulation capabilities respond more to why MHNs enact their roles while also adding to the 'how'. These central MHN purposes of influencing and developing

others reflects not only the user focus theme discussed in Chapter 6 , but also the goal of talk based therapies.

7.3.3 Managing the self

3. Personal regulation (71% of participants with 45 references) – Participants identified the following self-management capabilities as being central to MHNs engaging with talk based therapies:

- Trustworthiness
- Adaptability
- Achievement drive
- Initiative
- Conscientiousness.

> (Researcher) So for us as mental health nurses we're more tolerant to the strange?
>
> (RP7) Yes, our threshold is higher in the context of our settings. I was dealing with somebody the other day who was literally screaming at me and threatening my children and spitting at me, which is not normally an everyday occurrence, and I accept that it was part of that day. That

behaviour was accepted; you know, it was a young girl, drug induced psychosis; that was her on that day with that behaviour.

While participants focused upon the EI capability areas of personal recognition and social regulation fairly evenly, there was a drop in the percentage of participants who highlighted personal regulation. However, a majority of participants identified this area as being important for MHNs engaging in talk based therapies, and the number of references made to this quadrant of EI capabilities remained high. Given the findings arising from the MHN lifeworld of low perceived worth in Chapter 5, and those by Crawford *et al*. (2008) of MHNs standing behind their service users and waiting for recognition, it is noteworthy that these capabilities received the attention that they did. Self-management capabilities focus upon the strengths of the individual to respond to challenges arising from both their social environment and their internal awareness. Consequently, it can be contended that many participant MHNs spoke of powerful and influential personal and professional strengths, despite describing themselves as being anything but powerful and influential. In commenting on research into EI that incorporated numerous professions and non-professional groups, Boyatzis (2002) notes that the articulation of the ideal self is often neglected, suggesting that the MHNs are not alone in minimising discourse that looks at personal strengths.

Findings from other studies have reflected those shown above. Mikolajczak *et al*. (2007) demonstrated that EI traits are highly effective protective factors in stressful

environments. In their study of over 100 nurses, those with high levels of EI traits showed markedly lower levels of stress or somatic problems. McMullen (2002) links EI with adapting to challenging health service working environments, while Humple and Caputi (2001) and Humple, Caputi, and Martin (2001) linked resilience to stress to EI refined over years of work experience, particularly in the case of female nurses. Finally, Guleryuz *et al*. (2008) in their study of nurses associated EI with job satisfaction and organisational commitment.

RP25 quoted below articulated not only the clinical necessity of regulating emotions but also the connectedness of these capabilities to MHN identity. As noted in Chapter 6, a central feature of MHN identity is that of generic specialism, the capacity to move between multiplicities of roles in response to service user need. Adaptability, a key EI capability of personal regulation, is consequently pivotal to MHN identity, MHN responsiveness to user need and, as articulated by RP12 here, MHN capability to respond to organisational change:

> (RP25) I seem to be going back to the mentality that yeah, emotional self-awareness is very important. Self-control; … being aware of emotions, it's not enough. They need to be able to effectively regulate emotions when you are working with somebody so that your own emotions aren't spilling out onto the relationship of the service user. I think you need to be trustworthy as well and I suppose adaptability, because of what I've already said about the idea of shape shifting.

(RP12) I think probably we are pretty good already at self-management; you know, nurses are trustworthy and conscientious and adaptable and we change with each new wave of change.

(Researcher) You smile when you say “wave”.

(RP12) We've had lots of practice at that so to a certain extent people are encouraged to use their initiative.

Continuing the focus on adaptability being highly important to mental health nursing, RP9 placed adaptability at the centre of her or his identity of being a MHN:

(Researcher) For you, how would you describe your identity as a mental health nurse; what makes you a mental health nurse?

(RP9) I think it's around being flexible and adaptable, because fundamentally we are dealing with individuals that are very unwell, very unpredictable because of illness … and being able to deal with very difficult challenges but not letting it have an effect on you.

Other participants focused upon trustworthiness as being central to MHNs engaging effectively with talk based therapies. Such a focus reflects the longstanding and uncontested acceptance of trustworthiness as being essential for users to move toward wellness within therapeutic relationships (Rogers, 2007). RP5 and RP14 not only made this link, but also established a connection with the time that MHNs spend with users, another key identity theme discussed in Chapter 6:

(RP5) Yes ... the patients do trust MHNs and I would say though that the opportunities for developing their trust and relationship are greater for nursing.

(Researcher) What sort of skills and capabilities do you get from that prolonged exposure to people?

(RP14) I think being open and honest is number one, even with somebody who is psychotic. If you say you are going to be there in two minutes, be there in two minutes and make sure that you provide that therapeutic time with the patient.

RP14 went on to make a connection between EI capabilities such as achievement drive being held by MHNs and the impact that organisations have upon those capabilities. Akerjordet and Severinsson (2004) reflect this finding as participants in their study identified inner motivation as a key element of maintaining their clinical effectiveness. Arguably where organisations fail to communicate their worth toward EI driven behaviours and values the potential for those capabilities to diminish increases:

(RP14) Achievement drive – I think I'm disappointed because … quality comes when you have been qualified two years or 22 years. It's all right doing course after course …. It's whether you have digested the information. The NHS, I'm afraid, I believe, is quantity …. It's the years of experience, so you could have 22 years of experience without linking it

to the theory and linking it to reflective practice …. If anything, it's the biggest demotivator.

Capabilities such as adaptability, conscientiousness and initiative appear central to the participants' understandings of not only their generic mental health nursing roles, but also future ones in talk based therapies. These capabilities not only add to our understandings of how MHNs promote the development of others, but also offer an insight into how MHNs survive in, and at times flourish within, the challenging MHN lifeworld described in Chapter 5.

7.3.4 Acknowledging others

4. Social recognition (71% of participants with 36 references) – Participants identified the following social awareness capabilities as being central to MHNs engaging with talk based therapies:

- Empathy
- Service orientation
- Organisational awareness.

Although it is the least focused upon quadrant of the EI capabilities, social recognition is separated from personal regulation only by a small number of references. Additionally, nearly three quarters of participants identified capabilities within this area as being of importance. In their study directed at MHNs and EI, Akerjordet and Severinsson (2004) also found that participants highlighted empathy as being central to providing effective clinical care, while in their study Austin,

Evans, Magnus and O'Hanlon (2007) also identified empathy as being of central concern to health care delivery.

RP12 quoted below emphasised the necessity of MHNs having the empathic capability to be able not only to target where to help others, but also to ensure that the person being helped remains empowered. Through highlighting the difference between rescuing and enabling others through enacting empathic capabilities, RP12 also communicated the capability of service orientation:

> (RP12) Empathy is definitely one that nurses, mental health nurses have, and need to have …. Your empathy doesn't trigger some kind of rescuing response where you can jump in and save the day and get the credit for it …. At the end of the day you can help this person; you can help them become better at being themselves.

RP18 quoted here also communicated the complexities that underlie empathy. While focusing upon empathic capabilities, RP18 connected the social regulation capability of communication to empathy and consequently demonstrated that MHNs employ multiple EI capabilities to achieve positive outcomes with service users. Also evident in the words of RP18 is the capability of responding to diversity:

> (RP18) I think that nurses have the ability to relate to people. You know, I found they have a good way of relating to different cultures. And you know, I just think, you know, they can talk to their – you can relate to different people but sometimes it can be difficult for medical staff to relate to people.

While RP18 communicated how MHNs employ an inter-connectivity of EI capabilities, RP25 offered an insight into how these capabilities may also be in conflict:

> (RP25) I think nursing is very much about trying to fit into the world of the needs of the patient and not institutional imperatives …. It's getting increasingly difficult to do because you have got the person sitting there crying, and you are only allowed 30 minutes to carry out your triage, and you've got to give them the confidentiality statement to sign, and you have got to do the risk assessment, so you haven't really got the time to respond to that person, to be warm and empathic.

RP25 highlighted that organisational awareness and responding empathically to the service user can be in conflict. This conflict is arguably avoidable through priority being given to the users' needs, or through flexibility being built into organisational procedures. However, this finding does echo those of Stronach *et al.* (2002), who demonstrated the conflict between managerial priorities and those of clinicians being increasingly resolved with managerial views taking priority. Clinicians have been shown to be effective in negotiating these conflicts. In their grounded theory study of over 40 nurses, McCallin and Bamford (2007) found that clinicians were highly focused on meeting service needs. In relating their findings to EI, McCallin and Bamford (2007) also established links between capabilities within the social recognition and social regulation quadrants, with particular linking being found between having a service orientation and team working within multi-

disciplinary environments. Certainly, social recognition capabilities incorporate not only the need for MHNs to respond to service users' needs, but also the environmental conditions and circumstances in which those needs are presented.

7.4 Relationships with other findings

The data findings in this chapter have been specifically presented as a response to the second research question in this study. However, MHN experiences with EI have also been evident when exploring both the MHN lifeworld in Chapter 5 and MHN identity in Chapter 6. It was established in Chapter 2 that recent policy documents relevant to MHNs undertaking new roles have a focus on wanting MHNs to develop EI capabilities, thereby constructing a relationship between mental health nursing and EI. This connection was most apparent in the relationship management quadrant of the EI framework, but was also evident across all other quadrants. MHN education and training are identified within the policies and documents examined in Chapter 2 as the means to develop these EI capabilities. Through the establishment of EI as a construct that is relevant to all parts of this study, the imperative to focus upon developing MHN EI is made clearer. The following sections map key themes identified within this study to the constructs of EI to strengthen the argument for EI as being integral to MHNs, their workplace and their roles in talk based therapies.

7.4.1 EI and the MHN lifeworld

An emergent theme contributing to the MHN lifeworld discussed in Chapter 5 was that obstacles to success are an identifiable challenge to MHNs. Chapter 5 also

established that the organisational structures and cultures in which some participants worked contributed to these obstacles being either constructed or maintained. Work environments for MHNs were also identified in the literature discussed in Chapter 2 as being characterised by episodic discontinuity that has challenged health organisations to blend structures able to respond to change with existing rigid structures that allow accountability and bureaucratic governance (Hurley & Linsley, 2007b; Limerick, et al., 2002, p. 83). Additionally, conflictual expectations of organisational demands for proactive yet managed staffs can foster a sense that the organisation and its leaders are not respecting of staff, with a resultant exacerbation of a victim rather than a participant identity (Hurley & Linsley, 2007b).

It is from within this challenging environment that MHNs must have the intrapersonal and interpersonal capabilities to respond to their clients' needs for psychological therapies, as well as their own needs. Participants in this study articulated the EI capabilities listed below (adapted from Consortium for Research on Emotional Intelligence in Organisations, 1998) as how they responded to the obstacles to success that they encountered in their professional roles. These capabilities range across all quadrants of the EI framework, suggesting the need for complex EI responses to respond to these obstacles:

- Self-confidence - able to make sound decisions despite uncertainties and pressures
- Adaptability - adapt their responses and tactics to fit fluid circumstance**s**
- Achievement drive - are results-oriented, with a high drive

- Initiative - pursue goals beyond what's required or expected of them
- Service orientation - gladly offer appropriate assistance
- Communication - listen well, seek mutual understanding, foster open communication
- Conflict management - handle difficult people and tense situations with diplomacy
- Leadership - guide the performance of others while holding them accountable, lead by example
- Change catalyst - recognise the need for change and remove barriers.

Another key characteristic of the MHN lifeworld discussed in Chapter 5 was that participant MHNs perceived themselves as having low levels of power and worth. This view of a disempowered mental health nursing profession was also identified in the review of literature in both Chapter 2 and Chapter 3, with Clinton and Hazelton (2002) and Stronach *et al*. (2002) alike targeting this as a significant MHN challenge. Diminished influence on clinical decision making and the ownership by the psychology and medical disciplines of the delivery of psychological therapies certainly contribute to this historically disempowered positioning of MHNs (Brooker & Butterworth, 1994; Hurley & Ramsay, 2008).

EI capabilities (adapted from Consortium for Research on Emotional Intelligence in Organisations, 1998) articulated by participants in response to low power and worth include:

- Emotional self-awareness - have a guiding awareness of their values and goals
- Accurate self-assessment - show a sense of humour and perspective about themselves
- Self-control - manage their impulsive feelings and distressing emotions
- Empathy - show sensitivity and understand others' perspectives
- Conflict management - handle difficult people and tense situations with diplomacy and tact.

Uncertainty was another of the key characteristics of the MHN lifeworld. A key discussion in Chapter 5 was that, while some MHNs appear to have an orientation toward uncertainty, others do not, possibly influencing the areas in which they choose to work. In responding to this uncertainty, the following are the articulated EI capabilities (adapted from Consortium for Research on Emotional Intelligence in Organisations, 1998) employed by participants:

- Accurate self-assessment - show a sense of humour and perspective about themselves
- Self-confidence - able to make sound decisions despite uncertainties
- Self-control - manage their impulsive feelings and distressing emotions
- Adaptability - smoothly handle shifting priorities and rapid change; adapt their responses and tactics to fit fluid circumstances
- Leveraging diversity - respect and relate well to people from varied backgrounds; understand diverse worldviews

- Change catalyst - recognise the need for change and remove barriers
- Influence - use complex strategies to build consensus and support; orchestrate dramatic events to make a point effectively.

The capabilities listed above range across all quadrants of the EI framework, suggesting the need for complex EI responses by MHNs in response to the uncertainties that they face.

7.4.2 EI and MHN identity

The MHN identity themes discussed in Chapter 6 also had connections to EI, as evidenced by the participants' focus on self-awareness and developing others, both key EI constructs (Mayer, Salovey & Caruso, 2004). Evident within the identity constructions offered by the participants were a range of key EI capabilities. Below these identity themes discussed in Chapter 6 are listed with the associated EI capabilities adapted from the Consortium for Research on Emotional Intelligence in Organisations (1998). What is apparent through the volume of EI capabilities associated with the MHN identity themes is that EI and mental health nursing have considerable overlap. Consequently, MHN identity is reinforced as being a highly personal construct. Arising from the work of both Boyatzis (2002) and Cherniss *et al*. (1998) is that skilled, ethical and considered approaches to changing and influencing MHN identity are therefore required, rather than pursuing impersonal policy and bureaucratic driven approaches:

1. The MHN as generic specialist

- Adaptability - smoothly handle shifting priorities and rapid change; adapt their responses and tactics to fit fluid circumstances
- Achievement drive - results-oriented
- Self-confidence - able to make sound decisions despite uncertainties and pressures; present themselves with self-assurance
- Initiative - pursue goals beyond what's required or expected of them
- Leadership - lead by example.

2. The MHN as having a service user focus
    - Achievement drive - results-oriented with a high drive
    - Initiative - pursue goals beyond what's required or expected of them; mobilise others through unusual, enterprising efforts
    - Empathy - show sensitivity and understand others' perspectives; help out based on understanding other people's needs and feelings
    - Service orientation - gladly offer appropriate assistance; grasp a customer's perspective, act as a trusted advisor
    - Developing others - identify people's needs for development; mentor and offer assignments that challenge and grow a person's skill
    - Conflict management - handle difficult people and tense situations with diplomacy
    - Change catalyst - recognise the need for change
    - Collaboration - balance a focus on task with attention to relationships.

3. The MHN as positioning and utilising the personal self

- Emotional self-awareness - know which emotions they are feeling and why; have a guiding awareness of their values and goals
- Accurate self-assessment - show a sense of humour and perspective about themselves; reflective, learning from experience
- Self-control - manage their impulsive feelings and distressing emotions; think clearly and stay focused under pressure
- Trustworthiness - build trust through their reliability and authenticity; admit their own mistakes and confront unethical actions in others
- Conscientiousness - meet commitments and keep promises; hold themselves accountable for meeting their objectives
- Leveraging diversity - respect and relate well to people from varied backgrounds; understand diverse worldviews
- Empathy - show sensitivity and understand others' perspectives; help out based on understanding other people's needs and feelings.

4. The MHN as spending time with the service user
    - Self-control - manage their impulsive feelings and distressing emotions
    - Influence - use complex strategies to build consensus and support
    - Conflict management - handle difficult people and tense situations with diplomacy and tact; spot potential conflict and deescalate
    - Communication - listen well, seek mutual understanding; foster open communication and stay receptive to bad news as well as good.

5. The MHN as delivering talk based therapies in versatile ways

- Leadership - guide the performance of others while holding them accountable; lead by example
- Change catalyst - recognise the need for change and remove barriers; challenge the *status quo* to acknowledge the need for change
- Communication - listen well, seek mutual understanding; foster open communication and stay receptive to bad news as well as good
- Developing others - identify people's needs for development
- Leveraging diversity **-** respect and relate well to people from varied backgrounds; understand diverse worldviews
- Adaptability - smoothly handle shifting priorities and rapid change; adapt their responses and tactics to fit fluid circumstances
- Achievement drive - are results-oriented, with a high drive; set challenging goals and take calculated risks
- Initiative - pursue goals beyond what's required or expected of them; mobilise others through unusual, enterprising efforts.

6. The MHN as having an everyday attitude
    - Emotional self-awareness - know which emotions they are feeling and why; have a guiding awareness of their values and goals
    - Accurate self-assessment - show a sense of humour and perspective about themselves; reflective, learning from experience
    - Self-control - manage their impulsive feelings and distressing emotions
    - Adaptability - smoothly handle shifting priorities and rapid change
    - Empathy - show sensitivity and understand others' perspectives

- Teamwork - model team qualities like respect, helpfulness and cooperation.

7. The MHN as having transferable skills
    - Collaboration - balance a focus on task with attention to relationships
    - Change catalyst - recognise the need for change and remove barriers
    - Communication - listen well, seek mutual understanding
    - Service orientation - gladly offer appropriate assistance; grasp a patient's perspective, acting as a trusted advisor
    - Achievement drive - are results-oriented
    - Adaptability - smoothly handle shifting priorities and rapid change.

7.4.3 The importance of EI to mental health nursing

The above list of EI capabilities matched against findings from this study has helped to construct a matrix in which EI and mental health nursing are inseparable. While adopting such a position naturally remains contestable, the importance of putting this view forward cannot be understated. EI capabilities refer to the person who is a MHN, and as such require attention from educators, managers and strategic level policy makers. Unless the case for making EI central to current and future MHN identity performances is strengthened, wider educational, managerial and strategic considerations will potentially overwhelm this personal and individualised viewing of MHNs. What has been sought is to place a spotlight upon this view of MHNs, particularly as they engage with and hopefully promote the service users' development.

The EI capabilities discussed above echo the stance of Barker (2006), who advocates less attention being paid to the role of MHNs in favour of what people need from them. While these capabilities offer a rich response to service users' needs, this study has not focused upon the service user. As this research sought the views of MHNs rather than service users, the constructions from the participants respond more to what MHNs want or feel able to give to people than to what people need from them. Arguably, this attention to MHNs is comparatively under reported despite being an essential focus of investigation. Establishing the priorities of MHNs and contrasting these with the needs of users enable the extent of the congruence toward therapeutic priorities between these groups to be more closely considered.

As identified in the literature review, studies focusing upon service users' requirements from their MHNs have consistently identified service users as wanting their MHNs to be self-aware, mature and adaptable, as well as empathic and able to forge respectful relationships (Rydon, 2005; Welch, 2005). These user based expectations of their MHNs appear highly congruent with the priorities and directions of professional drives expressed by the participant MHNs in this study. Policies such as "Rights, Relationships and Recovery" (Scottish Executive, 2006a) and to a lesser extent "The Chief Nursing Officer's review of mental health nursing: From values to action" (Department of Health, 2006a) list a multiplicity of EI capabilities seen as being essential for MHNs. However, despite this palpable sharing of priorities among service users, MHNs and health policy, the strategies

directing the preparation of nurses for roles in talk based therapies fail to adopt such a focus (Department of Health, 2008; Skills for Health, 2007).

This schism reflects the wider divides that characterise much of mental health care delivery within the UK (Stronach et al., 2002). Strategic moves for increasing MHN participation in talk based therapies steadfastly ignore the relevance of EI, and as such make no provision for their inclusion and enhancement in educational preparation. Rather, a drive to embed CBT is prioritised, despite even the BACP challenging this and offering the inter- and intra-personal capabilities of the therapist as being at least as significant as, if not more significant than, the therapeutic approach taken (Andrews, 2008). Hence, it can be contended that the dominant discourses promote only CBT because RCTs have gained dominance over the discourses of users and MHNs who value the enactment of EI capabilities. Arguably these dominant discourses arise from outside the MHN profession and, while undeniably wanting enhanced user benefits, also seek to entrench the influence of psychology, medicine and management over the roles and hence the identities of MHNs.

7.5 Chapter summary

This chapter has presented the voices of the MHN participants articulating a relationship with all the EI capabilities. For these participants, the capabilities that focused on self-awareness and developing relationships with others were the most frequently acknowledged. The findings presented in the chapter have also been shown to be reflective of similar and sometimes larger studies, adding worth to the

findings reported here. Through a relationship between the EI capabilities highlighted in this study and foundational studies and models such as those by Barker (2000) and Peplau (1989) having been established, the thematic resonances of MHN experiences with the construct of EI can be argued as having been at least tentatively established. In doing so additional voices have been added to the discourses toward the epistemological direction of mental health nursing.

Introduced into this debate is the proposition that participant MHNs have constructed a value toward the intra- and inter-personal capabilities related to mental health nursing, MHN identity and assuming roles in talk based therapies. This co-construction by participants arose from across individuals' varied positioning toward CBT, evidence based practice and stances toward hierarchies of evidence. This signals that EI can be a unifier not only across the divides within the MHN profession, but also among other stakeholders in the delivery of mental health care. It is argued that education and training for roles in talk based therapies must overtly incorporate the enhancement of EI capabilities so as to resonate with the needs of service users.

While being partially reflective of foundational models and studies, the findings reported here also make a new contribution to the understanding of mental health nursing. Through identifying EI capabilities as being resonant with the participant MHNs, a clearer understanding of MHN identity can be argued as having been constructed. This understanding is one based upon a primacy toward having self-awareness in order to enable an effective use of the self for the development of

others. Consequently, through establishing a relationship between EI and mental health nursing, longstanding characteristics of the profession such as the use of self and adopting a service user focus can be explained through a framework of capabilities, rather than being viewed as being simply unattached and individualistic preferences toward care. This lens of understanding sharpens the view toward MHNs as possessing advanced capabilities, ones worthy of attracting value, especially given the priority that service users place on those capabilities.

This value and worth need to co-exist democratically with those directed toward holding strategy based capabilities. Reminiscent of Walker and Evers' (1988) approach to epistemological unity in research, MHN identity can be viewed through a lens that incorporates an inclusive continuum of capabilities from the deeply intra/inter personal to the profoundly scientific. It is noteworthy that MHN identity, as constructed from the text of the interviews with the participants and from policy, has resonance with EI. Findings from the literature review of policies reported in Chapter 2 established a relationship between EI capabilities and those capabilities sought by policy makers. With participants from clinical, managerial and academic areas also establishing a relationship between EI capabilities and mental health nursing, shared understandings, values and directions for the MHN profession can be argued as having been clarified. Unambiguously these values and directions are toward enabling those with mental health difficulties to experience more rewarding, empowered and socially inclusive lives. While the means to achieve this end will remain areas for potentially transformational discourses, EI offers the shared ground from which to underpin those discourses.

Also highlighted was that EI capabilities are employed by MHNs in response to their sometimes challenging workplace environments. It is apparent that the participant MHNs employed an extensive array of EI capabilities within this environment not only to fulfil their core roles of helping others, but also to mitigate emotionally and psychologically challenging constructs such as uncertainty, low power and obstacles to success. Exposing this breadth of EI capabilities helps to see the MHN as a highly capable and resilient professional, while areas for development of those struggling with such environmental challenges can be targeted.

Chapter 8 now moves on to explore the journeys undertaken by the participants to reach their EI laden identity. While Chapter 5 described the context in which MHN identity is at least partially forged, Chapter 6 outlined key identity markers constructed from the participants' discourses. Within this chapter EI was identified as being a lens through which to view and understand MHN identity. Consequently, MHN identity has been addressed in this study from the questions of where it is formed and what it may be, but not from the question of how it was influenced or formed. Without understanding the processes of MHN identity formation an overarching aim of this study cannot be attained, that of beginning to offer a MHN response to education and training for assuming roles in talk based therapies. Through exploring these identity journeys key indicators can be uncovered which will help inform such education and training.

CHAPTER 8 MHN IDENTITY JOURNEYS

> (RP13) I've never really thought about a professional identity. I try to be faithful to myself, to my basic principles, and I try to be this non-judgemental empathetic being. In some ways my professional identity is how better I can help the patient; what new skills can I take on board to enhance that role?

8.1 Chapter introduction

Chapter 8 presents findings emergent from the 24 conducted interviews that responds to the third and final research question:

- What journeys through structures of social rules and processes did MHNs undertake to reach their current identities, both personally and professionally?

This research question seeks to gain an understanding of how MHNs arrived at their current identity performances. As has been highlighted in Chapter 6 and Chapter 7, this identity is multi-faceted, being simultaneously individual and partially shared and personal yet responsive to others' needs. MHN identity has also been shown and constructed as being a package of identity markers with a resonance with the construct of EI. Highlighting the significant journeys that MHNs have undertaken to perform their current identities alerts us to a clearer articulation and hence a comprehension of MHN identities. Through a better understanding of how MHN identities are influenced education and training packages for roles in talk based therapies can be potentially enhanced.

As in the previous data reporting chapters, findings responding to the third research question are first presented as themes which are briefly described, and then presented as numerical data. The constructions of MHN identity that arise from analysing the numerical aspects of the data are then presented. Each theme is subsequently discussed and critically analysed with reference to findings from comparative studies and relevant literature. What emerges is that the journeys undertaken by the MHN participants to reach their current identity performances are influenced by education and training, particularly those experienced within workplace settings. It is also evident that these journeys have a personal quality, one that pre-dates contact with the MHN profession, and that contains essences of the EI capabilities discussed in Chapter 7. Findings in this chapter offer insight into how for many of the participants their experiences with the MHN profession have built upon and enhanced their EI. For other participants their journeys have taken them away from identifying themselves as being or having a MHN identity.

8.2 MHN identity journey themes: An overview

In response to the third research question that sought clarification about what journeys through structures of social rules and processes MHNs undertook to reach their current identities, analysis of participants' discourses offered the following themes:

1. Identity journeys through work based experiences (96% of respondents with 92 references) – Participants identified the workplace as being central to their MHN identity formation. Participants learnt MHN roles, behaviours

and capabilities as well as knowledge through influences such as role models, socialisation and the specific challenges of their clinical settings.

2. Identity journeys through non-work based education and training (83% of respondents with 60 references) – Participants spoke of the significant influence that education and training had upon their professional identity performances. This theme is inclusive of education and training that may or may not lead to an academic award, as well as education and training programs conducted away from the workplace regardless of its duration.

3. Identity journeys through assuming new titles and new roles (62% of respondents with 34 references) – Participants spoke of how varied job titles within both the nursing profession and their expanding roles in talk based therapies impacted upon their professional identity. The influence of a title upon identity formation was evident within this theme.
4. Beginning identity journeys (58% of participants with 26 references) – A majority of participants spoke of how life experiences gained prior to entering the MHN profession influenced their current professional identity, inclusive of relevant nursing capabilities.

5. Exit journeys (50% of participants with 21 references) – Linked with the theme of identity journeys through assuming new titles and new roles, half of the participants spoke of how they or other MHNs effectively left the MHN profession through new roles or non-nursing titles or through identifying with another profession.

8.3 Themes as numerical data

Table 8.1 below reports the extent to which each category of MHN participant provided evidence that constructed the MHN identity journey themes. These are expressed as the percentage of participants within each category and the number of references made to construct the theme. The participant demographic breakdown, as initially outlined in Chapter 4 has been repeated immediately below to assist in interpreting the results.

MHN Experience	0-10 years	5
	10-20 years	10
	20+ years	9
Gender	Female	13
	Male	11
Research site	England based	7
	Scotland based A	9
	Scotland based B	8
Academic level	Diploma	4
	Degree	10
	Masters	10
Therapy qualification	None	4
	Short course	11
	Formal qualification	9
Core role	Academic	4
	Managerial	3
	Clinical	17

Table 8.1 MHN journey identity themes

Categories	Identity journeys through work based experiences	Identity journeys through non-work based education and training	Identity journeys through assuming new titles and new roles	Beginning identity journeys	Exit journeys
Academic	100% (24)	100% (13)	100% (12)	75% (5)	100% (6)
Clinical	88% (54)	76% (35)	53% (14)	58% (19)	23% (9)
Manager	100% (12)	67% (10)	33% (4)	33% (2)	100% (5)
England	100% (27)	100% (22)	28% (6)	85% (14)	43% (5)
Scotland site A	77% (33)	55% (10)	67% (11)	44% (5)	55% (7)
Scotland site B	100% (30)	87% (26)	75% (13)	50% (7)	37% (8)
Early career	100% (14)	80% (6)	40% (4)	80% (9)	20% (2)
Mid career	90% (33)	80% (26)	40% (7)	30% (6)	50% (9)
Late career	89% (43)	78% (26)	89% (19)	89% (11)	62% (9)
Diploma	100% (20)	75% (10)	75% (4)	75% (4)	0
Degree	100% (34)	80% (21)	40% (7)	50% (11)	50% (11)
Masters	80% (36)	80% (27)	70% (19)	60% (11)	60% (9)
Not therapy qualified	75% (11)	20% (1)	50% (3)	50% (5)	0
Short course qualified	91% (47)	91% (27)	55% (14)	91% (19)	45% (9)
Formal therapy qualification	89% (26)	78% (28)	67% (13)	22% (2)	56% (10)
Male	82% (38)	64% (19)	55% (15)	55% (13)	55% (8)
Female	100% (52)	92% (39)	61% (15)	61% (13)	38% (12)

8.3.1 Discussion and analysis of numerical data

As noted in previous chapters, given the small numbers within each category and the qualitative approach to this study, there is little value in engaging in detailed

statistical analysis of the above figures. Rather, value lies in identifying any general trends within each category, as well as between categories.

Managers placed least emphasis upon what capabilities people bring into the profession, suggesting a preference for capabilities generated from within health organisations, and hence under their influence. Managers also placed least emphasis on identity journeys through new work roles and titles, implying that role expansion and education and training are seen from their perspective as strengthening MHNs' capabilities within their current organisational positions, rather than moving the MHN toward promotion, progression or greater influence. This finding reflects the positioning adopted in the reviews of mental health nursing recently completed in England and Scotland (Department of Health, 2006a; Scottish Executive, 2006a), as well as implementation plans for MHNs to assume roles in talk based therapies (Department of Health, 2008; Skills for Health, 2008).

Within this category of work role, the other notable finding appears to be that of clinicians having the lowest emphasis on identity journeys that exit the profession; this may suggest a strong attachment toward the MHN profession when engaged with clinical activities compared with teaching or managerial activities. When considered alongside the finding from Chapter 6 of MHN identity being integral to helping service users, this idea of clinicians having a stronger attachment to the profession owing to engagement with clinical activities appears reinforced.

Differences between sites were minimal, with wide emphasis on work based experiences as influencing identity formation. There appeared to be a weaker focus on non-work based education and training within Scotland, as well as a lower emphasis in Scotland on what people bring into the profession. Site A from Scotland reported the lowest emphasis on identity journeys through either work based or education and training based experiences, as well as on those from prior to entering the profession. Site A participants also spoke most of exit journeys from the profession. This may be interpreted as a resistance to change, or being more attached to historical ways of being "a MHN" compared to other sites.

Also noteworthy within the category of sites was that English participants placed the lowest emphasis on identity journeys through new titles and roles. This appears compatible with the finding from Chapter 6 where English participants reported a 100% identity focus on both generic specialism and versatility. English participants could therefore be constructed as having a highly flexible and inclusive professional identity, and consequently one that is less impacted upon by changing roles and titles.

Findings arising from other categories showed that emphasis on exit journeys rose with career experience, but that identity journeys through new roles and titles were highest in late career, possibly reflective of greater opportunity for achieving new roles through having greater experience. Also of note was that identity formation and learning in both work and non-work settings were constant throughout career progression. This finding reflects the theoretical pillar of identity being in a state of

constant movement, as well as lifelong learning theory (Bandura, 1994; Foucault, 1991b, p. 94). Little variance was evident when viewing educational level, with the exception that those at diploma level or with no therapy training did not speak of exit journeys. Those with no therapy training also reported the least emphasis on non-work based education and training, and identity journeys through new roles and titles. Considering that these participants are most likely to be in their early careers or not yet contemplating undertaking roles in talk based therapies, this finding is not surprising.

Those participants with formal training in talk based therapies exhibited least emphasis on experiences and capabilities gained prior to entering the profession and the highest emphasis on exit journeys. This is suggestive of these participants placing greatest value on the knowledge gleaned through formal training, and that their qualifications in talk based therapies are more likely to lead them away from identifying as being a MHN. Finally, little difference was evident between participants in terms of gender, with female participants verbalising their identity journeys through both work and non-work based experiences slightly more than their male counterparts.

8.4 Identity journey theme: The workplace

1. Identity journeys through work based experiences

> (RP12) I think things like role modelling and coaching, exposure to good clinicians, getting a chance to hear these good clinicians talk out loud

about what they do, why they did it and what skills they tapped into. What – you know, potentially what in the past would have been intuitive skills and now which people have become much better at describing their intuitive skills. I think working with people and getting feedback has helped. I think one of them is, is especially in mental health …. It's probably led from people being with inpatients 24 hours a day.

Learning was integral to the MHN identity journeys articulated by the participants. RP12 above summarised the impact that work based learning had upon most of the participants in terms of their identity formation. RP12 highlighted not only the roles of other MHNs, but also that of the service user, embedding MHN identity formation as being a relational and socially mediated process. This finding links with the findings from Chapter 6 that reported the themes of time spent with service users, and having a user focus as being central to MHN identity. Although it was not included in the quotation above, RP12 also spoke of the necessity of having self-awareness to be able to engage with the learning and identity formation process articulated above. This reflects the EI theme of personal recognition reported in Chapter 7 as also being central to MHN identity.

RP4 reinforces both the importance of the service user in relation to learning and identity formation and the connection with EI through expressing themes of social regulation:

(RP4) I embarked on a lifelong learning journey around mental health, mental disorder, mental illness, whatever you like to call these things, to

> understand how that all fits. I was trying to understand what was making this person behave this way and what made them tick and how the hell do you function when you've got all this stuff in your head?

Previous studies also reflect the importance of work based learning and identity formation, although the majority of these focus upon new practitioners entering the profession rather than across a career lifespan as this study does. Cope, Cuthbertson and Stoddart (1999) highlighted how professional identity is reinforced through workplace learning and socialisation, particularly for novice practitioners. Palmer, Harner, Callister, Johnsen and Matsumura (2005) identified the vital role that experienced nursing staffs play in passing on knowledge and behaviours, again with novice or student nurses. Similarly, Deppoliti (2008) studied nurse identity formation over the first three years following qualification. Her findings uncovered learning in the workplace as being central to identity formation and identified service users and their families as being important in identity formation. In an echo of the findings reported in Chapter 5, Deppoliti (2008) identified the negotiation of the nurse with a stressful, conflictual and disempowering workplace environment as impacting upon identity formation for novice nurses.

In her grounded theory study, MacIntosh (2003) likewise studied the identity formation of over 20 nurses across a similar career lifespan to that of this study. As with this study, learning was central to how nurses reworked their identity over a career span. Additionally, workplace learning, work based socialisation and feedback from and to others within the workplace were pivotal as nurses entered,

established themselves and then constructed a clinical reputation. An emerging understanding from both these findings and those from this study is that the identity journeys undertaken by nurses are ongoing in nature, as well as being highly complex. Arguably, the rules and processes influencing these journeys are unspoken and variable, dependent upon the nature of the environment and influential individuals. Consequently, nurses seeking to establish their professional identities successfully can be seen as requiring an intuition toward the expectations of others, as well as possessing capabilities such as flexibility and resilience to negotiate the journey successfully.

RP24 quoted below articulates how workplace learning and identity formation transcend the attainment of policy driven clinical capabilities or academic learning outcomes alone. As with the studies by Deppoliti (2008) and MacIntosh (2003), as well as those cited in Chapter 5 such as those by Lewis and Urmston (2000), this study highlights the workplace as being challenging on both personal and professional levels:

> (RP24) Right, I think what's really contributed towards it [professional identity] hasn't mainly been positive things; I think there have been a lot of negative things that have happened, a lot of traumatic experiences really, where it's caused pain. But coming through that has made me who I am because it really has made me look at my – look at me and go right into me and ask, "Who are you, what am I doing, what do I do well, what I don't do so well?". Our journey and the traumatic things we go through in life are quite different, but actually for me it has added to

> who I am and what I bring with me to my practice at all levels and when I say at all levels, I mean, when I'm engaging with patients, carers and managers.

What is also communicated through the words of RP24 is the mix of the personal and the professional self within MHN identity, a mix reported in Chapter 6 as well as by authors such as Jackson and Stevenson (2000) and Barker (2000). The findings constructed in this study highlight the workplace as the site of this important and often highly personal facet of professional identity formation. What is also evident from RP24 above is the breadth of EI capabilities being stimulated, deployed and developed within the workplace setting, reinforcing EI as being inherent to MHN identity. Other participants such as RP7 and RP18 spoke of gaining confidence through their workplace experiences, which in turn was positive in other aspects of their lives.

A sub theme within this theme of identity journeys through work based experiences was that of role modelling. This central role of experienced staff impacting upon nurse identity formation has also been identified in other studies such as those by Dutoit (1995), Fagerberg and Kihlgren (2001) and Gregg and Magilvy (2001). Of interest from these studies is that such bonding to the profession through role modelling transcended pedagogical approaches, culture and nationality, as well as other demographic indicators. While it must be stressed that these studies, as with this research, found that factors such as a service user focus also played a vital role

in professional identity formation, role modelling within work based environments was a prominent factor.

In this study participants articulated that the way in which experienced staffs conducted themselves acted as a major learning influence upon the formation of their own professional behaviours, values and attitudes. Such a finding embeds the importance of work based learning into any MHN education and training. RP14 and RP16 articulate not only the importance of role modelling by mentors, but also that both negative and positive role models promoted constructive professional identity formation:

> (RP14) I don't know – I think the way student nurses are shaped in the practice setting is very much down to the mentor that they get. So, if people were in an environment where everybody was encouraging and valuing everybody's contribution and sharing the skills, then you would get practice at such a higher level, and if people were more adaptable and willing to try out different things then, yeah, it would be such a fantastic place to work in.

> (RP16) I've seen through my training really good mental health nurses and I've [seen] some really bad ones and the good ones obviously stick in your mind, as do the bad, but the good ones because they were really, really good. They have the ability to speak to people on their level and if that meant, you know, taking their tie off and rolling up their sleeves to engage with somebody then, so be it, and it was the really bad ones that

came to work immaculately dressed every day and/or wouldn't ever deviate from the straight and narrow.

The value attached by the participants quoted above to learning within workplace settings was expanded upon by RP17 and RP13 within the context of preparing for roles in talk based therapies:

(Researcher) What would you say would be the stand out or the major contributors in this preparation for you to be someone engaged in talk based therapies?

(RP17) In some way I think it's not the college degree, you know, which I really enjoyed, and I learnt a heck of a lot from that. I think that it has actually been my nursing career rather than the psychology degree itself that has been the most, because I did my first two years as a qualified nurse and I learnt a lot more about people.

(RP13) Well, I think it's entirely up to tacit knowledge, knowledge gained on the job and that dimension of knowing somebody within a different frame of reference. Let me just make myself more clear: it's about intuition, it's about knowing the client and it's about knowledge gained through just by being with that particular patient, tacit knowledge, stuff that you've learnt on the job. The term I use is "enhanced empathy" because you've done it and because you've engaged and then you can … start to prejudge, pre-empt and start to develop ideas of ways of working because you've got a feeling and knowledge that's not

necessarily in textbooks, because you've worked for all those years within a particular field.

When viewed in the context of the Department of Health (2008) policy preparations for delivering increased talk based therapies into clinical practice, a divide is apparent. While policy seeks preparation in a restricted number of higher education institutes and therapy approaches, participants in this study attributed value to learning that arose from clinical practice, an arena shown in Chapter 5 to be partially characterised by uncertainty. Saunders (2006), in an extensive review of literature, theory and studies related to connections among education, learning and work, echoed such dissonance. Indeed, Saunders (2006) identified that group and individual identity formation will be increasingly influenced through learning outside formal institutions. The need for a successful fusion of formal and work based learning for MHNs is highlighted in a study by Buus (2008), where ward based knowledge and identity generation were shown to perpetuate unhelpful and poor quality clinical communication and consequently learning.

RP17 offered clinical supervision as a process that can help in the transition to assuming increased roles in talk based therapies:

(Researcher) So this would be a fairly big cultural shift in your experience – that nursing would have to undertake the shift to have been more engaged in talk based therapies?

(RP17) Yeah, I would say so, be opened up to supervision and not just lip service. I think you know a commitment on behalf of senior staff to

supervise and commitment on behalf of the trainee and the nurses that need to be trained up to do that too. I think it's new territory for a lot of people.

RP17 highlighted that this transition requires committed talk based relationships between clinical and senior staffs, echoing the underpinnings of the social constructionist theory of Gergen (1999, p. 116) that prioritises the expression of relationship to enable the creation of new conversations, words and actions, and hence new possibilities. Also echoed is the concept of endogenic educational approaches with learner centred orientations to critical reflection (Gergen, 2001, p. 117). However as previously noted, a tension potentially exists between these endogenic approaches and the direction of policy. Such potential tension may impact upon the identity journeys of MHNs as they engage with talk based therapy learning through establishing exogenic educational rules and processes that may excessively minimise more learner centred learning approaches.

8.5 Identity journey theme: Formal pathways

2. Identity journeys through non-work based education and training

(RP8) The big thing about CPN training was not only did it equip you with psychological techniques that you could use, but it also enabled you to understand the world in which your patients lived, and the world in which you lived, and what you needed to do in order to transact politically.

While constructions from the participants' dialogue showed the highest priority for identity formation and learning being through work based experiences, there was also a palpable construction of identity journeys through non-work based education and training. For many of the participants, their engagement with formal education and training advanced their clinical practice beyond what informal work based experiences could provide. Indeed, for many participants it was this type of learning that was most transformational, in the sense of expanding their practice and impacting positively upon their sense of self-worth and confidence. Additionally, for many of the participants formal education and training culminated in a strengthened sense of professional worth. RP8 quoted above articulated gaining a range of new understandings from a formal course. Reflective of the user focus theme that partially constructed MHN identity discussed in Chapter 6, RP8 also linked MHN learning with improved capacity to respond to service users' diverse needs.

MacIntosh (2003), who studied the identity formation of nurses across a similar career lifespan to this study, also found that formal education and training influenced identity formation. This influence of formal education and training has also been noted in other studies such as those by Crawford *et al*. (2008) and Deppoliti (2008), as well as Gregg and Magilvy (2001).

Of central interest to this study is the impact of non-work based education and training on delivering talk based therapies. While Cameron and Kapur (2005) found that the MHNs who undertook training in talk based therapies were less prone to

stress, other authors such as Bradshaw, Butterworth and Mairs (2007) and Stickley (2002) have identified that the quality of such training has been at least partially problematic. Additionally, the Department of Health (2007, 2008) and Skills for Health (2008) echo this concern, consequently advocating training that is contained and controlled in terms of content and delivery sites.

RP18 highlighted that only through levels of training such as that advocated by these policies could the registration body, the BACP, accept MHNs as talk based therapists:

> (RP18) … they've changed the structure of the course, so basically they will allow more nurses; you can just do the first couple of modules. You don't have to do postgraduate qualifications …., but then you have got to question what level of psychological therapy is being delivered at that level, because – you know, it's quite difficult to become registered with the BACP. You've got to show your standard of practice, your reflection, your supervision and what you can do and it requires quite a lot.

Interestingly RP18 articulated the tensions among the BACP standards of entry into their professional register, the ambitions of policy and the need for more nurses to gain capabilities in talk based therapies. RP18 described how a talk based therapy course was shortened to enable more staffs to be trained, but at a level where these staffs fell short of BACP standards. These tension points can be best understood in relation to the question, "When is training for talk based therapy

roles enough to respond to service users' needs effectively?" RP23 offers an alternative view to that of RP18:

> (RP23) I think it [a training course in CBT therapies] allowed my practice to become more structured, and what I've found is I'll work and do a much, much fuller assessment than I ever did before. You know what nurses are like and your care plans …., and I think it was almost like the assessment that you had to get it over with as quickly as possible. Whereas actually if you look at how psychology works, they actually take a lot of time to do an assessment.

Reflective of findings from Crawford *et al*. (2008), and of identity findings from Chapter 6 of this study, RP23 articulated how her or his professional behaviour was altered and indeed improved through formal learning gleaned from another profession, even where this fell short of BACP entry standards. Many other participants also spoke of the positive impact that formal education or training had upon their practice. These positive impacts were reflective of both the findings on EI reported in Chapter 7 and the theme of positioning of the self within MHN identity reported in Chapter 6:

> (Researcher) You've spoken about self-awareness; you've spoken about adaptability as part of your job. What has contributed to that development in yourself?
>
> (RP19) I think some of that was because I did the CPN course, and I think that kind of focuses you in a different way of doing things because you aren't in a hospital setting – you know, you don't have control.

(RP3) So you know there seems to be evidence that qualified staff can improve their performance, can get their interest back, get to start to demonstrate interest again, start to work upon the areas that need working on just by providing information on emotional intelligence; just talking about emotional intelligence seemed to make a difference, you know.

Both RP19 and RP3 connected either education or training to EI capability development, as did many other participants. Given the thematic resonance that EI has with MHN identity, this impact by formal education and training is noteworthy. While RP3 referred directly to EI, other participants spoke of EI development as a by-product from education and training focused upon other topics or areas of development. The importance of formal education and training in preparing MHNs to assume roles in talk based therapies is consequently strengthened, particularly with EI having been established in Chapter 7 as being central to both MHN identity and delivering effective talk based therapy.

In an interesting contrast to the theme of identity journeys through work based experiences, RP20 highlighted that being away from such settings promotes reflection and the possibility of future change:

(Researcher) Has anything in particular helped to develop those insights [self-awareness and adaptability]?

(RP20) Well, training, the opportunity to have time out and to focus on developing through attending training and, yeah, and the time that goes along with that …. In nursing we need to do, we need to do, we need to do and we don't always often get the opportunity to sit back and think about "Why are we doing this?"

Such a focus upon completing the tasks of nursing at the cost of reflecting upon those tasks has been previously reported by other authors such as Clifton (2002), Lynch and Happell (2008) and Mullarkey and Playle (2001).

8.6 Identity journey theme: Names

3. Titles and new roles

(RP1) What the hell, you [MHNs] think you're psychiatrists and you [MHNs] think you're psychologists now, and so there might actually be ambivalence in there.

This third theme of identity journeys closely reflects the central pillars of identity theory discussed in Chapter 3. As proposed by Giddens (1997, pp. 582-583), one of the most important markers of an individual's identity is her or his name, with naming also being centrally important to group identity. Eisenberg (2001) identifies the social arena as being central to the construction, dismantling and reconstruction of identity, highlighting the importance of individuals' lived experiences to their identity constructions. This theme is also closely connected to the final theme of exit journeys, but is constructed separately as the focus here is upon staying within mental health nursing rather than leaving it. However, RP1

quoted above reminds us that the opaque identities historically associated with MHN roles can generate ambivalence and confusion as to what mental health nursing identity is.

This ambivalence is echoed by RP17, who is both a MHN and a CBT trained therapist and who offers some possible insights into future identity journeys for many MHNs:

> (Researcher) Would you identify yourself as being a nurse or a therapist or a hybrid?
>
> (RP17) I knew you were going to ask that. That's really difficult because I'm not really too sure about that at the moment, because my title here is CBT therapist. I'm not a nurse therapist; I'm a CBT therapist … and in some way I know I'm still a registered mental health nurse.

RP16 offered an insight into the internal divisions and hierarchies of worth that exist within the mental health nursing profession:

> (RP16) When I was training I referred to myself as a nurse and when … I got the job, now I refer to myself as a CPN, so I'm definitely a Community Psychiatric Nurse. It is almost like I want to distance myself to the other side [the inpatient side] and just right this second I've realised I've done that.

RP16 associated a specialist community title rather than a generic MHN title with better nursing practice and career advancement. This reflects findings by Stark *et*

al. (2002), who identified competition within and among professions, and by Callan *et al*. (2007), who found that people preferred identification with smaller groups to gain distinctiveness. RP16 also reflects the repercussions of the MHN lifeworld characteristics of perceived low worth and powerlessness. As nursing is perceived as being of lower worth than that of other professions, internal positioning for worth and power is consequently conducted within the profession.

RP8 also voiced the need for a title that gives understanding and hence worth as well as purpose to the roles assumed by MHNs:

> (RP8) I would love to see pride coming back to calling themselves psychiatric nurses and absolutely I think we need to bring the word "psychiatric" back. A community mental health nurse – what does that mean; what the hell does that mean? It doesn't say to me what I did with my life at all. If you see it as somebody as a community psychiatric nurse, they know what that means, and there is a difference, there is a difference.

RP8 passionately spoke of the difference between psychiatric and mental health, with the latter referring to working with people experiencing any mental health issues and the former to working with those with severe mental illness. This was again reflective of Giddens (1997, pp. 582-583), as well as of Stronach *et al.* (2002), who reported MHNs as describing hollowed out and meaningless roles. Here RP8 associated the job title with purpose and meaning, consequently suggesting worth.

However, RP13 offered a counter view that negated the importance of naming, focusing instead upon what the MHN is capable of:

> (RP13) We have now been given the opportunity to develop and grow as a profession. I do see the introduction of talk based therapies and psychology therapies as part of mental health nursing. It's just now the opportunity where we can take that extended role on. But you know, when's a nurse not a nurse; where's the cutoff point? I think we are very much seeing mental health nurses taking on doctors' roles, psychologists' roles and what have you. What we are actually talking about is not development of the role, but development of the person's skills.

RP13 encapsulated the central identity themes constructed and reported upon in Chapter 6. Through focusing upon generic specialism and adopting a user focus, RP13 communicated a highly inclusive view of MHN identity that is built upon MHNs having the skills to respond to users' needs. This focus upon identity as being capability based as opposed to being title based highlights the uncertain identity journey for MHNs in the UK. The findings from this study and those just discussed show minimal agreement about a unified identity title for MHNs. Indeed, existing identity labels based upon perceived worth and roles undertaken may merely highlight internal divisions within the profession rather than offer a greater understanding of what mental health nursing is.

As new roles such as talk based therapies enter mental health nursing, the rules and processes influencing identity formation may well be complicated further, consequently increasing the potential for additional fracturing of MHN professional identity. Given that the profession has survived, and arguably even evolved, over many years without widespread internal agreement on a professional title, such fracturing may not be 'fatal'. However, when considering the pressures from the wider nursing profession for increasing generic working (Nursing Midwifery Council, 2007), and from the psychology profession to influence MHN engagement in talk based therapies (Department of Health, 2008), having weak internal MHN identity titles offers potential risk of eroding the profession.

8.7 Identity journey theme: Bringing the personal

4. Beginning journeys

> (RP13) I think there is a certain type of person that is attracted to mental health nursing: somebody who … has empathy …, somebody that people can get on with and find they can open up to. I think what nurse training does is then enhance that, and I think what psychological therapies does is enhance it further and it is for the benefit of the nurse and the patient.

The fourth theme constructed from the participants' discourse in response to the question of how participant identities were developed is that of beginning journeys. Participants articulated that they brought capabilities with them as they entered the profession, capabilities developed from personal life experiences. This theme reflects the understanding of identity as being multiple (Giddens, 1997, pp. 582-

583), as being generated through engagement with human communities (Gergen, 1999, pp. 47-49) and as being a social task (Goffman, as cited in Gergen, 1999, p. 77).

As articulated by RP13 above, this theme also relates to the positioning of the self theme, identified in Chapter 6 as being central to MHN identity. Participants spoke of bringing their personhood into being MHNs, a finding reflective of larger studies that identified the use of self as being crucial to mental health nursing (Barker, 2000; Edwards et al., 2000; Jackson & Stevenson, 2000). RP13 also linked the development of EI capabilities and the development of the person through engaging with formal training as a MHN, a development enhanced even further through undergoing training in talk based therapies.

RP14 reinforced how personal life journeys developed EI capabilities central to MHN identity, capabilities used as an integral part of their professional practice:

> (Researcher) From your experiences, what sorts of experiences have mostly developed your emotional intelligence?
>
> (RP14) Just life; I think I'm quite good on self-awareness because of life experiences.
>
> (Researcher) Right, so not just work experiences?
>
> (RP14) I think I was already pretty self-aware before coming into nursing, and coming from different working environments you bring different knowledge and skills that again the NHS do not acknowledge or

recognise, so it's very frustrating, especially coming from the background that I do that the NHS is 20 years behind.

(RP12) I think the very good people have a willingness to be reflective; they have got some idea of who they are, and are well grounded. They can manage themselves in these situations [working with the seriously mentally ill] and carry the stress without having to feel responsible for other people, but still care. So I think that's what good people have, and I'm not sure of how much of that can be learnt.

RP14 not only established the importance of life experiences in developing relevant MHN capabilities, but also reflected the findings of MHN powerlessness reported in Chapter 5. Arguably the value assigned by the NHS to the capabilities, skills and knowledge that are internally generated reflects the social constructionist view that power is central to the construction of what is best, good or required (Gergen, 1999, pp. 47-49). Viewed in the context of preparing MHNs for talk based therapies, it appears important also to acknowledge and integrate capabilities gleaned from outside clinical practice or policy formation into education and training, rather than negate them.

RP12, who articulated the complexities of working with challenging client groups, as well as the development of that capability from outside formal learning, reinforced that valuing these capabilities is vital. RP15 encapsulated how capabilities are

developed through journeys prior to nursing that are then enhanced within the profession through a mixture of formal learning and work experience:

> (RP15) I think some of them, you just have them, it is the way you are, but some come from learning. I think you learn things like leadership …. you would learn that from people. I think life experience, adaptability and self-control and all that from experience.

Indeed, RP15 highlights not only the process of capability development, but also that of the MHN identity journey. These pre-existing journeys and social encounters lead the person to enter the MHN profession with some expectation of feeling able or at least wanting to influence positively those experiencing mental health challenges. These highly individual journeys and experiences may well be the basis of the lack of consensus toward a homogeneous MHN identity and professional titles, a basis that is maintained over time through MHN roles requiring the partial use of the personal self.

8.8 Identity journey theme: Leaving

5. Exit Journeys

> (RP2) Everybody likes to think of themselves as a therapist; I don't want to think of myself as a therapist. I think nursing and therapy are two separate things and ought to be.
>
> (Researcher) Can nurses be therapists?
>
> (RP2) I think if you give up your title of nurse you can be a therapist.

The final theme arising from the constructions of participants' discourse in response to research question three was that of journeys taking them out of the MHN profession. This finding mirrors that of Crawford *et al*. (2008), who also found that community MHNs used professional development as an exit strategy from the profession. However, as was stated by RP2 above, participants in this study also expressed a belief that nursing and therapy are mutually incompatible.

While a minority of participants made this distinction, there existed a palpable undercurrent that the generic specialist characteristic of mental health nursing is incongruent with specialising in talk based therapy:

> (RP17) I was offered either to go into the community mental health team or come up here and do CBT, and I came here and did CBT. It's been – it's been really good actually because I think having done the diploma [CBT] my interest always lay in those sort of specific – you know, doing sort of this kind of psychological work, rather than being a more kind of generic based nurse role.

RP17 articulates a tension point between the genericism associated with mental health nursing and the specialism inherent within talk based therapies generally and CBT in particular. Such positioning raises the question of to what depth MHNs can assume therapy roles while still maintaining not only a MHN identity, but also the multiple other roles that they undertake. While of importance to MHN professional identity, this also appears vital to the success of the government policy

critically examined in Chapter 2 (Department of Health, 2007, 2008). More talk based therapists are needed and, as was discussed in Chapter 2 and Chapter 3, there will be fewer MHNs to maintain current roles, yet alone assuming new ones that may result in MHNs exiting the profession. Training MHNs in talk based therapies that help only service users with basic psychological issues would offer some chance of addressing this tension point. However, as discussed in the previous theme, this would negate BACP recognition and raise doubts about expertise. Some participants sought to overcome these tensions between their generic MHN roles and identity and their talk based therapy roles through having set days as a MHN, and others as a therapist. This assumption of multiple identities appeared to have raised confusion for both other staffs and service users.

Critical examination of the "Improving Access to Psychological Therapies Implementation Plans: National Guidelines for Regional Delivery" policy (Department of Health, 2008) suggests that the strategy of training MHNs to basic levels is being pursued. Whilst the tension points within service delivery would potentially be minimised, such an approach constructs MHNs as second class therapists and maintains the traditionally unbalanced power relationships. Additionally, those MHNs who expanded their training in therapies would be assimilated into the psychology profession:

> (Researcher) You obviously did training in CBT.
>
> (RP22) Yeah, my experience has been to kind of almost to metamorphose into something that isn't a MHN.

> (RP4) One is a family therapist and one is child and family [therapist] and they chose – they say they are not nurses but they so happen to be nurses .... They don't see themselves as nurses. They are not on a nurse's pay scale; they are not on a nursing hierarchy; they are not even on a medical hierarchy; they are in psychology.

As discussed in Chapter 5, the findings from this study cannot be viewed in isolation from the MHN lifeworld. In relation to this theme of exiting the profession, many participants identified talk based therapies as a means of escaping this lifeworld, which was characterised by uncertainties, powerlessness and perceived low worth:

> (RP8) They're leaving the profession and they are aligning themselves elsewhere. Almost as if they … at some subconscious level have hit at an idea that they need to latch onto a different profession because this one is going**,** and the others [professions] have got more clout, don't they? We need to bring some of that back, and we need to make psychiatric nurses proud of being psychiatric nurses, and we need to enable them to be assertive again and we are not doing that at the moment.

RP8 spoke not only of the shift by MHNs trained in CBT to leave the nursing profession owing to its comparative powerlessness, but also of the MHN leaders having failed to make the MHN profession appealing. RP12 reiterates such failings by MHN leaders, as well as the influence that more powerful professions can exert upon MHNs, with the consequence of them leaving the profession:

(RP12) You've outgrown yourself and the position you are in ... but boundaries are applied for all sorts of reasons. You know, historical reasons about traditional roles and empire building reasons; you know, if someone's got six wards and two day hospitals under their control they don't want somebody who is working across boundaries and being very, very capable within that because it might upset staff. Psychiatrists, senior nurses, people who have in some ways missed the boat, and maybe got to senior positions and become quite drained and burnt out, and it's hard for them to see other people eclipsing them.

8.9 Chapter summary

This chapter has presented thematic constructions in response to the question of what journeys through structures of social rules and processes MHNs undertook to reach their current identities, both personally and professionally. These identity journeys were constructed narratively, with the participants' identity stories being immersed with those of significant others and social organisations, reflecting the social constructionist identity theory of meaning being generated through language and text embedded within human communities (Gergen, 1999, pp. 47-49). Identity construction through relational moments and negotiation with both themselves and others was also evident from the discourses of the participants. The identity journeys were in essence an individual's subjective autobiography with historical and contemporary identity views, but also with future identity orientations that encapsulate the temporal aspects of identity theory (Howard, 2006).

What has been offered in this chapter is that the journeys undertaken by the participants have reflected the MHN identity themes discussed in Chapter 6, thereby reinforcing both sets of findings. The identity journeys have encompassed both personal and professional arenas, reflecting the core MHN identity theme of 'the positioning of the self', as well as findings from previous studies such as those by Barker (2000) and Edwards (2000) that also highlighted this mix of the personal and the professional within mental health nursing. Additionally, the application of identities gleaned from before entering the profession to current nursing roles reflects the identity theme presented in Chapter 6 of the MHN having everyday attitudes.

The development of EI capabilities prior to entering the MHN profession was also noteworthy, especially as these capabilities were refined and therapeutically applied once becoming a MHN. Such crossover of findings with those reported in Chapter 7 that relate to EI adds strength to both sets of findings. The finding that EI has been enhanced through MHN identity performances offers a noteworthy insight into the possibilities for education and training for roles in talk based therapies. With findings from Chapter 7 establishing EI capabilities as being essential for delivering talk based therapies, the impact of both work based and formal learning on their enhancement indicates that a blended approach to preparing MHNs for these new roles is worthy of consideration.

The generic underpinnings of MHN identity analysed in Chapter 6 that are reflective of other studies such as those by Edwards *et al.* (2001) and Crawford *et al.* (2008)

have also been made apparent. These generic underpinnings have been shown as representing a tension point in the construction of MHN identity. The journey of MHN identity construction at the interface with talk based therapies has been clarified as a mediated process, both in relation to other MHNs and with the constructions of policy that seek to maintain traditional power relationships. With identity construction being situated within social contexts, the impact of managers and policy upon MHN identity can be shown as being highly influential (Altheide, 2000). While small in number, participants within managerial roles appeared to view MHNs who assumed new capabilities in talk based therapies as simply being more skilled within their current organisational positioning. With generic capabilities attracting less worth than specialisation, MHNs who undertook such training would receive no additional expressed organisational worth or advancement without leaving their current posts.

Also influential are the constructions of MHNs in relation to the integration of, or the divisions between, talk based therapies and mental health nursing. While both Department of Health (2008) and National Education Scotland (2008) policy directions indicate a CBT dominated MHN preparation for talk based therapies, constructions from participants' responses suggested that such specialisation heralds exiting the profession. Indeed participants with formal therapy qualifications constitured the highest number of exit journeys from the profession. Conversely, counselling based approaches and psycho-social interventions, both of which offer more generalist approaches to talk based therapies, were seen as being not only inclusive of mental health nursing, but also progressive for the mental

health nursing profession. Given that BACP support can be found for the worth of such approaches (Andrews, 2008), the stance across the UK toward supporting CBT dominated education and training can be put forward as requiring revisiting to allow genuine co-constructions by all stakeholders.

Perhaps the most noteworthy finding in response to this third and final research question was the central role of education and training, both work based and formal, in constructing MHN identity. Work based learning has historically been the bedrock of MHN education and training (Raelin, 2007) and is immersed in the unpredictability of clinical practice where it also needs to be applied. However, as articulated above, MHNs with therapy qualifications had a comparatively high number of exit journeys from the profession. Paradoxically, this grouping of MHN needs to be expanded and then maintained so as to allow for a large, stable pool of positive, skilled and qualified work based role models.

The role of the service user in aiding this learning and identity forming process also reinforced 'the service user focus' MHN identity theme discussed in Chapter 6, as well as highlighting the relationship between service user and MHN as being mutually beneficial. In conjunction with the therapy qualified MHNs, the service users represent a powerful learning resource based on the heutagogic work based learning environment in which MHNs flourish. Such roles for both therapy qualified MHNs and users offer opportunities for enhancing their own perceived worth and empowerment through making positive contributions to themselves and the development of others.

While work based identity journeys appeared more significant, with role models being a notable identity influence, formal education was also described by most participants as highly influential and potentially more transformational than work based learning. As such, the policies driving the strategic implementation of MHNs assuming talk based therapy roles are partially reflective of the journeys MHNs take in developing their identity performances, in that they prioritise formal education mechanisms. Clearly, negotiation is required for this exclusively formal approach toward preparing MHNs to assume talk based therapy roles to shift. However, as managerialism becomes increasingly influential there appears little hope of such negotiations occurring.

This would represent a lost opportunity to build upon the shared ground that EI constructions have generated. With formal learning away from the workplace constructed as being important by participants and policy alike, a common direction for MHN preparation in talk based therapies is alluringly close. Policy generation and application would need to accept that a multiplicity of truths exist toward such preparations for future MHN identity generation to be a genuine co-construction. Interestingly, academic participants were the only grouping apparently comfortable with such an inclusive approach to education and training.

Chapter 9, the final chapter of this study, presents a synthesis and fusion of the analysis of findings discussed over the last three chapters. This synthesis is then

applied to the future challenges facing MHNs as they engage with preparing for talk based therapies. Finally, a reflective account of the conceptual, methodological and personal learning gleaned from the process of undertaking this study is offered.

CHAPTER 9 REMINDERS OF AND REFLECTIONS ON MHN IDENTITY

> (RP5) Shaping identity for me in nursing has being around celebrating patients, people's successes. Yeah, but I think I'll be haunted by what nursing is until the day I die, particularly mental health nursing where there are certain aspects that we offer that other professional don't.

9.1 Chapter introduction

Chapter 9, the final chapter in this dissertation, initially covers the key issues and findings that have emerged from the review of literature, critical discussion of theory relevant to the study and results for each of the research questions. A coherent fusion of these issues and findings is then presented as a platform from which to offer discussions that respond to the overarching aim of the study. Contributions to knowledge and areas for future research are then discussed as a closure to the dissertation.

Through the presentation of this synthesis of findings and their potential for future research, the complex nature of MHN identity is made clearer. During the course of this study a spotlight has been directed toward MHNs, highlighting their unique contributions to the delivery of talk based therapies. Capabilities reflective of EI have also been shown to play a crucial role in how MHNs engage in their identity performances. These performances are a blend of personal and professional identities, and have been shown to be influenced by personal experiences, work based learning and formal training. With MHNs being comparatively new to

delivering talk based therapies the findings that have been reported in this study potentially offer an important contribution to preparation for those roles.

9.2 Summary of findings: Questions and answers

The aims and aspirations of this study were to commence a MHN discipline specific response to some of the challenges of assuming expanding roles in talk based therapies. In doing so, the study sought to uncover understandings of the impact of these expanding roles on MHN professional identity. Consequently I posed the research question of:

- What, if any, are the perceived unique qualities, abilities and behaviours of MHNs engaged in the delivery of psychological therapies in the United Kingdom?

This study also sought to understand whether EI played a part in MHN identity performances, and if so how this part of MHN identity was enriched. Accordingly the following questions were posed:

- What, if any, are the thematic resonances of MHN experiences with the construct of Emotional Intelligence?

- What journeys through structures of social rules and processes did MHNs undertake to reach their current identities, both personally and professionally?

The key area of investigation within this study focused upon MHNs, not only within their workplace contexts, but also to incorporate the wider arena in which their

identities were performed. Consequently, as a response to the three questions this study placed value on discourse, inter- and intra-personal relating, and the social contexts in which these elements were enhanced or negated.

In Chapter 1 I introduced the contexts in which MHN identities were being continually constructed, deconstructed and performed. MHN identity was presented as being historically influenced by other, more influential professions such as medicine and psychology. Within contemporary settings MHN identity was shown still to be under these historical influences, as well as under the increasingly dominant influences of UK health policy (Hurley & Ramsay, 2008). Given the longstanding ambiguity of MHN professional identity markers, these influences were argued as having an amplified impact. Expanding MHN roles in the delivery of talk based therapies was shown as one such impact, and as such a focus for this study. These policies were presented as generative texts whose constructions of MHN identities have been culminating in rapidly expanding roles and expected capabilities. Chapter 1 also introduced the construct of EI as being woven into the fabric of these new roles and capabilities as well as traditional MHN identity, in the process alerting the reader to an important justification of this study.

The imperative for the voices of MHNs to be included in the construction of the profession's reactions to the challenges arising from new roles within talk based therapies was raised in response to their historically low influence in their own identity constructions. Indeed, the first research question, which sought MHN perceptions of their differences from other mental health professionals and other

nurses, shifted focus toward internal rather than external identity discourses. Through the key constructs of social constructionism being briefly outlined, the discourses of the participant MHNS were introduced as counternarratives to those of policy and other professions.

The review and critical analysis of both literature and relevant policy in Chapter 2 highlighted and reinforced the significant influence of recent UK health policy in generating future MHN identities. Globally, mental health nursing was shown to be experiencing profound pressures arising from diminishing entrants into the profession while simultaneously many were leaving, and professional roles expanding (Elsom et al., 2009; Forster Committee, 2005; Health Resources and Services Administration, 2002; Royal College of Nursing, 2005). The UK countries were shown as being among the few that offered specialist pre-qualification training in mental health nursing, but it was also seen that there was pressure to shift to generic training despite international evidence of poor outcomes for mental health nursing from such training (Wynaden et al., 2000).

Education and training for MHNs generally, and for talk based therapies in particular, were described as being dominated by repeated competency mapping exercises, and as being historically inadequate (Stickley, 2002). These educational challenges were shown to be exacerbated by in-patient settings having barriers to the successful delivery of talk based therapies by MHNs (Van Den Berg et al, 2004). Consequently, MHNs' engagement with talk based therapies was highlighted as being highly problematic and worthy of being the focus for this study.

Chapter 2 also presented the construct of EI, and the links between the underpinning theory of EI and key aspects of this study demonstrated a resonance among EI, mental health nursing and talk based therapies. The development of EI capabilities was shown through the work of Boyatzis (2002) and Cherniss *et al*. (1998) to be change that must be self driven toward that which a person is inspired to become. This imperative for enhancing EI within MHNs was clarified as a point of tension, with policies by the Scottish Executive (2006a) and the Department of Health (2006a) identifying what EI capabilities MHNs must develop. This point of tension was subsequently expanded by the findings of a critical review of recent UK health policies undertaken through the lens of social constructionism. What was exposed was a monological representation characterised by the privilege of those external to the mental health nursing profession. Fashioning a future for MHNs was identified as problematic, with the absence of a shared descriptive language and voice between MHNs and policy makers in relation to the future well-being of mental health nursing. MHN identities were presented as being opaque and poorly understood and as having been given little influential voice. However, this critical examination of relevant policy further highlighted and reinforced EI as being intrinsic to mental health nursing, and to MHNs assuming roles in talk based therapies, offering potential for a shared generation of future MHN identity.

In Chapter 3 the core theoretical components of this study were outlined and critically examined. Social constructionism was argued as being a highly congruent theoretical framework for the study through its evocation of the key themes of

relatedness and linguistic discourse (Berger & Luckmann, 1966, p. 13). Additionally, social constructionism applies power and influence to future meaning generation of truth and reality within social relationships, relevant to tension points between policy and MHN driven responses to roles in talk based therapies. Through seeking 'a' truth rather than an 'absolute' truth, social constructionism was shown as offering opportunities for multiple discourses in relation to MHN identity (Gergen, 1999, pp. 47-49). Given that identity is in itself multiple and temporally bound, such multiplicities of constructionist understandings of MHN identities are required (Howard, 2006). Importantly, social constructionism incorporates considerations of power and influence in relation to discourses that influence the construction of future realities. Applying this understanding to findings from the literature review further justified the imperative for advancing MHN narratives about their future expanding roles.

The work of Foucault (1991a, p. 94) was used in Chapter 3 to highlight that MHN identity, as with all identity, cannot be argued as being fixed and permanent, but is rather in a state of constant becoming. These identity journeys were analysed as being both personal and professional and as being influenced through life experiences, education and training. Despite identity being made manifest as individual and fluid, it was also highlighted in Chapter 3 that the identity facades of homogeneous professional categories were dominant within health organisations. Consequently, the fractured and opaque MHN identity attracts poor understanding and hence value from those external to the profession (Barker & Buchanan-Barker, 2005).

In Chapter 4 I presented the research framework of social constructionism and the direct phenomenological research method employed in this study. The congruence among the research framework, the research method and the topic of investigation was also highlighted. All share an emphasis on the research participants' voices and social actions, which in turn generate greater understandings of MHN identities. Additionally, social constructionist views of knowledge generation can be argued as being reflective of the very purposes of mental health nursing and talk based therapies. All place value upon knowledge acquisition being focused on emergent qualities of interconnected people and applied to generate transformational truths (Gergen, 2001, p. 119). Also of significance to this study is that social constructionism incorporates the gritty lifeworld contexts in which current realities are enacted and future ones generated. Consequently, findings about the MHN lifeworld reported in Chapter 5, while not directly responding to a specific research question, were absolutely necessary to understand fully the findings arising from this study.

Chapter 5 commenced the data reporting section of this dissertation by offering constructions distilled from participants' discourses that described the environmental context in which MHN identity is partially forged and performed. Additionally, the MHN lifeworld articulated in Chapter 5 offered insights into the challenges facing both MHNs and health policy makers in establishing talk based therapies in clinical practice arenas. The MHN lifeworld was presented as being themed by low power and worth, obstacles to success and uncertainty, and as such

was an overarching consideration for all other findings from the study. While contributing to findings from authors such as Lewis and Urmiston (2000) and Barker (2001), the identification of EI as mitigation of power imbalances offers a potentially new understanding. This new understanding places the focus of addressing power imbalances upon the individual through being more self-aware and motivated to develop others. Additionally, unlike policy documents such as the Chief Nursing Officer's review of mental health nursing (Department of Health, 2006a), findings about power, worth and barriers to success highlighted in Chapter 5 identify both MHNs and managers as generating these problems, and hence as being responsible for addressing them.

While Barker (1996) had connected uncertainty with mental health nursing, this study has offered a deconstruction of uncertainty via the specific uncertainty theory areas of complexity, ambiguity and unpredictability and then applied these areas to mental health nursing (Sorrentnio et al., 2008). This deconstruction provides additional clarity about the responses to uncertainty. These possible responses have been highlighted as not necessarily having to be ones that seek to contain and vanquish uncertainty. Many participant MHNs spoke in Chapter 5 of identifying with uncertainty or at least of being comfortable in working with and within it. Conversely, the constructions of policy critically analysed in Chapter 2 suggested an intolerance of uncertainty with consequent attempts in increase control over MHN behaviours, values and attitudes, as well as the approaches to talk based therapies that they will be trained in. This fracture line between policy that seeks to generate certainty and the recipients of policy who dwell within and at times even thrive

upon uncertainty was presented in Chapter 5 as being an important tension point for the MHN profession to respond to.

Chapter 6 presented my analysis of the participants' discourses that offered the uniqueness of MHNs' contribution to talk based therapies as being a complex identity package of seven characteristics that no other discipline can offer. Findings contributed to new knowledge through focusing upon what MHNs bring to talk based therapies, consequently highlighting the innovative engagement by MHNs in delivering talk based therapies, as well as their transferable capabilities and applications of everyday attitudes. Additionally, while the breadth of MHN roles has been previously reported by others such as Edwards *et al*. (2001) and Crawford *et al*. (2008), the articulation of the stance of MHNs occupying a specialist status owing to their generic capabilities is an important contribution to current knowledge. While these co-constructions across categories of participants were evident, there were also variations on emphasis on MHN identity. This reinforces the imperative to strengthen representations to those external to the MHN profession that its identities are multiple, and at times even individual, while remaining unified in relation to meeting user needs.

In Chapter 7 I mapped the discourses of the research participants with regard to the construct of EI and in doing so offered a fresh means through which to understand MHN identity. A relationship among mental health nursing, MHN identity and EI was made evident through connecting EI not only to the capabilities, values and words expressed by the participants, but also to those of the recent health policies

discussed in Chapter 2 (Department of Health, 2006a; Scottish Executive, 2006a). However, it was made apparent in Chapter 7 that other policies such as "*Improving access to psychological therapies implementation plan: National guidelines for regional delivery"* (Department of Health, 2008) and "*Consultation on the development of national occupational standards for psychological therapies"* (Skills for Health, 2007) relegate EI capabilities to the status of a secondary consideration in favour of establishing structures and strategies to accommodate regulated training. In other words, the supposed certainties of CBT therapies and managed education have been privileged over EI representing something individual, and hence less predictable and certain. Despite this emphasis upon controlling clinical performances – itself a theme shown to thread throughout the entirety of this and similar studies (Stronach et al., 2002) – EI was demonstrated in Chapter 7 as representing an important unifying position for all mental health service stakeholders.

Chapter 8 completed the data reporting for this dissertation and in doing so demonstrated that the journeys undertaken by MHNs to construct their professional identities are highly personal and multi-dimensional. Identity construction through relational moments and negotiations with both themselves and others was evident, and again showed EI as being central to MHN identity. Some participants spoke of how formal and work based education and training increased capabilities associated with EI. The identity journeys outlined in Chapter 8 reflected the identity themes from Chapter 6, reinforcing the relevance of both sets of findings. Perhaps most evident was the influence of both work based and formal

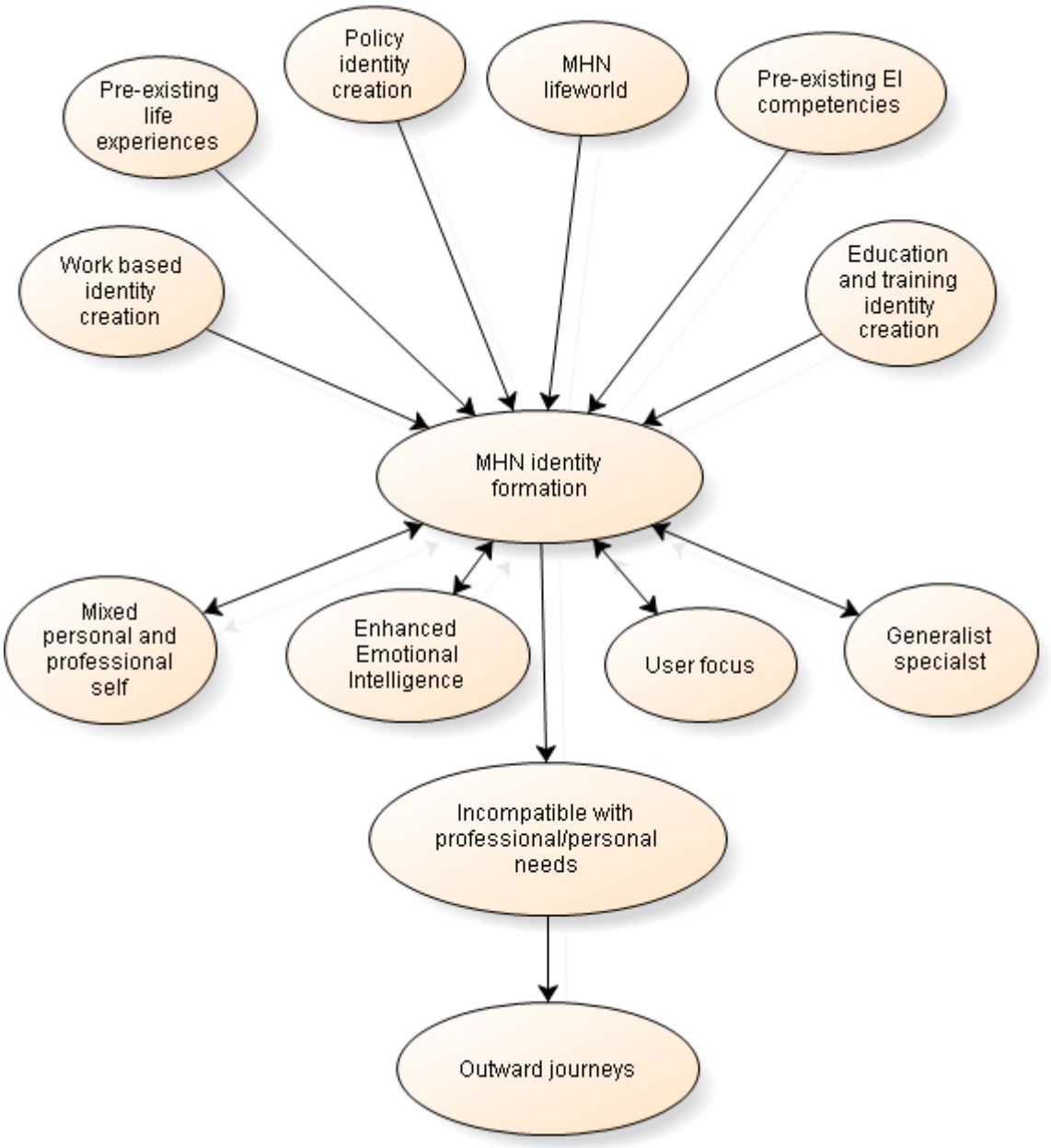
learning upon identity formations and performances. Exit journeys from the profession were most frequently undertaken by MHNs who held therapy qualifications, paradoxically the category of MHN most needed to offer the positive role modelling that MHNs learn from and within the workplace setting.

In summary, the first research question seeking unique MHN contributions to talk based therapies has been answered through showing these contributions as being a multi-faceted package of capabilities that other professions do not have. The second research question has also been answered with EI capabilities being shown as having resonance with the MHN participants. Finally, the third research question has been responded to through highlighting the influences of both work based training and formal education upon the identities that participants brought into the profession.

9.3 Fusions

There is worth in seeking to highlight resonances across the constructs of this study in order to move closer to an understanding of the essence of MHN identity. This essence is inclusive of the vital social contexts impacting upon MHN identity. Consequently, rather than seeking the end product of absolute reductionism as initially proposed by Edmund Husserl (1859-1938), this essence incorporates the ecological environment in which the study was conducted (McLeod, 2001 p. 39). Figure 9.1 below visually draws together the core underpinnings of MHN identity as they engage with talk based therapies, as identified in the study.

Figure 9.1: Core underpinnings of MHN identity



While some aspects of MHN identity have, as already stated, been highlighted in previous studies such as Edwards *et al*. (2001) and Crawford *et al*. (2008), Figure 9.1 offers a holistic overview not only of the identity features of MHNs, but also of the process of their ongoing identity formation. As is evident from the above figure, MHN identity is multi-faceted, and as identified by Howard (2006) is in constant movement. It is also apparent that MHN identity is subject to multiple influences

that shape the MHN on professional and personal levels and can result in the MHN leaving the profession. EI is prominent in underpinning MHN identity as well as new roles in talk based therapies. Additionally, learning, EI and MHN identity have been shown as being highly influential upon one another. Shifting from visual representations to written constructions of MHN identity offers a further opportunity to explore both points of harmony and tensions in relation to MHN identity.

Comparing the constructions by participants with those of policy emphasises this duality of harmony and tensions. Constructions from the participants' discourses suggest a truth of MHN identity as being:

> An emotionally intelligent, widely competent and flexible application of personal professionalism guided by user needs, and enacted within often unpredictable and disempowering work based contexts.

Conversely, a distillation of the stated capabilities, values and desired behaviours for MHNs articulated in the policy documents examined and presented in Chapter 2 culminates in another truth of MHN identity:

> Therapeutically targeted ethical use of a critically reflective self for the empowerment of diverse and disempowered others.

Debate about these differing truths highlights the worth of seeking whatever common ground may exist between the two positions. Each offers a truth and perhaps more importantly utilises language, text and relationships to convey meaning to different communities (Gergen, 2001, p. 15). Service users represent a

co-construction between the clinically dominated MHN research participants and the non-MHN dominated policy makers. Additionally, EI runs throughout each constructed truth of MHN identity. The development of others, MHN engagement with reflective self-awareness and the search for user benefice within non-maleficent frameworks also represent pivotal co-constructions.

These co-constructions must also be viewed within the context of points of tension. While the findings of this study about MHN identity can be described as a co-construction between researcher and participant within a social relationship, the constructions by policy hold little self-generation of professional identity (Gergen, 1999, p. 133). Additionally, the social relationship in which those policy constructions were generated can be argued as being characterised by disempowering social interactions and external ascription achieved through hegemonic relationships. The constructions of research participants' discourses that showed disempowerment and little perceived worth demonstrated the lines of demarcation exhibited by these MHN identity constructions.

Managerialist and positivist dominance show little appetite for sharing power; indeed, through occupying a dominant performance discourse position, increased power and control of MHNs' roles and professional behaviours can be argued as being sought (Department of Health, 2006a; Stronach et al., 2002). Contrasting the two MHN identity constructions within this study highlights that the points of difference rest with exactly those issues – issues of power and predictability.

When both the highly personalised view that participants held of their MHN identity and the distancing of MHNs by policy makers in reviewing the MHN profession are considered, a strong case can be made for MHN identity being constructed with partial mutual disregard. As the profession interfaces with role expansion inclusive of talk based therapy roles, this duality of identity offers challenging tension points. While policy advocated that MHNs embrace CBT taught through selected academic institutions, participants' discourses suggested preferences for generic approaches to talk based therapies, and work based learning enhanced through academic education (Department of Health, 2008). Additionally, while policy sought the placement of those trained in talk based therapies in therapy teams, participants' discourses suggested that MHN identity stops at the point of specialisation. While EI represented a co-construction of the future generation of MHN identity, any application of power risks shattering this shared position. Boyatzis (2002) and Cherniss *et al*. (1998) identify that EI enhancement must be self driven toward that which a person is inspired to become. Consequently, the EI capabilities sought through policy cannot be successfully implemented into mental health nursing without the MHNs being inspired to choose to adopt them. Building such inspiration may require engaging in discourses that alter balances between power and control with transformational leadership and learning approaches that in turn can be successfully applied to a challenging MHN lifeworld (Gergen, 2001, p. 119).

This mixture of shared and competing narratives that seek to influence both current and future identities of MHNs can be arguably best viewed through the theme of

uncertainty discussed in Chapter 5. Multiple and individual identities, and performances of those identities, are in tension with the governance needs of NHS policy. Conflict is subsequently enacted through moves to gain dominance within these identity negotiations. However, these negotiations are not so clearly marked as existing purely between policy and clinician, or MHN and non-MHN. What has been made apparent is that many of the constructionist narratives conducted by clinical and academic MHNs toward what mental health nursing is (and what it is not) effectively expel or bar other MHNs from membership of the profession. In short, the negotiations of MHN identity are expansive as well as potentially destructive from both within and without the profession.

9.4 Commencing the journey for MHN education and training for therapies

Within its limitations, this dissertation commenced with the stated aim to commence informing a MHN driven response to preparing MHNs for expanded roles in talk based therapies. The beginning of this journey for MHN education and training for roles in talk based therapies started with the first research question of the study.

Constructions from the research participants' discourses commenced this process by identifying EI capabilities, particularly those of personal recognition, as being central to MHN identity and for developing others. Despite variations on emphasis or focus toward different clusters of EI capabilities between categories of participants and policies, there was shared recognition of the need for them. This

shared imperative crossed models of care and approaches not only to incorporate the medical and recovery models, but also to capture the essence of the tidal model (Barker, 2000).

This study commenced the journey to MHN education and training for EI and therapies with a focus on enabling and enhancing the personal and hence the professional capabilities of the MHN. What has been argued is that, by making individual MHN enablement more prominent, nurses will be better equipped to meet the needs of their clients and organisations, as well as themselves (Hurley & Rankin, 2008). Participants in this study who continue to identify themselves as being MHNs have articulated that a melding of traditional mental health nursing skills with knowledge and skills from talk based therapies has been transformational for their clinical practice, and for their views of themselves. Additionally, MHNs have been shown as being transformational toward the therapies that they utilise, bringing in innovation and inclusiveness. This symbiotic relationship is one that calls for nurturing and should ideally not be used as another epistemological battleground between and within health professions. An emergent truth from this study is that a highly inclusive approach to education and training for these roles is required, one that commences with enabling the individual's EI capabilities, yet that also incorporates the structure and direction of a variety of talk based therapy approaches. It also emerged that this education and training should be conducted across formal education and work based training sites, with a powerful and stable pool of effective MHN role models being in place. However, these role models will also require support. As stated in Chapter 3 feelings of perceived job related

inadequacy can result in an imposter syndrome with the individual being constantly in fear of being 'found out' as posing as a competent teacher (Brookfield, 1995, pp. 228-235). In all likelihood this individual would seek to avoid the in-depth scrutiny associated with the clinical supervision and critical reflection needed to perform training roles with talk based therapies. Consequently, the very presence of the imposter syndrome needs addressing, possibly through experienced clinicians and educators sharing their own experiences with it. Further research is required to embed and advance the findings identified here.

9.5 Areas for future research

This section seeks to highlight the potential for future research that arose from the findings reported in this study. These potential areas include EI, uncertainty and MHN identity and are proposed with possible contexts such as learning communities in which they may be studied in the future.

Boyatzis (2002) and Cherniss *et al.* (1998) both establish that EI enhancement can be achieved through education and training, given certain approaches and pre-conditions. Some of these have congruence with the findings from this study. EI enhancement recognises the duality of personal and professional being and learning, the pivotal influence of role models and the importance of setting specific behavioural goals that are clear and challenging within workplace environments. Reinforcing the need for all categories of MHNs as well as policy makers to generate performative co-constructions, successful EI enhancement also requires generating

an organisational culture that is safe for experimentation with the new behaviours (Boyatzis, 2002; Cherniss et al., 1998).

Given the congruence with findings from this study, the central role that EI plays in delivering mental health nursing and talk based therapies and the paucity of nursing research into preparing MHNs in such a manner, further investigations appear well justified. Commencing such investigations under the framework of learning communities and through heutagogic learning approaches appears to be one potentially useful way forward. Heutagogy, a learner or self-determined approach to learning, acknowledges that people learn through random response to unpredictable needs, frequently when faced with the limits of their current knowledge or capabilities, reflective of the MHN lifeworld articulated in Chapter 5 (Hase & Kenyon, 1999).

Learning communities or communities of practice place a powerful emphasis on learning as a socially underpinned and practice based exercise that highlights learning as being inherent within human nature (Wenger, 1996). Pivotally, learning communities seek and acknowledge that learning develops and hence changes who the learner is, accurately reflecting important EI considerations and incorporating identity as being central to learning. Additionally, the workplace emphasis reflects the learning preferences of MHNS as constructed in this study. Learning communities also acknowledge boundaries, such as those that exist within MHN identity perceptions in relation to talk based therapies or boundaries between the makers of policy and clinical staffs.

Generating and then communicating additional understandings of uncertainty within a mental health context will be responding to a significant schism. Uncertainty and the responses to it have meandered through and at times exploded from the texts and discourses analysed in this study. As identified in Chapter 5, uncertainty is a key characteristic of the MHN lifeworld, and one that has been acknowledged in previous MHN studies such as those by Barker (1996) and Mitchell and Pilkington (2000). However, little research has been conducted to apply uncertainty theory to mental health nursing (Sorrentino et al., 2008). Clarification of the uncertainty orientations of MHNs, managers and policy makers, as well as the strategies that they employ to respond to uncertainty, may aid better communion among these groupings. Additionally, such understandings may impact upon minimising exit journeys from the MHN profession or even aid in recruitment. The impact of uncertainty orientations on the implementation of user care also warrants attention.

Further exploration of MHN uniqueness, particularly uniqueness which generates additional worth and empowerment, is required in light of their established hegemonic relationships and perceived low worth in comparison to other professions within mental health settings. Such exploration requires significantly more participants than this or other similar studies discussed in Chapter 6. This is particularly so given that this study focused on talk based therapies while other roles such as nurse prescribing and diagnosing are also rapidly growing.

Any possible relationship between increasing education and training and diminishing MHN utilisation of the self within therapeutic relationships deserves attention. When considered in combination with MHNs with therapy qualifications being the most likely to exit mental health nursing, further investigations into the prevalence of and the drivers behind such outcomes are required urgently.

Finally, while this study has placed a focus on resonances between EI and mental health nursing, similar resonances can be argued between EI and conducting qualitative research. The skills and capabilities required for each have a tremendous cross over owing to the intra- and inter-personal nature of this research orientation. Understanding the qualities of such resonances, as well as the possible means by which to enhance them, appears to be a worthwhile area for future research.

9.6 Contributions to knowledge

Empirically this study has also contributed new understandings of MHN identity. While I have in this chapter offered reductionist styled definitions of mental health nursing, I have also shown MHN identity to be personal and individual. The study has also contributed to identifying EI as an important area of co-construction for the, at times, disparate stakeholders within mental health service delivery. Raising the profile of EI within mental health nursing contexts makes a contribution to

striking a balance between generating an externally recognisable and homogeneous professional identity and acknowledging the multiplicity of such identities.

Publications that have been generated from this study have added to discussions that seek to address the marginalisation of MHN voices in constructing their own futures (Drummond, 2008; Hurley, Ramsay & Mears, 2008). In returning to the underpinnings of social constructionism it is exactly such generative discussions that contribute to the creation of new understandings and ways of knowing (Gergen, 1999, pp. 47-49). Additionally, my stance that the generic characteristics of MHN identity have the worth and value of specialism has also generated international interest (Hurley, 2009). Highlighting the contributions and consequently the worth of MHNs in relation to talk based therapies has also been an important contribution to knowledge, especially given that the focus of policy has been on their capability deficits (Department of Health, 2006a, 2008). Another key contribution to knowledge is that, through identifying that a blended approach to work based and formal learning has resonance with MHNs, alternative possible ways of delivering education and training to MHNs delivering talk based therapies in the UK have been articulated. Hopefully, through such educational approaches MHNs may feel more enabled to remain within the nursing profession whilst simultaneously assuming skills and capabilities within talk based therapies.

As identified in Chapter 2 and Chapter 4, the ultimate purpose of this study, that while focusing upon the MHN and EI, is that the service user receives valued health interventions. This study has highlighted in both the literature review and findings

that service users value emotionally intelligent MHNs, and that MHNs value being able to respond to a breadth of service user needs. This study contributes an understanding that service users will benefit from MHN delivered talk-based interventions where the nurses are EI enabled, and organisationally situated to be able to respond to the service users bio-psycho-social needs. Additionally, MHNs will have a clearer picture on how to integrate their talk-based therapy capabilities into an eclectic framework of nursing. This will promote MHN capacity to deliver recovery based interventions through talk-based therapies that are enabling of others (Davidson, 2005). Additionally, by offering findings underpinned by research that adds talk-based therapy capabilities to traditional generic understandings of MHN identity, individual nurses will potentially be more confident and effective in these roles. MHNs can consequently look toward the nursing profession as a place where they can enact their practice, rather than feel compelled to leave the profession. If nurse education and training providers can initiate an EI based preparation, a genuine improvement in the quality of MHN interventions is possible. Having more MHNs working within generic mental health settings who are not only willing to use talk-based interventions but, are also trained in them, will only benefit the service user.

In addressing knowledge related to conceptual issues, the most significant contribution is arguably the application of psychotherapy knowledge and skills to research. A resonance exists between existential psychotherapy concepts and phenomenological research. Both require self-initiated and sustained bracketing from habitual ways of thinking to allow for a full immersion in the experiences of

the existential environment (Idhe, 1977, as cited in Yontef, 1993). Rather than presuming a pre-existing understanding of phenomena, both respond to the basic question of "What is going on here?" As was shown in Figure 4.1, the research process is an empowerment mechanism for participants when bound by ethical conduct, as is the psychotherapy process. Additionally, both qualitative research and existential psychotherapy approaches also ask of the participant to look within themselves, in effect employing and then communicating self-awareness in the social presence of a non-judgemental other. In deploying micro-skills such as paraphrasing, reflection, summarising and challenging to encourage research participant discourse, I was simultaneously using the micro-skills of counselling. A majority of participants either stated or paraphrased the words "I only just realised that about myself now" while engaged in discourse specifically directed at the aims of this study. This suggests that a possible outcome of research participation is the potential for greater self-awareness.

The methodological contribution to knowledge that this study makes is to add to the growing body of qualitative research work undertaken through the use of NVivo software. Rather than being experienced as a barrier or filter to the data, the software has, based on my experiences, been a more efficient way of managing those data. I chose which text to engage with and which groupings of text were growing into themes. Additionally, it was I as the researcher who chose and discarded text as being irrelevant to the study. The capacity to produce quickly numerical matrix data such as those presented at the front of each data reporting chapter offers an additional depth to data reporting without distracting from the

participants' narratives. Additionally, these numerical counts can act as a defence against accusations of qualitative researchers projecting their own bias onto the data through offering a substantive quantitative source from which qualitative narrative themes were drawn.

9.7 Reflections: Revisiting my personal positioning

At the beginning of this study I explained mental health nursing and talk based therapies as being central to my personal position. Just as I am a professional with the identities of being a MHN, psychotherapist and educator, this study has reflected the mixture of personal and professional journeys articulated by many of the participants. This has been both an academic and an emotional journey whose destination, like many holiday destinations depicted in glossy brochures, has culminated in both contentment and disappointment.

Contentment has been generated through being struck by the high quality of professionalism, knowledge and attitudes of the participant MHNs. These intelligent and grounded individuals communicated profound insights and wisdom toward an uncertain professional arena. I was also struck by the ever present humour and resilience that were communicated in the interviews, despite the often troubling lifeworlds in which these nurses dwelt. I also experienced contentment through offering ways to view MHNs with greater worth and value through highlighting their expanse of skills and capabilities.

My increasing understanding of social constructionism and the powerful role of generative discourse, however, has left me with a pessimistic gaze on the future. Distance appears to exist between MHN strategic and policy leaders and those in clinical and academic fields. There appears to my mind little reason to hope that any negotiations will occur that will lead to genuine co-constructions, especially ones that reduce managerial controls and increase perceived uncertainties.

I commenced this study with a self doubt that has in truth never entirely gone away; indeed, knowledge acquisition is arguably one of the most humbling of experiences. I have found that through gaining new knowledge I have also found previously unknown and expansive areas of ignorance. Co-existing with this newly found ignorance is also a deeper understanding of identity, research orientations and my own profession. While all of these are important, gaining knowledge about the power and influence of words in generating truths has been highly significant in promoting my understanding of my own lifeworld contexts

9.8 Chapter summary

This chapter concludes by offering both an overview and a synthesis of findings, and by pointing to future directions of exploration for MHN identity as those MHNs engage with new roles. Arguably, this role expansion is unprecedented in the history of the profession, and as MHNs engage in increasingly complex roles their identities shift and the relevance of pre-existing understandings directed at mental health nursing are challenged.

MHNs cannot be the sole architects of their profession, given that it exists for the purpose of assisting service users and other professionals who are also focused upon improving the health and social well-being of service users and carers. Additionally, mental health nursing does not dwell in isolation from UK government policy commitments to and responsibilities for delivering effective health and social services to the general public. In short, there are many health and social care stakeholders who are affected by the roles of MHNs, and as such they must have a voice in contributing to the future directions of the profession as it shifts and evolves in response to need. However, this study has sought to provide an evidence based and structured contribution to such responses through focusing upon the MHN. In doing so the originally stated aims of the study have been met through positioning the voices of MHNs at the forefront rather than the background of constructing a future for their own profession. Now if only they are heard.

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APPENDICES

Appendix A: "Promoting Nurse Leadership for Patient Quality & Safety"

"Promoting Nurse Leadership for Patient Quality & Safety"

MHLDNDL FORUM

SPRING CONFERENCE

"Nursing Leadership in a Quality Led NHS."

Breakfast session—Supporting the Role of Assistant & Deputy Directors

Dr Ben Thomas – Vision for the future of mental health and learning disability nursing

Ian Hulatt – Political Influencing in today's NHS

Concurrent sessions include work streams- Infection Control, Safeguarding Children and Adults, Embedding Quality

Lis Jones—A personal reflection of Nursing Leadership

Debate - "Will Associate Mental Health Practitioners replace Mental Health Nurses"

Pre Conference Dinner
23rd April 2009
8pm onwards

£28 per person,
email forum.admin@kiosgroup.com
a menu and to book a place.

RCN Accreditation has been sought

Liverpool—Marriott City Centre
Pre-conference dinner 23/24 April 2009

Location Details

To book a room on the 23rd please contact the Marriott on 0870 400 7268. You will need to state the date and Mental Health Forum.

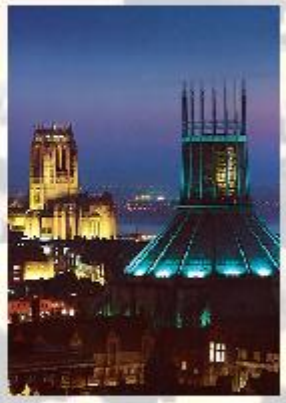
£91 B&B. This rate will only be confirmed to 23rd Feb, all bookings after this may vary.

Liverpool Marriott® Hotel City Centre

One Queen Square

Liverpool, L1 1RH United Kingdom

Phone: 44 151 476 8000 Fax : 44 151 474 5000



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Appendix B: NMC Review of Pre-Registration Nursing Education

NMC Review of Pre-registration Nursing Education

Bulletin 1 February 2009

Welcome to the first of a series of monthly bulletins providing an update on the NMC Review of pre-registration nursing education. The NMC are very keen to be open and transparent about the Review and inform stakeholders and the public of developments and progress as it becomes available. There will be a great deal of activity over the coming months in order to build on the on the principles agreed by Council in September 2008 and develop new Standards of proficiency for pre-registration nursing education. A monthly bulletin will provide ongoing information on the progress of the review.

This month's bulletin provides details of the background to the Review, an overview of the first phase and an update on the second phase.

Background to the Review

Changes in the UK in relation to demographics, patterns of disease, social influences on health and illness and technological advances are changing the way that healthcare is delivered in the UK. Regulation of nurses and midwives must continue to provide contemporary standards, advice and guidance in the context of UK health care policy and to the issues that affect practice in the 21st century. The NMC is therefore reviewing the current framework for pre-registration education programmes and will make the changes necessary to ensure that programmes continue to provide students with the knowledge, skills and competencies they will require to deliver safe and effective care in the future.

A more detailed overview of the background to the review can be found at **http://www.nmc-uk.org/aArticle.aspx?ArticleID=2526**

The first phase of the Review

The first phase of the Review of pre-registration Nursing Education commenced in April 2007 and closed in September 2008. A literature and policy review was commissioned to provide context entitled *Nursing: towards 2015* (Longley et al 2007). This looked at potential changes in UK health care policy, nursing, and nurse education, it set out potential future scenarios and provided a reference point for the UK wide consultation.

The project workgroup was chaired by the Chair of the NMC Nursing Committee and regular progress reports were provided to the Nursing Committee. Key stakeholders were represented within project and reference groups and contributed to the formulation of consultation questions to explore principles to underpin a new framework for pre registration nursing education. This UK wide independent consultation ran from November 2007 to February 2008.

The consultation

Alpha Research Ltd conducted and reported on the main survey and Focus Group UK ran and reported on the focus groups within the same period. The focus group findings contributed to the main survey report. Both reports are available to download from:
http://www.nmc-uk.org/aArticle.aspx?ArticleID=2641

The consultation focused on principles to shape a future framework for pre-registration nursing education with opportunities to explore more radical approaches, consider how current arrangements could be modernised, or alternatively whether any change was needed.

Nine focus groups, including one group specifically for lay people, explored similar issues. The five key areas around which the NMC consulted asked:

- should the minimum academic level for Pre-registration nursing in the UK be at Diploma in Higher Education level, or at degree level?
- should the concept of the specialist 'branch' remain, and if so which of the existing four branches should be retained?
- should there be a new 'generalist' programme for pre-registration, and if so whether this generalist programme should form a new branch, alongside any new or existing branches?
  should a specific time be set for learning in practice in the community?
  should there be a mandatory consolidation period set by the NMC following initial registration, and if so how long should it be, what should it contain, and whether it should be linked to the first renewal of registration?

There were also detailed questions asked about shared learning, the common foundation programme, common core, arrangements for stepping on and off programmes, common pathways and themes, sub-specialisation, and the meeting of EU requirements associated with 'general care'.

More than 3000 responses were received including key stakeholder organisations, other organisations and individuals, via the survey questionnaire, through letters, and through the UK wide focus groups. There was good representation from across the UK, although overall the individual response was in favour of those in Scotland and Wales, and for the nursing branches, a disproportionate return in favour of the children's, mental health, and learning disability nursing.

Consultation outcomes and the way forward

The consultation findings were not interpreted as being a vote. The views expressed together with feedback from major stakeholders, recent developments in UK health policy, and other inter-related work within the NMC were considered. There appeared to be an appetite for gradual modernisation of pre-registration nursing education rather than for radical change. A series of principles was subsequently developed around which to develop the most appropriate framework. Council agreed these principles on 4 th September 2008. Principles to support a new framework for pre-registration nursing education.
http://www.nmc-uk.org/aArticle.aspx?ArticleID=3396)

Scoping of the second phase of the Review

A scoping exercise took place from September to December 2008 to determine how best to build upon the principles agreed by Council and develop new Standards of proficiency for pre-registration nursing education.

This included work with key stakeholders to analyse the impact of new framework and a fullEquality Impact Assessment - see:
http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=4919

The second phase of the Review

This phase aims to have in place new standards for pre-registration nursing education by the autumn of 2010. This will include the development of:
- an overarching structure for new pre-registration nursing education programmes,
- new generic and field specific competencies.

The planned timeframe for the second phase is outlined in the table below

Policy Development: Development of proposed new standards for pre-registration nursing education	January - December 2009
Consultation a) UK wide consultation b) Final amendments	January - December 2010 January - March 2010 March - September 2010
Publication of new standards	Autumn 2010
Earliest introduction of new programmes	Autumn 2011

Mandatory preceptorship

Preceptorship is about providing support and guidance to newly registered nurses and midwives, enabling them to consolidate their education and develop confidence in their new role and ensuring that they are able to make the transition from student to accountable practitioner.

One of the principles agreed by Council is that a period of mandatory preceptorship should follow initial registration. However, clearly there are a number of implications and challenges which will need to be addressed before this principle can be further developed. For instance, it is currently unclear how this principle could be applied across all the settings in which a newly registered nurse might work including the private, independent and third sector and for those who may chose to practise independently or in a self-employed capacity.

There are also issues around how this principle could apply to those nurses who choose not to or were unable to practise at the point of initial registration and for those who choose to work outside the UK. Furthermore, consideration needs to be given to whether this principle would apply only to graduates of UK pre-registration nursing programmes or could be applied more widely to all new entrants to the NMC register including those newly registering from Europe and overseas. In addition, issues relating to objectives, period required, protected learning time, nature of assessed outcome and potential links to first renewal of registration need to be explored.

For these reasons, the principle of mandatory preceptorship has now been uncoupled from the second phase of the Review and will shortly be subject to a feasibility study. A decision will be made as to how this principle will be progressed once the outcomes of the study are available.

Ways in which people can be involved in the Review

The NMC are very keen to involve as wide a range of stakeholders as possible in the review. Some individuals and groups will be targeted at various stages to provide advice, help develop particular aspects of the new framework or to comment on drafts of documents.

However, there will also be opportunities for all individuals and groups who have an interest in the Review to contribute their views and make comments on progress at key stages. Information on progress and requests for wider stakeholder feedback will be displayed on the website at these key stages.

In addition, in accordance with the Nursing and Midwifery Order, the NMC's primary legislation (http://www.opsi.gov.uk/si/si2002/20020253.htm), a full public consultation will be undertaken providing all interested individuals and groups with an opportunity to see a draft of the new Standards for Pre-registration nursing education and make comments before the document is finalised and published. The full consultation will occur at the beginning of 2010 and will last for a period of three months.

References

Longley, Shaw & Dolan [2007] Nursing: Towards 2015. London, NMC.

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Mitchell, D (2008) A Review of pre-registration nursing education - Report of consultation findings. London, Alpha Research Ltd, prepared for NMC.

Appendix C: Ethics Clearance from the University of Southern Queensland

AUSTRALIA

TOOWOOMBA QUEENSLAND 4350
AUSTRALIA
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OFFICE OF RESEARCH AND HIGHER DEGREES
Gillian Fulton
Postgraduate Students and Research Ethics Officer
PHONE (07) 4631 1438 | FAX (07) 4631 2955
EMAIL fulton@usq.edu.au
GFE010

5 February 2008

Mr. John Hurley
School of Nursing
University of Dundee (Ninewells campus)
Dundee DD19SY
Scotland, UK

Re: Ethics Clearance for Research Project – Exploring mental health nurse experiences at the interface of psychological therapies: Commencing the journey toward emotionally intelligent nurse training.

Dear John

The USQ Human Research Ethics Committee recently reviewed your amended application for ethical clearance. Your project has been endorsed and full ethics approval was granted 05/02/08. Your approval reference number is: **H07STU711** and is valid until **05/02/09**.

The Committee is required to monitor research projects that have received ethics clearance to ensure their conduct is not jeopardising the rights and interests of those who agreed to participate. Accordingly, you are asked to forward a **written report** to this office after twelve months from the date of this approval or upon completion of the project.

A questionnaire will be sent to you requesting details that will include: the status of the project; a statement from you as principal investigator, that the project is in compliance with any special conditions stated as a condition of ethical approval; and confirming the security of the data collected and the conditions governing access to the data. The questionnaire, available on the web, can be forwarded with your written report.

Please note that you are responsible for notifying the Committee immediately of any matter that might affect the continued ethical acceptability of the proposed procedure.

Yours sincerely

Gillian Fulton
Postgraduate Students and Research Ethics Officer
Office of Research and Higher Degrees

Appendix D: Ethics Clearance from the National Health Service

NHS Fife NHS Forth Valley NHS Tayside

Fife, Forth Valley & Tayside Research Ethics Service

Fife & Forth Valley Research Ethics Committee
Research Ethics Office
Level 9
Ninewells Hospital & Medical School
DUNDEE
DD1 9SY

Mr John Hurley
Lecturer
School of Nursing, University of Dundee
Ninewells Hospital & Medical School
DUNDEE
DD1 9SY

Date: 05 March 2008
Your Ref:
Our Ref: FB/RH/**08/S0501/12**
Enquiries to: Miss Fiona Bain
Extension: Ninewells extension 32701
Direct Line: 01382 632701
Email: fionabain@nhs.net

Dear Mr Hurley

Full title of study: **Exploring mental health nurse experiences at the interface of psychological therapies: Commencing the journey toward emotionally intelligent nurse training**
REC reference number: **08/S0501/12**

Thank you for your letter of 20 February 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Sub-Committee of the REC held on 04 March 2008. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application		17 December 2007
Investigator CV		29 November 2007
Protocol	1	29 November 2007
Covering Letter		29 November 2007
Summary/Synopsis	1	29 November 2007
Letter from Sponsor		10 December 2007
Compensation Arrangements		05 September 2007
Compensation Arrangements		24 August 2007
Interview Schedules/Topic Guides	1	29 November 2007