

**Title:****Distinguishing Characteristics of Mental Health Nurses and their Professional  
Self Esteem****Authors**

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**Abstract**

The study outlines the views of mental health nurses in Australia, Ireland and Scotland on what mental health nurses do. The responses from the eight groups were subject to thematic content analysis. Six themes emerged of which, “Cynical perspectives” is the subject of this paper. The theme described mental health nurses as being ‘go-fors’, having a negative effect on service users and being agents of the medical profession. The discussion centres on mental health nurses’ perceptions of their professional image and also their role in relation to their practice. Possible explanations for these perceptions are considered. Potential ways of changing mental health nurses perceptions of their professional image and their role are outlined.

**Key words**

Mental health nursing, psychiatric nursing, Partnership in Coping (PinC), recovery, common humanity, self esteem, role ambiguity

### **What do mental health nurses do?**

Mental health in developed countries has been undergoing major change in terms of the liberalisation of legislation, decentralisation of decision making and adoption of the recovery orientated approach. Like other developed countries such as Australia and the UK Ireland has been going through major changes affecting mental health nursing including mental health law, policy and service delivery. A new Irish Mental Health Act (2001) has recently been introduced. This Act brings Ireland into line with the international human rights standards and offers respect for the rights of the person to dignity, bodily integrity, privacy and autonomy by such means as establishing a automatic independent review of people who have been detained involuntarily in hospital (Government of Ireland 2001). The Vision for Change report which was released in Ireland in 2006 recommended a community based focus with a recovery orientation including greater involvement of service users and their carers (DoHC 2006). Other changes in Ireland have been in mental health nurse education with the introduction of the direct entry degree programme to mental health nursing and the role of the mental health nurse with the creation of the clinical nurse and the advance nurse practitioner roles. Given these new circumstances, mental health nurses are faced with the task of modifying their practice to incorporate these changes. However it is recognised that change does not always come easily. This can be exacerbated when individuals are not clear about their role.

There is a degree of conflict and confusion over the role of the mental health nurse. Some (Mustsatsa, and Rinomhota, 2002, Burnard, 2002, Gournay 1995a, 1995b) feel that mental health nurses should focus on the administration and monitoring of

medications including side effects whilst others (Clarke, 2002 ) believe that nurses need to be cautious about what they are 'buying into' as they may be endorsing a medical view of human behaviour. Barker (1996) reinforces the latter view. He advocates that mental health nurses need to move away from the biological sciences. Morrall (1998), on the other hand, feels that mental health nurses need to cooperate with the medical and social work professions by returning to a position where mental health nursing dominates through enforcing social control.

Practicing mental health nurses themselves have trouble describing their role with some seeing the main aspects of their work involving caring, counselling, advocacy, alleviation of distress and 'being there' for patients whilst others talk more of maintaining control, monitoring and administration of medications (O'Brien and Cole, 2004). This role confusion can affect the way nurses see themselves with this extending into a concern by mental health nurses about how other disciplines perceive them (O'Brien and Cole, 2004).

Lawrence, Wearing and Dodds (1996) describe mental health nurses as looking for recognition of their work amongst their peers and especially in their interactions with other disciplines. Mental health nurses felt that being acknowledged by others assisted them to feel comfortable in their role. Hague et al (2002) concur with this, in their study they highlight the importance of mental health nurses receiving recognition from others for their work as well as experiencing feelings of being valued when working alongside other disciplines. Hague et al (2002) warn of the pitfalls of poor role definition stating that this can mean that nurses will play only a limited function within the multidisciplinary team. How mental health nurses perceive their role especially within their working relationships with other mental health professionals is

therefore an important aspect that influences the mental health nurse's own professional image. With this in mind mental health nurses in this study were asked 'What do mental health nurses do?'

### **Aim**

The aim of this study is to identify the views of a sample of inpatient and community mental health nurses in Australia, Ireland and Scotland on the role of the mental health nurse.

### **Methodology**

This descriptive study was carried out in Scotland, Ireland and Australia with mental health nurses from both inpatient and community settings. Eight groups (three groups of mental health nurses from Scotland, three from Ireland and two in Australia) were used in the study. Each group ranged in number from 8-26 people. Data were collected using focus groups with a facilitator and a scribe. The focus groups were held prior to each of a series of workshops on the development of mental health nursing practice. The data were analysed using thematic content analysis. Validation and reliability were established through the process of seeking feedback from the participants on the appropriateness of the themes/categories developed.

### **Results**

In response to the question 'what do mental health nurses do?' six main themes emerged from the data namely Cynical Perspectives, Mental Health Nursing Practice, Safety and Security, Working with Others, Administration and Health Promotion. This paper examines the theme "Cynical Perspectives" in detail.

### **Cynical Perspective**

Within this theme three sub-categories were identified, namely 'go-fors', negative effects on service users/patients and agents of the medical profession.

#### ***Go-fors***

Many of the responses refer to low status and menial tasks such as fetching and carrying (go for this and go for that). Among these tasks described were:

- Unblock sinks
- Clearing up
- Hanging pictures
- Doing everything that no-one else will do
- Driving the hospital bus
- Making beds
- Answering the phone
- Making the tea
- Filling the gaps
- Writing copious amounts of notes

#### ***Negative effects on service users/patients***

Other more general cynical responses refer to their negative effects on service users or patients such as:

- Invalidator
- Colluding with other professionals
- Disempowering patients

- Burying their heads

### *Agents of medical profession*

The third sub-category referred to mental health nurses acting on behalf of doctors.

- Medicalising people
- Policing the medical model
- Drug pushers
- Fostering the myth of mental illness
- Giving out drugs and stopping fights.

### **Discussion**

In examining the findings the question of why mental health nurses expressed a low opinion of their discipline warrants consideration. One possible answer is that mental health nurses have adopted the dominant value system of professionals in the mental health service. This value system and relating practices emphasise a common understanding and acceptance of a particular model, namely the traditional medical model (Shanley 2001). This model values having a professional relationship with patients/clients which involves maintaining an appropriate distance from patients, and the use of a 'scientific' approach. For example, the medical interview is a 'constrained, pre-structured form of talk' (Freund and McGuire 1991, p233) with the verbal exchanges being initiated and controlled by the doctor. The conversation centres on eliciting from the patient information relevant to the doctor's scientific perspective. Only a relatively small number of questions are asked by the patient (West 1983). In this way a professional distance is established and a 'scientific' approach applied.

Within the study there was no mention by participants of a structured or systematic approach to mental health nursing. This does not seem to be a new problem to mental health nursing, with Edwards (2000) highlighting a review of the role of the mental health nurse in the late 1960's in which the literature suggest that mental health nursing had no real identity and was considered a 'Jack of all trades' profession. The closest participants came to identifying a single encompassing term for what mental health nurses did was 'eclectic'.

Cody (1996) describes eclecticism in nursing as borrowing from other disciplines while dedicating less time and energy to nourishing and growing the knowledge base of nursing. He goes on to say;

*'nurses continue in the traditional role of Jack- or Jill- of-all trades and master of none. The lion's share of what nurses who work in non-nursing theories know and do is known in greater depth and done better by members of other disciplines...'* (Cody 1996, p87)

Unfortunately in using an 'eclectic' approach mental health nurses do not have to adhere to any philosophy, method or programme in dealing with service users nor are their practices exposed to examination or justification within a framework just as other disciplines are. While one mental health nurse may describe his/her 'eclectic' approach in anxiety management as mixing aspects of cognitive behaviour therapy, and gestalt therapy, another, in dealing with the same issue, may describe his/her approach as using a concoction of psychoanalytic, Rogerian and brief solution therapy. Therefore the 'eclectic' approach gives the clinician a license to mix and match, exploit, misuse and mishandle care approaches that were never meant to be

reinterpreted and used in such a fashion. Indeed, Cody (1996) calls this the 'black bag' approach where practising nurses have gathered a selection of theories from different disciplines to use as they see fit and depending on the circumstances of their situation at the time. Cody (1996) goes on to say that to continue to have this 'black bag' of parts of theories at hand is to have an in-depth knowledge of none. Mixing and matching parts of theories that are incompatible is considered by Cody (1996) to be intellectually and ethically indefensible. The 'eclectic' approach then has the potential to create issues around problems of hidden assumptions, danger of inconsistency and accountability of practice, spontaneous decision making and difficulty in communicating with colleagues about the therapy being undertaken. This has a knock on effect leading not only to difficulty in building a common skills based practice for mental health nurses but may also be a threat to the service users wellbeing as well as the nurses professional integrity.

Mental health nurses have found it hard working with competing philosophies of care and without theoretical frameworks for practice (O'Brien and Cole, 2004). Without a common philosophy and framework on which to base their own practice mental health nurses have adopted the dominant value system and processes prevalent in mental health. The lack of clear role definition (Haque, 2002), the absence of a professional distance from service users (Forster, Morrissey and Wilbourn 2001) and the use of an 'eclectic' rather than a 'scientific' approach has resulted in the mental health nursing discipline being judged negatively against the criteria that is applied to psychiatrists and psychologists.

How then can mental health nurses deal with their professional self image? Three major ways of coping with being seen as a member of a low status group are, firstly, to accept the prevailing value system and see one's group as we think others see us that is, in the case of mental health nurses, as go-fors and secondly, to distance themselves from the image of the group (Hamburger 1994). In the case of mental health nurses, individuals may become nurse therapists, nurse counsellors or behaviour therapists. This move will allow them to gain status by distancing themselves from the image of mainstream mental health nursing which has been seen by other disciplines as an applied science only with no unique nursing knowledge of its own (Cody, 1996).

A third way of mental health nurses dealing with a negative professional self image is to change one's views of mental health nursing and identify what is good about mental health nursing rather than bad, e.g. adopt something similar to the 'black is beautiful' slogan (Argyle 1992) used by another devalued group. Another example of a group that rejected the view of the dominant group is seen in South Africa. Here white South Africans saw Hindu as inferior while South African Hindus identified their own strengths as superior to Caucasians in spiritual, social and practical matters (Mann 1963).

This process of identifying what is good about mental health nursing rather than bad involves rejecting the value system of the dominant groups namely doctors and psychologists who value the more 'scientific' approach to mental health, e.g. drug therapy, cognitive behaviour therapy and the maintenance of a professional distance with patients/service users. Instead it involves a greater focussing on the unique strengths of mental health nurses.

Do mental health nurses have any characteristics that can be considered good?

The following characteristics of mental health nurses are seen by the authors as distinguishing strengths of the discipline (Shanley and Jubb-Shanley, 2007):

### ***Unscripted dialogue***

Mental health nurses possess skills to deal with unpredictable behaviour and situations. They encounter ambiguous situations that may be threatening and deal with them. Other mental health professionals have more scripted encounters with service users. They meet in controlled settings, with agreed appointment times and durations and the encounter between the expert and the service user is more predictable and secure. Few mental health nurses do sessional work and normally work using unscripted dialogues.

### ***Use of every-day speech***

Service users value talking to mental health nurses in that they use the same language (Rogers and Pilgrim, 1994). This minimises the inequality in the power relationship, improves communication and helps develop a therapeutic relationship. Mental health nurses are less likely to categorise what service users say they are experiencing and so there is less chance of the service user feeling excluded or misunderstood. The ability of the nurse to appear ordinary and approachable with a sense of fair play and humanity promotes affinity between service users and clinicians (Walsh 1999). Sitting down and having a cup of tea with a service user is highly valued and represents an act of ordinary humanness and civility (Jackson & Stevenson 2000)

### ***Variable contexts and times***

Compared to other professionals nurses see service users in all sorts of situations and at all sorts of times. The nurses' role brings them into contact with the service users' family, their friends, relationships with neighbours and their social and financial situations. Mental health nurses have impromptu encounters with service users, planned and unplanned. In the community setting they may meet in the person's house, in cafes or other public places. And they may meet at different times with meetings varying in length depending on immediate issues. Mental health nurses have the opportunity to obtain insight into the service users' environment.

### ***Self-Disclosure***

The promotion of clinician self-disclosure can be derived from the work of Carl Rogers, in particular the quality he labelled as 'congruence' or 'genuineness'. Rogers saw this as the degree to which a clinician is self insightful and the extent to which the clinician acts towards the service user without the use of a disguise or smokescreen (Rogers, 1961). Several authors in discussing self-disclosure highlight the importance of the clinician showing genuineness (Reid, 1977, Shadley, 2000).

According to Hill (2004) clinician self-disclosure reveals something that the clinician has learned about himself/herself and these disclosures are designed to facilitate the service user's understanding of their own thoughts, feelings, behaviours and issues. Hill (2004) advocates this use of self rather than the use of challenges or interpretations to stimulate insight for the service user. Indeed in Shadley's (2000) work it is indicated that therapists felt that their own personal characteristics, such as, genuineness were a vital part of their professional way of relating to others. Burkard et al (2006) reports that clinicians use self disclosure to enhance their therapeutic

relationship and that this has a positive effect on the therapy by helping the service user to feel understood and be able to then focus on the issues at hand. Because of the nature of their relationship with service users mentioned above mental health nurses are in a position to engage in the process of self disclosing provided of course the disclosures are part of the therapeutic process and not for the benefit of the nurse.

### *Holistic perspective*

Given the nature of encounters with service users, mental health nurses take the widest perspective on the service user's experiences. Other mental health professionals have a much narrower gaze or perspective and encounter service users in more restricted settings. Of all the professionals, mental health nurses spend the most time with service users and as such are often privy or witness to the circumstances in which individuals live thus facilitating a holistic perspective on the person's life. These circumstances can range from whether individuals have hot and cold running water in their house, what foods they buy, what pets they have, their relationship with their family, next door neighbours, their hopes, dreams, ambitions and plans for the future. It is this level of intimate contact with another person that promotes a greater sense of common humanity in which there is an increased recognition and acceptance that others share the human condition in having vulnerabilities, needs and frailties. Part of the sense of common humanity is the ability to be empathetic towards the individual. According to Olsen (1991, p 74) 'empathy occurs when one person experiences a commonality with another'. He goes on to say that all experiences of empathy are based on common humanity, that is, the acknowledgement of another being like oneself and therefore equal to self and this is at the most fundamental human level.

Comment [H1]:

### **An Organised Approach**

One system of mental health nursing that has identified and uses the unique strengths that distinguish mental health nursing from the other mental health professionals is the Partnership in Coping (PinC) system of recovery (Jubb-Shanley and Shanley 2007). This system was developed from the principles of the recovery oriented approach (Anthony, 1993)

The PinC system of recovery is based on the view that the mental health nurses' role centres around having a strong sense that the establishment and maintenance of a therapeutic relationship along with the value of an ordinary interaction is a key element in their day to day work (Shanley, Jubb and Latter 2003). The importance of the therapeutic relationship and also an 'ordinary' interaction has been recognised in the writings of many individuals (Wortans, Happell and Johnstone, 2006, Adam, Tilley and Pollock, 2003, Rogers and Pilgrim, 1994, Hill and Michael, 1996, Barker, 1996, Jackson and Stevenson, 2000). Hill and Michael (1996) extended this further when they give the example of the mental health nurse being more willing than other groups of mental health professionals to do ordinary things for service users such as, purchasing and delivering coal to the service user.

This issue of ordinariness has been substantiated by service users (O'Brien and Cole, 2004, Johansson and Eklund, 2003, Wortans, Happell and Johnstone, 2006, Adam, Tilley and Pollock, 2003, Rogers and Pilgrim, 1994) who describe mental health nurses as being non judgemental, caring, having a sense of humour, comforting, understanding, being sincere, good listener, respectful, using ordinary language and empathetic. Rogers and Pilgrim (1994) survey results indicated that service users felt that nurses, compared to other mental health professionals, were considered to be the

most helpful and that the nursing care they regarded the most highly involved listening and ordinary relating.

### **Conclusion**

How can we maximise the strengths of mental health nurses? The use of unscripted dialogue, everyday speech, variable contexts and time, self-disclosure and a holistic perspective gives mental health nurses the ability to begin to see the service users as sharing a common humanity. The existence of a sense of common humanity assists mental health nurses to develop what is essentially the central component of the nurses' role namely the creation of a close therapeutic relationship. On its own the presence of this relationship can have therapeutic effects for the service user (Howgego et al 2003). However, the authors believe that if the named strengths/distinguishing characteristics of mental health nurses were explicitly embedded in the work that nurses do with service users then outcomes for service users would be further enhanced.

Currently the strengths of mental health nurses are not taken advantage of because they are working under the direction of a value system and processes that have a different focus. If mental health nurses were to use a system such as the PinC system of recovery which overtly encourages the use of the distinguishing characteristics of the discipline then mental health nurses have the potential to further enhance the work they do with service users. In addition to this benefit, the use of the PinC system of recovery is likely to give greater recognition to mental health nurses and identify more succinctly their contribution within the multi-disciplinary team by reducing their role ambiguity. Consequently the use of this system will, more clearly, defining their

role in their own eyes and those of their colleagues from other disciplines. As indicated by nurses who participated in the study carried out by Jubb-Shanley and Shanley (in press) '*the PinC system gives a structure to my own practice*', is '*empowering for nurses as well as service users. (It) validates what you do with service users*'. '*This system shows others that what we are doing is serious*'.

A clearly defined role for mental health nurses will lead to the enhancement of their professional self esteem and the likely reduction in outpouring of cynical comments about their role as evidenced in this study.

### References

- Adam, R., Tilley, S. and Pollock, L. (2003). Person first: what people with enduring mental disorders value about community psychiatric nurses and CPN services. *Journal of Psychiatric and Mental Health Nursing*, 10. 203-212. (6)
- Anthony, W.A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16(4), 11-22.
- Argyle, M. (1992). *The social psychology of everyday life*. London: Routledge
- Barker, P.J. (1996) Chaos and the way of Zen: psychiatric nursing and the 'uncertainty principle'. *Journal of Psychiatric and Mental Health Nursing*, 3, 235-243.
- Burkard, A.W., Knox, S., Groen, M., Perez, M. and Hess, S. (2006). European American Therapist Self-Disclosure in Cross Cultural Counselling. *Journal of Counselling Psychology*, 53(1), 15-25.
- Burnard, P. (2002). Not waving but drowning: a personal response to Barker and Grant. *Journal of Psychiatric and Mental Health Nursing*, 9, 221-237.(11)
- Clarke, L. (2002). Doubts and certainties in the nursing profession: a commentary. *Journal of Psychiatric and Mental Health Nursing*, 9, 221-237(9)
- Cody, W. L. (1996). Drowning in eclecticism. *Nursing Science Quarterly*. 9(3) 86-88.
- Department of Health and Children (2006). *A vision for change: report of the expert group on mental health policy*. Dublin. Stationery Office.

Edwards, K. (2000). Service users and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 7, 555-565.

Forster, S, Morrissey, M. and Wilbourn, M (2001) The nurse as clinician. In *The role of the mental health nurse*, ed S Forster, 182-206. Cheltenham: Nelson Thornes.

Freund, P. E. S. and McGuire, M. B. (1991). *Health, Illness and the Social Body: a critical sociology*. New Jersey: Prentice Hall.

Government of Ireland (2001). *Mental Health Act*. Dublin. Stationery Office.

Gournay, K. (1995a). New facts on schizophrenia. *Nursing Times*, 91(25), 32-33.

Gournay, K. (1995b). What to do with nursing models. *Journal of Psychiatric & Mental Health Nursing*, 2(5), 325-327.

Hague, M.S., Nolan, P., Dyke, R. and Khan, I (2002). The work and values of mental health nurses observed. *Journal of Psychiatric and Mental Health Nursing*, 9(6), 673-680. (12)

Hamburger, Y. (1994). The contact hypothesis reconsidered: effects of the atypical out-group member on the out-group stereotype. *Basic and Applied Social Psychology*, 15, 339-358.

Hannigan, B., Burnard, D., Edwards, J. and Turnball, J. (2001) Specialist practice for UK community mental health nurses: the 1998-99 survey of course leaders. *International Journal of Nursing Studies*, 38, 427-435.

Hill, C.E. (2004). *Helping skills: facilitating exploration, insight, and action* (2<sup>nd</sup> ed). Washington: American Psychological Association.

Hill, B. and Michael, S. (1996) The human factor, *Journal of Psychiatry and Mental Health Nursing*, 3, 245-248.

Howgego, I. M., Yellowlees, P., Owen, C., Maldrum, L. and Dark, F. (2003). The therapeutic alliance: the key to effective patient outcomes: a descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry*, 37, 169-183.

Jackson, S. and Stevenson, C (2000). What do people need psychiatric and mental health nurses for? *Journal of Advanced Nursing*, 31(2), 378-388.

Johansson, H. & Eklund, M. (2003). Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal of Caring Sciences*, 17, 339-346.

Jubb-Shanley, M and Shanley, E (2007) Trialling of the Partnership in Coping (PinC) system. *Journal of Psychiatric and Mental Health Nursing*, 14, 226-232.

Lawrence, J.A., Wearing, A.J., & Dodds, A.E. (1996). Nurses' representations of the positive and negative features of nursing. *Journal of Advanced Nursing*, 25, 375-384.

- Mann, J. W. (1963). Rivals of different rank. *Journal of Social Psychology*, **61**, 11–28.
- Morrall, P. (1998) *Mental Health Nursing Social Control*. London: Whurr.
- Mutsatsa, S & Rinomhota, S. (2002). Nursing and extrapyramidal symptoms: a response to Clarke. *Journal of Psychiatric and Mental Health Nursing*, **9**, 221-237.(8)
- O'Brien, L. & Cole, R. (2004). Mental health nursing practice in acute psychiatric close-observation areas. *International Journal of Mental Health Nursing*, **13**(2), 89-99.
- Olsen, D.P. (1991). Empathy as an ethical and philosophical basis for nursing. *Advances in Nursing Science*, **14**(1), 62-75.
- Reid, K.E. (1977). Worker authenticity in group work. *Clinical Social Work Journal*, **5**(1), 3-16.
- Rogers, A. & Pilgrim, D. (1994). Service users' views of psychiatric nurses. *British Journal of Nursing*, **3** (1), 16-18.
- Rogers, C.R. (1961). *On becoming a person*. Boston: Houghton Mifflin.
- Shadley, M.L. (2000) Are all therapists alike? Revisiting research about the use of self in therapy. In *The use of self in therapy (2<sup>nd</sup> ed.)* ed M. Baldwin, 191-211. New York: Haworth Press Inc.
- Shanley, E. and Jubb-Shanley, M (2007). The recovery alliance theory of mental health nursing. *Journal of Psychiatric and Mental Health Nursing*. **14**, 734–743
- Shanley, E. (2001). Common experiences of mental health nurses and consumers: Ingredients of a symbiotic relationship? *Australian and New Zealand Journal of Mental Health Nursing*, **10**(4), 243-251.
- Shanley, E., Jubb, M. and Latter, P. (2003). Partnership in Coping: an Australian system of mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, **10**, 431-441.
- Walsh, K. (1999). Shared humanity and the psychiatric nurse-patient encounter. *Australian and New Zealand Journal of Mental Health Nursing*, **8**, 2-8.
- West, C. (1983). "“Ask me no questions...” an analysis of queries and replies in physician-patient dialogue' In *The social organisation of doctor-patient communication*, eds S. Fischer and A. Todd. New Jersey: Ablex.
- Wortans, J., Happell, B. & Johnstone, H. (2006). The role of the nurse practitioner in psychiatric/mental health nursing: exploring consumer satisfaction. *Journal of Psychiatric and Mental Health Nursing*, **13**(4), 78-84.